Gagandeep Munday 09/01/2020

ER: Health And Physical

Identifying Data:

Full Name: JC
Address: Flushing, NY
Date of Birth: X/XX/1951
Date & Time: 09/01/2020 at 9:00 AM
Location: NYHQ, Queens, NY

Religion: Catholic
Source of Information: Self
Reliability: Reliable
Source of Referral: Walk in
Mode of Transport: Walked in

Chief Complaint: "I have pain on the side of my stomach with an itchy rash" x2 days

History of Present Illness:

69 y/o hispanic female with pMHx of diabetes complaining of constant 7/10 "tingling" LT flank pain x2 days. Pt states she has an "itchy painful rash right where it hurts" on the "left side to her stomach". Pt states that rash "appeared suddenly" 2 days ago, denies having past h/o similar rashes.

Pt took 1 gram of tylenol last night, notes no relief of pain.
Last oral intake was oatmeal at 7:00 AM, states she was able to tolerate food and liquids.
Last defecation was at 6:30 AM, states that her stool "was normal"

Denies h/o abdominal surgeries, recent antibiotic use, recent travel/outdoor experiences, intake of new medications, prescription dosage changes, nausea, vomiting, diarrhea, constipation, rectal bleeding, blood in stool, dizziness, radiation of pain, change in appetite, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, inguinal pain, vaginal bleeding/discharge, h/o STIs, h/o kidney stones, dysuria, urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, fever, body aches, chills, sore throat, cough, chest pain, SOB, trauma.

Past Medical History:

Present illnesses – Diabetes Mellitus Type II, 10 years
Patient Denies other past medical medical illnesses
Immunizations – Up to date

Past Hospitalizations:

Denies any past hospitalizations

Past Surgical History:

Denies any surgical history
Denies history of eye surgery, cholecystectomy, or appendectomy.

Medications:
Metformin, 1000 mg, QD, 1 tab PO, for Diabetes Mellitus Type II
Jardiance, 10 mg, QD, 1 tab PO, for Diabetes Mellitus Type II
Pt denies usage of any other prescription medications.

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

Family History:
Mother – Deceased at age of 91 from natural causes
Father – Deceased at age of 85 from natural causes
Brother – Alive and well as per patient, denies any medical history
Sister – Alive and well as per patient, denies any medical history
Denies family history of cancer and heart disease

Social History:
JC is a married female, living in a 3 story house with her husband. She retired 20 years ago from her business in jewelry. She has three living children and states that they are "all healthy".
Habits - Denies any past or present usage of illicit drugs or smoking. Admits to drinking wine once every 2 months during a special occasion.
Travel - Denies any recent travel
Diet - Patient states that she usually starts the day with an oatmeal for breakfast with a small cup of coffee. She eats home cooked meals for lunch and dinner. These meals usually consist of cooked rice with chicken, pork, or fish. Admits to drinking 9 cups of water a day.
Exercise - Goes on an evening walk every other day.
Safety measures - Admits to wearing a seat belt.
Sexual Hx - Patient is sexually active, heterosexual and monogymous with her husband. Does not use barrier protection. Denies history of sexually transmitted diseases. Denies any other sexual partners.

Review of Systems:
General – Denies fever, chills, night sweats, generalized weakness/fatigue, loss of appetite, recent weight loss or gain

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

Head – Denies headaches, vertigo, head trauma, unconsciousness, coma, fracture

Eyes – Denies lacrimation, pruritus. Denies other visual disturbances, photophobia, contacts or glasses use. **Last eye exam was on June 2020, pt does not know 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 August 2019, was unremarkable**

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

Breast – Denies lumps, nipple discharge, or pain. **Last mammogram was in April 2019**

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

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. See HPI.

Genitourinary system – See HPI

Sexual History – See social history

Menstrual – Last normal period was in 2002. Denies vaginal bleeding, vaginal discharge, dyspareunia

Obstetrical – G4T3P0A1L3

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 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

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Psychiatric – Denies depression/sadness (feelings of helplessness, lack of interest in usual activities, suicidal ideation), anxiety, OCD or ever seeing a mental health professional. Denies past or present usage of psychiatric medications

---

Physical

General - Non-distressed overweight female laying on hospital bed, in hospital gown, neatly groomed, looks of stated age of 69 year

Vital Signs-

BP:	R	L
Seated	136/72	130/72
Supine	128/76	130/78

R: 20/min unlabored P: 86 bpm, regular rate and rhythm

T: 98.3 degrees F (oral) O2 Sat: 98% Room air

Height 62 inches Weight 147 lbs. BMI: 26.89

Skin - **Grouped 3-4mm sized vesicles on erythematous base on LT upper abdomen and LT flank, follows a dermatomal distribution along T8, and does not cross the midline**. Overall skin is warm & dry, good turgor. Nonicteric, no scars, no tattoos.

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. PERRL, EOM intact with no nystagmus on horizontal gaze.
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Ears -

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.

Lips - Pink, moist, no cyanosis or lesions. Non tender to palpation.

Oral Mucosa & Palate - Pink; Well hydrated. Palate intact and continuous with no lesions, masses, or scars. No masses/lesions noted on oral mucosa. Non tender to palpation. No leukoplakia

Teeth - good dentition, no dental carries noted, no discolorations

Gingivae - Pink, moist. Non hyperplasia, no recession, no lesions, masses, erythema, or discharge. Non tender to palpation.

Tongue - Pink; well papillated; no masses, lesions or deviation noted. Non tender to palpation.

Oropharynx - Moist, no erythema, no exudates, no masses/lesions; no foreign bodies. Tonsil grade 1, no injection or exudates. Uvula midline and rises symmetrically with phonation, no uvular edema or lesions.

Neck - Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. No palpable adenopathy noted.

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

Chest - Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxical 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 appreciated.

Heart - JVP is 2.5 cm above the sternal angle with head of bed at 30 degrees. PMI in 5th ICS in the midclavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

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. No hepatosplenomegaly, non-tender to palpation and tympanic throughout, no guarding or rebound noted, no CVA tenderness appreciated

Breasts - Symmetric, no dimplint, no masses to palpation, nippples symmetric without dischardfe or lesions, No axillary nodes palpable.

Genitalia - No erythema or lesions on external genitalia. Vaginal mucosa is pink w/o evidence of inflammation, erythema or discharge. Cervix multiparous, pink, without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. No inguinal adenopathy.

Rectal - No masses, tenderness, external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. Rectovaginal wall intact. Trace brown stool present in vault. FOB negative.

Mental Status -
Alert and oriented to person, place, and time. Patient dressed in an ER gown. Patient is cheerful with insight and judgement intact. Memory and attention is intact. Digit span and serial 7s were accurate. Remote memory intact. Receptive and expressive abilities intact. Communication coherent, audible, clear & distinct with even rhythm. Conversation progressed logically. Able to follow two stage commands, repeat words, name objects, and write a sentence. No dysarthria, dysphonia, or aphasia noted. Clock drawing is good. Calculations intact. No evidence of delusions, hallucinations, phobias, or obsessions. Denies suicidal ideation, extreme emotions, depression, and anxiety.

Cranial Nerve Exam -

CN I: Nares patent bilaterally. Pt perceived odors and identified them correctly in both nares.
CN II, III, IV, VI: See eye physical exam
CN V: Corneal reflex intact bilaterally; Facial sensation present & equal bilaterally to light touch & pain; strong contraction of jaw muscle w/o any fasciculations/atrophy
CN VII: Symmetric and fluid facial movements; No difficulty w/ BMP speech sounds; Pt has strong eye muscles that remain closed with resistance; Correctly identified sweet, salt, and sour tastes in anterior ⅔ of tongue.
CN VIII: See ear physical exam
CN IX & X: Soft palate rises & uvula remains midline, no difficulty swallowing, no hoarse/ nasal voice. Gag reflex intact. Correctly identified sweet, salt, and sour tastes in posterior ⅓ of tongue.
CN XI: FROM at neck w/ 5/5 strength & strong shoulder shrug against resistance bilaterally
CN XII: Tongue midline; Strong & symmetric tongue; No difficulty with LTND speech sound.

Peripheral Neurological Exam -
No atrophy, tics, tremors or fasciculations. Symmetric muscle bulk with good tone. Muscle strength 5/5 throughout. Full active/passive ROM of all extremities without rigidity or spasticity.

Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis.

Sensation in all extremities intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally.

Gait steady with no ataxia. Tandem walking and hopping show balance intact. Romberg negative, No pronator drift noted. Reflexes 2+ throughout, negative Babinski, no clonus appreciated.
No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

---

DDx

1) Shingles
   - Likely due to presence of a painful vesicular rash that follows along a dermatome and does not cross the midline. Pain is localized to the area of the rash with no radiation of pain. Patient denies any abdominal, urinary, or other constitutional symptoms. Diagnosis would be made clinically. DFA testing and viral culture can be done if in doubt.
2) Heat Rash
   - This type of rash is also described as an itchy and burning superficial rash. However it has a varied presentation (can be vesicular/papular/vesiculopustular) and does not follow a dermatome. This type of rash would be more common in

hot, moist climates. The patient denies any recent travel and outdoor experiences. Diagnosis would be made clinically.

3) Drug Eruption
    - Due to the length of time since onset of the rash, the symptoms might be due to a drug eruption. These types of rashes can mimic many inflammatory skin conditions. However the patient denies any constitutional symptoms and the rash is not symmetric. Also the patient denies intake of antibiotics, usage of other new medications or any dosage changes to pre existing prescriptions. Would need to observe and inquire further about new medications.
4) Ureterolithiasis
    - Due to the complaint of left flank pain, symptoms might be due to a urinary stone. However the patient denies any nausea, vomiting, hematuria and h/o kidney stones. Would need to do a urinalysis, evaluate urinary pH, take a KUB, a non-contrast CT or ultrasound to rule out.
5) Acute pyelonephritis
    - Due to the complaint of left flank pain, symptoms might be due to acute pyelonephritis. However the patient denies any urinary urgency/frequency, nausea, vomiting, hematuria, dysuria, fever, and chills. There was no suprapubpic or CVA tenderness eplicited upon physical examination. Would need to do CBC, urinalysis, urine culture, and a CT or renal US to rule out.

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
S. Shami, J. Yuan & M. Malavet
(718) 262-3793
Fax: (718) 262-2504

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

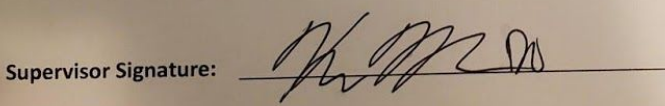
Clinical Site: ER

Date of Visit: 9/1/20

Activity performed: H&P

Supervisor:

Name and Credentials: Kenneth Chang DO PGY-2 EM

Supervisor Signature: 

Supervisor Comments:
Excellent work. Stayed above & beyond.
Great H&P. Medical knowledge at and above his level
of training. Very professional & kind. Keep up the great work
will go very far.