Jordan Villaruel
Hospital Visit H&P #1
Physical Diagnosis II HPI + ROS + Physical Exam + A&P

Identifying Data

Date:	09 / 28 / 2021
Time:	8:30 AM
Location:	NYP Queens Pre-Admission Testing
Patient Name:	M.H.
Sex:	F
DOB:	08 / 27/ 1965
Informant:	Self
Reliability:	Reliable

Chief Complaint

"Lower back pain" x 15 years

HPI

M.H. is 56-year-old female with no significant PMHx presents to PAT with complaints of lower back pain for 15 years. She claims the back pain is due to heavy breast weight following breast augmentation in 2006. The pain has gradually gotten worse over the last year. Upon interview of the patient, she admits the back pain is constant and throbbing. She describes the pain to be localized to the lumbar region and radiates to the neck and shoulders. She rates the pain 10/10. The pain is alleviated with Advil 600mg and is aggravated with sudden movement and exercise. Admits to neck stiffness, arm weakness, and limited ROM. Denies SOB, headache, fever, chills, weight loss, recent injury / trauma, changes in urinary habits, paresthesias, lower extremity pain, claudication, recent infection, chest pain, and abdominal pain. Since patient has lost 20 lbs required for surgical intervention, breast reduction surgery is scheduled in 7 days to alleviate back pain.

Past Medical History

Present Illnesses:	Denies
Past Illnesses:	Denies
Immunizations:	Up to date Flu vaccine yearly COVID-19 vaccine 2021
Screening Tests:	Endoscopy 2010 negative Mammogram 2015, 2021 both negative
Hospitalizations:	Bilateral broken thumbs 2009 Early stage non-alcoholic fatty liver disease (NAFLD) 2012

Medications:	Denies
Allergies:	Morphine

Past Surgical History

Surgeries:	Cholecystectomy 2004, NYPQ – no complications Bilateral thumb ligament reconstruction 2009 NYPQ – Due to work injury, no complications Bariatric surgery 2012 NYU Langone– Due to NAFLD, no complications
Transfusions:	Denies

Family History

Mother:	Living at 80 years old with dementia
Father:	Deceased at 67 years old, natural causes
Daughter:	Living, 26 years old with Chron's disease
Son:	Living, 24 years old and healthy
Son:	Living, 19 years old and healthy

Social History

M.H. is a 56 yo female, who is married and currently living in Queens by with her husband and 3 children. She currently works as a part-time certified nurse assistant in the Bronx.

Habits:	Drinks 1-2 cups of tea every day. Denies past and present alcohol, tobacco, substance use.
Diet:	She claims to have an "inconsistent diet" consisting of breakfast sandwiches or fruits for breakfast and lunch. Occasionally will have chips and cookies for snacks. Rice, dairy, and beef frequently for dinner.
Exercise:	Walks her dog 1 mile every day. Sleeps well about 7 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	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	Denies blurring, diplopia, scotoma, eye fatigue, scotoma, halos, lacrimation, photophobia, pruritus, redness, or discharge. Denies contact or glasses use. Last eye exam 2017 – 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	Admits to neck pain, stiffness, decreased range of motion secondary to heavy breast weight. Denies trauma, localized swelling, or lumps.
Breast	Denies lumps, nipple discharge, pain, swelling in breast and armpit area. Last mammogram 2021 – normal.
Respiratory	Denies SOB / DOE, coughing, wheezing, hemoptysis, cyanosis, orthopnea, or PND.
Cardiovascular	Denies history of HTN, palpitations, irregular heartbeat, edema / swelling of legs or feet, syncope, or known heart murmur.
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.
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: sexually active Denies history of sexually transmitted diseases.
Menstrual/Obstetrical	G5 P0 T3 P0 A2 L3 Menarche age 11 LMP age 50. Denies dysmenorrhea, metrorrhagia, menorrhagia, premenstrual symptoms, abnormal vaginal discharge, bleeding or spotting, foul odor, trauma, itchiness, pain.
Nervous	Admits to recent changes in memory, forgetfulness. Denies seizures, headaches, loss of consciousness, numbness, paresthesias, dysesthesias, hyperesthesia, ataxia, loss of strength, change cognition / mental status, 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	Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiters, excessive sweating, or hirsutism.
Psychiatric	Denies depression, anxiety, OCD, memory loss, mental disturbance, suicidal ideations, hallucinations, paranoias, psychiatric medication use or ever seeing a mental health professional.

Physical Exam

Vitals	BP: 125 / 84 RA, Fowler's position 122 / 84 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 56. A&Ox3, 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 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. 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, adventitious / diminished breathsounds. 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 gallops. No splitting of S2 or frictions rubs 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 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.

Pelvic	Did not inspect or perform external, internal, bimanual examination due to time constraint. If inspection and examinations were unremarkable → External genitalia without erythema, lesions, or tenderness. Vaginal mucosa pink without inflammation, lesions, or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender, and not enlarged. No adnexal tenderness or palpable masses noted. Pap smear obtained. No inguinal adenopathy.
Rectal	Did not inspect, palpate, or perform rectovaginal exam due to time constraint. If inspection and examination were unremarkable → Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation, lesions, masses, or excoriations. Good anal sphincter tone. No palpable masses or tenderness. Trace brown stool present in vault. FOB negative.
Breast	Symmetric, no dimpling or retraction. Scars from previous breast augmentation noted. No erythema, skin thickness, rashes, or lesions. Nipples symmetric without discharge or lesions. No masses or tenderness to palpation. No axillary nodes palpable.

Assessment

M.H is a 56-year-old patient currently in stable condition scheduled for breast reduction surgery in 1 week to alleviate on-going back pain. Low surgical risk level.

Differential Diagnosis

1. Chronic lower back pain secondary to heavy breast weight
    - No evidence of neurologic compromise
    - Heavy breast tissue places patient at a higher risk of developing persistent disabling back pain
    - Pain starting after breast augmentation to size 38 H
    - ROM limited by pain and pain worse with movement
2. Muscle strain
    - No evidence of neurologic compromise
    - ROM limited by pain and pain worse with movement
3. Disc herniation
    - Lumbar back pain worsened with movement
4. Ankylosing spondylitis
    - Lumbar back pain associated with stiffness
5. Osteoarthritis / Spinal stenosis
    - Lumbar back pain

Plan

M.H. may proceed with breast reduction surgery as scheduled, pending anesthesia clearance and unremarkable lab findings. Follow-up with patient upon notification of medical clearance. Discuss pre-op and post-op management and possible complications.

Tests	Lumbar CT, EKG UA, PT/PTT, T&S, CBC, BMP

Medication	Naproxen 500mg PRN
Consult	Plastic Surgery, Anesthesiology