

Perfecting the Oral Presentation

Sample Case #2

Underline or highlight the phrases that you would want a third year medical student to present during an oral case presentation on Rounds

CC: The patient is a 12 month old male who presents with vomiting and diarrhea

HPI: This is a 12 month old previously well male who began to have vomiting 2 days ago. Yesterday, he also began to have loose, green, watery diarrhea. He has not had bloody or bilious vomiting and no blood in his stools. His temperature this morning was 101.2 F and this was treated with alternating Tylenol and Motrin. He did spit up the Motrin on one occasion. He has not been eating well and today has not been able to hold any liquids down. He has no wheezing or difficulty breathing and has no history of asthma. His mother brought him to the E.R. this morning, and the EDP recommended admission.

There are sick contacts at daycare with similar illnesses. He has made only 2 wet diapers in the past 24 hours.

PMH: No hospitalizations, no surgeries, no injuries.

Medicines: Tylenol & Motrin

Allergies: NKDA

Birth history: Full term, Mom rubella immune, HepB negative, GBS positive, HIV negative C-section without complications and baby went to normal newborn nursery. Mom A+. Mom and baby went home together after 3 days.

Family history: Asthma in mom and maternal aunt. No diabetes, heart disease, mental illness, cancer in the family

Social history: Lives with his mother, father in Greensboro. No one smokes at home. City water. In daycare 4 days/week.

Developmental history: Sat up at 5 months, cruised at 10 months, no words yet but babbles, understands 1-step commands. Not toilet trained. Mom has no concerns about his development or about his hearing or vision.

Diet history: Eats table foods, vegetables, fruits. Three 8-oz bottles of Enfamil lipil per day, one 6-oz bottle of juice.

Primary Care Provider: Bright Futures Pediatrics, Dr. Jones.

ROS:

Skin: No rashes, no hives

Head: No head injury, no headache, no dizziness

Eyes: No conjunctivitis

Nose: No nose bleeds, no snoring, no mouth breathing

Ears: No hearing difficulty, no earaches

Mouth and Throat: No difficulty swallowing, no teeth problems, no hoarseness

Neck: No pain or stiffness

Chest: No wheezing, no cough, no difficulty breathing

Heart: No palpitations, no sweating

Gastrointestinal: No bloody stools

Genitourinary: No pain on voiding, no weak urinary stream

Neuromuscular: no convulsion, no coordination problem, no weakness, no spasticity

Behavioral History: No unusual behavior

Physical Exam:

Vitals: T 100.1, HR 135, BP 86/70, RR 30, Pox 99% on RA, Wt 27# (90 %tile),
Ht 31 in (75 %tile), HC 18.5 in (75 %tile)

General: Sitting up in mom's lap, crying but consolable

HEENT: NC/AT, pupils equal & reactive, conjunctiva clear, eyes nonsunken,
crying but no tears, nares clear. oropharynx clear without lesions, MM dry,
normal cry

Neck: Supple, no lymphadenopathy

Chest: CTA bilaterally

Heart: RRR no murmurs. Cap refill <2 sec

Abdomen: Soft, nontender, nondistended, hyperactive bowel sounds, no
hepatosplenomegaly

Genitalia: Testis down bilaterally, tanner 1 male

Extremities: No clubbing or cyanosis

Skin: No rashes, delayed skin turgor

Neurological: reflexes 2+ throughout, moves all extremities

Labs:

CBC: wbc7.8, Hb 12.1, platelets 312, 70% neutrophils, 26% lymphocytes

Chem7: Na 136, K 3.8, Cl 102, Bicarb 14, BUN 34, Cr 0.4, Glucose 108