Nicole Skwisky
December 9, 2019
H&P #3; Internal Medicine #2

## HISTORY/IDENTIFICATION

Full name: HL
Sex: Male
Pronouns: he/him/his
Race: Asian
Nationality: Chinese
DOB: 04/27/1947
Age: 72 years old
Marital status: Married
Religion: Buddhist
Address: Flushing, NY
Date/Time: 12/3/2019; 9:45 AM
Location: NYP Queens, ~~Internal Medicine~~, 5th Floor

## INFORMANT/REFERRAL SOURCE

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

## CHIEF COMPLAINT

"I've had rectal bleeding" x 4 hours.

## HISTORY OF PRESENT ILLNESS

HL is a reliable 72 year old, married Chinese male, with a past medical history of hypertension, hemoglobin H disease, coronary artery disease/CABG, and polycystic kidneys and a family ~~d~~ history of hypertension and myocardial infarction, presented to the ER c/o rectal bleeding x 4 hours. with intractable rectal bleeding and blood in diarrhea that had sudden onset and lasted for about 4 hours, on Sunday 12/1 evening. HL's wife brought him to the ER after he went to the bathroom 9-11 times in four hours, with each episode consisting of uncontrollable diarrhea that was presenting with blood and rectal bleeding was bright red. The patient was not presenting with any pain or associated symptoms, and nothing was able to alleviate the intensity or bleeding. HL originally thought the bleeding was from hemorrhoids but the amount of blood was greater than what he expected

With a ruptured hemmorrhoid. This was the first time this has happened to the patient; however, the issue completely took over his night as he was unable to leave the bathroom. The diarrhea and rectal bleeding was contained while he was at the ER, and he was admitted to internal medicine for a low GI bleed. He was being prepped for a colonoscopy while the interview was taking place. Patient admits to diarrhea, hemmorrhoids, rectal bleeding, blood in stool, pain in flank, muscle and joint pain, vertigo, and anemia. Patient denies fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss, intolerance to certain foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, jaundice, change in bowel habits, constipation, easy bruising or bleeding, lymph node enlargement, or history of DVT/PE.

great!

## PAST MEDICAL HISTORY

Present medical illnesses: Admits to hypercholesterolemia, hypertension, coronary disease, hemoglobin B disease, benign prostate hyperplasia x 1 year, polycystic kidneys. Patient was able to disclose how long he has had each disease (only the enlarged prostate).

Childhood illnesses: Denies

Hospitalizations: Admits to hospitalization after CABG (see surgical Hx)

Immunizations: Up to date; flu vaccine 10/2019, zoster 10/2017; denies pneumonia vaccination

Screening tests/results: Admits to prostate exam, 10/2018, diagnosis of benign prostatic hyperplasia. Admits to colonoscopy, 2017, normal.

## PAST SURGICAL HISTORY

Coronary artery bypass surgery - age 72, 8/2019, St. Francis Hospital (Roslyn, NY). Patient was hospitalized for five days following the surgery. Well healed scar superior to the sternum measuring about five inches was observed during physical exam. No complications, denies blood transfusion.

Cholecystectomy - age 57, 2004, St. Vincent's Hospital (Manhatten, NY; now closed). No complications; denied blood transfusion.

## MEDICATIONS

Aspirin 81 mg, 1 tablet by mouth for hypertension, last dose Sunday 12/1

Metoprolol 50mg, 1 tablet by mouth for hypertension, last dose Sunday 12/1

Losartan 25 mg, 1 tablet by mouth for hypertension, last dose Sunday 12/1

Atorvastatin 10mg, 1 tablet by mouth for hypercholesterolemia, last dose Sunday 12/1

Furosemide 40 mg, 1 tablet by mouth for kidney disease, last dose Sunday 12/1

Tamsulosin 0.4mg, 1 tablet by mouth for benign prostatic hyperplasia, last dose Sunday 12/1

Finasteride 5mg, 1 tablet by mouth for benign prostatic hyperplasia, last dose Sunday 12/1
alb 12/10/19 mg

Ferrous sulfate iron 325 mg, 1 tablet by mouth for general health, last dose Sunday 12/1

Super B complex (dose unknown), 1 tablet by mouth for general health, last dose Sunday 12/1

Vitamin E 400 units, 1 tablet by mouth for general health, last dose Sunday 12/1

Men's multivitamin (dose unknown), 1 tablet by mouth for general health, last dose Sunday 12/1

## ALLERGIES

Denies any drug, environment, and food allergies.

## FAMILY HISTORY

Maternal/paternal grandparents - deceased at unknown age and unknown reasons

Mother - deceased at 90 due to complications with Alzheimer's
Father - deceased in his 70s (pt was unsure of definitive age) due to MI
Son - 51, alive and well
Son - 49, alive and well
Grandson - 29, alive and well
Granddaughter - 19, alive and well
Grandson, 17, alive and well
Admits to family history of hypertension and myocardial infarction. Denies family history of diabetes, cardiovascular diseases, hypercholesterolemia, chronic kidney disease, coronary artery disease, or cancers.

## SOCIAL HISTORY

HL is a married male, living with his wife and no pets in a co-op in Flushing, Queens. He has been retired for about 15 years after selling his restaurant.

Habits: He denies alcohol, smoking, vaping, and illicit drug usage. Admits to caffeine drinking (1 coffee each day).

Travel: Admits to recent traveling/cruise to Miami and Carribbean in 7/2019. Denies other traveling.

Diet: HL has a coffee with light cream and sugar for breakfast. He has two large meals a day that consists of a large plate of food. Each meal typically has rice, vegetables, and meat (such as red meat or chicken) or seafood (such as shrimp or scallops). HL denies snacks but admits to overeating when he does eat.

Exercise: HL goes to the local senior center three times a week with his wife for about two hours. He likes to swim, walk on the track, and dance classes with his wife.

Sleep: Admits to getting 7 hours a night.

Safety measures: Admits to wearing a seat belt.

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

## REVIEW OF SYMPTOMS

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

Skin, hair, nails: Admits to changes in ~~skin~~ nail texture. US 12/8/11 Denies excessive dryness or sweating, discolorations, pigmentations, pruritus, changes in hair distribution, moles/rashes.

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

Eyes: Admits to use of glasses. Denies use of contacts, lacrimation, visual disturbances, fatigue, photophobia, pruritis. Last eye exam unknown.

Ears: Denies deafness, pain, discharge, tinnitus, and use of hearing aids.

Nose/sinuses: Denies discharge, epistaxis, obstruction.

Mouth/throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, use of dentures. Last dental exam unknown.

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

Pulmonary system: Denies dyspnea, shortness of breath, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal noctural dyspnea.

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

Gastrointestinal system: Admits to hesitancy, dribbling. Denies changes in frequency or color of urine, incontinence, dysuria, nocturia, urgency, oliguria, polyuria. Last prostate exam 10/2018, enlarged prostate.

this sounds like Genito-Urinary ROS. Where is Gastro?

Musculoskeletal system: Admits to muscle/joint pain. Denies deformity or swelling, redness, arthritis.

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

Hematological system: Admits to anemia. Denies easy bruising or bleeding, lymph node enlargement, history of DVT/PE.

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

Nervous: Admits to changes in memory retention. Denies seizures, loss of consciousness, sensory disturbances (including numbness, paresthesias, dysesthesias, hyperesthesias), ataxia, loss of strength, change in cognition/mental status, asymmetric weakness.

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

dx 12/8/19

cns 12/8/19

# PHYSICAL EXAM

**General:** Alert and oriented x 3. Average male, neatly groomed, dressed in hospital issued gown, good posture.

**Vital signs:**

Height: 67 inches
Weight: 155 pounds
BMI: 24.3
Temperature: 98.6° F, oral
Oxygen satration: 99% room air
RR: 12 breaths/minute, unlabored
Pulse: 60 bpm, regular
BP: right, seated 122/70
left, standing 120/70

**Skin, Hair, Nails, Head**

Skin: Warm, moist, good turgor, nonicteric, no evidence of lesions, tattoos. Evidence of CABG scar on medial thorax, well healed. No other evidence of scars. No blanching, redness, or warmth.

Hair: Average quantity and distribution.

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

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

**Eyes**

Symmetrical between both eyes. No evidence of strabismus, ptosis, and exophthalmos. Sclera white and conjunctiva/cornea clear.
Visual acuity: uncorrected, 20/40 in both, 20/40 in left, 20/40 in right.
Visual fields: full OU, PERRLA, EOMs full with no nystagmos.
Fundoscopy: red reflex intact in both eyes, cup:disc < 0.5 OU. No evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, neovascularization OU.

## 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. TM 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 TM. 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, foreign bodies. Tonsils are present with no injection or exudate. Uvula is pink, no edema or lesions.

## NECK

Trachea is midline. No evidence of lesions, masses, scars, or pulsations. Lymph nodes are normal size and color. Firm consistency, discrete, mobile. 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.

## ABDOMEN

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

HEART

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

93 2