Malka Einhorn

5/2/23

H&P- ER

History

Identifying Data:

Date & Time: May 2, 2023, 9:00 AM

Full Name: C.S.

Location: Flushing, Queens, NY

Sex: Male

Date of Birth: March 21, 1995

Marital Status: Single

Religion: Christian

Source of Information: Self

Reliability: Reliable

Source of Referral: Self

Mode of Transport: Self

Chief Complaint: "I have lower back pain" x2 days.

History of Present Illness:

28 year old male with PMH of asthma presents to ER complaining of lower back pain for two days, with no known trauma to area. Pt admits to pain that comes and goes throughout the day. When the pain comes it begins as a sharp pain that lasts about 1 min and then becomes a dull, achy pain which persists for about 20-30 minutes. Pain is the worst during the first minute and is ranked at a 7/10, with it then turning into pain at a level of 4/10 after the first minute of sharp pain. Pain is confined to the lumbar spine region with no radiation. Pt admits that lying down for long periods of time exacerbates the pain, whereas there are no known alleviating factors.

Pt denies fatigue, fever, loss of strength, weakness, sensory disturbances, muscle deformity or swelling

Past Medical History:

Present illnesses: Asthma x 24 yrs, well controlled on meds

Childhood illnesses: None

Immunizations: up to date, flu vaccine received 11/22, received 3 doses of the Pfizer covid vaccine

Screening tests and results: none needed at this age

Past Surgical History:

None

Medications:

Albuterol (unknown dose) PRN, for asthma

Denies use of any other medications/supplements.

Allergies:

NKDA, denies food/environmental allergies.

Family History:

Paternal/maternal grandparents – deceased at unknown ages due to unknown reason

Mother – alive and well, 68 years old

Father – alive, diagnosed with DM at age 50, 69 years old

Children- None

Siblings- 4 brothers (aged 40, 37, 36, 31), all alive and well

Social History:

Habits: Pt admits to drinking alcohol occasionally on the weekends (approx. 3 drinks each weekend) and to drinking about 3 cups of coffee per week. Denies smoking history and present illicit drug use. Denies history of substance abuse.

Travel: Denies any recent travels out of state or country.

Marital History/Home Situation: Single, living with 2 roommates.

Occupational History: Cashier

Diet: Admits to diet with “too many carbs.” Tries to maintain a diet of meats, vegetables and healthy grains.

Sleep patterns: Pt sleeps 6-7 hours daily, however the sleep is restless with a lot of tossing and turning. Sleep quality declined with onset of pain.

Exercise: Goes jogging for a half hour twice a week.

Safety Measures: Admits to wearing seatbelts.

Sexual History: Heterosexual. Reports being sexually active with 3 female partners in the past 6 months. Admits to use of barrier protection.

Review of Systems:

General: Denies generalized weakness /fatigue, recent weight loss, loss of appetite, fever, chills, or night sweats.

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

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbance, lacrimation, photophobia, or pruritus. Wears contact lenses, last eye exam was in 08/22.

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

Nose/Sinuses: Denies discharge, epistaxis, or obstruction.

Mouth and Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures. Last dental exam 08/22, normal.

Neck: Denies localized swelling/lumps or stiffness/decreased range of motion.

Breast: Denies lumps, nipple discharge, or pain.

Pulmonary System: Denies shortness of breath, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System: Denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System: Denies loss of appetite, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, constipation, rectal bleeding, hemorrhoids or blood in stool. Admits that bowel movements are regular, daily.

Genitourinary System: Denies urinary frequency, nocturia, dysuria, urgency, flank pain, oliguria, polyuria and incontinence.

Nervous System: Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory.

Musculoskeletal System: Admits to muscle/joint pain. Denies deformity or swelling, redness or arthritis.

Peripheral Vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes.

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

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric: Denies feelings of helplessness, hopelessness, lack of interest in usual activities, or suicidal ideations, anxiety, obsessive/compulsive disorder, or ever seeing a mental health professional.

Physical

General: well developed, well-nourished, slightly overweight male in no apparent distress. Appears stated age of 28. Neatly groomed, alert and oriented x3. Lying in bed so no assessment on ability to ambulate.

Vital Signs:

BP:

R- Seated:125/81 mm Hg

Supine :123/77 mm Hg

L- Seated: 125/82 mm Hg

Supine: 120/80 mm Hg

R: 15/min, regular rate and rhythm, unlabored

P: 71 beats per minute, regular rate, rhythm and amplitude

T: 98 degrees F(oral)

O2 Sat : 98% room air

Height: 70 inches Weight: 202 lbs BMI: 29.0

Skin & Head:

Skin: Warm and moist, good turgor. Nonicteric, no lesions, scars, or tattoos noted.

Hair: Frontal balding with average texture. No alopecia, seborrhea, or lice on exam.

Nails: No clubbing, cyanosis, or lesions. Capillary refill < 2 seconds in upper and lower extremities.

Head: Normocephalic, atraumatic with no evidence of contusions, ecchymoses, hematomas, or lacerations, and nontender to palpation throughout.

Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.

Visual acuity – 20/20 OS, 20/20 OD, 20/20 OU

Visual fields – full OU. PERRLA. EOMs intact with no nystagmus.

Fundoscopy – red reflex intact OU on fundoscopy. Cup to disk ratio < 0.5 OU. No AV nicking, hemorrhages, exudates, or neovascularization OU

Ears: Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TMs pearly gray/intact with light reflex in good position AU.

Auditory Test:

Auditory acuity intact on whisper test

Weber is midline

Rinne AC> BC bl

Nose/Sinuses:

Nose: Symmetrical. No masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa is pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No foreign bodies.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.

Mouth/Pharynx:

Lips: Pink and moist. No cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink and well hydrated. No masses, lesions or leukoplakia. Non-tender to palpation.

Palate: Pink and well hydrated. Palate intact with no lesions, masses, scars. Continuity intact. Non-tender to palpation.

Teeth: Good dentition. No obvious dental caries noted.

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

Tongue: Pink and well papillated. No masses, lesions or deviation. Non-tender to palpation.

Oropharynx: Well hydrated. No injection, exudate, masses, lesions or foreign bodies. Tonsils present with no injection or exudate. Grade 1 tonsils. Uvula midline, pink with no edema or lesions.

Neck/Trachea/Thyroid:

Neck: Trachea midline. No masses, lesions, scars, pulsations. Supple and non-tender to palpation. FROM, no stridor noted. 2+ carotid pulses, no bruits or thrills noted bilaterally. No cervical adenopathy.

Thyroid: Non-tender to palpation. No masses, thyromegaly or bruits noted.

Thorax and Lungs:

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

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Cardiac Exam:

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

Abdominal Exam:

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

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. Seligson, J. Yuan &
L. Sanassi
Contact: Jeanetta Yuan
jyuan1@york.cuny.edu

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.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Malka Einhorn

Clinical Site: NYPQ

Date of Visit: 5/2/23

Activity performed: History + Physical

Supervisor:

Name and Credentials: Anita Lui, DO

Supervisor Signature:

Supervisor Comments: