

Date: \_\_\_\_\_

### Standardized Patient Information Form

*The following requested information is to help us better assign standardized patients to cases/activities. All information provided on this form is confidential and will remain secured in SP Program files. This information will only be used by the program's administrative office and will not be shared.*

Name: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Method of Contact: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_ Languages You Speak: \_\_\_\_\_

Highest Level of Education: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Not Employed/Retired  
 FT Student  PT Student

Occupation If Employed: \_\_\_\_\_

\*\*\*\*\* **Please provide the following information when submitting for child 18y or younger** \*\*\*\*\*

Parent/Guardian: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Preferred Method of Contact (in case of emergency): \_\_\_\_\_

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Please list all medical conditions, scars, or tattoos that you have which may be noticed or discovered during a physical exam. Example: Scar from removed appendix, back problems, knee replacement....

Do you have any of the following?

Marks	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes please describe type, size, and location
Scars	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birthmarks	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tattoos	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you had any of the following?

Serious Illnesses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe
Hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgeries	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever been told that you have ...?

- Abnormal Lung Sounds  Yes  No
- Abnormal Heart Sounds  Yes  No
  - Gallop Rhythm
  - Heart Murmur
  - Clicks
  - Rubs
- Nerve Damage  Yes  No
- Knee or Other Joint Damage  Yes  No
- Muscle Weakness  Yes  No
- Abnormal Thyroid  Yes  No
  - Hyperthyroid
  - Hypothyroid
- Diabetes  Yes  No
  - Type 1
  - Type 2
  - Blood Sugar
  - Insulin

- High Blood Pressure  Yes  No
- Back Problems  Yes  No
- Abnormal Retina in Eye  Yes  No
  - Harmonious
  - Unharmonious
  - Paradoxical
- Abnormal Blood Vessels  Yes  No
- Osteoporosis  Yes  No
- Arthritis  Yes  No
  - Osteoarthritis
  - Rheumatoid
- Given Birth  Yes  No
  - Vaginal # \_\_\_\_\_
  - C-Sectional # \_\_\_\_\_
- Latex Allergy  Yes  No

Type of Reaction \_\_\_\_\_

- Do you smoke?  Yes  No  Occasionally
- Do you drink alcohol?  Yes  No  Occasionally
- Do you have limited mobility?  Yes  No  Occasionally

Would you be willing to talk about your own health problems with students?

Yes       No

Would you feel comfortable giving feedback, both positive and negative, to students?

Yes       No

Would you be willing to role play situations that are emotionally charged, such as dealing with terminal illness, death, mental health, or loss issues?

Yes       No

What life experiences have you had that would contribute to your role as a standardized patient? (e.g. friend with cancer or mother with diabetes)

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What qualifications or experiences do you have that would contribute to you being an effective standardized patient? (e.g. communication skills, theater experience, improv etc)

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Do you have any children? If so, please list including age and gender.

Child 1: Age: \_\_\_\_  Male     Female      Child 3: Age: \_\_\_\_  Male     Female  
Child 2: Age: \_\_\_\_  Male     Female      Child 4: Age: \_\_\_\_  Male     Female

Would you be interested in your children participating in the Pediatric SP component of the program?

Yes       No

Child 1: \_\_\_\_\_      Child 3: \_\_\_\_\_  
Child 2: \_\_\_\_\_      Child 4: \_\_\_\_\_

**General Availability**

*In general, most SP activities are scheduled between 7 AM and 6 PM Monday through Friday.*

Please check when you are available.

AM (7:00-Noon):  Mon  Tues  Wed  Thurs  Fri  Sat  Sun

PM (Noon-6:00):  Mon  Tues  Wed  Thurs  Fri  Sat  Sun

*If you are a student please pick up an additional scheduling form. We understand that your schedule changes often.*

Please describe any other fact or circumstance that might limit your participation in the program. Such facts or circumstances include, but are not limited to, religious preferences or criminal background.

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Reviewed: 4/2/2014