Arianne Diaz
March 06, 2023
Physical Diagnosis I
Professor L. Sanassi

History and Physical

History

Identifying Data:

Full Name: H.F.
Address: N/A
Date of Birth: 09/09/1941
Date & Time: 02/28/2023, 10:15 am
Location: Queens Presbyterian Hospital
Religion: N/A
Source of Information: Self
Reliability: Reliable
Source of Referral: Cardiologist
Mode of Transport: N/A

Chief Complaint: "My cardiologist told me to go to the Emergency Room because my potassium was too high and my legs were swollen" for several months.

History of Present Illness:

81-year-old female with 86-pack year history, PMH COPD, HTN, Atrial Fibrillation, and Hypercholesterolemia presents to the internal medicine after being evaluated in the emergency room for complaints of "several months" of bilateral lower leg edema L>R and hyperkalemia. Sates that pain is constant but worse at night and radiates up bilateral legs. Has not taken any OTC medication for pain and rates it 4/10. Reports that pain is worse when she walks long distances or stands "for too long" and is alleviated by sitting or lying down (here I should have asked how many times she is able to walk up and down the hall/for how many minutes can she stand before she feels discomfort). Pt was previously on Acetazolamide and Losartan, but was switched to Entresto and Farxiga about 1 month ago. Pt denies any h/o surgery, recent travel, fevers, chills, nausea, vomiting or diarrhea.

Past Medical History:

COPD
HTN
Atrial Fibrillation
Hypercholesterolemia

No Childhood Illnesses
Immunizations – Up to date; COVID vaccine + Booster
Screening test and results – Screening Colonoscopy 2018, benign.
Screening Mammography 2017, benign
Venous Doppler US (11/13/2022) was unremarkable.

Past Surgical History:
Denies past surgeries.
Denies any blood transfusions.

Medications:
Patient did not recall the dosing for any of her medications
Medication for Hypercholesterolemia
Losartan for Hypertension
Acetazolamide "as a water pill"
Digoxin "for the heart"
Symbicort "but [patient] does not know why she takes it"

Allergies:
NKDA
No known food or environmental allergies

Family History:
Mother – Deceased at unknown age & unknown reasons; had no medical history as per pt
Dad – Deceased at unknown age & unknown reasons; had no medical history as per pt
Denies family history of cancer, diabetes or myocardial infarctions
Patient has two sons (at this point I should have asked if either of her sons have any medical issues)

Social History:
H.F is a widowed F living with her eldest son
Habits – Pt has 86 pack year history (2 packs a day for 43 years). Reports occasional EtOH use.
Drinks 1-2 cups of coffee/day. Denies any illicit drug use.
Travel – No recent travel.
Diet – consists of "Meals on Wheels" which patient states is "lousy"
Exercise – walks around nursing station x2-3 a week
Safety measures – Pt is fall-risk, uses walker to ambulate
Sexual Hx – Patient is not sexually active
Denies history of sexually transmitted diseases

Review of Systems:

General – Admits generalized fatigue and weakness. Denies loss of appetite, recent weight loss or gain, fever, chills, night sweats.

Skin, hair, nails – Reports black/blue discoloration on bilateral hands and arms from needlesticks performed while in the hospital. Denies any changes in texture, excessive dryness or sweating, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Head – Denies headache, vertigo, head trauma, unconsciousness, coma, or fracture.

Eyes – Admits lacrimation b/l eyes, uses glasses. Denies contact use, visual disturbances, photophobia, or pruritus. Last eye exam was Jul 13, 2022.

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

Nose/sinuses – Denies discharge, obstruction or epistaxis.

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

Breast – Denies lumps, nipple discharge, or pain.

Mouth/throat – Admits she uses partial dentures. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, or voice changes. Last dental exam was 5 years ago.

Pulmonary system – Admits SOB, orthopnea. Uses 3-4 pillows to sleep. Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – h/o HTN. Admits to irregular heartbeat, edema/swelling of ankles and feet. Denies syncope or known heart murmur.

Gastrointestinal system: Has regular bowel movements daily. Admits to h/o hemorrhoids. Denies nausea, diarrhea and abdominal pain, change in appetite, vomiting, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies nocturia, dysuria, urinary frequency or urgency, oliguria, polyuria, incontinence, or flank pain.

Menstrual/Obstetrical – Pt is menopausal, G: 2 T:2 P:0 A:0 L:2

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

Nervous – Admits paresthesia of the fingertips. Denies seizures, headache, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

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

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

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric – Admits to feeling occasionally sad. Denies depression, anxiety, OCD or ever seeing a mental health professional.

Physical

General: Male appears clean & well groomed, alert & oriented to time, place, and person. Also has good posture and seems like a reliable source of information. No signs of acute distress, appears as stated age.

Vital Signs: BP: (R) Seated 132/85 P: 86 beats/min, regular
(L) Seated 130/79
R: 16 breaths/min, unlabored O2 Sat: N/A

T: N/A

Height: 65 inches Weight: 182 lbs BMI: 30.3