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

Identifying Data

Date:	11 / 30 / 2021
Time:	10:00 AM
Location:	NYP Queens Emergency Department
Patient Name:	A. A.
Sex:	M
DOB:	08 / 15 / 1977
Informant:	Self
Reliability:	Reliable

Chief Complaint

"Heart palpitations for 4 hours"

HPI

A.A. is 44-year-old male with PMHx of HTN, DM II, GERD, General Anxiety Disorder, and arrhythmias presents to ER with complaints of heart palpitations for 4 hours. He states the palpitations started 4 hours ago when he woke up for work at 6 AM. He describes the palpitations as a sudden onset of pounding and racing sensations. The palpations are irregular, constant, and located in the upper left chest with no radiation. He states the palpations have remained the same since arriving to the ED. Pt denies any alleviating or exacerbating factors. He reports his blood glucose this morning was higher than usual at 273 mg/dL. Admits to diaphoresis, dry mouth, bilateral leg swelling, frequent urination, and feeling more anxious and stressed than usual. Denies chest pain, dizziness, dyspnea, nausea / vomiting, cough, fever, chills, loss of consciousness, drug or alcohol use, recent infection, tremor, heat intolerance, pyrosis, or any noticeable triggers. A.A. states he has never experienced this in the past.

Past Medical History

Present Illnesses:	HTN x 2 years DM II x 2 years GERD x 2 years Anxiety Disorder x 1 year Arrhythmia (type unknown) x 1 year
Past Illnesses:	Denies
Immunizations:	Up to date Flu vaccine yearly COVID-19 vaccine 2021
Screening Tests:	Prostate exam 2019 negative Colonoscopy 2016 negative

Hospitalizations:	Syncope 2019 Arrhythmia (type unknown) 2020
Medications:	Metformin 500mg, 2 tabs PO daily for DM Omeprazole 40mg, 1 tab daily for GERD Amlodipine 10mg, 1 tab daily for HTN Hydrochlorothiazide 25mg, 1 tab daily for HTN Aspirin 81mg, 1 tab daily for implantable loop-recorder
Allergies:	Morphine

Past Surgical History

Surgeries:	Loop recorder implant 2020, NYPQ – Due to arrhythmia, no complications
Transfusions:	Denies

Family History

Mother:	Living at 70 years old with hx of breast cancer
Father:	Living at 71 years old with HTN, DM
Daughter:	Living, 9 years old and healthy
Daughter:	Living, 6 years old and healthy

Social History

A.A. is a 44 yo male, who is married and currently living in Queens with his wife and 2 daughters. His occupation is a construction worker, in which he works 12 hour shifts 6-7 days a week.

Habits:	Denies past and present alcohol, tobacco, substance use.
Diet:	He claims to have a pescatarian diet consisting of fruits, vegetables, whole grains, and fish. Tries to minimize salt and sugar intake.
Exercise:	He is physically active, getting exercise daily at work by lifting or operating heavy machinery. Sleeps about 6 hours each night.
Sexual Hx:	Heterosexual, monogamous.

Review of Systems

General	Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever, chills, or night sweats.
Skin / hair / nails	Admits to excessive sweating throughout. Denies changes in texture, excessive dryness, discolorations, pigmentations, redness, open wounds, moles/rashes, pruritus, or changes in hair distribution.
Head	Denies headaches, vertigo, light-headedness, or recent head trauma.

Eyes	Denies blurring, diplopia, scotoma, eye fatigue, scotoma, halos, lacrimation, photophobia, pruritus, redness, or discharge. Admits to contacts use. Last eye exam 2016 – normal. Visual acuity is unknown.
Ears	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 neck pain, stiffness, decreased range of motion, trauma, localized swelling, or lumps.
Breast	Denies lumps, nipple discharge, pain, swelling in breast and armpit area.
Respiratory	Admits orthopnea x 5 years, uses 2 pillows. Denies SOB / DOE, coughing, wheezing, hemoptysis, cyanosis, or PND.
Cardiovascular	Admits to a history of HTN x 2 years, arrhythmia x 1 year, and bilateral edema / swelling of the legs and feet x 4 hours. Denies irregular heartbeat, syncope, or known murmurs.
Gastrointestinal	Denies irregular bowel movements, intolerance to specific foods, nausea, vomiting, pyrosis, dysphagia, unusual flatulence, eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding or blood in stool. Last colonoscopy 2016 – normal.
Genitourinary	Admits to frequent urination. Denies nocturia, urgency, polyuria, oliguria, dysuria, change in urine color, incontinence, hematuria, pyuria, dark brown urine, or flank pain. Last prostate exam 2019– normal. Sexual Hx: sexually active Denies history of sexually transmitted diseases.
Nervous	Denies seizures, headaches, loss of consciousness, numbness, paresthesias, dysesthesias, hyperesthesia, ataxia, loss of strength, change cognition / mental status, weakness, or tremors.
Musculoskeletal	Admits to swelling in the lower extremities bilaterally x 4 hours. Denies muscle/joint pain, deformity, redness, or arthritis.

Peripheral Vascular	Admits to peripheral edema in lower extremities x 4 hours. Denies intermittent claudication, coldness or trophic changes, varicose veins, or color changes.
Hematologic	Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.
Endocrine	Admits to polydipsia, polyuria, excessive sweating. Denies polyphagia, heat or cold intolerance, goiters, or hirsutism.
Psychiatric	Admits to anxiety x 1 year, sees a therapist for stress management. Denies depression, anxiety, OCD, memory loss, mental disturbance, suicidal ideations, hallucinations, paranoias, psychiatric medication use.

Physical Exam

Vitals	BP: 135 / 95 RA, Fowler's position 135 / 94 LA, Supine RR: 19 breaths / min, unlabored Pulse: 105 beats / min O2 Sat: 98% Room air Temp: 36.8 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 44. A&O x3, cooperative, appears comfortable, not in acute distress.
Skin	Warm, moist, smooth, even texture, good turgor. 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 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. 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 intact 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 due to limited time with patient. 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 are unremarkable and symmetric. Uvula midline. Hard and soft palette intact. Tongue is pink, well papillated. No masses, lesions, or deviations or injection. Did not palpate for tenderness. Oropharynx shows no injection, masses, lesions, foreign bodies, discharge, exudates. Did not 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 accessory muscle use. No clubbing of fingernails, no peripheral cyanosis. Clear to auscultation and percussion bilaterally, anteriorly and posteriorly. Tactile fremitus unremarkable and symmetrical throughout. No wheezes, rhonchi, crackles, adventitious / diminished breath 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 palpable in 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 revealed S1 and S2 are distinct with no murmurs or gallops. No splitting of S2 or frictions rubs were appreciated. No S3/S4 heard.
Abdomen	Abdomen symmetric with no scars, bruises, varicosities, straie, lesions, masses, deformities, jaundice, ecchymosis, hernias, visible pulsations/peristalsis noted. Non-tender to palpation and tympanic throughout. 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 liver 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.
Pelvic	Did not inspect or palpate penis and scrotum. Did not perform hernia examination due to time constraint and patient discomfort. If inspection and examinations were unremarkable → Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias palpated.

Rectal	Did not inspect, palpate, or perform anus, rectum, prostate exam due to time constraint and patient discomfort. If inspection and examination were unremarkable → No perirectal lesions, fissures, erythema, or signs of inflammation. External sphincter tone intact. Rectal vault without masses. Prostate lobes smooth and non-tender bilaterally with palpable median sulcus.
Neurologic	Cranial + Peripheral. See following.
CN I	Did not have odors to sample. If CN I exam were unremarkable → Intact smell to coffee and mint odors bilaterally.
CN II	Visual fields full OU by confrontation, PERRLA. EOMS intact with no nystagmus. Visual acuity 20/20 OU, uncorrected. Red reflex present, normal discs with sharp borders. No hemorrhages, exudates, or papilledema, optic atrophy.
CN III, IV, VI	EOMS intact with no nystagmus. Pupils reactive to direct light, consensual light and accommodation. Unremarkable convergence present. No ptosis.
CN V	Face sensation intact bilaterally to light touch and pain. Corneal reflex intact bilaterally. Strong contraction of jaw muscles without fasciculations or atrophy.
CN VII	Did not have taste solutions to sample. If CN VII exam were unremarkable → Intact taste sweet, salt, sour tastes. Facial expressions are symmetric and intact. No difficulty with BMP speech sounds. Strong eye muscle closure against resistance.
CN VIII	Auditory acuity intact to whispered voice AU. Weber lateralizes to none of the ears. Rinne reveals AC > BC AU.
CN IX and X	Uvula midline with elevation of soft palate, gag reflex intact. No difficulty swallowing. No hoarseness.
CN XI	Full ROM at neck. Strong shoulder shrug against resistance bilaterally.
CN XII	Tongue midline without fasciculations. Strong and symmetric tongue. No difficulty with LTND speech sounds.
Motor	Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Full active/passive ROM of all extremities without rigidity or spasticity. Strength 5/5 throughout against resistance.
Cerebellar	Coordination by rapid alternating movement, point-to-point intact, heel-shin test intact bilaterally. No asterixis Romberg, gait, pronator drift not performed because patient would not stand. If tests were unremarkable → Romberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact.

Sensory	Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, graphesthesia, two-point discrimination intact bilaterally.
Reflexes	Not performed due to time constraint. If reflexes were unremarkable → Deep tendon and abdominal reflexes 2+ throughout. Negative Babinski. No clonus appreciated.
Meningeal	No nuchal rigidity noted. Brudzinski's and Kernig's signs negative
Mental Status	Admit to history of GAD x 1 year, currently feels worried and stressed, sense of dread, and loss of interest in social activities. Intact judgement, insight, and cognitive function. Oriented to time, place, and person. Intact memory and attention for recent / remote events, digit span, and serial 7s. Intact language and speech. No depression or suicidal ideations.
Vascular	Edema 1+ bilaterally in lower extremities. Extremities are appropriate in color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No calf tenderness bilaterally, equal in circumference. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No bruits noted. No clubbing or cyanosis. No stasis changes or ulcerations.
MSK	No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral lower and upper extremities. Non-tender to palpation and no crepitus throughout. Full ROM of upper and lower extremities bilaterally.

Assessment

A.A. is a 44-year-old male with HTN, DM, GERD, GAD, and a loop recorder for arrhythmias presents to the ED with heart palpitations x 4 hours. Vitals within normal limits except for tachycardia. No concerning findings on PE besides MSE showing evidence of anxious mood.

Differential Diagnosis (most to least likely)

1. General Anxiety Disorder exacerbation
    - History of diagnosed GAD, currently sees a therapist for stress management / CBT
    - Presents diaphoretic, tachycardic, and feels more anxious than normal
    - Admits to recent stressful events at home and work
2. Arrhythmia
    - History of diagnosed arrhythmia (type unknown)
    - Implantable loop recorder
    - Presents tachycardic
3. Hyperglycemia
    - History of DM
    - Blood glucose level abnormally high at 273 mg/dL
    - Presents with increased thirst, frequent urination
4. CHF
    - History of hypertension
    - Presents with bilateral leg edema
5. MI
    - History of arrhythmias

Plan

1. DM
    - Continue home regimen: Metformin 500mg, 2 tabs PO daily for DM
    - Glucose monitoring with finger sticks q4
    - Consult nutrition for pt education
    - Notify PA if glucose abnormal
    - Measure I & O q6 for c/o polyuria & polydipsia
2. HTN
    - Continue home regimen: Amlodipine 10mg PO, Hydrochlorothiazide 25mg PO
    - Monitor BP q4
    - Notify PA if vitals abnormal
3. GAD
    - Consult psych
    - Start Escitalopram 5mg PO qd
    - Continue weekly CBT sessions with therapist
4. GERD
    - Continue home regimen: Omeprazole 40mg PO
    - Consult nutrition for pt education
5. Arrhythmia / Loop recorder
    - Continue home regimen: Aspirin 81mg PO
    - Obtain baseline EKG
    - CXR to check loop recorder positioning

Labs EKG, CBC, CMP, UA, HgA1c, Fingerstick
Troponins, CPK-MB
CXR

Consult Psychology, Cardiology, Nutrition