Case Study/Possible Diagnoses

Name: 
Date: 
Class: 

First Diagnosis: 

Typical Age of Onset of Disease/Disorder: 

How is it diagnosed? 

Symptoms 

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Prognosis 

__________________________________________________________________________

__________________________________________________________________________

Treatment 

__________________________________________________________________________

__________________________________________________________________________

Second Diagnosis: 

Typical Age of Onset of Disease/Disorder: 

How is it diagnosed? 

__________________________________________________________________________
Prognosis

Treatment

Third Diagnosis: ________________________________

Typical Age of Onset of Disease/Disorder: ________________________________

How is it diagnosed? ________________________________

Symptoms

Prognosis

Treatment

The case studies below describe illnesses that have developed in two siblings, a male and a female, both of which have similar symptoms that have arisen differently. Your job is to gather the research necessary to determine the possible diagnosis for each of the individuals. You may use the internet and any additional sources necessary to collect information that would be useful in completing this project. You may or may not conclude that the diagnoses are the same. Provide a written report detailing your conclusions as to whether or not Patient A and B suffer from the same illness, what that illness is, and what the prognosis/treatment is for the determined illness(es).

Patient A

Patient A is a thirty-eight year old female who has noticed a progressive worsening in the control of her swing on the golf course over the past two years. Her movements tend to be uncoordinated; in high school she was an avid golfer and won athletic awards for her outstanding achievements. Over recent weeks, she has decided to give up the game completely out of frustration over her declining performance.

Patient A complains of forgetfulness, from where she parked her car to forgetting to pick up her kids at school. Lately, she has found herself more tired than usual, lacking the energy she used to exude. To regain her lost momentum, Patient A has been adding an afternoon nap to her daily routine.

Patient A has no history of mental illness and has never taken medication for a neurological disorder. She is currently taking birth control pills and Zomig, a medication used to treat migraines and their accompanying symptoms (nausea, blurred vision...). She has been taking Zomig for five months.
Patient A - Female

Palo Alto Medical Foundation
A Sutter Health Affiliate

Adult Medical History Form
PLEAS Eric COMPLETE ALL 3 PAGES

Your answers on this form will help your provider understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates. Thank you!

AGE: 38  How would you rate your general health?  □ Excellent  □ Good  □ Fair  □ Poor

PRESENT HEALTH CONCERNS:  forgotten, often, lack of muscle central in arms/legs, lack of coordination

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

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<thead>
<tr>
<th>Medication</th>
<th>Dose (e.g., mg/pill)</th>
<th>How many times per day</th>
<th>When started</th>
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</thead>
<tbody>
<tr>
<td>Zonig</td>
<td>1 pill</td>
<td>when needed</td>
<td>5 mos. ago</td>
</tr>
</tbody>
</table>

ALLERGIES or REACTIONS TO MEDICINES: penicillin allergy

When were your most recent IMMUNIZATIONS:

Hepatitis A  □  Hepatitis B  □  Influenza (Flu Shot)  □  Measles  □  Pneumovax (Pneumonia)  □
Rubella  □  Tetanus (Td)  □  Varicella (chicken pox) shot  □  or  □ Illness

When were your most recent HEALTH MAINTENANCE screening tests:

Lipid (Cholesterol Screening) □ Results? normal □ PSA (Prostate cancer screen) □ Results? normal
Mammogram □ Results? normal □ Stool test for blood □ Results?
Ever abnormal? no  □ Details: normal
Pap Smear □ Results? normal □ Sigmoidoscopy? □ Results?
Ever abnormal? no  □ Details: normal

PERSONAL MEDICAL HISTORY:
Please indicate whether you have had any of the following medical problems (with dates):

- □ Heart disease:  □ Bleeding/clotting problem: (266.9)
  specify type: □ Blood transfusion: (V58.2)
  □ Heart attack: (412)
  □ High blood pressure: (401.9)
  □ Diabetes: (Endo, 250.00)
  □ High cholesterol: (272.4)
  □ Thyroid problem: (246.9)
  specify type:
  □ Alcoholism: (Sub, 303.90)
  □ Cancer: (Malignancy)  □ Other problems (specify):
  specify type
  □ Stroke
  □ Depression/suicide attempt: (311)

SURGICAL HISTORY:
Please list all prior operations (with dates): Shoulder surgery to repair torn rotator cuff - 10 years ago
SOCIAL HISTORY
Substance & Sexuality
Tobacco Use
Cigarettes: Never □ Quit Date _______ # of yrs _______
□ Current: Smoker: packs/day _______
Other Tobacco: □ Pipe  □ Cigar  □ Snuff  □ Chew
Are you interested in quitting? □ No  □ Yes
Alcohol Use
Do you drink alcohol? □ No  □ Yes: # drinks/week _______
Is alcohol use a concern for you or others? □ No  □ Yes
Drug Use
Do you use any recreational drugs? □ No  □ Yes
Have you ever used needles? □ No  □ Yes
Sexual Activity
Sexually Active: □ Yes  □ No  □ Not currently
Current sex partner(s) is/are: □ male  □ female
Birth control method: Ortho Novum □ None needed
Have you ever had any sexually transmitted diseases (STDs)? □ No  □ Yes
Are you interested in being screened for sexually transmitted diseases? □ No  □ Yes

Socioeconomics
Occupation: Homemaker  □ Employer  □ N/A
Years of Education/Highest Degree □ Some Coll  □ Marital Status: □ S □ M □ D □ W □ Other: _______
Spouse/Partner’s name: □ Husband □ Children
Who lives at home with you? □ Husband □ Children

SPECIALTY HISTORY: For women: # pregnancies: □ # deliveries: □ # abortions: □ # miscarriages: □
1st day, most recent period: □ Today □ Age at 1st period: □ 14 Frequency of periods: □ 1/28 days □ length of each: □ 5 days
Do you have any concerns about your periods? □ No  □ Yes: _______
Do you have any concerns about menopause? □ No  □ Yes: _______

REVIEW OF SYMPTOMS: Please check (✓) any current problems you have on the list below:

Constitutional
□ Fears/chills/sweats
□ Unexplained weight loss/gain
□ Change in energy/weakness
□ Excessive thirst or urination

Eyes
□ Change in vision

Ears/Nose/Throat/Mouth
□ Difficult hearing/ringing in ears
□ Problems with teeth/gums
□ Hay fever/allergies

Cardiovascular
□ Chest pain/discomfort
□ Palpitations

Chest (breast)
□ Breast lump/nipple discharge

Respiratory
□ Cough/wheeze
□ Difficulty breathing

Gastrointestinal
□ Abdominal pain
□ Blood in bowel movement
□ Nausea/vomiting/diarrhea

Genitourinary
□ Migraines

Nighttime urination
□ Leaking urine
□ Unusual vaginal bleeding
□ Discharge: penis or vagina

Musculo-skeletal
□ Muscle/joint pain

Skin
□ Rash/ mole change

Neurological
□ Migraines

Headaches
□ Dizziness/light-headedness
□ Numbness
□ Memory loss
□ Loss of coordination

Psychiatric
□ Anxiety/stress
□ Problems with sleep
□ Depression

Blood/Lymphatic
□ Unexplained lumps
□ Easy bruising/bleeding

Other
□ Problems with sexual function
FAMILY HISTORY:

Please indicate the current status of your immediate family members:

<table>
<thead>
<tr>
<th></th>
<th>Alive</th>
<th>Deceased</th>
<th>Age (now or at death)</th>
<th>Comments/Cause of death</th>
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<td>Mother:</td>
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<td>Sister(s):</td>
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<td>Daughter(s):</td>
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<td>Sons(s):</td>
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Please indicate with a check (✓) family members who have have had any of the following conditions:

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<td>Tuberculosis</td>
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<td>Other: Lung Cancer</td>
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<td>Other: Huntington's</td>
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Patient B

Patient B is a thirty-two year old male whose wife began noticing severe mood swings and personality changes over the past year. He has become extremely withdrawn from friends and family in the past six months. His friends have acknowledged a lack of interest, on his part, in social events. Concerned about these behavioral changes, Patient B's wife encouraged him to see a doctor. He agreed, and Patient B was just recently evaluated and diagnosed with a depressive disorder.

Patient B has had increasing feelings of loneliness and helplessness which he finds reprieve from when running. He has recently given up this passion, as he has begun to find it difficult to maintain his balance and coordination. Patient B seems to have progressively lost the energy he was formerly so full of. He finds it harder and harder to complete the same tasks in a day that he used to complete with ease.

Patient B is not currently taking any medications and had no prior history of depression or mental illness.
Adult Medical History Form

PLEASE COMPLETE ALL 3 PAGES

Your answers on this form will help your provider understand your medical concerns and conditions better. This form will NOT be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific dates. Thank you!

AGE: 32

How would you rate your general health? □ Excellent X Good □ Fair □ Poor

PRESENT HEALTH CONCERNS: Balance + coordination problems when running, depression

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose (eg, mg/pill)</th>
<th>How many times per day</th>
<th>When started</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. John's Wort</td>
<td>1 pill</td>
<td>2x</td>
<td>2 mos. ago</td>
</tr>
</tbody>
</table>

ALLERGIES or REACTIONS TO MEDICINES: none

When were your most recent IMMUNIZATIONS:

- Hepatitis A
- Hepatitis B
- Influenza (Flu Shot)
- Measles
- Pneumovax (Pneumonia)
- Rubella
- Tetanus (Td)
- Varicella (chicken pox) shot

or Illness

When were your most recent HEALTH MAINTENANCE screening tests:

- Lipid (Cholesterol Screening) Results? Normal
- PSA (Prostate cancer screen) Results? Normal
- Mammogram Results?
- Ever abnormal? Details:
- Stool test for blood Results?
- Pap Smear Results?
- Sigmoidoscopy? Results?

PERSONAL MEDICAL HISTORY:

Please indicate whether you have had any of the following medical problems (with dates):

- Heart disease:
  □ specify type
- Heart attack (412)
- High blood pressure (401.9)
- Diabetes (Endo, 250.00)
- High cholesterol (Endo, 272.4)
- Thyroid problem (246.9)
- Bleeding/clotting problem (286.9)
- Blood transfusion (V58.2)
- Cancer (Malignancy)
- Stroke
- Alcoholism (Sub, 303.90)
- Other problems (specify):
  □ specify type
  □ specify type

SURGICAL HISTORY:

Please list all prior operations (with dates): none
SOCIAL HISTORY
Substance & Sexuality
Tobacco Use
Cigarettes □ Never □ Quit: Date 20 yrs. ago □ Current: Smoker: packs/day ____ # of yrs __________
Other Tobacco: □ Pipe □ Cigar □ Snuff □ Chew
Are you interested in quitting? □ No □ Yes
Alcohol Use
Do you drink alcohol? □ No □ Yes: drinks/week 1+ Is alcohol use a concern for you or others? □ No □ Yes
Drug Use
Do you use any recreational drugs? □ No □ Yes Have you ever used needles? □ No □ Yes
Sexual Activity
Sexually Active: □ Yes □ No □ Not currently Current sex partner(s) is/are: □ male □ female
Birth control method: □ None needed
Have you ever had any sexually transmitted diseases (STDs)? □ No □ Yes Are you interested in being screened for sexually transmitted diseases? □ No □ Yes
Socioeconomics
Occupation: Stock broker Employer A.G. Edwards
Years of Education/Highest Degree MBA Marital Status: □ S □ M □ D □ W □ Other: __________
Spouse/Partner's name: Debra Number of children/ages: ________
Who lives at home with you? ________ wife

SPECIALTY HISTORY:
For woman: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: ____
1st day, most recent period: ________ Age at 1st period: ________ Frequency of periods: ________ Length of each: ________
Do you have any concerns about your periods? □ No □ Yes: __________________________
Do you have any concerns about menopause? □ No □ Yes: __________________________

REVIEW OF SYMPTOMS:
Please check (✓) any current problems you have on the list below:
Constitutional
□ Fever/chills/sweats □ Unexplained weight loss/gain
□ Change in energy/weakness □ Excessive thirst or urination
Eyes
□ Change in vision
Ears/Nose/Throat/Mouth
□ Difficulty hearing/ringing in ears □ Problems with teeth/gums
□ Hay fever/allergies
Cardiovascular
□ Chest pain/discomfort □ Palpitations
Chest (breast)
□ Breast lump/nipple discharge
Respiratory
□ Cough/wheeze □ Difficulty breathing
Gastrointestinal
□ Abdominal pain □ Blood in bowel movement
□ Nausea/vomiting/diarrhea
Genitourinary
□ Nighttime urination □ Leaking urine
□ Unusual vaginal bleeding □ Discharge: penis or vagina
Musculo-skeletal
□ Muscle/joint pain
Skin
□ Rash/mole change
Other
□ Problems with sexual function

Other Concerns
CAFFEINE Intake: □ None □ Coffee/tea: ______ cups/day
□ Sodas: ____ /day □ Chocolate: ____ oz/day
WEIGHT: Are you satisfied with your weight? □ No □ Yes
DIET: How do you rate your diet? □ Good □ Fair □ Poor
Do you take SUPPLEMENTS? □ multi-vit ______
Do you drink 4 lg. glasses of milk daily or take CALCIUM supplements? □ No □ Yes
EXERCISE: Do you exercise regularly? □ No □ Yes
What kind of exercise? jogging/running
How long (minutes) 120+ How often? 5 x week
If you do not exercise, why? __________________________
BIKE HELMET: Do you use a bike helmet? □ No □ Yes
SEAT BELT: Do you use seatbelts consistently? □ No □ Yes
Is VIOLENCE at home a concern for you? □ No □ Yes
Have you ever been ABUSED? □ No □ Yes
Do you have a GUN in your home? □ No □ Yes
FAMILY HISTORY:

Please indicate the current status of your immediate family members:

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<th>Alive</th>
<th>Deceased</th>
<th>Age (now or at death)</th>
<th>Comments/Cause of death</th>
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<td>Mother:</td>
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<td>Father:</td>
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<td>Sister(s):</td>
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<td>Daughter(s):</td>
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<td>Sons(s):</td>
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Please indicate with a check (✓) family members who have had any of the following conditions:

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<th>Medical Condition</th>
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<th>Dad</th>
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