Jordan Villaruel
Hospital Visit H&P #3
HPI + ROS + Physical Exam

Identifying Data

Date:	05 / 18 / 2021
Time:	9:15 AM
Location:	NYP Queens Internal Medicine
Patient Name:	M.M.
Sex:	F
DOB:	07 / 03 / 1934
Informant:	Self
Reliability:	Reliable

Chief Complaint

"Chest pains" x 12 hours

HPI

M.M. is 86-year-old female with PMHx of HTN, HLD, hypothyroidism presented to the ED with complaints of chest pains for 12 hours. Pt Is A&O x 3 and not in any acute distress. Upon interview of the patient, she admits the chest pain began gradually when she got up this morning. She describes the chest pain was felt in the substernal region, is persistent in nature, has a "burning sensation" to it, and does not radiate elsewhere. She states the chest pain lasted for 12 hours before calling an ambulance. She rates the pain 7/10. The chest pain is not alleviated by anything and is worsened by lying down. Pt has not noticed any triggering factors. Admits to pyrosis, decreased appetite, chills, slight dysphasia, and sore throat. Denies nausea, vomiting, SOB, headache, palpitations, fever, abdominal pain, recent injury, changes in urinary/bowel habits, regurgitation of food, food intolerances, melena, aspirin use, or history of cardiac disease. Pt states she has never experienced this in the past and came to the hospital when the chest pain has not subsided.

Past Medical History

Present Illnesses:	HTN x 30 years, Hypothyroidism x 30 years, HLD x 20 years
Past Illnesses:	Denies
Immunizations:	Up to date Flu vaccine yearly
Screening Tests:	Mammogram 1995, 2005 both negative Colonoscopy 2012 negative Endoscopy 2007 negative
Hospitalizations:	Appendicitis in 1970 Infected Bartholin's cyst 1995

Medications:	Diltiazem 180 mg, 1 tab daily for hypertension Levothyroxine 75 mcg, 1 tab daily for hypothyroidism Simvastatin 10mg, 1 tab daily for hyperlipidemia
Allergies:	NDKA- Denies allergies to medication / food / environmental factors

Past Surgical History

Surgeries:	Appendectomy 1970, NYPQ – no complications
Transfusions:	Denies

Family History

Mother:	Deceased at 99 years old, cholangitis and breast cancer
Father:	Deceased at 67 years old, throat cancer
Daughter:	Living, 67 years old with HTN
Son:	Living, 62 years old and healthy
Son:	Living, 52 years old with Crohn's disease

Social History

M.M. is an 86 yo female, who is recently widowed and currently living in Queens by herself. A home nurse aide comes to assists her every other day.

Habits:	Drinks a cup of coffee every other day. Denies past and present alcohol, tobacco, substance use.
Diet:	She claims to have well-balanced diet consisting of fruits, vegetables, whole grains. Drinks Ensure every day. Tries to minimize salt and sugar intake.
Exercise:	Walks 10 minutes every other day around the neighborhood with the home nurse aide. Participates in her group center's virtual stretching exercise classes x 1 week. Sleeps well about 8 hours each night.
Sexual Hx:	Heterosexual, monogamous.

Review of Systems

General	Admits to recent fatigue, generalized weakness, loss of appetite, and chills since onset of chest pain. Denies recent weight loss or gain, fever, or night sweats.
Skin / hair / nails	Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, redness, open wounds, moles/rashes, pruritus, or changes in hair distribution.

Head	Denies headaches, vertigo, light-headedness, or recent head trauma.
Eyes	Admits to bifocal glasses use x 20 years. Denies blurring, diplopia, scotoma, eye fatigue, scotoma, halos, lacrimation, photophobia, pruritus, redness, or discharge. Last eye exam 2015 – normal. Visual acuity is unknown.
Ears	Admits to gradual loss of hearing in left ear for x 2 years. Denies deafness, pain, discharge, tinnitus, hearing aid use.
Nose / Sinuses	Denies discharge, epistaxis, nasal obstruction, trauma, pruritis or difficulty breathing.
Mouth / Throat	Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, swelling, pain, dryness, or use of dentures. Last dental exam unknown.
Neck	Denies decreased range of motion, neck pain and stiffness, trauma, localized swelling, or lumps.
Breast	Denies lumps, nipple discharge, pain, swelling in breast and armpit area. Last mammogram 2005 – normal.
Respiratory	Denies SOB / DOE, coughing, wheezing, hemoptysis, cyanosis, orthopnea, or PND.
Cardiovascular	Admits to HTN x 30 years. Denies palpitations, irregular heartbeat, edema / swelling of legs or feet, syncope, or known heart murmur.
Gastrointestinal	Admits to loss of appetite, pyrosis, dysphagia since onset of chest pain. Denies intolerance to specific foods, nausea, vomiting, pyrosis, dysphagia, unusual flatulence, eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding or blood in stool.
Genitourinary	Denies frequency, nocturia, urgency, oliguria, dysuria, polyuria, change in urine color, incontinence, hematuria, pyuria, dark brown urine, awakening at night to urinate, or flank pain. Sexual Hx: not sexually active Denies history of sexually transmitted diseases.
Menstrual/Obstetrical	G4 P0 T3 P0 A1 L3 Menarche age 12 LMP age 50. Denies dysmenorrhea, metrorrhagia, menorrhagia, premenstrual symptoms, abnormal vaginal discharge, bleeding or spotting, foul odor, trauma, itchiness, pain.

Nervous	Denies seizures, headaches, loss of consciousness, numbness, paresthesias, dysesthesias, hyperesthesia, ataxia, loss of strength, change cognition / mental status / memory, weakness, or tremors.
Musculoskeletal	Denies muscle/joint pain, deformity or swelling, redness, or arthritis.
Peripheral Vascular	Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes.
Hematologic	Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.
Endocrine	Admits to cold intolerance and hair loss since being diagnosed with hypothyroidism x 30 years. Denies polyuria, polydipsia, polyphagia, heat intolerance, goiters, excessive sweating, or hirsutism.
Psychiatric	Admits to having anxiety for 40 years. Has seen improvements due to seeing a mental health professional. Denies depression, OCD, memory loss, mental disturbance, suicidal ideations, hallucinations, paranoias, or psychiatric medication use.

Physical Exam

Vitals	BP: 147 / 74 RA, Fowler's position 148 / 75 LA, Supine RR: 18 breaths / min, unlabored Pulse: 95 beats / min O2 Sat: 98% Room air Temp: 36.9 C, oral Height: Info not provided / no equipment available Weight: Info not provided / no equipment available BMI: Info not provided / no equipment available
General	Neatly groomed, well- nourished, overall well appearing, appears stated age of 86. A&Ox3, cooperative, appears comfortable, not in acute distress.
Skin	Poor skin turgor, mild tenting. Warm, moist, smooth, even texture. Bilateral skin temperature consistently warm on all extremities. No masses, lesions, deformities, scars, tattoos. No discoloration, rashes, moles, pigmentations, bruises, macules, papules. Nonicteric.
Nails	Capillary refill <2 seconds throughout upper and lower extremities Unremarkable shape and color. Unremarkable nails and nail beds. No lesions, clubbing, infection.

Hair	Unremarkable quantity, even distribution, texture is thick. No seborrhea, lice, nits, dandruff. No masses, lesions, deformities on scalp. No swelling, trauma, tenderness, lesions on scalp.
Head	Unremarkable symmetry. Normocephalic, atraumatic, non-tender to palpation throughout. No abnormal facies. No, lesions, mass, deformities, depressions. No swelling, edema, scars.
Eyes	No signs of lesions, masses, deformities, discharge, abnormal color. Symmetrical OU. Sclera white, cornea clear, conjunctiva pink without injection or discharge. No strabismus, exophthalmos, ptosis. Visual acuity and visual fields not accessed due to limited time with patient. If exam was unremarkable→ Visual acuity uncorrected 20/20 OU. Visual fields full OU by confrontation, PERRLA. EOMS intact with no nystagmus.
Fundoscopy	Positive red reflex intact OU. Cup to disk ratio <0.5 OU. Diffuse yellow deposits noted. No opacities of lens, cornea. No AV nicking, hemorrhages, papilledema, or neovascularization OU.
Ears	Symmetrical and appropriate in size. No lesions, masses, deformities, trauma, swelling on external ears. No discharge / foreign bodies in auditory canals AU. Appropriate amount of cerumen. Tympanic membrane pearly white/intact with light of reflex AU. Auditory acuity poor to whispered voice AU. Weber lateralizes to none of the ears. Rinne reveals AC > BC AU.
Nose / Sinus	Unremarkable symmetry. No lesions, masses, discharge, deformities, discoloration, erythema, ecchymosis. No tenderness, bogginess, trauma, or step off. Rhinoscopic exam and sinus transillumination exam was not performed because patient felt discomfort and limited time. If exam was unremarkable → Nares patent bilaterally. Nasal mucosa pink & well hydrated. Septum midline without lesions / deformities / injection / perforation. Turbinates without erythema or edema. No foreign bodies. Sinuses are non-tender to palpation and percussion.
Mouth	Lips pink, moist, no cyanosis or lesions, swelling, fissures. Non-tender to palpation. Mucosa is pink, well hydrated. No masses, lesions, scars. Palate is pink, well hydrated and intact. Gums are pink, moist. No masses, lesions, erythema, discharge. Tonsils unremarkable and symmetric. Uvula midline. Hard and soft palette intact.

	Tongue is pink, well papillated. No masses, lesions, or deviations or injection. Did not to palpate for tenderness. Oropharynx shows no injection, masses, lesions, foreign bodies, discharge, exudates. Did not to palpate for tenderness.
Neck	Trachea midline rises well with swallowing. Symmetrical with no masses, lesions, scars. No abnormal pulsations noted, JVD, carotid thrills Supple, non-tender to palpation. Did not auscultate for carotid bruits.
Thyroid	Non-tender. No palpable masses, nodules, irregularities, cysts, thyromegaly. No palpable lymphadenopathy in pre/postauricular, occipital, tonsillar, submandibular, submental, superficial, anterior cervical, posterior cervical, supraclavicular, infraclavicular.
Thorax	Symmetrical, no deformities, no trauma, lesions, masses, or scars. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. No signs of pectus excavatum / pectus carinatum, scoliosis, or kyphosis. Non-tender to palpation throughout.
Lungs	Chest expansion on respiration and diaphragmatic excursion symmetrical and unremarkable. No clubbing at finger nails, no peripheral cyanosis. Clear to auscultation and percussion bilaterally, anteriorly and posteriorly. Tactile fremitus unremarkable and symmetrical throughout. No wheezes, rhonchi, crackles or adventitious sounds. No signs of consolidation. Resonant throughout percussion.
Heart	JVP is 2.5 cm above the sternal angle with the head of the bed at 30 degrees. No JVD noted. PMI not visualized. No abnormal pulsations noted. PMI palpablein the 5th intercostal space at midclavicular line. Did not palpate for hepatojugular reflex due to time constraint. If palpation for hepatojugular reflex was unremarkable → Hepatojugular reflex demonstrated distention of jugular veins. Carotid pulses are 2+ bilaterally without bruits. No heaves or thrills or lifts on palpation. Regular rate and rhythm. Auscultation reveled S1 and S2 are distinct with no murmurs or gallopps. No splitting of S2 or frictions rubs appreciated. No S3/S4 heard.
Abdomen	Protuberant abdomen and slight tenderness to palpation in epigastric region. Abdomen symmetric with no scars, bruises, varicosities, straie, lesions, masses, deformities, jaundice, ecchymosis, hernias, visible pulsations/peristalsis noted. Liver and spleen not percussed or palpated due to time constraint. If liver and spleen percussion and palpation were unremarkable → Liver span unremarkable in RUQ midclavicular line with lever edge palpable at R costal margin. Splenic percussion and palpation unremarkable.

Bowel sounds normoactive in all 4 quadrants with no aortic / renal / femoral bruits.
No venous hums / friction rubs.
Tympanic throughout. Liver measuring 6-12 cm at midclavicular line in RUQ.
No guarding or rebounding noted. No presence of ascites from negative fluid wave.
No hepatosplenomegaly to palpation. No CVA tenderness appreciated.
Negative Psoas, Obturator, Murphy's Rovsing's, Obturator, Fluid Wave, Shifting dullness signs.