**Figure 1:** Schematic to represent “what makes a case presentation complex?”

+/- Positive / Negative; EHR Electronic Health Record; SOAP Subjective Objective Assessment Plan; CC chief concern or complaint; HPI History of Present Illness; PMHx Past Medical History; SHx Social History; FHx Family History; ROS Review of Systems; PE Physical Exam; A/P Assessment and Plan; OPQRST+ Onset of symptom, Palliating / Provocating factors, Quality, Radiation, Severity, Timing, associated symptoms; DDx Differential Diagnosis