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Medicine Writing Tests 6 – 10 with Sample Answers

WRITING TEST 6

Time allowed:
Reading Time : 05 Minutes
Writing : 40 Minutes

Read the case notes and complete the writing task which follows.

Patient History:

Patient: Mary Reylon

DOB: 4th Sept 1963

Allergies: dust / penicillin

Social History: Professor at the university (teaches physics)
Lives with her husband (Winston Reylon)
Works for women rights organization

Family History:

- **Mother** – high BP, rheumatoid.
- **Father** – liver failure
- **Maternal Grandmother**- died of a heart attack (75)
- **Maternal Grandfather** – died of heart attack (81)
- **Paternal Grandfather** – a patient of high BP
- **Paternal Grandmother** – died at the age of 65 due to an accident

Past medical history:

- RSV illness (1965)
- Chicken pox (1973)
- Tonsils removed (1981)
- Miscarriage due to an accident (1987)
- Hyperthyroid (1989)

12 June 2009 Injury to the head (fell down the stairs)
Tourniquet applied (to stop the flow of blood)
Dizziness and queasiness
Large bump on the head
Patient complained of pain even after two days
Unable to sleep (for a week)
Took slipping pills three times (as suggested by the doctor), no effect

Other signs:

- Persistent or worsening headaches
- Imbalance
- Vomiting

Inference: Suggestive of intracranial hematoma

Plan: CT scan is the definitive tool for accurate diagnosis of an intracranial hemorrhage.

Writing Task:

Using the information in the case notes, write a letter of referral for further investigation and definitive diagnosis to the neurologist, Dr. Wilson, at London Bridge Hospital, 27 Tooley St London, Greater London.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.

END OF WRITING TEST 6

WRITING TEST 7

Time allowed:

Reading Time : 05 Minutes
Writing : 40 Minutes

Read the case notes and complete the writing task which follows.

Patient History:

Patient: Nicole Katie

DOB: 12 July, 1971

Social History:

Lives with her husband (Ivan) and their daughter (Lydia Imogen)
House wife (left work after she was married)

Family history: No family history
But mother died of kidney failure

Past medical history:

Suffered severe attack of TB (1983)
Appendices (1987)
Depression (due to the sudden death of the first baby – 1992)
Allergic reactions (uterine infection - 1997)

15 April 2005

Failure in digestion
Unable to eat properly due to pain in the stomach
Took pain relievers, analgesics (for two continuous days)
Problem worsened
Felt pain, radiating back to the lower abdomen

Change in coloration of urine (yellowish)
Loss of appetite
Weight loss – 2.5 kg within 15 days
Vomited twice

18 April, 2005

Other signs:
Severe pain, lasted for several hours
Pain and vomiting, shortness of breath
Blood in bowel motions and urine
High fever and sweats

Plan: Abdominal CT scan suggested for accurate diagnosis of abdominal pain.

Writing Task:
Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Ralph Emerson, at Royal London Hospital, Whitechapel Rd, Greater London E1 1BB, United Kingdom.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.

END OF WRITING TEST 7

Medicine Writing Tests 6 – 10 with Sample Answers

WRITING TEST 8

Time allowed:
Reading Time : 05 Minutes
Writing : 40 Minutes

Read the case notes and complete the writing task which follows.

Patient History:

Mark Henry is 53-year-old patient at your General Practice. Just recently, he complained of acute onset of double vision and right eyelid droopiness.

Social History:

The patient lives with his wife
Works as a car mechanic
Denies use of illicit drugs or tobacco
Rarely drinks

Family History:

His mother suffered from migraines (died at the age of 83 due to heart attack)
His paternal father had a stroke at the age of 67
No other family history of strokes or vascular diseases

9/07/2009

Was sitting in his room; felt sensation in eye lids
Noticed blurred vision
Appearance of double vision (with objects appearing side by side)
Pain in both the eyes
Transferred to the hospital by his son
Intermittent pounding bifrontal headache
Rated the pain as 7 or 8 on a scale of 1 to 10

General physical examination:

The patient is significantly overweight.
Temperature is 37.6.
Blood pressure is 130/60.

Pulse is 85.
There is no tenderness over the scalp or neck and no bruits over the eyes or on the neck.
No proptosis, lid swelling, conjunctival injection, or chemosis.
Cardiac exam shows a regular rate and no murmur.

Past Medical History:

1) Migraine headaches, as described in HPI.
2) Depression.
There is no history of diabetes or hypertension.

Allergies: None.

Medications: Zoloft 50 mg daily, ibuprofen 600 mg a few times per week, and vicodin a few times per week.

Other necessary information

He denies associated vomiting, nausea, numbness, weakness, photophobia, loss of vision, seeing flashing lights or zigzag lines etc.
His recent headaches differ from his "typical migraines" (occurred 4 -5 in his entire life time).
He has never taken anything for these headaches (other than ibuprofen or vicodin).

Writing Task:

Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Martin, at National Hospital for Neurology, 33 Queen Square, London WC1N 3BG, United Kingdom.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.

END OF WRITING TEST 8

WRITING TEST 9

Time allowed:
Reading Time : 05 Minutes
Writing : 40 Minutes

Read the case notes and complete the writing task which follows.

Patient History:

Medicine Writing Tests 6 – 10 with Sample Answers

Joseph Malcolm is a patient at your General Practice. Just recently, he started complaining of occasional breathlessness and difficulty in breathing.

Age: 42

Gender: male

Occupation: office manager

Subjective Patient Complaints:

Adult onset asthma- dyspnea, cough
Occasional wheezing symptoms upon increased exercise or when under stress.

Prior contributory health history:

1) Seasonal upper respiratory allergies
2) Occasional loose stools when under stress
3) Occasional episodes of mild eczema (dermatitis)
4) Reports a history of being healthy, aside from this recent asthma problem

What provokes the symptoms?

Provoked by exercise, emotional/physical stress
Cigarette smoke
Seasonal respiratory allergies

Site of symptomatology:

Bronchial, lung, chest/thoracic region
Time of day/duration of symptoms:
Daily episodes of dyspnea
Symptoms often worsen at 3-5 AM (coughing increases)

Medications:

Symptoms temporarily eased with prescription (bronchial inhaler medication).

Writing Task:

Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Robert Frances,
at St. George's Hospital, Black Shaw Road, London SW17 0QT,
United Kingdom.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.

END OF WRITING TEST 9

WRITING TEST 10

Time allowed:
Reading Time : 05 Minutes
Writing : 40 Minutes

Read the case notes and complete the writing task which follows.

Patient History:

Mr. Marques is a patient at your general practice who has recently complained of

severe abdominal pain.

Name of the patient: Mr. Marques

Age: 65

October 7, 2006

Chief complaint: abdominal pain

- ☐ Complained of a sharp, epigastric abdominal pain (gradually worsening over the past 1-2 months).
- ☐ Pain is located in the epigastric region and left upper quadrant of the abdomen.
- ☐ Doesn't radiate.
- ☐ The pain is relatively constant throughout the day and night (but does vary in severity).
- ☐ Rated the pain as 6/10 at its worst.
- ☐ He has not tried taking any medicines to relieve the pain.
- ☐ The pain is not associated with food or eating (but occasional heartburn).
- ☐ Denies any abdominal trauma or injury.
- ☐ Complained of weight loss (5lb weight loss over the past 1-2 months).
- ☐ The patient has experienced some nausea with the abdominal pain but has not vomited.

Family History:

Father died due to a heart attack.

Mother's medical history is not known.

No known family history of colon cancer.

Social History:

The patient is a retired lecturer.

He lives with his wife and two grandchildren.

He denies past or present tobacco and illicit drug use.

He denies alcohol use.

Past Medical History: other active problems

High blood pressure, diagnosed two years ago, but well-controlled now.

Depression poorly controlled; started prozac 2 months ago, but still feels depressed.

Hospitalizations: MI, 2003.

Surgeries/procedures: Cardiac catheterization, post-MI, 2003.

Medications:

Aspirin 81mg po qd, since his MI 3 years ago

Metoprolol 100mg po qd, for two years

Prozac 20mg po qd, started 2 months ago

Allergies: No known drug allergies.

No food or insect allergies.

Other information

Pulmonary – denies shortness of breath, denies cough.

Cardiovascular – denies chest pain, denies palpitations.

Genitourinary – denies dysuria, denies increased frequency or urgency of urination.

Writing Task:

Using the information in the case notes, write a letter of referral for further investigation and a definitive diagnosis to Dr. Ivan Gonz, at Willington Hospital,

Central Building, 21 Wellington Road, St John's Wood London.

In your answer:

- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.

END OF WRITING TEST 10

Sample Letter 6

Dr. Wilson

London Bridge Hospital

27 Tooley St London

Greater London

(Today's date)

Dear Dr. Wilson,

Re: Mrs. Mary Reylon, DOB 4th Sept 1963

Mrs. Mary Reylon is a patient, who was admitted into our hospital on the 12^{thof} June 2009.

Mrs. Mary Reylon fell from the staircase and suffered an injury to her head. As she was profusely bleeding, a tourniquet was also applied around her head, to stop the flow of blood. The patient began to feel dizziness and queasiness after that and a large bump on

her head developed too. The patient began to complain of pain even though pain killers were given.

The patient has not been able to sleep for about a week now; the patient even tried sleeping pills to get enough sleep but the sleeping pills have proven to be ineffective for her. The patient has also complained of persistent headaches, imbalance and vomiting, which are all suggestive of intracranial hematoma. The CT scan is the definitive tool for accurate diagnosis of intracranial hemorrhage. Hence, it is requested that the scan is taken so that proper action can be taken.

Please, contact me with any queries or if you would like to know more about the patient.

Yours sincerely,

Head Doctor

Sample Letter 7

Dr. Ralph Emerson

Royal London Hospital

Whitechapel Rd

Greater London E1 1BB

United Kingdom

Medicine Writing Tests 6 – 10 with Sample Answers

(Today's date)

Dear Dr. Ralph Emerson,

Re: Mrs. Nicole Katie, DOB 12 July 1971

Mrs. Nicole Katie is a patient, who was admitted into our hospital on the 15th of April 2005. Nicole Katie was suffering from some kind of digestion problem, which was undetected.

The patient was not able to eat properly and was feeling a lot of pain in her stomach. The patient took some pain relievers (names are mentioned in the attached report) which, in fact, worsened the problem. The patient began to feel pain which radiated back to her abdomen and also noted a change in the color of her urine. The patient had lost her appetite, causing her to lose almost 2.5 Kg within the course of 15 days.

During her stay at our hospital from April 15 to April 18, the condition of the patient continued deteriorating; especially on the 18th of April, when the patient complained of much more severe pain which lasted for hours. She experienced pain, shortness of breath and vomiting. Blood in her bowel motion and urine was also noted. The patient has had a high fever and has been suffering from severe sweating.

Hence, it is requested that the abdominal CT scan should be taken for an accurate diagnosis of the abdominal pain, as a matter of urgency.

Please, contact me with any queries.

Yours sincerely,

Head Doctor

Sample Letter 8

Dr. Martin

National Hospital for Neurology

33 Queen Square London WC1N 3BG

United Kingdom

(Today's date)

Dear Dr. Martin,

Re: Mr. Mark Henry, acute onset of double vision and right eyelid droopiness.

Mr. Mark Henry is a patient, who was admitted into our hospital on 9 / 7 / 2009 with complaints of acute onset of double vision and right eyelid droopiness.

On 9 / 7 / 2009, the patient was sitting in his room when he felt a strange sensation in his eyelids; he began to feel pain in his eyes as well. He also complained of the sudden appearance of double vision and an intermittent pounding bifrontal headache.

Reports on the general examination were clear: his pulse was 85 and BP 130 / 60; there was no swelling of the lids or proptosis.

His medical history shows that he has suffered from migraines (headaches) and depression. The patient was prescribed Zoloft (50 mg - daily) and ibuprofen (600 mg - a few times per week).

The patient denied associated vomiting, nausea, numbness or weakness or loss of vision etc. but said that his recent headaches differ from his typical migraines, which actually only occurred 4-5 times in his whole life time. The patient has never taken anything for the headaches, except ibuprofen or vicodin.

As the problem presented by the patient is a complex one, further investigation and a definitive diagnosis is required.

Please, contact me with any queries.

Yours sincerely,

Head Doctor

Sample Letter 9

Dr. Robert Frances

St. George's Hospital

Black Shaw Road

London SW17 0QT

United Kingdom

(Today's date)

Dear Dr. Robert Frances,

Re: Mr. Joseph Malcolm, age 42

Mr. Joseph Malcolm is a patient at our hospital who visits regularly. Just recently, he complained of occasional breathlessness and difficulty in breathing. The patient's health history shows seasonal upper respiratory allergies and occasional episodes of mild eczema. The patient is reported to be healthy, apart from this recent asthma related problem.

This problem related to asthma, or breathlessness, in the words of the patient, increases with exercise, emotional or physical stress and cigarette smoking.

The patient has been experiencing problems related to dyspnea for many days (dates are not mentioned). The symptoms often get worse in between 3-5 am; the patient coughs a lot and he is not able to have full control over his daily activities.

Sometimes, the above symptoms temporarily go away when the patient uses bronchial inhaler medication; but when the patient doesn't pay attention to medication or gets involved in any kind of physical activity, then the same problem of difficulty in breathing occurs.

Further investigation and a definitive diagnosis is vital here as the patient has not been feeling well for quite a while now.

Please, contact me with any queries.

Yours sincerely,

Head Doctor

Sample Letter 10

Dr. Ivan Gonz

Willington Hospital

Central Building

21 Wellington Road

St John's Wood London

(Today’s date)

Dear Dr. Ivan Gonz,

Re: Mr. Marques, age 65

Mr. Marques has been a patient with us for several months now. Just recently, he complained of severe abdominal pain; the patient complained of a sharp, epigastic abdominal pain which he says has increased over the last two months.

The pain is located in the epigastic region and left upper quadrant of the abdomen. This pain is relatively constant throughout the day, but may sometimes vary in severity. The patient has rated this pain as 6 on a scale of 1-10 and hasn’t taken anything to relieve the pain. He has denied any abdominal trauma or injury.

The patient's medical history includes the fact that he has been a BP patient for over two years; his blood pressure is now well controlled. In addition, he has been suffering from depression related problems too; he started taking prozac two months ago, but he still feels depressed. The patient is reported to have no drug allergies or food or insect allergies.

Mr. Marques was once hospitalized for myocardial infarction, in 2003, and he has been on medications regularly since then. Presently, the patient is taking aspirin - 81mg po qd, and has been since his MI, 3 years ago; and metoprolol 100 mg po qd, which he has been taking for the past two years.

There is a need for further investigation and a definitive diagnosis.

Please, contact me with any queries.

Yours sincerely,

Head Doctor

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