John Alexander Carter

Full Name: John Carter
DOB: January 12, 1980
Age: 45
Gender: Male
MRN: 102345
Reason for Visit: Chest pain

BP: 142/88 mmHg
Heart Rate: 88 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.6°F
Oxygen Saturation: 97%

Height: 70 inches (178 cm)
Weight: 195 lbs (88.5 kg)
BMI: 28

Current Medications: Metoprolol 50 mg daily, Aspirin 81 mg daily
Allergies: Penicillin
Chronic Illnesses: Hypertension, Hyperlipidemia
Past Surgical History: Appendectomy (2005)
Immunizations: Flu vaccine (Oct 2024), COVID-19 booster (Jan 2025)
Family Medical History: Father with coronary artery disease, Mother with diabetes
Social History: Former smoker (quit 2018), occasional alcohol, civil engineer, lives with spouse and two children
Symptoms: Chest pain started 2 days ago, intermittent, moderate, exacerbated by exertion

Patient Interaction Goals: Acute symptom triage, risk assessment, immediate plan

Emily Rose Anderson

Full Name: Emily Anderson
DOB: March 15, 1992
Age: 33
Gender: Female
MRN: 102346
Reason for Visit: Migraine

BP: 120/78 mmHg
Heart Rate: 72 bpm
Respiratory Rate: 14 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 99%

Height: 64 inches (162 cm)
Weight: 130 lbs (59 kg)
BMI: 22

Current Medications: Ibuprofen as needed
Allergies: None
Chronic Illnesses: Migraines
Past Surgical History: None
Immunizations: Tdap (2024)
Family Medical History: Mother with migraines
Social History: Never smoker, rare alcohol use, teacher, lives alone
Symptoms: Severe headache onset yesterday, nausea, sensitivity to light

Patient Interaction Goals: Pain history, lifestyle triggers, migraine plan

Carlos Miguel Hernandez

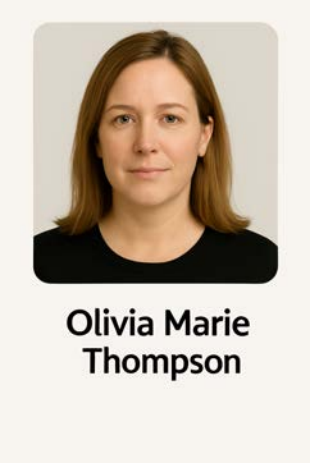
Full Name: Carlos Hernandez
DOB: July 20, 1975
Age: 50
Gender: Male
MRN: 102347
Reason for Visit: Diabetes follow-up

BP: 130/85 mmHg
Heart Rate: 80 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.7°F
Oxygen Saturation: 98%

Height: 68 inches (173 cm)
Weight: 180 lbs (81.6 kg)
BMI: 27

Current Medications: Metformin 500 mg BID
Allergies: None
Chronic Illnesses: Type 2 Diabetes
Past Surgical History: None
Immunizations: Flu vaccine (2024)
Family Medical History: Father with diabetes
Social History: Non-smoker, occasional alcohol, construction worker, lives with family
Symptoms: Routine check, mild fatigue

Patient Interaction Goals: Glucose control, fatigue, lifestyle reinforcement



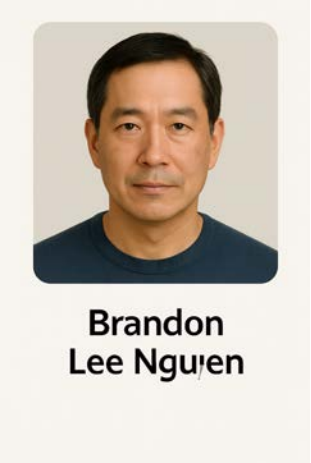
Full Name: Olivia Thompson
DOB: August 5, 1987
Age: 37
Gender: Female
MRN: 102348
Reason for Visit: Persistent cough

BP: 118/74 mmHg
Heart Rate: 76 bpm
Respiratory Rate: 20 breaths/min
Temperature: 99.1°F
Oxygen Saturation: 96%

Height: 66 inches (167.6 cm)
Weight: 145 lbs (65.8 kg)
BMI: 23.4

Current Medications: Loratadine 10 mg daily
Allergies: Dust mites
Chronic Illnesses: Asthma
Past Surgical History: Tonsillectomy (1995)
Immunizations: Flu vaccine (Oct 2024), COVID-19 booster (Jan 2025), Pneumococcal (2023)
Family Medical History: Brother with asthma
Social History: Non-smoker, occasional wine, marketing executive, lives with partner
Symptoms: Dry cough for 3 weeks, worse at night, no fever

Patient Interaction Goals: Respiratory history, asthma control, nighttime symptoms



Full Name: Brandon Nguyen
DOB: November 22, 1968
Age: 56
Gender: Male
MRN: 102349
Reason for Visit: Routine hypertension check

BP: 145/90 mmHg
Heart Rate: 82 bpm
Respiratory Rate: 15 breaths/min
Temperature: 98.2°F
Oxygen Saturation: 98%

Height: 69 inches (175 cm)
Weight: 200 lbs (90.7 kg)
BMI: 29.5

Current Medications: Lisinopril 10 mg daily
Allergies: Sulfa drugs
Chronic Illnesses: Hypertension
Past Surgical History: Gallbladder removal (2012)
Immunizations: Shingles vaccine (2024), Flu (2024)
Family Medical History: Mother with stroke, father had high blood pressure
Social History: Retired teacher, lives with spouse, occasional beer, former smoker
Symptoms: Asymptomatic, here for follow-up

Patient Interaction Goals: BP control, medication compliance, lifestyle adjustment

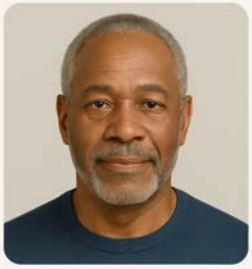
Full Name: Sophia Patel
DOB: February 2, 1999
Age: 26
Gender: Female
MRN: 102350
Reason for Visit: Annual physical

BP: 112/70 mmHg
Heart Rate: 68 bpm
Respiratory Rate: 14 breaths/min
Temperature: 98.5°F
Oxygen Saturation: 99%

Height: 63 inches (160 cm)
Weight: 120 lbs (54.4 kg)
BMI: 21.3

Current Medications: Oral contraceptive
Allergies: None
Chronic Illnesses: None
Past Surgical History: Wisdom teeth removal (2020)
Immunizations: HPV (completed), Flu (2024)
Family Medical History: Father with high cholesterol
Social History: Grad student, non-smoker, vegetarian, no alcohol
Symptoms: None, preventive visit

Patient Interaction Goals: Preventive care, screening, risk behavior discussion



Marcus Elijah Brown

Full Name: Marcus Brown
DOB: May 10, 1959
Age: 66
Gender: Male
MRN: 102351
Reason for Visit: Joint pain

BP: 128/80 mmHg
Heart Rate: 78 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.9°F
Oxygen Saturation: 97%

Height: 71 inches (180 cm)
Weight: 210 lbs (95.3 kg)
BMI: 29.3

Current Medications: Acetaminophen as needed
Allergies: None
Chronic Illnesses: Osteoarthritis
Past Surgical History: Knee arthroscopy (2015)
Immunizations: Flu (2024), Pneumococcal (2023), Tdap (2024)
Family Medical History: No known major illnesses
Social History: Retired bus driver, widowed, walks daily, no tobacco
Symptoms: Chronic knee pain, worsened over last 2 months

Patient Interaction Goals: Pain evaluation, mobility, daily living impact

Full Name: Hannah Garcia
DOB: December 9, 2001
Age: 23
Gender: Female
MRN: 102352
Reason for Visit: Fatigue and irregular periods

BP: 116/72 mmHg
Heart Rate: 74 bpm
Respiratory Rate: 14 breaths/min
Temperature: 98.3°F
Oxygen Saturation: 99%

Height: 65 inches (165 cm)
Weight: 135 lbs (61.2 kg)
BMI: 22.5

Current Medications: Multivitamin
Allergies: Latex
Chronic Illnesses: Polycystic Ovary Syndrome (PCOS)
Past Surgical History: None
Immunizations: HPV, Flu (2024)
Family Medical History: Aunt with PCOS
Social History: Fitness trainer, non-smoker, occasional alcohol, lives with roommates
Symptoms: Irregular menses, low energy, occasional acne

Patient Interaction Goals: Reproductive health, hormonal balance, symptom burden

Derek James Wilson

Full Name: Derek Wilson
DOB: April 18, 1983
Age: 42
Gender: Male
MRN: 102353
Reason for Visit: Back pain

BP: 125/82 mmHg
Heart Rate: 70 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.6°F
Oxygen Saturation: 98%

Height: 72 inches (183 cm)
Weight: 205 lbs (93 kg)
BMI: 27.8

Current Medications: Naproxen as needed
Allergies: None
Chronic Illnesses: None
Past Surgical History: Hernia repair (2010)
Immunizations: Flu (2024), Tdap (2023)
Family Medical History: Father with chronic back issues
Social History: IT technician, works long hours at a desk, drinks socially, no tobacco
Symptoms: Low back pain for 1 week, dull ache, worsens with prolonged sitting

Patient Interaction Goals: Work-related strain, pain management, posture advice

Full Name: Aisha Rahman
DOB: June 30, 1972
Age: 52
Gender: Female
MRN: 102354
Reason for Visit: Follow-up for thyroid management

BP: 122/78 mmHg
Heart Rate: 74 bpm
Respiratory Rate: 15 breaths/min
Temperature: 98.2°F
Oxygen Saturation: 98%

Height: 62 inches (157 cm)
Weight: 155 lbs (70.3 kg)
BMI: 28.4

Current Medications: Levothyroxine 100 mcg daily
Allergies: Shellfish
Chronic Illnesses: Hypothyroidism
Past Surgical History: C-section (2003)
Immunizations: COVID booster (2025), Flu (2024)
Family Medical History: Mother with thyroid disease
Social History: Homemaker, non-smoker, no alcohol
Symptoms: Mild fatigue, otherwise stable

Patient Interaction Goals: Fatigue, medication compliance, long-term monitoring

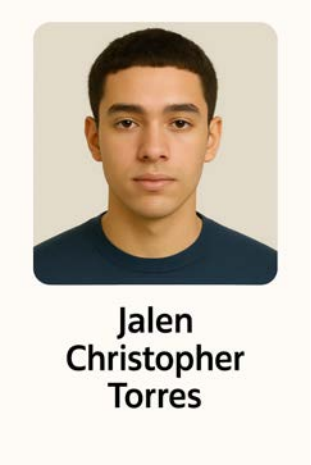
Alina Rose Bennett

Full Name: Alina Bennett
DOB: March 6, 1996
Age: 29
Gender: Female
MRN: 102354
Reason for Visit: Muscle tightness and sleep disruption

BP: 118/74 mmHg
Heart Rate: 72 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 99%

Height: 64 inches (162.5 cm)
Weight: 138 lbs (62.6 kg)
BMI: 23.7

Current Medications: Baclofen 10 mg TID
Allergies: Sulfa drugs
Chronic Illnesses: Down's Syndrome with co-existing spastic cerebral palsy
Past Surgical History: Tendon release surgery (2012)
Immunizations: Flu (2024), COVID-19 booster (2025)
Family Medical History: Mother with rheumatoid arthritis
Social History: Graphic designer, uses a wheelchair, nonverbal—communicates via speech-generating device, often attends appointments with her sister
Symptoms: Increased lower limb spasticity, disrupted sleep, difficulty with positioning
Patient Interaction Goals: Optimize spasticity control, improve sleep quality, enhance positioning and comfort strategies.



Full Name: Jalen Torres
DOB: October 9, 2004
Age: 20
Gender: Male
MRN: 102355
Reason for Visit: Chronic knee pain and opioid refill request

BP: 122/78 mmHg
Heart Rate: 68 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.5°F
Oxygen Saturation: 98%

Height: 71 inches (180 cm)
Weight: 190 lbs (86.2 kg)
BMI: 26.5

Current Medications: OxyContin 10 mg BID
Allergies: None
Chronic Illnesses: None
Past Surgical History: Right knee arthroscopy (2024)
Immunizations: Flu (2024), COVID-19 booster (2025)
Family Medical History: Father with chronic back pain, prescribed opioids long-term
Social History: Undergraduate student at UofA on athletic scholarship, weightlifter, self-described "health nut," denies smoking or alcohol use, lives in off-campus housing with two teammates
Symptoms: Ongoing right knee pain, increased stiffness with training, reports difficulty sleeping and focusing in class, concerned about medication wearing off early

Patient Interaction Goals: Manage knee pain safely, reduce opioid reliance, improve sleep, support academic and athletic performance. Encourage to use Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategies (https://www.samhsa.gov/substance-use/treatment/sbirt) in interaction.

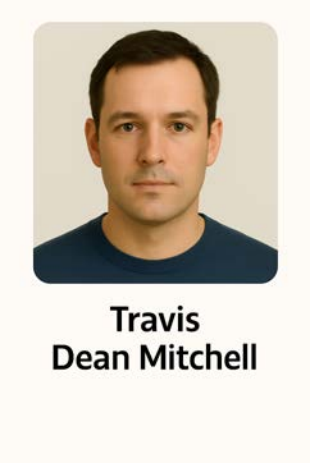
Natalie
Elaine Foster

Full Name: Natalie Foster
DOB: May 15, 1985
Age: 40
Gender: Female
MRN: 102356
Reason for Visit: Tobacco cessation support

BP: 124/80 mmHg
Heart Rate: 76 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.6°F
Oxygen Saturation: 97%

Height: 66 inches (167.6 cm)
Weight: 152 lbs (68.9 kg)
BMI: 24.5

Current Medications: None
Allergies: Penicillin
Chronic Illnesses: None
Past Surgical History: Tonsillectomy (1990s)
Immunizations: Flu (2024), COVID-19 booster (2025)
Family Medical History: Mother with COPD; father deceased (lung cancer)
Social History: Real estate agent; has smoked about 10–15 cigarettes per day for 20 years; drinks socially (1–2 times/week); lives with partner and teenage daughter; has tried quitting twice using nicotine gum
Symptoms: Increased shortness of breath during showings and open houses; concerned about long-term health and setting an example for her daughter; motivated but anxious about withdrawal and failure
Patient Interaction Goals: Support smoking cessation, address withdrawal anxiety, reinforce motivation and long-term health goals. Encourage to use Motivational Interviewing (MI) strategies (https://en.wikipedia.org/wiki/Motivational_interviewing) in conversation.



Full Name: Travis Mitchell
DOB: February 22, 1987
Age: 38
Gender: Male
MRN: 102357
Reason for Visit: Persistent Sore Throat and tobacco use history

BP: 128/82 mmHg
Heart Rate: 74 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.7°F
Oxygen Saturation: 98%

Height: 70 inches (177.8 cm)
Weight: 178 lbs (80.7 kg)
BMI: 25.5

Current Medications: None
Allergies: None
Chronic Illnesses: None
Past Surgical History: Appendectomy (2008)
Immunizations: Flu (2024), COVID-19 booster (2025), Tdap (2023)
Family Medical History: Father with hypertension; paternal grandfather died of throat cancer
Social History: Outside sales representative; chews tobacco and dips daily since college baseball (about 15+ years); hides his use from coworkers and family; no alcohol or recreational drug use; married with two children
Symptoms: Mild but persistent sore throat for the past few weeks, especially noticeable in the mornings. He describes it as a scratchy or irritated feeling, not painful enough to interfere with eating or speaking, but unusual for him. He denies recent illness or allergies. Given his daily use of smokeless tobacco, family history of throat cancer, he's become more aware of changes in his mouth and throat. His wife reportedly urged him to get it checked.

Patient Interaction Goals: Evaluate sore throat, counsel on tobacco risks, initiate cessation support with follow-up plan.

Full Name: Alma Martinez
DOB: August 20, 1971
Age: 53
Gender: Female
MRN: 208773
Reason for Visit: Dizziness, fatigue, and nausea during a heatwave

BP: 100/60 mmHg
Heart Rate: 102 bpm
Respiratory Rate: 22 breaths/min
Temperature: 101.3°F
Oxygen Saturation: 95%

Height: 61 inches (155 cm)
Weight: 172 lbs (78 kg)
BMI: 32.5

Current Medications: Hydrochlorothiazide 25 mg daily, Lisinopril 10 mg daily, Acetaminophen PRN for arthritis pain
Allergies: None known
Chronic Illnesses: Hypertension, Osteoarthritis, Early-stage chronic kidney disease (CKD)
Past Surgical History: Cataract surgery (2017), Gallbladder removal (2009)
Immunizations: Flu vaccine (Oct 2024), COVID-19 booster (Jan 2025)
Family Medical History: Sister with heart failure, Mother had diabetes and hypertension
Social History: Widowed, lives alone in a mobile home park, fixed income, limited transportation, no A/C, uses a swamp cooler that failed during the power outage, relies on Meals on Wheels and senior center for food and social support, no alcohol, no tobacco use
Symptoms: Alma reports feeling dizzy, weak, and nauseous for the past day. Symptoms began after her swamp cooler stopped working during a 110°F day. She's been drinking limited fluids to avoid frequent urination due to joint pain and mobility issues. She was brought in by a neighbor after she was found confused and lying on the porch.

Patient Interaction Goals: Recognize heat-related illness and social vulnerability, demonstrate interprofessional care planning under extreme climate conditions, explore language access and

cultural humility in patient communication, assess home safety, access to cooling, transportation, hydration, and medication effects during extreme heat, coordinate care transitions (e.g., social work, community health outreach, follow-up)

Full Name: Liang Chen
DOB: November 3, 1949
Age: 75
Gender: Male
MRN: 302778

Reason for Visit: Joint pain, concerns about memory issues and fall risk

BP: 136/84 mmHg
Heart Rate: 76 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.2°F
Oxygen Saturation: 97% (room air)
Height: 68 inches (173 cm)
Weight: 212 lbs (96.2 kg)
BMI: 32.2

Current Medications: Acetaminophen 650 mg TID, Sertraline 50 mg & Vitamin D 1000 IU
Allergies: Penicillin (rash)
Chronic Illnesses: Osteoarthritis (knees and hands), Hypertension, Generalized anxiety disorder
Past Surgical History: Left knee arthroscopy (2010), Cataract surgery (2018)
Immunizations: Flu (2024), COVID-19 booster (2025), Shingles vaccine (2023)
Family Medical History: Mother had Alzheimer's disease, Father had hypertension and osteoarthritis

Social History:
Retired postal worker. Lives alone in a single-level home with grab bars and fall prevention modifications. No tobacco use; occasional glass of wine. Has a daughter nearby who checks in weekly. Walks daily but has started limiting outdoor activity due to joint pain and fear of falling. Reports increased forgetfulness and worries may be early dementia.

Symptoms:
Reports worsening knee and hand stiffness in the mornings and difficulty standing after long periods. Describes increased anxiety about falling at home and forgetting appointments or misplacing items. No major falls, but had two near-misses in the past month.

Patient Interaction Goals:
Explore onset, frequency, and severity of joint pain to guide pain management strategies, assess memory concerns and screen for possible cognitive impairment, evaluate recent near-falls and review home safety/fall prevention measures, address anxiety related to falling and memory loss, review medication adherence and potential side effects, encourage activity modifications to maintain mobility and independence while minimizing fall risk, discuss support systems including family involvement and community resources

Full Name: Matthew Dawson
DOB: March 14, 1990
Age: 35
Gender: Male
MRN: 105482
Reason for Visit: Ongoing PTSD symptoms, trouble sleeping, irritability, and difficulty concentrating

BP: 134/86 mmHg
Heart Rate: 88 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 97%
Height: 71 inches (180 cm)
Weight: 192 lbs (87.1 kg)
BMI: 26.8

Current Medications: Sertraline 50 mg daily; Melatonin 3 mg nightly PRN
Allergies: None
Chronic Illnesses: PTSD, mild hypertension
Past Surgical History: Right knee arthroscopy (2015)
Immunizations: Up to date; COVID-19 booster (2024), Flu (2024), Tdap (2022)
Family Medical History: Father with hypertension; mother with depression

Social History: U.S. Marine Corps veteran, served two tours in Afghanistan; works as a security consultant; divorced; limited alcohol use; non-smoker; lives alone; exercises sporadically

Symptoms: Nightmares, hypervigilance, irritability, poor sleep (4–5 hours/night), difficulty focusing at work, avoids crowded places

Patient Interaction Goals: Explore coping strategies, assess medication adherence and effectiveness, address sleep hygiene, discuss support systems, evaluate for possible referral to therapy or veteran support services

Full Name: Anna Goldstein
DOB: March 15, 1948
Age: 77
Gender: Female
MRN: 2025081101
Reason for Visit: Bilateral leg edema, history of lymphedema

BP: 138/76 mmHg
Heart Rate: 79 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.1°F
Oxygen Saturation: 95% on room air

Height: 64 inches (163 cm)
Weight: 220 lbs (99.8 kg)
BMI: 37.6

Current Medications: Oxygen 3 lpm at night with CPAP; Multiple Vitamins with Zinc daily; Vitamin D3 50 mcg daily; ammonium lactate 12% topical cream PRN; bumetanide 1 mg daily; spironolactone 25 mg daily; ondansetron 4 mg every 8 hours PRN; Lantus 30 units nightly; Metoprolol Tartrate 25 mg daily; levothyroxine 200 mcg daily; Mirapex 0.5 mg daily; methotrexate 2.5 mg – 3 tablets weekly on Sunday; warfarin 3 mg daily

Allergies: No known drug allergies (NKDA)

Chronic Illnesses: Hypertension, Hypercholesterolemia, Diabetes Type II, Rheumatoid arthritis, CAD, atrial fibrillation, fibromyalgia, asthma, COPD, depression, right ventricular dilation with reduced systolic function, hypothyroidism, restless leg syndrome, lymphedema, chronic kidney disease – Stage 3a; ADLs: Partially dependent, limited mobility due to shortness of breath and leg edema, fall risk; Durable Medical Equipment: Four-wheeled walker, cane, wheelchair, home oxygen, CPAP machine

Past Surgical History: Hysterectomy and oophorectomy

Immunizations: COVID-19 (2024 booster), shingles vaccine (Shingrix, completed 2-dose series in 2023), annual flu shot (Oct 2024)

Family Medical History: Mother – Type II Diabetes; Father – Coronary artery disease; Sister – Hypothyroidism

Social History: Lives with husband in a single-story house; Religious preference: Hasidic Judaism, observes Rosh Hashanah; religious customs include wearing a head scarf at all times, sleeves past elbows, skirts below knees; Nutrition: Nutritious meals prepared by husband

Symptoms: Bilateral leg edema mostly below knees and feet; history of weeping serous fluid due to lymphedema, improved since recent hospital stay and diuretic changes

Patient Interaction Goals: Assessment and management of lymphedema, evaluation of comorbid conditions

Full Name: Bob Griffin
DOB: March 14, 1968
Age: 57
Gender: Male
MRN: 104589
Reason for Visit: Follow-up for new foot wound after wearing new shoes over the weekend

BP: 154/92 mmHg
Heart Rate: 84 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.7°F
Oxygen Saturation: 97%

Height: 68 inches (173 cm)
Weight: 265 lbs (120.2 kg)
BMI: 40.4

Current Medications: Metformin 500 mg oral tablet 2 tablets by mouth twice daily with meals, Metoprolol Tartrate 25 mg oral tablet daily, Cephalexin 500 mg oral tablet 1 tablet by mouth every 6 hours for 5 days, Cetirizine 10 mg oral tablet at night PRN, Fluticasone 50 mcg/inh nasal spray 1 actuation each nostril BID PRN, Calcium 500 mg (as calcium carbonate 1,250 mg) chewable tablet 1 tablet 3x/day PRN
Allergies: NKDA
Chronic Illnesses: Diabetes Type 2, CKD – Stage 2, CAD
Past Surgical History: None
Immunizations: Flu vaccine (Oct 2024), COVID-19 booster (Jan 2025), Tdap (2023)

Family Medical History: Uncle and father both had to have foot amputations when they were in their 50s

Social History: Black male, obese, works as a cook and on his feet most of the day, former smoker (quit 2012), drinks alcohol socially, lives alone in a small apartment

Symptoms: Presented at home with complaints of a new foot wound. Patient reports he wore new shoes over the weekend, developed a blister on the bottom of his foot that is now open. States he has never had a wound like this before. Was seen in ED 2 days ago where the blister was popped, skin

removed, a culture and x-ray were taken, and Keflex prescribed. Denies pain. Reports using a Band-Aid instead of bulky dressing due to difficulty wearing shoes.

Patient Interaction Goals: Evaluate diabetic foot ulcer, assess wound care adherence, consider perfusion status, reinforce appropriate footwear and offloading, review home glucose monitoring needs, check his medication compliance, support interprofessional follow-up planning.

Full Name: Sharon Miller
DOB: July 12, 1963
Age: 62
Gender: She/They
MRN: 207843
Reason for Visit: Adverse reaction after cannabis use; bradycardia, respiratory suppression, altered mental status

BP: 138/84 mmHg
Heart Rate: 88 bpm
Respiratory Rate: 9 breaths/min
Temperature: 98.2°F
Oxygen Saturation: 93% on room air

Height: 65 inches (165cm)
Weight: 170 lbs (77.1kg)
BMI: 28.3

Current Medications: Hydrocodone/acetaminophen 5/325 mg PO q12h PRN, Sertraline 50 mg PO daily, Lisinopril 10 mg PO daily, Atorvastatin 20 mg PO nightly
Allergies: NKDA
Chronic Illnesses: Chronic back pain, Depression, Hypertension, Hyperlipidemia, Minor ischemic stroke (2023)
Past Surgical History: None
Immunizations: Flu (2024), COVID-19 booster (2024)
Family Medical History: Non-contributory
Social History: Lives with partner in Tucson, AZ, Caring for 5-year-old grandchild (2-week visit), No current alcohol or tobacco use, Cannabis use: last in college (~40 years ago); tried again today on friend's recommendation
Symptoms: Dizziness, lightheadedness, respiratory distress after cannabis use, Bradycardia (HR 49), hypoventilation (RR 9), pinpoint pupils, Diaphoresis, hypersalivation, lethargy, Intermittently responsive but distressed, Differential diagnosis includes: Drug interactions (SSRI, opioids,

antihypertensives), Synthetic cannabinoids or potent THC, **Probable organophosphate pesticide contamination** (parasympathetic toxidrome: ↑ acetylcholine, ↓ HR/BP, secretions), Toxicology pending; Poison Control referral likely

Patient Interaction Goals: Establish rapport despite altered mental status, assess recent cannabis use and context, explore possible environmental exposures, identify potential drug interactions, demonstrate nonjudgmental communication, and initiate appropriate interprofessional referrals.

Full Name: Julie Parker
DOB: March 18, 2003
Age: 22
Gender: Female
MRN: 102365
Reason for Visit: Shortness of breath with minimal exertion, seeking nutritional guidance for weight management and pre-diabetes prevention

BP: 128/84 mmHg
Heart Rate: 86 bpm
Respiratory Rate: 18 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 98%

Height: 64 inches (163 cm)
Weight: 285 lbs (129.3 kg)
BMI: 48.9

Current Medications: None
Allergies: Kiwi, Pineapple
Chronic Illnesses: Pre-diabetes
Past Surgical History: None
Immunizations: COVID-19 booster (Dec 2024), Flu vaccine (Oct 2024)
Family Medical History: Mother with type 2 diabetes, Father with hypertension
Social History: Non-smoker, no alcohol use, full-time college student, lives with parents, most meals are fast food due to busy schedule
Symptoms: Gets out of breath easily, difficulty with prolonged walking, motivated to change eating habits
Patient Interaction Goals: Explore dietary changes, encourage physical activity suited to fitness level, discuss resources for nutritional guidance and weight management

Jennifer Anne Douglas

Full Name: Jennifer Douglas
DOB: June 14, 1974
Age: 51
Gender: Female
MRN: 203481
Reason for Visit: "I can't sleep and I feel anxious quite a bit since caring for my aging parent."

BP: 128/82 mmHg
Heart Rate: 86 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 98%

Height: 64 in (163 cm)
Weight: 142 lbs (64.5 kg)
BMI: 24.4

Current Medications: Multivitamin daily; occasional melatonin 3 mg at bedtime
Allergies: No known drug allergies
Chronic Illnesses: None reported
Past Surgical History: Cesarean section (2002)
Immunizations: Up to date – Flu (2024), COVID-19 booster (2025)
Family Medical History: Mother – hypertension and early dementia; father – deceased (heart disease)
Social History: Lives with her mother (full-time caregiver). Divorced, two adult children out of state. Works part-time as a bookkeeper. Denies tobacco or drug use; drinks wine socially (1–2 glasses/week).
Symptoms: Reports restlessness, trouble sleeping (mind racing at night), fatigue, and increased worry about her mother's declining memory. No suicidal thoughts or history of depression treatment.

Patient Interaction Goals:

- Demonstrate empathic listening and non-stigmatizing language.
- Explore stressors and coping strategies.
- Identify opportunities for interprofessional support (behavioral health, social work, pharmacy for sleep aids, nutrition, public health for caregiver resources).
- Model communication skills for screening mild anxiety or insomnia and referral for follow-up care.

Kevin L Tran

Full Name: Kevin Tran
DOB: March 3, 1997
Age: 28
Gender: Male
MRN: 208731
Reason for Visit: Bleeding gums during brushing

BP: 122/76 mmHg
Heart Rate: 72 bpm
Respiratory Rate: 14 breaths/min
Temperature: 98.4°F
Oxygen Saturation: 99%

Height: 69 inches (175 cm)
Weight: 200 lbs (90.7 kg)
BMI: 29.6

Current Medications: None
Allergies: None known
Chronic Illnesses: None diagnosed. Pre-diabetic
Past Surgical History: None
Immunizations: Up to date, including COVID-19 booster (2024)
Family Medical History: Father with type 2 diabetes; Mother healthy

Social History:
Works as an assistant manager at a local coffee shop; on feet most of the day.
Lives with girlfriend.
Brushes once daily in the morning; rarely flosses.
Drinks energy drinks regularly for long shifts.

Vapes occasionally (“just when I’m stressed”).
No dental visit for over 5 years due to cost concerns.

Symptoms:
Reports bleeding when brushing for the past several weeks. Mild generalized gum swelling and occasional bad breath. No significant pain or loose teeth. Denies fever or trauma.

Patient Narrative:
“I keep seeing blood when I brush, and my girlfriend says my breath smells bad sometimes. I feel like I’m too young to have gum problems, but it’s been getting worse lately. I don’t really like going to the dentist — it’s expensive and I don’t have insurance right now. Can’t I just use mouthwash or something to fix it?”

Patient Interaction Goals:
Build rapport and trust; conduct focused oral health history; communicate with the patient about the periodontal disease process using motivational interviewing; explore barriers to care; explore nutrition and weight management; explore oral-systemic connection/metabolic syndrome, demonstrate empathy.

Emily Amelia Thompson

Full Name: Emily Thompson
DOB: May 14, 1959
Age: 66
Gender: Female
MRN: 207451

Reason for Visit: Ongoing difficulty understanding conversations and increased frustration during meetings and phone calls.

BP: 118/74 mmHg
Heart Rate: 76 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.2°F
Oxygen Saturation: 98%

Height: 65 inches (165 cm)
Weight: 138 lbs (62.6 kg)
BMI: 23

Current Medications: Oral contraceptive; occasional ibuprofen for headaches
Allergies: None known
Chronic Illnesses: Mild seasonal allergies
Past Surgical History: None
Immunizations: Up to date
Family Medical History: Mother with early-onset hearing loss; father with hypertension

Social History:
Marketing professional working in an open office environment. Enjoys hiking, concerts, and social gatherings. Recently remarried. Reports increasing stress from managing remote and in-person team meetings. No tobacco or drug use; drinks socially.

Symptoms:
For the past six months, Emily has noticed increasing difficulty following conversations in noisy environments and frequent requests for repetition from coworkers and her spouse. She reports occasional ringing in her ears (tinnitus), more noticeable at night. She describes feeling “mentally drained” after long meetings and is starting to avoid group settings. No recent illness or ear infections.

Patient Interaction Goals:

Conduct a case history focused on ear health, hearing concerns, and communication needs related questions, explain what hearing assessment procedures will be performed, counsel the patient on hearing conservation measures, and discuss tinnitus management options.

Danielle D. Morrison

Full Name: Danielle Morrison
DOB: May 9, 1996
Age: 29
Gender: Female
MRN: 306492
Reason for Visit: Concern about her 12-year-old Labrador Retriever, “Buddy,” who has been losing weight, refusing food, and less active for the past two weeks

Patient (Animal) Information
Name: Buddy
Species/Breed: Canine – Labrador Retriever
Age: 12 years
Sex: Male, neutered
Weight: 65 lbs (29.5 kg)
Temperature: 101.9°F
Heart Rate: 96 bpm
Respiratory Rate: 26 breaths/min
Mucous Membranes: Pale pink, slightly tacky
Capillary Refill Time: 2 seconds

Current Medications: None
Allergies: None known
Vaccination History: Up to date on core vaccines; last visit 18 months ago
Diet: Commercial dry food (senior formula) with occasional table scraps
Environmental History: Indoor/outdoor dog, fenced yard, no known toxin exposure

Owner (Human) Medical & Social History:

- Elementary school art teacher; lives alone with Buddy.
- Recently went through a breakup; describes Buddy as her emotional support.
- Non-smoker; drinks wine occasionally.
- Reports high stress related to work and emotional attachment to her pet.

Symptoms (as described by owner):

“He just isn’t himself anymore. He’s lost weight, won’t eat his food, and seems tired all the time. Sometimes he just stares off or pants for no reason. He still drinks water, but he barely wants to go on walks now. I know he’s getting old, but I’m scared he’s in pain.”

Veterinary Observations:
Buddy appears underweight with mild muscle loss along the hind limbs. Abdominal palpation reveals slight tenderness. Gait is slow but steady. No evidence of trauma.

Patient Interaction Goals:

Build rapport with a concerned and emotional pet owner. Demonstrate empathy and clear communication when discussing diagnostic options. Educate the owner on possible causes (geriatric changes, chronic disease, pain). Model sensitivity when addressing the potential need for advanced testing or palliative care. Explore the owner’s emotional state, beliefs, and support system to strengthen trust and shared decision-making.

Kathryn Marie Lawson

Full Name: Kathryn Lawson
DOB: September 22, 1968
Age: 57
Gender: Female
MRN: 512884
Reason for Visit: Progressive difficulty understanding conversations, especially in noisy environments, and persistent ringing in both ears.
BP: 124/78 mmHg
Heart Rate: 72 bpm
Respiratory Rate: 16 breaths/min
Temperature: 98.1°F
Oxygen Saturation: 98%
Height: 64 inches (163 cm)
Weight: 154 lbs (69.9 kg)
BMI: 26.4
Current Medications: Hydrochlorothiazide 12.5 mg daily; daily multivitamin; occasional acetaminophen for headaches
Allergies: None known
Chronic Illnesses: Controlled hypertension; mild osteoarthritis in hands
Past Surgical History: Cesarean section ×2; tonsillectomy (childhood)
Immunizations: Up to date
Family Medical History: Mother with age-related hearing loss beginning in mid-60s; father with hypertension and osteoarthritis
Social History: Elementary school librarian working in a moderately noisy environment. Enjoys gardening, audiobooks, and volunteering with an animal rescue. Lives with spouse; three adult children. No tobacco or drug use; drinks wine socially. Reports past noise exposure from concerts, lawn equipment, and power tools without hearing protection. Often listens to audiobooks or music at high volume.
Symptoms: For the past 8–10 months, Kathryn has experienced increasing difficulty hearing

speech clearly in background noise, trouble understanding soft voices, and a need for frequent repetition from family and coworkers. Reports bilateral tinnitus described as a constant high-pitched ringing, worse at night. Turns the TV volume higher than others prefer and experiences listening fatigue after work. Denies vertigo, drainage, ear infections, or sudden hearing loss.

Patient Interaction Goals:

Gather a focused history that helps distinguish possible noise-induced versus age-related hearing loss, understand how her tinnitus and listening fatigue affect daily life, and provide clear, supportive counseling on hearing conservation, tinnitus management, and what to expect from hearing assessments and treatment options such as amplification or assistive listening devices.