Daniela Arias Rodriguez

Physician Assistant Program

Physical Diagnose II, Spring 2019

Hospital Visit 2, Preadmission Testing

**History**

Identifying Data:

Full Name: Mrs. C

Address: Queens

Date of Birth:

Date & Time: March 5, 2019

Location: New York-Presbyterian, Flushing Queens

Religion: unknown

Source of Information: daughter

Source of Referral: Unknown

Mode of Transport: brought to the hospital by daughter

Chief Complaint: “Left knee pain x 2 years”

History of Present Illness:

Mrs. C is a reliable 62 y/o Asian female, with a significant past medical history of hypercholesterolemia and arthritis presented to preadmission testing for final testing prior to her knee replacement surgery. Patient has been experiencing left knee pain for 2 years due to arthritis. The pain was under control with injections, but it got worse in the last year reason why she decided to have the surgery. Pain is described as sharp and appears with exertion or walking. It does not radiate to other parts of the body. Pain is 8/10 and it is not worsen or alleviated by anything. Patient admits lower back pain when leaning forward. Patient denies swelling, deformities, or redness in muscle and joints, intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color changes or mechanical fall.

Past Medical History:

Present illnesses – cholesterol x unknown, arthritis in left knee x 2 years

Past medical illnesses – left breast lumpectomy x known, hemorrhoids x unknown, eye cataract surgery x known,   
Hospitalized – (detail in surgery section).

Childhood illnesses – denies any known childhood illness.

Immunizations –up to date; received flu vaccine.

Screening tests and results– Colonoscopy 2016, benign.

Past Surgical History:

Tubal ligation– age unknown. No complication. Unknown hospital.

Hemorrhoid surgery– age unknown. No complications. Unknown hospital.

Cataract surgery –age unknown. No complication. Unknown Hospital.

Denies past injuries, broken bone or blood transfusions.

Medications:

Pravastatin 20mg, PO daily, hypercholesterolemia. Last dose.

Meloxicam 15 mg PO daily, arthritis. Last dose

Restasis one drop each eye every 12 hours as needed reason. Last dose.

Zolpidem 5mg PO at bedtime as needed, sleeping problems. Last dose.

Hyalgan left + right (sodium hyaluronate). Last dose April 8, 2018.

Allergies:

Denies drug, environmental or food allergies.

Family History:

Mother – Deceased at unknown age and reason.

Father – Deceased at unknown age and reason.

Children– 1 adult, alive and healthy

Siblings – 2 deceased, one of leukemia. 5 alive and healthy.

Maternal/ paternal grandparents – deceased at unknown age and unknown causes.

No family history of diabetes mellitus, HTN, cancer, endocrine or nervous disorders, heart, kidney, GI or lung diseases.

Social History:

Mrs. C is a retired Asian female who lives alone.

Habits – She denies smoking or use of alcohol and recreational drugs.

Travel – She denies traveling outside of state or US.

Diet – consists of pasta, vegetables, meat and waffles.

Sleep patterns- Patient admits having difficulty falling and staying asleep reason why she was prescribed Zolpidem.

Exercise –unknown

Safety measures - Unknown

Sexual Hx – Unknown

Review of Systems:

General – Denies loss of appetite, generalized weakness/fatigue, weight loss, fever, chills or night sweats.

Skin, hair, nails – Patient admits excessive sweating during the discomfort chest episode two days ago. Patient denies any change in texture, dryness, pruritus or change in hair distribution.

Head – Patient denies any headache, vertigo, light-headedness or head trauma

Eyes – Admits dryness and sometimes pruritis. Denies photophobia, diplopia, scotoma, halos or fatigue with use of eyes. Patient wear glasses for reading. Unknown last eye exam.

Ears – Patient denies deafness, pain, discharge, tinnitus and use of hearing aids.

Nose/sinuses – Denies any nose discharge, epistaxis or obstruction.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, or changes in voice. Patient has 3 teeth implants. Unknown last dental exam.

Neck - localized swelling/lumps and stiffness/decreased range of motion

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

Cardiovascular system – Denies HTN, palpitations, chest pain, peripheral edema, syncope and known heart murmur.

Gastrointestinal system – Denies vomiting, nausea, diarrhea, constipation, rectal bleeding or change in bowel movements, changes in appetite, intolerance to specific food, abdominal pain. Hemorrhoid surgery x unknown. Flatulence, dysphagia, eructation, jaundice, pyrosis and light clay-colored stool. Colonoscopy or sigmoidoscopy.

Genitourinary system –Patient denies urgency, nocturia, oliguria, polyuria, frequency, dysuria, incontinence, hematuria, pyuria or dark urine, awakening at night to urinate or pain. Sexual history.

Menstrual/Obstetrical- date of last normal period, menarche, menstruating (interval between periods, duration and amount of flow, dysmenorrhea, metrorrhagia, menorrhagia, premenstrual symptoms), postcoital bleeding, vaginal discharge, dyspareunia, menopause (date of cessation, associated symptoms, break through bleeding), obstetrical history - number of pregnancies, number of deliveries, complications, abortions (spontaneous or elective).

Nervous system– States parethesias in the fingers and change in memory. Denies seizures, headache, loss of consciousness, numbness, dysesthesias, hyperesthesia, ataxia, change in cognition / mental status / weakness.

Musculoskeletal system – Admits having arthritis in the left knee x 2 years. Patient admits having a sharp lower back pain when leaning forward. The pain does not radiate to other body parts. She describes the pain as 6/10 and it is not worse or alleviate by anything. She denies swelling, redness, deformity of muscles or joints.

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

Hematological system – Denies any blood transfusion in the past. Anemia, easy bruising or bleeding, lymph node enlargement, History of DVT/PE

Endocrine system – Denies polyuria and excessive sweating. polydipsia / polyphagia, heat or cold intolerance, goiter, Hirtuism.

Psychiatric- depression/sadness, anxiety, obsessive / compulsive disorder, seen a mental health professional, medications

**Physical**

General: small-build, well groomed, looks younger than her aged. Patient is AOx3 and does not appear to be distress.

Vital Signs: BP: R L

Seated 138/89 118/74

Supine 112/70 121/78

R: 16/min unlabored P: 127, regular

T: 98.0 degrees F (oral) O2 Sat: 100% Room air

Height 59 inches Weight 160 lbs. BMI: 32.3

Skin: warm & moist, good turgor, nonicteric, unremarkable thickness/opacity, no visible scars, tattoos, rashes or masses.

Nails: no signs of clubbing, lesions or Beau’s lines, paronychia, capillary refill <2 second.

Hair: average quantity, evenly distributed and thin texture. No signs of erythema, dryness in the scalp, alopecia, seborrhea or lice.

Head: normocephalic, no specific facies, no signs of trauma, non-tender and swelling to palpation.

Ear: symmetrical and normal in size, no sign of erythema, infection or inflammation, painless on palpation of tragus, auricles and mastoid areas. No signs of inflammation, erythema, foreign bodies, lesion on external auditory canal AU. Intact, pearly gray, and unremarkable cone of light of tympanic membrane AU. Auditory acuity: weber, rinner and whispering test.

Eyes - symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white;

conjunctiva & cornea clear. Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU).Visual fields full OU. PERRLA , EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU/no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

Mouth : Lips- Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa - Pink ; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia. Palate – Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation. Teeth - Good dentition / no obvious dental caries noted.

Gingivae – Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.Tongue – Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.Oropharynx - Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

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.

Chest - Symmetrical, no deformities, no evidence trauma. Respiration unlabored or padoxic respiration, no use of accessory muscles. Lat to AP diameter 2:1. Non-tender to palpation.

Lungs - Clear to auscultation bilaterally. No sign of rales, rhonchi or wheezing. Unremarkable bilateral percussion. Chest expansion and diaphragmatic excursion symmetrical. No sign of egophany. Tactile fremitus intact throughout.

Cardiovascular- Normal S1 and S2. No signs of murmur, S3, S4 or splitting of heart sounds, friction rubs or extra heart sounds. Regular rate and rhythm (RRR). JVP is 2.5 cm above the sternal angle with the head of the bed at 30. PMI in 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits.

Abdomen: Bowel sounds present in all 4 quadrants. Flat and symmetrical abdomen with no signs of scars, striae or caput medusae. abnormal pulsations. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Breast: symmetric, no dimpling, no masses, nipples without discharge. No axillary nodes palpable.

Genitourinary female: External - normal pubic hair pattern, no erythema, inflammation, ulcerations, lesions or discharge noted. BUS wnl. [BUS = Bartholins, Urethra, Skenes glands]

Vaginal mucosa without inflammation, erythema or discharge. Cervix nulli/multiparous without lesions or discharge. No cervical motion tenderness. Uterus retro-flexed, mobile, non-tender and of normal size, shape, and consistency. Adnexa without masses or tenderness.

Rectal Female : 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.

**Assessment:** Mrs. C is a reliable 62 y/o Asian female, with a significant past medical history of hyperlipidemia and arthritis presented to preadmission testing for final testing prior to her knee replacement surgery.

**Plan:**

1. Knee pain/ arthritis
2. Lower back pain
3. Hypercholesterolemia
4. Eye dryness
5. Sleep problems

**Differential**

1. Osteoarthritis ( are joint pain, stiffness, and locomotor restriction)

2. patellofemoral pain (anterior pain and around the knee cap)

3. Osteochondritis dissecans (pain triggered by physical activity and swelling/tenderness)

4. knee bursitis (pain when move or a rest, inflammation and tenderness)

5. Popliteal Baker’s cyst (pain, swelling and stiffness in the posterior aspect of the knee)