Malka Einhorn
Prof. Seligson

Identifying Data:
Full Name: S.S.
Address: Flushing, NY
Date of Birth: November 22, 1985
Date & Time: March 7, 2023, 10:15 am
Location: NYHQ, Flushing, NY
Religion: Atheist
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Ambulance

Chief Complaint: "I have HF" x 1 week.

History of Present Illness:
37 y/o male with PMH of HTN and CHF presents with chest pain, orthopnea, dyspnea on exertion and cough x 7 days. Pt states that chest pain began "out of nowhere" 7 days ago and that orthopnea, dyspnea (on exertion) and cough developed the next day. Chest pain stays localized on L side of chest with no radiation. The pain is described as heavy and is worse after any sort of activity (at any time of day). Pain lasts for a few minutes after resting. Walking (or activity) makes pain worse and rest is the only thing that provides some relief. Currently, pt says pain is 3/10 with the worst being 8/10 immediately after walking. Pt states that dyspnea is severe and that he can only walk 10-15 minutes without feeling short of breath. Additionally states that he cannot lie down without feeling short of breath, and has been sleeping while sitting upright x 6 days. These feelings lasted throughout the day with no alleviating factors. Exercise and laying down exacerbated the symptoms. Pt also states that he has peripheral edema and ascites x 7 days.

Denies fever, diaphoresis, headaches, diarrhea, palpitations, syncope, known heart murmurs, wheezing, hemoptysis, cyanosis and calf pain.

Past Medical History:
Present illnesses – Hypertension x 22 years, CHF x 5 years
Both poorly controlled due to poor patient adherence
Past medical illnesses – Denies all past medical illnesses
Childhood illnesses –Denies childhood illnesses.
Immunizations – Up to date; denies having flu or covid vaccines
Screening tests and results – no screening tests done

Past Surgical History:
Denies past surgeries, injuries or transfusions.
Pt has been hospitalized many times ("at least 35 times") for symptoms of CHF

Medications:
Aspirin 81 mg daily, oral
Atorvastatin 80 mg QHS, oral
Carvedilol tablet 6.25 mg BID, oral
Enoxaparin sodium 40 mg daily, subcutaneous
Folic acid 1 mg daily, oral
Furosemide 80 mg Q12H, IV
Hydralazine 50 mg Q8H, oral
Isosorbide dinitrate 10 mg TID, oral
Lisinopril tab 5 mg daily, oral
Multi vitamin 1 tablet daily, oral
Pantoprazole (enteric coated) 40 mg daily, oral
Thiamine tablet 100 mg daily, oral

Allergies:
No known drug, food or environmental allergies

Family History:
Mother – alive and well, unknown age
Father – alive and well, unknown age
Brother – alive and well, unknown age
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons
No children
Denies family history of cancer.

Social History:
Mr. S is a single male, living alone. He is unemployed, due to CHF and frequent hospitalizations.
Habits - He has a 17 pack year smoking history and admits to drinking liquor daily. Generally, does not drink coffee, however in the hospital has one cup of coffee daily. Denies drug use.
Travel – No recent travel.
Diet - He primarily maintains a vegan diet. Prefers to eat vegetables and fruits because he does not like to kill animals, however will eat chicken occasionally. Tries to limit fluid intake.
Exercise – Does not exercise; cannot walk for more than 10-15 minutes without dyspnea.
Safety measures - Admits to wearing a seat belt.
Sleep – 6-7 hrs nightly before onset of symptoms 7 days ago. Now, pt gets intermittent sleep throughout the night and feels fatigued throughout the day.
Sexual Hx – He is not sexually active and denies history of sexually transmitted diseases.

Review of Systems:
General – Admits to fatigue x 7 days. Denies recent weight loss or gain, loss of appetite, fever or chills, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headaches, vertigo or head trauma.

Eyes – Denies lacrimation, photophobia, pruritus and visual disturbances such as blurring, diplopia, fatigue with use of eyes, scotoma or halos. He does not wear glasses. Last eye exam unknown.

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

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use of dentures. Has never had dental exam.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Admits to cough, dyspnea, dyspnea on exertion, orthopnea, and paroxysmal nocturnal dyspnea (PND) x 7 days. Denies wheezing, hemoptysis and cyanosis.

Cardiovascular system – Admits to chest pain, edema/ankle swelling and ascites x 7 days. Has a history of hypertension x 22 yrs and CHF x 5 yrs. Denies palpitations, irregular heartbeat, syncope or known heart murmur.

Gastrointestinal system – Has regular bowel movements daily. Denies loss of appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructation, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Admits to urinary frequency, urgency and nocturia. Denies oliguria, polyuria, dysuria, hematuria, pyuria, incontinence and flank pain.

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

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Admits to peripheral edema x 7 days. Denies intermittent claudication, coldness or trophic changes, varicose veins, or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system – Admits to polydipsia x 2 weeks. Denies polyuria, polyphagia, heat or cold intolerance, goiter, excessive sweating or hirsutism.

Psychiatric – Denies feelings of helplessness or hopelessness, lack of interest in usual activities,

suicidal ideation, anxiety, OCD, use of psychiatric medications or history of seeing a psychiatrist.

Physical

General: Male. Patient appears stated age of 37, neatly groomed and oriented, in mild respiratory distress. Ambulates well without support.

Vital Signs:

BP:		R	L
	Seated	122/83	121/85
	Supine	118/80	119/79

R: 19/min slightly labored P: 63 bpm, regular

T: 97 degrees F (oral) O2 Sat: 98% Room air

Height 67 inches Weight 145 lbs. BMI: 22.7

Skin: Warm & moist, good turgor. Nonicteric, no scars, tattoos. Multiple red irritations on bilateral arms and forearms from IV.
Hair: Temporal balding with fine texture, no lice, lesions or seborrhea.
Nails**:** No clubbing, lesions or infection. Capillary refill <2 seconds in upper extremities.
Head: Normocephalic, atraumatic, non-tender to palpation throughout. No swelling noted.

YORK COLLEGE
The City University of New York

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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 Eynhorn

Clinical Site: Internal med

Date of Visit: March 7, 2023

Activity performed: HPI

Supervisor:

Name and Credentials: Bilal Hanif Senior PA

Supervisor Signature:

Supervisor Comments:

Excellent presentation