Carly Schreiber
Internal Medicine

History

Identifying Data:
Full Name - PK
Sex - male
Date of Birth - 1945
Date + Time - 2/11/20, 9:40 am
Location - NYP Queens, Flushing NY
Religion - Jewish
Race - Caucasian
Source of Information - self, Reliable
Source of Referral - Urgent Care

Chief Complaint: "I have a problem with sores on my foot and I tripped and thought I broke my leg." x 2 days ago

History of Present Illness:
PK is a reliable, 75 y/o overweight hypertensive Caucasian male with a significant past medical history of afib, peripheral vascular disease, sleep apnea, venous insufficiency, and urinary frequency presents to the floor c/o of leg pain from tripping. Pt claims he tripped on his cane and presented to urgent care, with a potential broken leg, who sent him to the ER for an x-ray which showed it wasn't broken. Upon appearing dyspneic, the pt was admitted for further testing. The pt's usually present SOB worsened a few weeks ago after travelling to Israel and pt characterizes it as panting and trying to catch his breath with a severity of 3-4. Reclining with his legs up and any sort of light activity including walking worsens the SOB and using a CPAP at night relieves it. Pt used to exercise but states he is no longer able to do even light walking with his walker. Pt admits to edema of his legs which worsened after his trip, current leg tenderness and a history of wearing compression hose due to poor circulation but stopped as they were putting too much pressure on his longstanding foot sores which he described as ulcers. Pt admits to coughing from a feeling of congestion, longstanding constipation, taking blood thinners and waking up 4 times or more each night to urinate. ↓ Pt (nocturia)

denies fatigue, weakness, chest pain, palpitations or wheezing. Upon no Pulmonary embolism appearing on CT scan, Pt is being tested for congestive heart failure.

Past Medical history:
Present Illnesses -
- Peripheral vascular disease × 10+ years (poor circulation in legs)
- Atrial Fibrillation × 10+ years = managed
- Urinary Frequency × 10+ years
- Sleep apnea × 3+ years

Past Medical Illnesses - N/A
Childhood Illnesses - N/A
Immunizations - up to Date
Screening Tests + Results - Unknown

Past Surgical history:
Surgical procedures -
- Outpatient procedure (name unknown) to improve leg circulation. 3x over 10 years
- Splenectomy - 1965

Pt denies any injuries, blood transfusions or complications with surgical procedures

Medications:
Eliquis - blood thinner for afib, 5 mg taken 2x a day orally
Metaprolol - HTN, unknown dosage
Rapaflo - bladder control, taken once daily
Probiotic - constipation

Allergies:
pt denies any food, seasonal or environmental allergies

Family history:
Pt claims family history is "unimpressive, nothing to note"
Mother - deceased, reason unknown
Father - deceased, reason unknown

Social History:

PK is a married male, living with his wife in Kew Garden Hills. He is a retired technician of 40 years.

Habits- pt denies any alcohol or illicit drug use and was a former cigarette smoker, smoking ½ a pack a day for 4-5 years, who quit 30 years ago. He used to drink coffee but stopped because he was afraid it would "irritate his bladder."

Travel- took a 2 week trip to Israel recently + returned a few weeks ago

Diet- eats mostly protein, vegetables, soy yogurt + refrains from eating bread during the week. Tries to keep an overall healthy diet.

Exercise- used to fence once a week + would walk with his walker but he is unable to walk well or exercise now.

Safety Measures- admits to wearing a seat belt

Sleep- uses a CPAP machine for his sleep apnea nightly and allows him to sleep around 5 hours a night. He uses the bathroom around 4x a night with machine use and uses the bathroom hourly without machine use.

Review of Symptoms:

General- Admits to recent weight gain from his trip to Israel. Denies fever, chills, night sweats, fatigue, weakness, loss of appetite or recent weight loss.

Skin, Hair, Nails- Denies any changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution.

Head- Denies headache, vertigo, head trauma, unconsciousness, coma or fracture.

Eyes- Last eye exam 2 years ago + notices weaker eyesight in past year. Denies contacts/glasses, visual disturbances, fatigue, lacrimation, photophobia, pruritus.

Ears- Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/Sinus- Denies discharge, epistaxis, obstruction.

Mouth + Throat- unknown last dental exam. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures.

~~Neck~~

Neck- Denies localized swelling/lumps, stiffness/decreased range of motion.

Breast- Denies lumps, nipple discharge, pain.

Pulmonary System- Admits to SOB, dyspnea, cough and orthopnea. Denies wheezing, hemoptysis, cyanosis or PND.

Cardiovascular System- Admits to irregular heart beat, HTN and edema of legs, feet and ankles. Denies chest pain, palpitations, syncope or known heart murmurs.

Gastrointestinal System- Admits to chronic constipation. Denies change in appetite, intolerance to food, nausea + vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, rectal bleeding, blood in stool, stool guaiac/colonoscopy/sigmoidoscopy, pain in flank.

Genitourinary- Admits to urinary frequency + nocturia. Denies change in color of urine, incontinence, dysuria, urgency, oliguria or polyuria.

Sexual history- Admits to one sexual partner (his wife), denies sexual activity.

~~Musculoskeletal~~ peripheral vascular System- Admits to ~~swelling of legs from~~ peripheral edema + venous insufficiency. Denies intermittent claudication, coldness of trophic changes or color change.

Hematologic System- Denies anemia, easy bruising or bleeding, lymph node enlargement or history of DVT/PE.

Musculoskeletal System- Admits to swelling of legs from edema. Denies muscle/joint pain, deformity, redness or arthritis.

Endocrine System- Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter or hirsutism.

Nervous System- Admits to change in memory in the last couple of years. Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesia, hyperesthesia), ataxia, loss of strength, change in cognition/mental status, weakness

Psychiatric- Admits to depression, anxiety and seeing a mental health professional. Admits to past usage of medication for depression 10 years ago but stopped ("pic wasn't working.") Denies obsessive/compulsive disorder and current medication usage.

Physical

General- Noted good lighting and draping on patient. Overweight male, well groomed, good hygiene, looks slightly younger than stated age of 75. Patient is alert + oriented to person, place + time.

Vital signs- BP: Sitting up 145/92 Right arm. pt only allowed one reading.
RR: 13 breaths/min, labored
P: 70 beats/min
T: 98.6 degrees F (oral)
O_2 Sat: pt had low Ox of 88% → given nasal oxygen tube
I would take height + weight to calculate BMI

Skin, Hair, Nails + Head-

Skin: warm + moist, good turgor, smooth texture, non-icteric. No moistness, opacities noted. No lesions, masses, scars or tattoos noted.

Hair: Average distribution + quality.

Nails: No clubbing, capillary refill <3 seconds throughout

Head: Normocephalic, atraumatic, no deformities or specific faces noted, non-tender to palpation throughout.

Eyes -

Symmetrical OU. Eyebrows + eyelashes even distribution, eyelids have no discharge or swelling, lacrimal glands have no excessive tearing, dryness, enlargement or erythema, lacrimal sac not inflamed or swollen. No strabismus, exophthalmos or ptosis. sclera white, conjuctiva clear.
visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU.
visual fields full OU. PERRLA, EOM's intact with no nystagmus.
Fundoscopy- red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Ears

Symmetrical + normal size. No lesions, masses or trauma on external ears. No discharge/ foreign bodies in external auditory canals AU. Tympanic membrane pearly white / intact with cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC > BC AU.

Nose -

Symmetrical, no masses lesions or deformities, trauma or discharge. Nares patent bilaterally, nasal mucosa pink + well hydrated. No discharge noted on anterior rhinoccopy. Septum midline w/out lesions, deformities, injection or perforation. No foreign bodies.

Sinuses -

Non-tender to palpation and percussion over bilateral frontal + maxillary sinuses.

Mouth -

Lips: pink, moist, no cyanosis or lesions. Non-tender to palpation.

Mucosa: pink, well hydrated. No masses, lesions noted. Non-tender to palpation. No leukoplakia

Palate: pink, well hydrated. Palate intact w/ no lesions, masses scars. Non-tender to palpation, continuity intact.

Teeth: Good dentition / no obvious dental carries noted.

Gingivae: pink, moist. No hyperplasia, masses, lesions, erythema or discharge. Non-tender to palpation.

Tongue: pink, well papillated, no masses, lesions or deviation noted. Non-tender to palpation.

Oropharynx: well hydrated, no injection, exudate, masses, lesions, foreign bodies. Tonsils present w/o no injection or exudate. Uvula pink, no edema, lesions.

Neck -

Trachea midline. No masses, lesions, ~~scars~~ scars noted. Slight pulsations present. Supple, non-tender to palpation. FROM, no stridor noted. 2+ carotid pulses, no thrills, bruits noted bilaterally, no palpable adenopathy noted.

Thyroid -

Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Thorax + Lungs

Chest - Symmetrical, no deformities, no evidence trauma. Respirations labored, no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.

Lungs - clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus throughout. No adventitious sounds.

Abdomen -

Abdomen flat and symmetric with no scars, striae, or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac/femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Heart -

JVP is 2.5 cm above sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Abnormal rate + rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Male Hernias
~~Female~~ Genitalia + ~~Rectal~~
~~Genitalia - External~~

Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis non-tender. No inguinal or femoral hernias noted.

Anus, ~~Rectum~~ + Prostate

No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and non-tender with palpable median sulcus. Stool brown + Hemoccult negative (if performed)

** Pt would not let me touch him past vitals so I was unable to do majority of physical exams.

Differential Diagnoses

Assessment - PK is a reliable, 75 y/o overweight hypertensive Caucasian male with a significant past medical history of afib, peripheral vascular disease, sleep apnea, venous insufficiency and urinary frequency presents to the floor c/o of leg pain from tripping.

DDx:

① CHF - congestive Heart Feulure
pt presents with dyspnea, SOB, edema bilaterally in legs/feet, irregular heart beat (afib), reduced ability to exercise, increased need to urinate at night.
Tests to order: ECG, chest x-ray, echo

② DVT/PE
pt presents with SOB, swelling/edema in legs/feet, leg tenderness, peripheral vascular disease + poor blood circulation. pt is over 60 yo, is overweight + just sat on airplane for extended period of time.
Tests to order: CT scan, Duplex ultrasound

③ BPH
pt presents with sx of cardiovascular disease, hypertension, urinary frequency, nocturia
Tests to order: urine flow study, digital rectal exam, prostate-specific antigen (PSA) blood test, prostate MRI or US

④ COPD - Chronic Obstructive Pulmonary Disease
pt presents with dyspnea, SOB during activity, cough, is overweight, venous insufficiency, poor circulation, edema in ankles/feet/legs
Tests to order: CT scan, Chest x-ray

⑤ Cellulitis in Foot
pt presents with pain/tenderness in foot, inflammation of skin, skin sore/rash
Tests to order: CBC, Creatinine levels, C-reactive protein (CRP)
if deep cellulitis → CT scan

YORK COLLEGE
The City University of New York

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
S. Shami, J. Yuan &
M. Malavet
(718) 262-3793
Fax: (718) 262-2504

History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:
- Obtain medical history and perform physical exam up to the point covered in class.
- Oral presentation to clinical site supervisor/preceptor

Student: Carly Schreiber

Clinical Site: Internal Medicine

Date of Visit: 2/11

Activity performed: H+P

Supervisor Name and Credentials: Susan Ann Denn, PA-C, MPAS
Administrative Chief Physician Assistant
Department of Medicine

Susan Ann Denn PA-C, MPAS

Supervisor Signature:

Supervisor Comments: