Friends and Family Gagandeep Munday

Identifying Data:
Full Name: HM
Address: East Elmhurst, NY
Date of Birth: X/XX/1998
Date & Time: November 22, 2019
Location: Outside Hospital, Queens, NY
Religion: Sikh
Source of Information: Self
Source of Referral: Walk in
Mode of Transport: Walked in

Chief Complaint: "my left knee has been hurting" x 2 weeks.

History of Present Illness:
HM is a 20 year old male with no significant past medical history who is currently complaining of pain in his left knee. Patient states that the pain started two weeks ago after he banged his left knee into a wooden bed frame. Patient describes the pain as 8/10 with intermittent episodic throbbing. He says that pain is alleviated mildly with ibuprofen of which he taking 400 mg twice a day. He notes increased pain with range of motion, and when jogging lightly.

He denies any radiation of pain, any deformity, past injury to left knee, erythema, swelling, strenuous activity or intake of any new medications. He denies any recent travel, history of DVT, or family history of DVT. Denies any radiation of pain.

Past Medical History:
Present illnesses – Denies any present or past illnesses
Childhood illnesses – Denies childhood illnesses.
Immunizations – Up to date

Past Surgical History:
Denies any surgical history
Denies history of eye surgery, cholecystectomy, or appendectomy.

Medications:
Denies any prescription medications

Allergies:
No known drug allergies
Denies other drug, environmental or food allergies.

Family History:
Mother – Alive, has history of HTN, hypercholesterolemia, hypothyroidism
Father – Alive, history of diabetes mellitus type II

Brother – Alive, denies any medical history
Denies family history of cancer.

Social History:
HM is a single male, living at home with his parents. He currently is a college student and runs an online business.
Habits - Denies usage of caffeine, illicit drugs, alcohol, or smoking.
Travel - Denies any recent travel
Diet - Patient admits to having a strict vegetarian diet. He starts day with a protein smoothie. He has a large lunch of home cooked lentils, beans, and/or spinach. States that he usually has the same thing for dinner.
Exercise - Follows an exercise plan, goes to the gym and weight trains 3 times a week.
Safety measures - Admits to wearing a seat belt.
Sexual Hx - Patient is not sexually active. He is not taking any hormones replacements. Denies history of sexually transmitted diseases.

Review of Systems:
General – Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, 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, pruritus. Denies other visual disturbances, or photophobia. Admits to wearing glasses. Last eye exam 2016 – does not know his visual acuity.

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 dentures. Last dental exam July 2019, normal.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies any history of palpitations or hypertension. Denies chest pain,

irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

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

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysura, incontinence, awakening at night to urinate or 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 – Notes pain in left knee. Denies pain anywhere else. Denies deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color 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 – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

Physical

General: Non-distressed male, neatly groomed, looks of stated age of 20 years

Vital Signs: BP:

	R	L
Seated	114/72	110/74
Supine	112/70	118/78

R: 20/min unlabored P: 64, regular

T: 98.2 degrees F (oral) O2 Sat: 99% Room air

Height 71 inches Weight 147 lbs. BMI: 21.1

Skin: warm & dry, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

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Hair: average quantity and distribution.
Nails: no clubbing, capillary refill <2 seconds throughout.
Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes - Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity - 20/40 OS, 20/40 OD, 20/30 OU
Visual fields full OU. PERRLA , EOMs intact with mild nystagmus on horizontal gaze.

Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Neck - Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable
adenopathy noted.

Thyroid - Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Nose - Symmetrical / no masses / lesions / deformities / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions / deformities / injection / perforation. No foreign bodies.

Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Chest - Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.
Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Abdomen - flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated