Gagandeep Munday　　H+P　　8/8/2019

Full name: IS　　Religion: Christian
Address: Flushing, NY　　Source of info: self
Date of birth: 9/22/1947　　Reliability: reliable
Date + Time: 8/8/2019 @ 8:30 AM　　Source of referral: self
Location: NYHQ, Flushing, NY　　Mode of transport: cab

Chief complaint: "feeling of something sitting on my chest" x 2 days

History of present Illness:
IS is a reliable 72 y/o married, African American female, with PMHx of asthma, CHF, and MI, who presented to ED today c/o a chest tightness and a heavy feeling on her chest for the past 2 days. She states that the symptoms are worsened when laying flat and also upon exertion. She describes the pain as 8/10 and as if something is sitting on her chest. She states that this chest pain started after getting "sick with the flu". She got sick 3 days ago, symptoms started with a dry cough and are associated with loose stool, vomiting after eating, lack of appetite, fatigue, light headedness, blurry vision, shortness of breath and 5/10 headaches. Patient states that she took OTC tylenol 325 mg PO once a day for 3 days with moderate relief of headaches but notes no relief of chest pain. Patient has not taken her asthma medication, Xopenex HFA, as of yet because the perscription had expired years ago.
Patient denies any recent trauma, strenuous activity, or intake of any new medications. She denies any nausea, blood in vomit/stool, abdominal pain, dizziness, increased sweating, fever, chills, body aches, sore throat, neck

stiffness, fainting, paroxysmal nocturnal dyspnea, or loss of consciousness.

Past medical history:

Present illnesses - Asthma (did not ask duration), Diabetes (did not ask duration), Hypertension (42 years), Hypercholesterolemia (did not ask duration)

Past medical illnesses - MI 14 years ago, CHF 12 years ago, Tolosa Hunt 15 years ago, Right Kidney failure 10 years ago, Anemia (did not ask how long ago)

Hospitalizations - for MI 14 years ago, for CHF 12 years ago, and Right Kidney Failure 10 years ago.

Childhood illnesses - Denies childhood illnesses

Immunizations - Up to date

Past surgical History:

Right Kidney transplant, 2009, Columbia University Medical Center, well managed by Dr. R.D.

Stent in Right leg artery, 2015, Columbia University Medical Center, has not gone to followups

Cataract surgery in both eyes, 2009, (Did not ask where it was done)

LT ear tube, 2013, (Did not ask where it was done)

Denies history of cholecystectomy or appendectomy

Medications:

Xoponex HFA, as needed, has not taken in years

Astagraf, 5 mg 1 capsule PO daily, last taken ~~thin~~ (GM) this morning

Myofortic, 360 mg 1 tab PO BID, last taken this morning

Hydrochlorathiazide, 25 mg 1 tab PO daily, for HTN, last dose yesterday
Norvasc, 5 mg 1 tab PO BID, last dose was yesterday evening
Coreg, 40 mg 1 tab PO daily, last dose was yesterday
Novalog flex pen, as needed, ~~did not ask~~ (GM) (did not ask about last dosage)
Levemir flex-touch pen, as needed, (did not ask about last dosage)

Allergies:
Penicillin - hives, facial swelling
Denies other drug, environmental, or food allergies

Family History:
Mother - Deceased at age 23, passed away from pneumonia
Father - Deceased at age 46, passed away from MI
Did not ask about children
Denies any family history of cancer

Social History:
IS is a married female, living with her husband in an apartment. She is retired teachers assistant and former bank teller.
Habits - She denies any regular alcohol use except during the holidays. She denies drinking hard alcohol/beer, or illicit drug use. She does 8 oz of caffiene twice a day. She admits to smoking since the age of 14, notes that she quit in 2014.
Travel - Denies any recent travel.

Diet - She says she has not been able to eat well for the past 5 days or so, however her regular diet is ~~SC~~ (GM) usually very light foods. She admits to having eaten yogurt yesterday.
Exercise - She does not get any exercise, states that most strenous movements makes her feel "tired".
Safety measures - Admits to wearing a seatbelt
Sexual history - She is currently sexually active with her husband. She is not taking any hormones (GM) replacements. Denies history of sexually transmitted diseases.

Review of Systems
General - Denies fever, night sweats, weakness, recent weight gain or loss
Skin, hair, nails - Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair disturbution.
Head - ~~Vert~~ (GM) Denies vertigo, head trauma, unconsciousness, coma, fracture
Eyes - Denies usage of contats, usage of glasses, any visual disturbances, ~~fo~~ (GM) lacrimation, photophobia, pruritus; Pt states last eye exam was 3 years ago.
Ears - Denies change in hearing, deafness, pain discharge, tinnitus, hearing aids
Nose/sinuses - Denies discharge epistaxis, obstruction
Mouth and throat - ~~bt~~ (GM) Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures; Pt states that last dental exam was last year.
Neck - Denies localize swelling/lumps, stiffness

or decreased range of motion.
Breast - Denies any lumps, nipple discharge, pain; Pt states that last mamogram was 16 years ago
Pulmonary system - Dyspnea, hemoptysis, cyanosis, orthopnea, PND; denies all of the above
Cardiovascular system - Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, ~~known heart murmur~~. Pt states she has a heart murmur.
Gastrointestinal system - Denies intolerance of foods, dysphagia, pyrosis, flatulence, ~~err~~ eructation, abdominal pain, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, stool/guaic/colonoscopy/sigmoidoscopy, pain in flank.
Genitourinary - Patient denies any intolerance to foods, dysphagia, pyrosis, flatulence, eructations, abdominal pain, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, stool guaiac/colonoscopy/sigmoidoscopy, pain in flank
Genitourinary - Patient admits to urinating 5x a day with color of urine being yellow/clear. States that this is her normal. ~~, incontin~~ Patient denies incontinence, dysuria, noctuna, urgency, oliguria polyuria.
Sexual history - Patient states that she is currently sexually active with her husband. Patient denies any history of sexually transmitted infections.
Menstrual and obstetrical - Patient is 72, states that she went ~~throught~~ through menopause 22 years ago.
Obsterical history - G: T: P: A: L: (Did not ask)
Muskuloskeletal system - Denies any deformity or swelling, redness, arthritis

Peripheral Vascular system - Patient denies any intermittent claudication, coldness of tropic changes, varicose veins, peripheral edema, color change

~~Hematologic system - ets~~ (CM) Patient denies any easy bruising or bleeding, lymph node elargement, history of DVT/PE

Endocrine system - Patient denies any polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Nervous system - Patient denies any seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysestheasias, hyperesthesia), ataxia, loss of strength, change in cognition/mental status/memory, weakness (asymmetric)

Psychiatric - Patient denies any feeling of depression, sadness, of hoplessness, lack of interest in usual ~~activity~~ (CM) activities, suicidal idelation, (CM) anxiety, obsessive/compulsive disorder. Patient states that they have never seen a mental heath professional or taken any psychiatric medications.

Physical

General - Overweight female, neatly groomed, looks of stated age of 72 years

Vital Signs - BP

	R	L
seated	132/72	unable to obtain due to
supine	128/70	AV fistula

Respirations: 20/min unlabored

Pulse: 98, regular

Temperature: 98.9 °F (oral)

O2 stat: 98% on room air

Height: 68 inches Weight: 148 lbs BMI: 22.5

Skin: warm & dry, skin is wrinkled. Nonicteric, no lesions noted, no scars, no tattoos. AV fistula scar noted to left upper arm.

Hair: average quantity and average distribution

Nails: no clubbing, capillary refill <2 seconds throughout

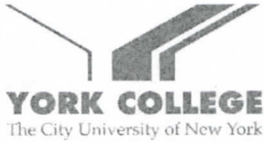
Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: Symmetrical OU. No strabismus, expthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.

Visual acuity - 20/40 OS, 20/40 OD, 20/30 OU

Visual fields full OU. PERRLA, EOM intact with nystagmus on horizontal gaze

Fundoscopy: Red ~~fe~~ (EA) reflex intact OU. Cup to disk ~~ratio~~ (EA) ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.



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S. Shami, J. Yuan & M. Malavet
(718) 262-3793
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History and Physical Verification Form

Class: Physical Diagnosis I (HPPA 502)

Student Expectation:
- Obtain medical history and perform physical exam up to the point covered in class.
- Oral presentation to clinical site supervisor/preceptor

Student: Gagandeep Munday

Clinical Site: NY presby

Date of Visit: 10/8/2019

Activity performed: HPI, PMH, FH, SH, ROS, Skin Exam, Eye Exam, Vitals

Supervisor:
Name and Credentials: Marion Mempm MD - Attending

Supervisor Signature: [signature]

Supervisor Comments: Comprehensive & well organized