STEVEN SIEGEL H+P PAT 2/10/20

HISTORY

Identifying data

Full name: Mr. N

Address: Not disclosed

Age: 83

Date and time: February 4, 2020, 9:00 AM

Location: NYPQ

Religion: Not disclosed

Source of information: self, patient speaks Greek, daughter serving as translator

Reliability: reliable

Source of referral: urologist

Mode of transport: daughter

Chief Complaint: "I am having excision of spermatocele on right testicle"

History of present illness:

83 year old male with history of hypertension, hyperlipidemia, hyperthyroid, bladder cancer, prostate cancer, acromegaly, and polymyalgia rheumatica presents to preadmission testing before proposed excision of spermatocele on right testicle on 2/13/2020 at NYPQ with Dr. F. Right testicular pain began 40 days ago (ABOUT 1 MONTH AGO). Pain is described as sharp and intermittent. Exacerbated by movement, sitting, and laying. Intermittent pain radiates to right lower quadrant of abdomen. Associated with constant swelling of scrotum. Taking levofloxacin 500 mg once daily orally for past 1 month with no improvement. Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss, Chest pain, shortness of breath, dyspnea on exertion, or LE edema. Denies history of DVT, PE, MI, seizures, sleep apnea, or stent placement.

HOW WAS THIS DIAGNOSED? BIOPSY? SONOGRAM?

Past Medical History:

Hypertension x 15 years. Well controlled on current regimen

Hyperlipidemia x 10 years. Well controlled on current regimen
Polymyalgia rheumatica x 6 years. Well controlled on current
Hyperthyroid x 15 years. Well controlled on current regimen
Acromegaly resolved s/p excision of pituitary tumor 12 years ago ✓
Prostate cancer s/p prostatectomy 18 years ago
Bladder cancer s/p TURP 14 years ago
Childhood illnesses - denies significant childhood history
Immunizations - up to date with all immunizations, last flu vacci
Screening tests - Colonoscopy in 1991, no significant findings. Last e
exam 2 months ago, does not wear glasses. Dental exam 7 m
ago, wears upper and lower dentures

Past surgical history:
Prostatectomy 18 years ago, no complications
TURP 14 years ago, no complications
Pituitary tumor excision 12 years ago, no complications ✓
Bilateral knee replacement 8 years ago, no complications
Bilateral Cataracts repair 4 years ago, no complications
Denies Cholecystectomy, appendectomy

Medications:
Prednisone 12.5 mg 1 tab daily PO, stopping on 2/9/2020 as per rheumatology
Methimazole 100 mg 1 tab daily PO
Amlodipine benazepril 10-20 mg 1 tab daily PO ✓
HCTZ 25 mg 1 tab PO on Monday, Wednesday, Friday
Simvastatin 10 mg 1 tab daily PO
No recent Changes in medications
No vitamins, herbal teas, or supplements

Allergies:
NKDA ✓
No known environmental allergies
No known food allergies, no shellfish or seafood allergies

Family history:
Mother - no significant medical history, deceased age 84
Father - no significant medical history, deceased age 95
Brother - history of tobacco smoking and lung cancer, deceased age 78
Sister - alive and well age 89
Brother - alive and well age 86 ✓
Sister - alive and well age 85
Daughter - alive and well age 49
Son - history of drug abuse, deceased age 32

Social history:
Mr. R is a married male living in a house with his wife and no pets. He is a retired furrier, food vendor, and police officer
Habits - does not drink alcohol. Former cigarette smoker, quit 20 years ago, smoked 0.5 packs per day for 10 years. Denies history of substance abuse or illicit substance use. Does not drink caffeine
Travel - traveled to Greece 3 years ago ✓
Diet - follows mediterranean diet. Breakfast: hard boiled egg. Lunch: salad with vegetables. Dinner: fish and vegetables ✓
Exercise: does not exercise regularly due to polymyalgia rheumatica ✓
Sleep: sleeps well for 6 hours per night, naps 1 hour in afternoon ✓
Safety - wears seatbelt in car. Has smoke alarm and CO monitor at home ✓
Sexual history - heterosexual. Not sexually active. Denies history of STIs

NEVER? → CAN ALSO SAY "NO HISTORY OF ETOH ABUSE" "THIS STATEMENT CAN IMPLY ETOH RECOVERY"
HOW LONG RETIRED?

Review of Systems:
General - see HPI ✓
Skin, hair, nails - denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, changes in hair distribution ✓
Head - denies headaches, dizziness, vertigo, head trauma ✓
Eyes - denies visual disturbances, photophobia. Does not wear glasses
p/p bilateral cataract surgery 4 years ago. Last eye exam 2 months ago ✓
does not know visual acuity, normal pressure

Ears - denies deafness, pain, discharge, tinnitus. Uses bilateral hearing aids ✓
Nose/sinuses - denies discharge, obstruction, epistaxis ✓
Mouth/throat - denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes. Last dental exam 7 months ago, uses upper and lower dentures FULL OR PARTIAL? ✓
Neck - denies localized swelling/lumps & stiffness/decreased ROM ✓
Pulmonary - denies wheezing, dyspnea on exertion, cough, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea ✓
Cardiovascular - denies chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur ✓
Gastrointestinal - denies intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence, eructations, diarrhea, hemorrhoids, jaundice, constipation, rectal bleed, blood in stool. Last colonoscopy in 1981, no significant findings ✓
Genitourinary - wakes up 2-3x per night to urinate. Denies urinary frequency, urgency, oliguria, polyuria, hematuria, dysuria, incontinence, flank pain ✓
Nervous - denies seizures, memory loss, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength or weakness ✓
Musculoskeletal - shoulder, elbow, wrist and hip pain, follows with rheumatology ✓
Peripheral vascular - denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, color changes ✓
Hematological - Easy bruising on hands. Denies anemia, bleeding, lymph node enlargement, blood transfusions, history of DVT/PE ✓
Endocrine - denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, goiter ✓
Psychiatric - denies depression, sadness, anxiety, OCD, or ever seeing a mental health professional ✓

Vital Signs:
BP: seated R: 124/73 L: 125/74
standing R: 127/75 L: 127/73 ✓
HR: 65 BPM, regular rate and rhythm

No pro

RR: 18 breaths per minute, unlabored
Temp: 98.5°F orally
O_2 sat: 95% room air ✓
Ht: 5'7"
Wt: 182 lbs
BMI: 28.5

WHAT COLOR? ABOUT WHAT SIZE?

Physical exam:
General: well developed, well groomed male in no acute distress. ✓
Alert and oriented x 3, appears stated age
Skin: warm and moist, good turgor, nonicteric, scattered lesions on bilateral hands, no scars or tattoos on upper extremities, otherwise unremarkable
hair: average quantity and distribution
nails: no clubbing, capillary refill <2 seconds throughout ✓
head: normocephalic, atraumatic, nontender to palpation throughout
eyes: symmetrical OU, no evidence of strabismus, exophthalmos or ptosis, sclera white, conjunctiva and cornea clear, visual acuity (20/20 OS, 20/20 OD, 20/20 OU) visual fields full OU, PERRLA, EOMs full with no nystagmus. Funduscopy: red reflex intact OU. Cup:disk ≤ 0.5 OU, no evidence of AV nicking, papilledema, hemorrhage, exudate cotton wool spots, neovascularization OU
ears: external ears symmetrical, no lesions, masses, trauma or external canals no discharge / foreign bodies in external auditory canals. TMs pearly white, intact with light reflex in (2) position bilaterally. ✓
Auditory acuity intact to whispered voice AU, Weber midline, Rinne reveals AC > BC AU
Nose: symmetrical, no masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, perforation. No foreign bodies. Sinuses nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

lips: pink, moist no cyanosis or lesions ✓
mucosa: pink, well hydrated. No masses, lesions noted. No leukoplakia ✓
palate: pink, well hydrated. Intact with no lesions, masses, scars ✓
teeth: dentures in place ✓ (FULL OR PARTIAL)
gingival: pink, moist. No hyperplasia, masses, lesions, erythema, discharge ✓
tongue: pink, well papillated no masses, lesions or deviation noted ✓
oropharynx: well hydrated, no injection, exudates, masses, lesions, foreign bodies. Tonsils present, no injection or exudate. Uvula midline, no edema or lesions ✓
Neck: trachea midline. No masses, lesions, scars, pulsations noted. Supple, nontender to palpation, FROM, no stridor noted. 2+ carotid pulses, no thrills, bruits noted, no palpable adenopathy noted ✓
thyroid: nontender, no palpable masses, no thyromegaly, no bruits ✓
Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored, no paradoxic respirations or use of accessory muscles noted ✓
Lat to AP 2:1. Non-tender to palpation
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. No adventitious sounds ✓
Tactile fremitus symmetric throughout
Heart: JVP 3.0 cm above sternal angle with head of bed at 30°. PMI in 5th ICS in midclavicular line on left. Carotid pulses 2+ bilaterally without bruits. Regular rate and rhythm, S1 and S2 ✓ distinct without murmurs, S3 or S4. No S2 splitting or friction rubs appreciated
Abdomen: flat and symmetrical without striae or pulsations. Bowel sounds normoactive in all 4 quadrants, no aortic/renal/iliac/femoral bruits. Nontender to palpation, tympanic throughout. No guarding or rebound. No hepatosplenomegaly, CVA tenderness. Negative Rovsing's, obturator, and psoas signs
Male genitalia: uncircumcised male, prepuce mobile and retractable. No penile discharge or lesions. Scrotal swelling, rash, discoloration. Testes descended bilaterally. Left testicle smooth. Right testicle smooth, epididymis with 2 x 2 cm firm nodule, fixed and tender to palpation. No inguinal

or femoral hernias noted

Anus, rectum, prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and nontender with palpable median sulcus. Stool ✓ brown, hemoccult negative

Assessment: 83 year old male with history of hypertension, hyperlipidemia, hyperthyroid, bladder cancer, prostate, acromegaly, and polymyalgia rheumatica presents (with sharp intermittent right testicular pain and swelling for past 10 days that radiates to RLQ.) TO PAT FOR EXCISION OF RIGHT TESTICULAR SPERMATOCELE

Differential:

1. Spermatocele - previously diagnosed by urologist. Palpable cyst on epididymus on right testicle
2. testicular torsion - suspected due to sharp testicular pain
3. hernia - suspected due to pain and swelling in scrotum and abdomen. Less likely due to lack of large scrotal masses and lack of bowel sounds in scrotum
4. hydrocele - suspected due to scrotal swelling. Less likely due to negative transillumination
5. appendicitis - suspected due to complaint of RLQ pain. Less likely due to abdominal physical exam showing negative Psoas, Rovsing's, and obturator signs, and RLQ nontender to palpation.