Rachel Freundlich
Professor Seligson

History

Identifying Data:
Full Name: D.S.
Address: Flushing, NY
Date of Birth: February 16, 1943
Date & Time: March, 7, 2023 10:25am
Location: New York Presbyterian Hospital, Flushing, NY
Religion: Hindu
Source of Information: Self (with assistance from patient's wife in the room)
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Driven by his son to the ER

Chief Complaint: "I had shortness of breath" x 3 days

History of Present Illness:
D.S. is an 80 y/o Indian man with significant PMH of CAD w/ stent, TIA, who presented to the ER 3 days ago with dyspnea at rest, DOE, slight lower chest pain x 3 days. Pt reports that the shortness of breath appeared suddenly and is exacerbated by simple movements such as walking. Dyspnea is most noticeable in the morning after his shower. Pt notes that chest pain began today localized to his lower right chest. He admits slight radiation to his upper back on inhalation. Pt notes that chest pain is consistent throughout the day, but is worsened on inhalation. Pt rated the pain as 3/10, dull, denied sharp sensations. Chest pain is relieved by sitting, lying down, and aggravated by deep inspirations. Pt has not taken pain medication. Pt also noted L. lower leg pain x3 days about three weeks ago. Pt traveled on a plane to Dallas 1 day following the onset of leg pain. Pt reports sharp pain rated 6/10 that was worsened by activity. Denies erythema and edema. Pt reports taking NSAIDs to alleviate pain. Pain was persistent throughout the entire day and disappeared after 3 days (while in Dallas).

Pt denies recent trauma, intense activity, and changes in medications or lifestyle. Pt denies current calf pain, nausea, vomiting, diarrhea, headache, dizziness, sweating, fever, lightheadedness or fainting. Pt reports he has not experienced shortness of breath since his MI and stroke 10 years prior. Pt's wife was concerned that the shortness of breath was worsening and advised her son to bring D.S. to ER on the third day. Pt experienced slight memory loss and vision changes due to his stroke (10 years ago); therefore his wife assisted in completing any missing information the pt was unable to provide.

Past Medical History:
Present illnesses – HTN, HLD, hypercholesterolemia
Past medical illnesses – CAD w/ stent, TIA
Hospitalized for abdominal hernia (see surgeries)
Childhood illnesses – Denies any illnesses.
Immunizations – Up to date; flu vaccine yearly (most recent November 2022). Received COVID booster in 2022.
Screening tests and results – Screening colonoscopy 2018, benign.

Past Surgical History:
Abdominal herniorrhaphy – age 70, Flushing, NY (unable to recall hospital). Lower abdominal hernia. No complications.
Cataract surgery – age 65, Flushing, NY (unable to recall where). No complications.
Denies past injuries or transfusions.

Medications:
Ramipril 2.5mg, 1 tab PO daily
Rosuvastatin 10mg, 1 tab PO nightly
Baby Aspirin 81mg, 1 tab PO daily
IV Heparin in 5% Dextrose 1000u/hr (started in hospital)

Allergies:
Pt denies any drug, environmental or food allergies.

Family History:
Mother – Deceased at unknown age, natural causes
Father – Deceased at unknown age, natural causes
Son – 58, alive and well
Brother – Deceased at age 75, natural causes
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons
Reports family hx of CAD (brother had an MI at age 70)

Social History:
D.S. is a married male living with his wife. He is a retired manager of a diamond company and currently spends most of his time at home watching TV and “occasional trips to the grocery store or walks with grandchildren”.
Habits - Pt denies drinking alcohol, smoking cigarettes, hookah, and illicit drug use. Pt does not drink coffee and has masala tea every morning.

Travel - He traveled to Dallas 3 weeks ago to visit his children for about 1 week.
Diet - He eats a vegetarian diet which mainly consists of bread, rice, and vegetables.
Exercise - He admits to minimal exercise which he noted includes walking down the block to the grocery store.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns and no recent changes.
Sexual Hx - Pt is sexually active with his wife and denies any hx of sexually transmitted diseases.

Review of Systems:
General – Recent weight loss (2 lbs). Denies loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headaches, vertigo or head trauma.

Eyes – No side vision in his L. eye and no upper vision in his R. eye due to TIA in 2013. Pt wears reading glasses. Last eye exam 2022.

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

Nose/sinuses – Slight nasal discharge in the morning, no unusual color or smell x 2 months. Denies obstruction or epistaxis.

Mouth/throat – Dental implants for his two front teeth. Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes. Last dental exam 2022, implants assessed, normal.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Reports dyspnea and dyspnea on exertion x 3 days. Denies cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – History of hypertension x 10 yrs, TIA, CAD w/ stent. Admits chest pain. Denies irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – Regular bowel movements daily. Denies change in appetite, 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 system – Consistently wakes up once each night to urinate for at least 2 years. Denies urinary frequency or urgency, oliguria, polyuria, dysuria, incontinence, or flank pain.

Nervous – Hx of TIA which resulted in memory loss. Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness or recent onset memory loss.

Musculoskeletal system – Admits calf pain x 3 days 3 weeks ago. 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, blood transfusions, or prior history of DVT/PE.

Endocrine system – Denies polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric – Denies depression/sadness, anxiety, OCD or seeing a mental health professional.

Physical

General: Frail, thin male appearing slightly malnourished, weak and looking about the stated age of 80.

Vital Signs: BP:

	R	L
Seated	113/66	112/64
Supine	110/66	113/68

R: 22/min slightly labored P: 70, regular

T: 99.1 degrees F O2 Sat: 98% Room air

Height: 67 inches Weight: 125 lbs. BMI: 19.58

Skin: Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, scars, or tattoos. Pt's R. inner elbow slightly irritated from IV site.

Hair: Scattered, thin strands of hair noted on Pt's head. No lesions, lice, or seborrhea.

Nails: No clubbing, lesions of infection. Capillary refill slightly >2 seconds in upper extremities.

Head: Normocephalic, atraumatic, non tender to palpation throughout. No swelling noted.

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Rachel Freundlich

Clinical Site: Internal Med

Date of Visit: 03/07/23

Activity performed: HPI

Supervisor:

Name and Credentials: Bilal Hanif Senior PA

Supervisor Signature:

Supervisor Comments:

Excellent presentation