Arianne Diaz
November 14, 2023
Physical Diagnosis II
Professor Natalia Lukanina-Wu

History and Physical

History

Identifying Data:

Full Name: K.R
Address: N/A
Date of Birth: 03/12/1983
Date & Time: 11/07/2023 at 10:35 AM
Location: Queens Presbyterian Hospital
Religion: N/A
Source of Information: Self
Reliability: Reliable
Source of Referral: PCP
Mode of Transport: Self

Chief Complaint: "I've been having some chest pain and shortness of breath since last night"

History of Present Illness:

40 y/o F w/ PMHIx asthma, HTN, and GERD presents to ED for chest pain and shortness of breath x1 night. Describes chest pain as burning and squeezing, originating in the center of her chest, and radiating to her RT back, LT arm, and LT lateral cervical region. Reports that pain is intermittent, occurs with exertion, and lasts 2-3 minutes before she is forced to sit down due to pain. Patient rates pain 8-9/10 severity with episodes aggravated by walking up and down stairs and alleviated with rest. Admits that symptoms began "after an emotional event" the night before in which she was screaming and "overworked" herself. States that she has always had some SOB due to her asthma and is currently on a 3-week prednisone taper for recurrent exacerbations but has been feeling "more breathless" since last night. Patient reports being unable to walk more than 15 minutes without feeling SOB despite usually being able to participate in 40-minute Zumba class once a week. SOB is accompanied by headache for which patient took one 325 mg Aspirin with relief. States that she is compliant with her medications. Denies fever, chills, intermittent claudication, abdominal pain, jaw pain, hemoptysis, palpitations, diaphoresis, unintentional weight loss, recent travel, surgery, h/o prolonged bedrest or h/o similar symptoms in the past.

Past Medical History:

Asthma (year of Dx unknown, Dx by PCP, location unknown)
HTN (year of Dx unknown, Dx by PCP, location unknown)

GERD (year of Dx unknown, Dx by PCP, location unknown)
Hypercholesterolemia (year of Dx unknown, Dx by PCP, location unknown)
Migraines (year of Dx unknown, Dx by PCP, location unknown)

Childhood Illness – Asthma (year of Dx unknown, location unknown)
Immunizations – Up to date; receives annual vaccination against influenza
Screening test and results – Colonoscopy, November 2023, normal.
PAP smear, 2023, normal.
Has never had a mammogram.

Past Surgical History:
Planned Caesarian Section (Northshore Manhasset, year unknown, pre-eclampsia at 30.5 weeks)
Planned Caesarian Section (Northshore Manhasset, year unknown, pre-eclampsia at 34 weeks)
Planned Caesarian Section (Northshore Manhasset, year unknown, pre-eclampsia at 36 weeks)
Various Oral Surgeries (location of procedure unknown, year unknown, no complications)

Medications:
Trelegy 200/62.5/25 mcg once daily for asthma and asthma exacerbation
Symbicort 160/4.5 mcg two inhalations BID for asthma and asthma exacerbation
Albuterol 2.5 mg in nebulizer PRN for asthma
Singulair 10 mg PO daily for asthma
Lisinopril 5 mg PO daily for HTN
Nifedipine ER 90 mg PO daily for HTN
Protonix 40 mg PO daily for GERD
N-acetyl cysteine unknown dose for GERD
Onzetra sumatriptan nasal powder 11 mg/nose piece PRN for migraine

Allergies:
Lamictal (reaction: hives)
Keppra (reaction: hives)
Latex (reaction: hives)
No known food allergies

Family History:
Mother – Alive; current medical history of HTN, Diabetes Mellitus Type 2, heart disease requiring two stents
Father – Deceased, past medical history of HTN, Diabetes Mellitus Type 2, death by lung and throat CA
Children – 3 children; denies any medical problems
Maternal grandparents – unknown

Paternal grandparents – unknown

Social History:

M.G. is married F living with her husband and three children.
Habits – Denies use of any tobacco products. Denies smoking. Denies illicit drug use. Admits to social consumption of EtOH, approximately 2-3 glasses of wine once a month
Travel – Denies recent travel
Diet – 1-2 coffee cups of coffee, fruits, and a muffin for breakfast, salad/pasta for lunch, meat and veggie-based meal for dinner
Exercise – 40-minute Zumba class once a week
Sleep – sleeps approximately 4-5 hours a night
Safety measures – practices seatbelt safety measures
Sexual Hx – currently sexually active with her husband, denies history of sexually transmitted infections.
Occupation – Con Edison Employee

Review of Systems:

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

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

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

Eyes – Admits photophobia, uses glasses for myopia. Denies visual disturbances, fatigue, lacrimation, photophobia, or pruritis. Last eye exam September 2023, normal.

Ears – Admits pain and tinnitus in LT ear. Denies deafness, discharge, or use of hearing aids.

Nose/sinuses – Admits congestion. Denies discharge, obstruction, or epistaxis.

Mouth/throat – Admits sore throat. Denies bleeding gums, sore tongue, mouth ulcers, voice changes, or use of dentures. Last dental exam 2 weeks ago, normal.

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

Breast – Denies lumps, nipple discharge, or pain. Has not had mammogram yet.

Pulmonary system – Admits SOB, cough. Denies dyspnea, wheezing, orthopnea, hemoptysis, cyanosis, or PND.

Cardiovascular system – Admits CP, HTN. Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope.

Gastrointestinal system: Admits pyrosis. Denies nausea, vomiting, anorexia, abdominal pain, constipation, dysphagia, flatulence, eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, presence of blood in stool, or pain in flank. Last Colonoscopy, November 2023, normal.

Genitourinary system – Denies nocturia, dysuria, urinary frequency or urgency, oliguria, polyuria, incontinence, or flank pain. Color of urine is "normal"

Menstrual/Obstetrical – date of LMP: current. Date of menarche unknown. Denies dysmenorrhea, premenstrual syndrome, vaginal discharge, break-through bleeding, associated menopausal sxs, or h/o STI. Last pap smear 2023, normal. G:3 T:3 P:0 A:0 L:3

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

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

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

Endocrine system – Reports cold intolerance and h/o goiter. Denies polyuria, polydipsia, polyphagia, heat intolerance, excessive sweating, or hirsutism.

Nervous –Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia), headache, ataxia, loss of strength, changes in cognition/mental status/memory, or weakness.

Psychiatric – Denies depression, sadness, (feelings of helplessness, hopelessness, lack of interest in usual activities, suicidal ideation), anxiety, obsessive compulsive disorder, or h/o of being evaluated by mental health professional.

Physical:

General: Patient 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: 96.8 degrees Fahrenheit

O2 Sat: 97% on room air
Height: 62 inches
Weight: 150 lbs
BMI: 27.4
Respiratory Rate: 20 breaths/min regular rhythm and unlabored
Heart Rate: 88 breaths/min regular rate and rhythm
Blood Pressure:
(R) Sitting Up 114/78 (L) Sitting Up 120/80

Hair, Head, and Face:
Hair is of average quantity and distribution. Black in color with silky texture and no sign of lice or nits.

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 or signs of ecchymosis.

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 - 20/30 OS, 20/30 OD, 20/30 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. Cerumen present AU**,** no 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.

Anterior rhinoscopy reveals edematous blue turbinates and clear, mucous-like discharge, no polyps noted. 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 with no signs of blisters, fissuring, or cyanosis.

The buccal mucosa is pink and well hydrated. 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.

The hard palate is continuous, with no 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.

PND noted, oropharynx is well hydrated, there is no tonsillar adenopathy, the uvula is darker shade of pink but moist and midline.

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. 2+ carotid pulses; no thrills, or bruits on auscultation.

Cardiac:

JVP is 2.5 cm above the sternal angle w/ the head of the bed at 30 degrees. Point of maximal impulse is in the 5th intercostal space in the midclavicular line. Carotid pulses are 2+ bilaterally w/o bruits. No heaves or retractions evident in the four quadrants of the chest wall. No vibrations, thrills, or pulsations are evident except at the point of maximal impulse. S1 and S2 are normal. No murmurs, S3, or S4 sounds on auscultation. No S2 split or friction rubs present.

Thorax and Lung:
Chest is symmetrical with no signs of deformity, or trauma. Chest wall is non-TTP. Respirations are unlabored without use of any accessory muscles. On auscultation bilateral coarse crackles over lung bases. Expiratory wheezes scattered throughout lung fields.

Abdomen:
Bowel sounds normoactive in all four quadrants with no aortic/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebounding noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated. Pfannenstiel incision scar well-approximated and well-healed without any evidence of appreciable masses around or underneath it.

Breast Exam:
B/L breasts are symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable.

Genitalia:
External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema, or discharge. Cervix parous (or 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. Pap smear obtained. 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 stool present in vault. FOB negative.

Cranial Nerves:
CN I- X11 are intact

Peripheral Neurologic Exam
Motor/Cerebellar – Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors, or fasciculation. Strength 5/5

throughout. Romberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis

Sensory – Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Reflexes – 2+ throughout, negative Babinski, no clonus appreciated

Meningeal Signs – No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

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.

Peripheral Vascular Exam

The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally (no C/C/E B/L) No stasis changes or ulcerations noted.

Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / edema noted bilaterally.

MSK Upper Extremity

No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Assessment:

40 y/o F w/ PMHIx asthma, HTN, and GERD presents to ED for chest pain and shortness of breath x1 night. CP and SOB began after "emotional event" the night before in which patient states she was screaming and "overworked" herself. States chest pain radiates from center of her chest to RT back, LT arm, and LT lateral cervical region. Pain is intermittent, lasting 2-3 minutes per episode. CP is aggravated by physical activity and alleviated by rest with severity 8-9/10. On physical exam patient is not in acute distress and vital signs are stable. Anterior rhinoscopy reveals edematous blue turbinates and clear, mucous-like discharge. PND and dark pink uvula noted when inspecting the oral mucosa. Bilateral coarse crackles heard over

lung bases on auscultation. Expiratory wheezes scattered throughout lung fields. Productive coughing noted throughout history taking and physical examination.

Plan:

Because my patient's chief complaint is chest pain and shortness of breath, I would like to order an EKG and cardiac biomarkers to rule out MI. Once that has been ruled out, I would order rapid flu and rapid COVID POC testing since my physical exam findings seemed indicative of some type of respiratory infection. For diagnostic imaging I believe a CXR is indicated to look for consolidations. Treatment plan would depend on results from labs and diagnostic imaging which I will elaborate on in my DDx.

DDx:

1. URI

URI is a non-specific term used to describe acute bacterial or viral infection involving the nose, sinuses, pharynx, larynx, trachea, or bronchi. On physical exam patient had edematous blue turbinates with clear, mucous-like discharge, PND, bilateral coarse crackles over lung bases, and expiratory wheezes. While taking the patient's history and performing the physical exam, I noted a productive cough which, if the patient coughs forcefully enough, can cause chest pain. Although the patient's chief complaint and symptoms are consistent with an issue that is cardiac in nature, the patient was not in acute distress and denied worsening chest pain from onset. Physical exam findings were also not consistent with acute MI. The rationale against URI would be the patient's report of non-reproducible chest pain radiating to the RT back, LT arm, and LT lateral cervical region. Based on my physical exam findings, I would rule out any emergency conditions such as MI and ACS first, then I would rule out PNA, and ultimately recommend symptomatic/supportive care.

2. Atypical PNA

Pneumonias are lower respiratory tract infections involving the pulmonary parenchyma. In regular cases of pneumonia, patients will have at least two of the following: productive cough, purulent sputum, dyspnea, tachypnea w/ RR > 20, rigors/chills, pleuritic chest pain **and** a new opacity on CXR. In atypical PNA, however, a patient may not necessarily present with the standard signs and symptoms of pneumonia. Upon looking at my patient's chart, I discovered she was recently hospitalized for COVID which could have caused inflammation of the lungs leading to the development of a pneumonia. Common signs and symptoms of atypical pneumonia include cough, SOB, fatigue, and headache all of which the patient admits to. The rationale against atypical pneumonia is similar to that for the rationale against URI in that the patient reports non-reproducible chest pain radiating to the RT back, LT arm, and LT lateral cervical region. I would order a CXR for my patient and initiate abx therapy if imaging shows a new consolidation.

3. Stable Angina

Stable Angina is a symptom of myocardial ischemia characterized by chest pain that becomes worse with exertion but is alleviated by rest or administration of nitroglycerin. Stable angina can also occur with emotional stress which my patient reported experiencing prior to the onset of her

symptoms. She states that her symptoms worsened with walking , specifically going up and down the stairs but improved with rest. Her chest pain is also non-reproducible and radiating which may be indicative of a potential cardiac etiology for her chest pain. Because my patient is a woman, she is more likely to present with atypical angina symptoms. The rationale against stable angina for my patient would be lack of risk factors. She does not engage in excessive alcohol consumption or illicit drug use, she participates in Zumba classes once a week for 40 minutes and is generally not sedentary at work, she does not smoke, or have unhealthy eating patterns. The only risk factor she possesses is stress. To further workup stable angina as the cause for her chest pain, I would send my patient for stress testing.

4. GERD

GERD is a common esophageal pathology characterized by a dysfunctional lower esophageal sphincter. The incompetent valve allows stomach contents to reflux back up into the esophagus and cause symptoms such as metallic taste metallic taste in mouth, pyrosis, chest discomfort, chronic cough, and dysphagia. Patient admits to a history of GERD and states she was experiencing some pyrosis while I was performing the review of systems. GERD can be exacerbated by consumption of alcohol and caffeine which the patient consumes. The rationale against a simple case of GERD are the physical exam findings which indicated that diagnosis is more likely to have a respiratory etiology.

5. Myocardial Infarction

MI is last on the list of differentials because it is a “Do Not Miss” diagnosis. Myocardial Infarction is important to consider because my patient’s complaints are consistent with MI. She has a strong family history of heart disease on her mother’s side, and she is diagnosed with HLD and HTN. She is also a woman which makes it more likely for her to present with atypical symptoms of MI. It is important that even if her EKG returns normal to draw cardiac biomarkers (incase the patient is having an NSTEMI) and use the HEART score to determine the likelihood of a major adverse cardiac event in the next 6 weeks. The rationale against MI is the patient’s HEART score which is around 1-2.

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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: Arianne Diaz

Clinical Site: NYPQ-ER

Date of Visit: November 07, 2023

Activity performed: History & physical exam

Supervisor:

Name and Credentials: Christine Chen MD

Supervisor Signature:

Supervisor Comments:
Solid history taking, very thorough and detailed! Also helped with formulating a differential diagnosis and treatment plan; had solid ideas that covered the major important areas. Great job!