Arianne Diaz
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Physical Diagnosis I
Professor L. Sanassi

History and Physical

History

Identifying Data:

Full Name: E.T
Address: N/A
Date of Birth: 03/25/1954
Date & Time: 03/28/2023, 9:40 AM
Location: Queens Presbyterian Hospital
Religion: Evangelist
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: N/A

Chief Complaint: "I was coughing a lot"

History of Present Illness:

68 y/o F w/ PMHIx COPD and childhood asthma presents to internal medicine x8 days for wheezing, purulent cough. States that cough comes from throat and describes it as a sensation of choking. Reports that episodes occur for about five minutes three times a day and cough is worse at night. As per patient, she is coughing up wet, heavy yellow chunks of sputum and reports that forceful coughing elicits chest pain, makes her dyspneic, and short of breath. Cough is aggravated by vaping; patient states that vaping usually precedes "coughing fit". Cough is alleviated by Robitussin and home remedy consisting of aloe, lemon, honey. States that although Robitussin helps temporarily alleviate cough, she feels "a lot of relief" when she uses her home remedy. Reports that severity of cough is 10/10. Admits that she has been hospitalized on two separate occasions for cough presenting with similar symptoms.

While hospitalized patient has noticed minimal RT foot swelling x3 days. States that swelling is localized to the RT foot and ankle. Complains of weakness, tingling, and numbness that last four minutes twice a day. Reports that these episodes usually occur in the morning and describes episodes as "ants crawling on her foot and ankle". Paresthesia is alleviated by flexing the foot and wiggling the toes but there are no aggravating factors. Patient has not had any treatment for paresthesia. States severity is 3/10. Patient states she is compliant with her medication. States that diet is poor and usually "will skip lunch or dinner on any given day" and she does not have an appetite. Patient is considered a fall risk as she uses a hoister to pick herself up and sit in her wheelchair. States that she engages in very little physical activity. Denies

hemoptysis, unusual weight loss, fatigue, palpitations, abdominal pain, fever, chills, nausea, vomiting, diarrhea.

Past Medical History:

COPD (year of Dx unknown)
Bipolar Disorder (type and year of Dx unknown)
Hypercholesterolemia (year of Dx unknown)
Multiple Sclerosis (year of Dx unknown)
h/o childhood asthma (year of Dx unknown)
h/o constipation, insomnia, heartburn, and seasonal allergies
Immunizations – Up to date; COVID vaccine + Booster
Screening test and results – Screening Colonoscopy 11/09/2021, benign.
Screening Mammography 06/20/2022, benign.
Papanicolaou 11/15/2022, benign.
Screening tests and results performed on my mother because I forgot to ask the patient.

Past Surgical History:

RT hip replacement (location and year of surgery unknown)
Denies any blood transfusions.

Medications:

Alpha Lipoic Acid 600 mg BID PO for Multiple Sclerosis
Duloxetine HCl 60 mg tab once daily PO; patient did not recall why she is taking Duloxetine.
Aspirin 81 mg tab once daily PO prophylactically
Myrbetiq ER 50mg once daily PO; patient did not recall why she is taking Myrbetiq.
Oxcarbazepine 300 mg once daily PO for Bipolar Disorder
Calcium, Vitamin D, Omega 3 PO for supplementation; patient did not recall dosing for these medications.
Quetiapine 200 mg BID PO for Bipolar Disorder
Simvastatin 10 mg PO for Hypercholesterolemia
Docusate 100 mg PO PRN for constipation
Melatonin 3 mg PO PRN for insomnia
Advair Diskus 250/50 1 inhalation BID for COPD
Albuterol 1 inhalation PRN for COPD; patient did not recall dosing.
Famotidine 20 mg PO PRN for heartburn
Cetirizine 10 mg PO PRN for symptoms of seasonal allergy

Allergies:

Levaquin – Reaction: urticaria
No known food or environmental allergies

Family History:
Mother – Deceased at unknown age & unknown reasons; had h/o untreated schizophrenia.
Dad – Alive; has h/o childhood TB.
Reports paternal aunt has breast cancer and diabetes. Denies familial h/o myocardial infarctions.
Patient one living child with no medical complications.

Social History:
E.T is a widowed F living with her two dogs.
Habits – Pt has 40 pack year history (one pack a day for 40 years). Admits to currently vaping. Denies EtOH use. Denies consumption of coffee. Denies any illicit drug use.
Travel – No recent travel.
Diet – states that she usually eats oatmeal w/ strawberries and bananas for breakfast but will skip lunch or dinner on any given day as she is not hungry. Enjoys eating ice-cream, cake, soda.
Exercise – very little exercise, reports she rarely ambulates.
Safety measures – Pt is fall-risk, hoister to get into wheelchair.
Sexual Hx – Patient is not sexually active.
Denies history of sexually transmitted diseases

Review of Systems:

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

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

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

Eyes – Admits she uses glasses. Denies contact use, visual disturbances, fatigue, lacrimation, photophobia, pruritis. Last eye exam was a year ago.

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, has sensitive gums. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, or voice changes. Last dental exam was last year.

Pulmonary system – Admits dyspnea, SOB, cough, wheezing, and orthopnea. Patient uses two pillows to sleep. Denies hemoptysis, cyanosis, or PND.

Cardiovascular system – Admits to pleuritic CP, swelling of the RT ankle/foot. Denies h/o HTN, palpitations, irregular heartbeat, syncope, known heart murmur.

Gastrointestinal system: Admits last bowel movement was 8 days ago. Denies nausea, diarrhea, abdominal pain, change in appetite, vomiting, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructation, jaundice, hemorrhoids, rectal bleeding, or blood in stool.

Genitourinary system – Patient has foley in place. Denies nocturia, dysuria, urinary frequency or urgency, oliguria, polyuria, incontinence, or flank pain.

Menstrual/Obstetrical – Pt is menopausal, G:1 T:1 P:0 A:0 L:1

Musculoskeletal system – Admits to swelling of the RT foot and ankle. Denies any muscle/joint pain, redness, arthritis.

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

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

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 anxious. Denies depression or symptoms of mania associated with her bipolar disorder.

Physical

General: Female appears clean & well groomed, alert & oriented to time, place, and person. Has good posture and appears to be a reliable source of information. Appears stated age and is not in acute distress.

Vital Signs:
Temperature: 98.4 degrees Fahrenheit
O2 Sat: 100 on nasal canula

Height: 63 inches
Weight: 150 lbs
BMI: 26.6
*Respiratory Rate:*16 breaths/min regular rhythm and unlabored
Heart Rate: 100 breaths/min regular rate and rhythm
Blood Pressure:
(R) Laying Down 130/80
(L) Laying Down 136/82

Hair, Head, and Face:
Some dandruff noted at the scalp. Hair is of average quantity, even distribution, and silky texture, no sign of lice.

Head is normocephalic, atraumatic, and non-tender to palpation.

Face is symmetrical with no signs of drooping, swelling, or trauma.

Skin, and Nails:
The skin is warm and moist with good texture and turgor. Non-icteric with no swelling, erythema, or rashes.

Nails do not exhibit digital clubbing, capillary refill less than 2 seconds in upper and lower extremities.

Eye:
The eyes are symmetrical OU. Conjunctiva is pink, sclera is white, cornea and lens are clear, the pupils and iris are round, there is no shadowing on the opposite side of the iris OU. The patient's lacrimal apparatus is non-tender to palpation bilaterally. There is no exophthalmos OU.

Visual Acuity - 20/50 OS, 20/40 OD, 20/50 OU Corrected

The patient's visual fields intact OU. PERRLA, EOMs intact with no nystagmus, strabismus, or signs of lid lag. Near point of convergence test is unremarkable.

Red reflex intact OU. Optic disc yellow, sharp, with disc to cup 0.5 OU. No AV nicking, copper wiring, hemorrhages, soft/hard exudates, or neovascularization in any of the four quadrants OU. Macula is yellow with no granulation or degeneration OU.
Ear:
Symmetrical and appropriate in size. No lesions, masses, or trauma on external ears. No discharge or foreign bodies externally AU. TM's pearly white/intact with light reflex in good

position, cone of light is present AU. No foreign bodies, discharge, effusions, perforations, or erythema AU. Auditory acuity intact to whispered voice AU. Weber is midline, Rinne indicates AC>BC AU.

Nose and Sinus:
The nose is symmetrical without masses, deformities, trauma, or discharge. There is no step off, crepitus or tenderness to palpation. Nares are patent bilaterally. Nasal mucosa pink and moist. No discharge, polyps, or swelling of the turbinates on anterior rhinoscopy. Nasal septum is midline without ulcerations, perforations, or deviations.

The frontal and maxillary sinuses are non-tender to palpation and percussion bilaterally.

Mouth and Pharynx:
The lips are pink, moist, with no signs of blisters, fissures, or cyanosis.

The buccal mucosa is pink and well hydrated. No masses or lesions noted. Non-tender to palpation.

The tongue is pink and covered in papillae with no signs or leukoplakia.

The gingiva is pink. No hyperplasia, erythema, masses, lesions, or bleeding. Non-tender to palpation.

Patient is wearing partial dentures and has a bridge over third molar. Patient's RT second molar is absent. There is no discoloration of the teeth.

The hard palate is continuous, with no ulcers, bony deformities, or bleeding. Non-tender to palpation.

The soft palate rises with phonation.

The floor of the mouth is well vascularized, the frenulum is intact, there is no discoloration.

The oropharynx is well hydrated, there is no tonsillar adenopathy, the uvula is pink, moist, and midline, there is no post-nasal drip.

The patient's gag reflex is present.

Neck, Thyroid, and Lymph Nodes:

The trachea is midline without masses or scars, it is supple and non-tender to palpation. The thyroid is consistent in size and shape and non-tender to palpation. The lymph nodes are freely mobile, non-tender and about 1 cm.