95

STEVEN SIEGEL H+P 10/8/19

HISTORY

Identifying Data:

Full Name: Mrs. M

Address: Not disclosed

Age: 76

Date: October 8, 2019

Location: NY-Presbyterian Queens, Flushing, NY

Religion: Not disclosed

Source of information: Self ✓

Reliability: Reliable

Source of referral: EMS

Mode of ~~transport~~ transport: EMS

Chief Complaint: "right sided back pain" x4 days ✓

History of Present Illness:

GRADUAL OR ACUTE ONSET?

Mrs. M is a 76 year old female with a history of hypertension, hyperlipidemia, hypothyroid, and vitamin D deficiency who presented to the ED 4 days ago for back pain. Constant stabbing back pain on right side described as "15/10" at onset. Pain began after manually lifting garage door 6 days ago, at onset she was unable to stand or walk. Pain is exacerbated by movement including twisting and standing. She did not try any oral medications but did apply lidocaine cream with no improvement and used heating pad with mild improvement. ~~Shooting~~ pain radiates down right leg and makes it difficult to lift right leg. ~~Patient is suspicious of kidney stone~~. Admits history of frequent antibiotic resistant UTIs, wakes up 1-2x per night to urinate, functional incontinence, decreased appetite. Denies joint deformities or swelling, dysuria, increased frequency or burning on urination, changes in urine color, fever, chills, fatigue, weakness, or night sweats

DYSURIA? HEMATURIA?

Past Medical History:
Hypertension x 20 years, well controlled on current regimen
Hyperlipidemia x 5-6 years, well controlled on current regimen
Hypothyroid x 10 years, well controlled on current regimen
Vitamin D deficiency x 10 years, well controlled on current regimen
Squamous Cell Carcinoma, on face, s/p Mohs, no evidence of recurrence
Childhood illnesses - denies significant childhood history
Immunizations - up to date, last flu vaccine 1 month ago
Screening tests + results - Colonoscopy at age 55, no significant findings. Last eye exam 10 months ago, does not wear glasses. Recent dental exam, no dentures

Past Surgical History:
Mohs - Multiple on face, most recent September 2019 on left cheek with dermatology Dr. Zuckerman. No complications
Denies eye surgery, cholecystectomy, appendectomy

Medications:
Toprol 50mg BID PO
Vitamin D3 5000 units QoD PO
Cozaar 50mg daily PO
Levothyroxine 50 mcg PO 2 tablets Monday + Friday, 1 tablet Tuesday, Wednesday, Thursday, Saturday, Sunday
Multivitamin daily PO + TAB
Vitamin B12 daily PO + TAB
Culturelle probiotic daily PO + TAB
No recent changes in medications, no herbal teas or supplements

Allergies:
Penicillin - diffuse rash, severe
Erythromycin - anaphylaxis, severe
Codeine - diarrhea, moderate

Statins - muscle aches, moderate
Dogs - anaphylaxis, rash, severe
No known food allergies, No shellfish or seafood allergies

Family History:
Mother - History of MI. Deceased age 62
Father - History of smoking and lung cancer. Deceased age 86
Sister - History of hypertension, squamous cell carcinoma. Alive and well
Brother - History of cardiomegaly, cigarette smoker, WTC exposure. Deceased age 72.
Grandparents - No significant medical history

Social History:
Mrs. M is an unmarried female who lives alone with no pets. She is a retired retail sales associate.
Habits - She drinks 1-2 glasses of wine on holidays, otherwise does not drink alcohol. No history of tobacco smoking or vaping. Denies history of substance abuse or illicit substance use. Denies caffeine intake
Travel - denies recent international travel
Diet - Monitors sodium intake. Maintains adequate hydration. Eats fruit and vegetables. Breakfast: oatmeal, fruit. Lunch: Salad. Dinner: Chicken or fish and rice with vegetables
Exercise - Walks daily and uses stairs at home
Sleep - sleeps well 8-9 hours per night
Safety - Wears seatbelt when driving, plans to stop driving due to difficulty with garage door. Smoke and CO monitors in home
Sexual history - Heterosexual. Not sexually active. Denies history of STIs

Review of Systems:
General - see HPI.

Skin, hair, nails - Denies changes in texture, excessive dryness or sweating,

discolorations, pigmentations, moles/rashes, pruritis, changes in hair distribution

Head - Denies headaches, dizziness, vertigo or head trauma

Eyes - Denies visual disturbances, photophobia. Last eye exam 10 months ago - does not know visual acuity, normal pressure

Ears - Denies deafness, pain, discharge, tinnitus or use of hearing aids

GLASSES?

Nose/sinuses - Denies discharge, obstruction or epistaxis

Mouth/throat - Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or denture use. Last dental exam 2019, unremarkable

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

Pulmonary - Denies wheezing, dyspnea on exertion, cough, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND)

Cardiovascular - History of hypertension x 20 years. Denies chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope or known murmur

Gastrointestinal - Denies intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool

Genitourinary - See HPI

Nervous - Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/Mental Status/memory, or weakness

Musculoskeletal - See HPI

Peripherovascular - Denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, color changes ✓

Hematological - Denies anemia, easy bruising, bleeding, lymph node enlargement, blood transfusions, history of DVT/PE ✓

Endocrine - Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter ✓

Psychiatric - Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional ✓

Vital Signs:
BP: seated 130/75 L, 130/80 R
HR: 58 BPM, regular
RR: 17 breaths/min, unlabored ✓
Temp: 36.5°C
O_2 Sat: 96% room air
Height: 5'6"
Weight: 200lbs
BMI: 32.3

Physical Exam:
General: Well developed, obese female in no apparent distress. Alert and oriented x3. Appears stated age ✓

Skin: Warm and moist, good turgor. Nonicteric, no lesions noted, no scars, 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 evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva and cornea clear. Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/200U). Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:disk ≤ 0.5 OU/no evidence of AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU ✓