Nicole Skursky
November 17, 2019
H&P #2, Shami → Internal Medicine

HISTORY/IDENTIFICATION

Full Name: CB
Sex: Male
Pronouns: he/him/his
Race: White
Nationality: Dominician
Date of Birth: Unknown

Age: 46 years old
Marital Status: Married
Religion: Catholic
Address: Queens, New York
Date/Time: 11/12/2019; 9:45AM
Location: NYP Queens; ~~Internal~~ Medicine (11/16/19) Internal

INFORMANT/REFERRAL SOURCE

Source of information: self
Reliability: reliable
Source of referral: ER
Mode of transport: car

CHIEF COMPLAINT

"I've had chest pain" x3 weeks.

HISTORY OF PRESENT ILLNESS

CB is a reliable 46 year old, married, obese Dominician male, with a past medical history ~~and a significant family history~~ of hypertension, who presents (to ER) with chest pain x3 weeks due to heart enlargement/heart failure (mention later). CB had the flu three weeks ago and originally thought the chest pain was related to subsequent symptoms of the flu. After the pain became unbearable on Sunday 11/3, CB's wife took him to the ER for evaluation. CB indicated that on admission to the ER, his blood pressure was elevated (value unknown) and he was experiencing palpitations. The pain was gradual and then became constant, throughout the day, localized to the center of his chest with no radiation, and was unable to be relieved by NSAIDs. On admission to the ER, his pain

was an 8/10 however, the pain is now a 3/10 CB indicated that his PCP had prescribed different medications for him to trial to see which was most efficacious; however, he tends to forget or not take the prescribed dosage of his medication. CB indicated that he is the primary breadwinner for his family and drives for Uber. Due to this, he tends to drive for long periods of time without breaks, is ~~send~~ WNS 11/16/19 sedentary for the grand majority of the day, has significant caffeine consumption, has poor sleeping habits, does not exercise, and has unhealthy eating habits as he tends to eat fast food or restaurant purchased food between Uber passengers/rides. CB admits to dyspnea, SOB, cough, wheezing, chest pain, hypertension, palpitations, irregular heartbeat, and abdominal pain. CB denies hemoptysis, cyanosis, orthopnea, paroxysmal noctural dyspnea, edema/swelling of the ankles or feet, syncope, weakness, known heart murmur, intermittant ~~claud~~ WNS 11/16/19 claudication, coldness of trophic changes, varicose veins, peripheral edema, or any color changes. Fever, chills, vomiting, any recent injuries cough?

Past MEDICAL HISTORY

Past medical illnesses? ex: pneumonia 2010

Present medical Illnesses: Hypertension x 3 years
Childhood Illnesses: Denies
Hospitalizations: Denies (current hospitalization is first time)
Immunizations: Up to date; flu vaccine 11/4/2019; denies pneumonia vaccination
Screening tests and results: Admits to prostate exam, date unknown, normal result. Denies colonoscopy.

PAST SURGICAL HISTORY

Hernia surgery - age 34, 2007, hospital unknown (in the Dominician

Republic. Patient was unsure of details but indicated that the hernia was in his lower left quadrant/same area as surgery in 2006. No complications, denies blood transfusion.

Hernia surgery - age 33, 2006, LIJ Hospital. Patient was again unsure of the details of this surgery but indicated that it was in his lower left quadrant of his abdomen. No complications, denies blood transfusions.

MEDICATIONS

Losartan (Cozaar) 50 mg, 1 tablet by mouth daily for high blood pressure, last dose Sunday 11/3.

FAMILY HISTORY

Maternal/paternal grandparents - deceased at unknown ages and unknown reasons
Mother - 65, alive and well
Father - Deceased at unknown age (when patient was a child), uncontrolled hypertension
Brother - 44, alive and well
Brother - 43, hypertension but otherwise alive and well
Sister - 42, alive and well
Brother - 41, hypertension but otherwise alive and well
Brother - 40, alive and well
Sister - 39, alive and well
Daughter - 23, alive and well
Son - 21, alive and well

Admits to family history of hypertension. Denies family history of diabetes, cardiovascular diseases, hypercholesterolemia, chronic kidney disease, myocardial infarction, coronary artery disease, or cancers.

ALLERGIES

Denies any drug, food, or environmental allergies.

SOCIAL HISTORY

CB is a married male, living with his wife, daughter and son, and has no pets. He works full time as an Uber driver throughout the tristate area (primarily in the major New York City area).

Habits: He denies alcohol, smoking, vaping, and illicit drug usage. Admits to caffeine drinking (4 coffees each day).

Travel: ~~Admits to~~ recent international travel, was in the Dominician Republic (one week, July 2019) and Colombia (one week, August ~~200~~ 2019 cms 11/16/19) to see family. No recent domestic travel.

Diet: Due to his employment, he is unable to pack a lunch and tends to purchase restaurant ~~food~~ or ~~fast food~~ for lunch and dinner. Breakfast is usually at home and consists of black coffee with 1 tsp of sugar and 2-3 mantecaditos (Dominician breakfast butter cookies), or a fresh squeezed green juice from a local shop. Lunch and dinner consist of sandwiches, salmon and vegetables, salads, or fast food.

Exercise: Denies.

Sleep: ~~Admits to getting~~ cms 11/16/19 ~~Gets~~ 3-4 hours per ~~hour~~ night cms 11/16/19

Safety measures: ~~Admits to~~ wearing a seat belt.

~~Sexual history~~: ~~Heterosexual~~, 1 ~~partner~~ (wife). ~~Admits to~~ being sexually active. Denies impotence, anorgasmia, condom use/contraception, or history of sexually ~~transmitted~~ infections

REVIEW OF SYSTEMS

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

Skin, hair, nails: Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, ~~prdr~~ mrs 11/14/19 pruritus, changes in hair distribution, or moles/nevi/rashes.

Head: Denies headache, vertigo, unconsciousness, head trauma, coma, fracture.

Eyes: Admits to lacrimation. Denies use of contacts and glasses, visual disturbances, fatigue, or pruritus. Last eye exam 3/2017, normal.
Ears: Denies discharge, deafness, pain, tinnitus, or use of hearing aids.
Nose/sinuses: Denies discharge, epistaxis, or obstruction.

Mouth/throat: Admits to "white dots" on his tongue after eating certain foods that are acidic or salty. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures. Last dental exam unknown.

Neck: Admits to stiffness. Denies localized swelling or current lumps, or decreased range of motion.

Pulmonary system: Admits to dyspnea, shortness of breath, cough, wheezing. Denies hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal ~~dsy~~ mrs 11/14/19 dyspnea.

Cardiovascular system: Admits to chest pain, hypertension, palpitations, and irregular heartbeat. Denies edema or swelling of the ankles or feet, syncope, or known heart murmur.

Gastrointestinal system: Admits to abdominal pain. Denies changes in appetite, intolerance to certain foods, nausea and vomiting, dysphagia, pyrosis, abnormal flatulence or eructation, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, or pain in flank. Denies colonoscopy.

Genitourinary system: Denies changes in frequency or color of urine, incontinence, dysuria, nocturia, urgency, oliguria, polyuria, hesitancy, or dribbling. Last prostate exam unknown.

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, or history of DVT/PE.

Endocrine system: Denies polyuria, polydipsia, polyphagia, cold or heat intolerance, or goiter.

Nervous: Denies seizures, loss of consciousness, sensory disturbances (including numbness, paresthesias, dysesthesias, hyperesthesias), ~~ax~~ us 11/14/17 ataxia, loss of strength, change in cognition/memory/mental status, asymmetrical weakness.

Psychiatric: Denies depression, sadness, feelings of helplessness or hopelessness, lack of interest in usual activities, suicidal ideation, anxiety, obsessive/compulsive disorder. Denies medications or therapy.

PHYSICAL EXAM

General: Alert and oriented X3. Average male, neatly groomed, dressed in hospital issued gown, good posture.

Vital signs:

Height: 68 inches
Weight: 198 pounds
BMI: 30.1
Temperature: 98.6°F, oral
Oxygen saturation: 99% room air
Respiratory rate: 16/minute, unlabored
Pulse: 76 bpm, regular
BP: Right, seated, 140/80
Left, standing, 138/78

Skin, Hair, Nails, Head

Skin: Warm and moist, good turgor, nonicteric, no evidence of lesions, scars, tattoos. No blanching, redness, or warmth.

Hair: Average quantity and texture.

Nails: No clubbing, capillary refill < 2 seconds throughout. No evidence of texture and shape changes, infections, or lesions.

Head: Normocephalic, atraumatic, non-tender to palpation throughout (frontal, temporal, parietal, and occipital regions).

Eyes: Symmetrical between both eyes. No evidence of strabismus, exophthalmos, or ptosis. Sclera white and corneal conjunctiva clear.

Visual acuity: uncorrected, 20/40 in both eyes, 20/40 in left eye, and 20/40 in right eye.

Visual fields: full OU, PERRLA, EOMs full with no nystagmos.

Fundoscopy: red reflex intact in both eyes, cup:disc < 0.5 in both eyes. No evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization in both eyes.

EARS: Symmetrical, normal size. No trauma, lesions, masses, on external ear. No evidence of pain on the external ear. No discharge or foreign bodies in the external auditory canal in both ears. Tympanic membrane is pearly white and intact with light reflex in normal position in both ears. No evidence of color changes, masses, perforation, plaques, scars, discharge behind or lesions on the tympanic membrane. Auditory acuity is intact to whispered voice in both ears. Weber midline. Positive Rinne test, air conduction is greater than bone conduction.

NOSE: Nose is symmetrical. No evidence of masses, lesions, deformities, trauma, or discharge. No evidence of tenderness, bogginess, or step off. Nares patent bilaterally. Nasal mucosa is pink and well hydrated. There is no discharge noted on the internal nose exam. The septum midline is without lesions, deformities, injection, perforation. No evidence of foreign bodies.

SINUSES: No evidence of sinus swelling, color change, or asymmetry. Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.

MOUTH / OROPHARYNX

Lips: Pink and moist. No evidence of lesions or cyanosis.

Mucosa: Pink and well hydrated. No evidence of masses, lesions. Non-tender to palpation.

Palate: Pink, well hydrated. Palate is intact with no lesions, masses, scars.

Teeth: Good dentition. No obvious dental caries noted.

Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema, or discharge.

Tongue: Pink, moist, well papillated. No masses, lesions, fissures, or deviations.

Oropharynx: Well hydrated. No injection, exudate, masses, lesions, or foreign bodies. Tonsils are ~~present~~ with no injection or exudate. Uvula is pink with no edema or lesions. MS 11/14/19

NECK: Trachea is midline. No evidence of lesions, masses, scars, or pulsations. Lymph nodes are normal size and color. Firm consistency, discrete, mobility. Non-tender to palpation. Thyroid is non-tender, no palpable masses, no Thyromegaly, no bruits noted.

THORAX AND LUNGS

Chest: Symmetrical, no deformities, no evidence of 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.

97