10/3/23

H&P- PAT

History

Identifying Data:

Date & Time: October 3, 2023, 9:23 AM

Full Name: M.G.

Location: Flushing, Queens, NY

Sex: Female

Date of Birth: November 28, 1975

Marital Status: Married

Religion: Christian

Source of Information: Self

Reliability: Reliable

Source of Referral: Doctor

Mode of Transport: Self

Chief Complaint: "I'm going to have the sleeve" in 1 week.

History of Present Illness:

45 year old female presents with BMI of 60.6 and is here for pre-op gastrectomy workup. Pt has struggled with fluctuating weight for many years, however the past 5 years has been marked with significant weight gain. Pt has a history of hypothyroidism not yet well controlled on meds. Despite attempts for weight loss with diet and exercise, adequate weight loss has not been achieved. Pt states that her weight interferes with her daily life. She is a technician in NYPQ and experiences dyspnea with even just a few steps. Pt also has asthma and says that with minimal exertion (walking a few steps), wheezing is induced and rescue inhaler is required. Additionally, pt states that she feels pain in bilateral knees, heels, shoulders and lower back. The pain has gotten worse in the past 5 years, as her weight increased considerably. The pain is described as a 10/10, sharp pain that lasts all day. The pain does not radiate and is only slightly relieved with oxycodone. The pain is aggravated by walking.

Pt denies DM, urinary frequency/urgency, nocturia, polydipsia, vaginal candidiasis, intermittent claudication, chest pain, cough, new heart murmurs, history of venous thromboembolisms, strokes or ACS.

Past Medical History:

Present illnesses: Hypothyroidism x1 year, currently uncontrolled, undergoing titration for dose

PCOS x20 years, well controlled on medication

Asthma x35 years, well controlled on medication

Anemia x5 years, well controlled on medication

Previous illnesses: None

Childhood illnesses: Chicken pox age 8

Immunizations: up to date, flu vaccine received 11/22 (due to get a new one this month), received 4 doses of the Pfizer covid vaccine

Screening tests and results: Mammogram 05/2023, no abnormal findings

Pap smear 04/2023, no abnormal findings

Past Surgical History:

- Partial hysterectomy, 2000- ectopic pregnancy, NYPQ, no complications
- Thyroidectomy, 2022- unknown reason, NYPQ, post-removal hypothyroidism
- Cholecystectomy, 09/2023- symptomatic gallstones, NYPQ, no complications

Medications:

- Levothyroxine (unknown dose) for hypothyroidism
- Unknown medication for PCOS
- Albuterol (unknown dose) PRN for asthma
- Vitamin B12 (unknown dose) for anemia
- Iron (unknown dose) for anemia

Denies use of any other medications/supplements.

Allergies:

PCN- hives and fever

Morphine- palpitations

Denies food/environmental allergies.

Family History:

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

Mother – alive (age 68) with HTN and DM

Father – alive (age 72) with HTN and DM

Children- two sons (twins), aged 7

Siblings- none

Social History:

Habits: Pt admits to drinking alcohol occasionally (about 1 drink per week) and drinking coffee once a week, in attempts to cut back on caloric intake. Denies smoking cigarettes, illicit drug use and history of substance abuse.

Travel: Returned from Ecuador last month (09/2023).

Marital History/Home Situation: Married, living with husband and children, no pets.

Occupational History: Hospital technician

Diet: Admits to unhealthy diet with chocolate and junk food, vegetables rarely and no protein.

Sleep patterns: Pt sleeps 5 hours daily and feels rested.

Exercise: No exercise.

Safety Measures: Admits to wearing seatbelts.

Sexual History: Heterosexual. Reports being sexually active with 1 male partner in the past 6 months. Denies use of barrier protection.

Review of Systems:

General: Denies generalized weakness /fatigue, 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 06/23.

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 04/23, normal.

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

Breast: Denies lumps, nipple discharge, or pain.

Pulmonary System: Admits to shortness of breath, dyspnea, dyspnea on exertion and wheezing. Denies cough, 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 constipation, loss of appetite, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, rectal bleeding, hemorrhoids or blood in stool.

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

Menstrual/Obstetrical: G2P0202, LMP 09/30/2023; denies postcoital bleeding, vaginal discharge, dyspareunia.

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 in knees and back. 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: Admits to anemia. Denies 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, obese female in no apparent distress. Appears stated age of 45. Neatly groomed, alert and oriented x3. Ambulates well without support, though dyspnea is noted on abulation.

Vital Signs:

BP:

R- Seated:100/71 mm Hg

Supine :97/70 mm Hg

L- Seated: 103/72 mm Hg

Supine: 100/70 mm Hg

R: 16/min, regular rate and rhythm, unlabored

P: 62 beats per minute, regular rate, rhythm and amplitude

T: 98.6 degrees F (oral)

O2 Sat : 98% room air

Height: 57 inches Weight: 280 lbs BMI: 60.6

Skin & Head:

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

Hair: No 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-palpable due to removal

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 round 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. No CVA tenderness appreciated.

Pelvic Exam:

Genitalia: external genitalia without erythema or lesions. Vaginal mucosa Pink without inflammation, erythema or discharge. Cervix multiparous, pink and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. No inguinal adenopathy.

Rectal: rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stools present in vault.

Neuro Exam:

Cranial Nerves: CN I- XII are intact

II, III, IV, VI: visual acuity 20/20 bilaterally. Visual fields normal in all quadrants. PERRLA. EOMS intact without ptosis.

V: Facial sensation intact bilaterally to dull and sharp stimuli.

VII: Facial muscle strength is equal and normal bilaterally.

VIII: Hearing is normal bilaterally.

IX, X: Palate and uvula elevate symmetrically, with intact gag reflex. Voice is normal.

XI: Shoulder shrug strong and equal bilaterally.

XII: Tongue protrudes midline and moves symmetrically.

Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal

quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Problem List

- Obesity
- Joint/back pain
- Hypothyroidism
- PCOS
- Asthma
- Anemia

Assessment

45 year old female with past medical history of hypothyroidism, PCOS, obesity and anemia presents with knee and back pain x5 years. Pt also experiences severe dyspnea with minimal exertion and dyspnea at rest. On exam, pt presents with a BMI of 60.6. No notable abnormalities on physical exam, other than no palpable thyroid post-thyroidectomy. The chief complaint is most consistent with obesity induced pain and dyspnea. No labs are available at this time.

Differential Diagnosis

1. **Obesity due to high caloric diet:** The pt admits to eating a poor diet filled with calorie dense foods. Obesity can cause the symptoms that she is experiencing such as joint pain and dyspnea.
    - This is a diagnosis of exclusion

2. **Arthritis:** Arthritis often presents with pain and stiffness of one or multiple joints, especially during movement. This is consistent with the pain that the pt is experiencing, which is exacerbated by movement. This differential does not account for the dyspnea.
    - X-ray of the lower extremities should be done to assess for arthritis of the knees

3. **Type 2 Diabetes Mellitus:** Due to the patient's BMI it is not unlikely that she also has DM2. DM2 can sometimes lead to knee pain that is worsened with walking, as she states she is experiencing. Additionally, pts with DM may experience dyspnea due to hyper or hypoglycemia. Although, this diagnosis is not so likely as the typical symptoms of vaginal candidiasis, polydipsia and urinary frequency are not present.
    - HgA1C should be obtained.

4. **COPD (chronic bronchitis):** Pts with chronic bronchitis often present with obesity and shortness of breath. However, this diagnosis is not so likely because the patient has no history of smoking. This diagnosis would also not explain the knee or back pain. Additionally, pts with chronic bronchitis must have a productive cough for 3 months for the past 2 years, which this pt did not experience.

- PFTs (looking at FEV1/FVC) and chest x-ray

5. **Gout:** Gout can cause flare ups of joint pain. This is not the best differential because it usually affects the big toe and causes redness and tenderness of the affected joint. This also would not explain the dyspnea. Additionally, flare ups are generally more acute and do not last 5 years.
    - Preferred diagnosis of gout is visualization of monosodium urate crystals on polarizing light microscopy from synovial fluid (arthrocentesis) of affected joint.

Work-Up

Lower extremity x-ray, chest x-ray, PFTs, HgA1C, arthrocentesis

Plan

Obesity

- Pre-op workup for gastrectomy
- Diet and exercise education

Joint/back pain

- Ibuprofen 200-400 mg Q4-6 hrs PRN
- If pain is refractory to ibuprofen: Oxycodone 5-15 mg Q4-6 hrs PRN
- Reassess post-op

Hypothyroidism

- Refer to endo for continued titration of Levothyroxine

PCOS

- Continue medications as prescribed
- Follow up with endo/gyn as needed

Asthma

- Albuterol PRN
- Follow up with pulm as needed

Anemia

- Continue B12 and iron as prescribed
- Follow up with heme as needed

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: ~~PAT~~ NYPQ

Date of Visit: 10/3/23

Activity performed: PAT

Supervisor:

Name and Credentials: Naeem Sadat, PA-C PRAC

Supervisor Signature:

Supervisor Comments: