Rachel Freundlich
Professor Seligson

History

Identifying Data:
Full Name: A.A.
Address: Flushing, NY
Date of Birth: April, 5, 1976
Date & Time: May 2, 2023 9:45am
Location: New York Presbyterian Hospital, Flushing, NY
Religion: None
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Train

Chief Complaint: "I had tremendous pain in my chest" x3 hours

History of Present Illness:
A.A. is a 47 y/o African American female with significant PMH of HTN, DM, asthma, and unintentional recent weight loss of 11% body weight, who presented to the ER with chest pain x 3 hours. Pt described the chest pain as a burst of pain that originated in her left chest. The pain then radiated throughout her entire chest and to her back. Pt reports feeling pressure building in her chest. She noted that the pain rated 11/10 before she arrived at the hospital. Currently, her pain is 5/10. Symptoms are exacerbated by standing and walking. Pt reports taking baby Aspirin which mildly alleviated her symptoms. Pt also noted that lying down relieved some pain. Since the time of onset this morning, pain has been consistent.

Pt reports that she experienced SOB for 2 months prior to this morning, but attributed it to her asthma and did not have a work up completed. She also notes increased stress lately with her new job. Pt denies recent trauma, changes in medications or lifestyle, or increased activity. Pt denies trouble sleeping, dizziness, headache, nausea, sweating, fever, lightheadedness or changes in vision. Pt notes no history of comparable symptoms.

Past Medical History:
Present illnesses – UTI, HTN, DM, asthma
Past medical illnesses – gastritis, diverticulitis
Hospitalized – broken ankle (see surgeries)
Childhood illnesses – Denies any illnesses.

Immunizations – Up to date; has not received the flu vaccine; received 2 doses of Pfizer COVID-19 vaccine
Screening tests and results – mammogram (November ‘22), pap smear (April ‘23), colonoscopy (September ‘19)

Past Surgical History:
Ankle surgery – age 28, Flushing, NY (Jamaica Hospital). Pt noted she was SOB post-op. She did not report any follow up measures taken.
Endoscopy – age 30, Flushing, NY (hospital not noted). No complications.
Colonoscopy – age 30, Flushing, NY (hospital not noted). No complications.
Denies past injuries or transfusions.

Medications:
Metformin, 1 tab PO daily
Jardiance, 1 tab PO daily
Albuterol, PRN
Flonase, PRN

Allergies:
Pt reports she is allergic to dust, mold, seafood, brazil nuts, tree nuts.

Family History:
Mother – hx of HTN, DM; Decease at 68, Leukemia
Father – hx of HTN, CVA; Deceased at 80, CHF
Sister – no medical history. Alive and wel; Age 52
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons
No children.

Social History:
A.A. is a female living with her sister. She is currently engaged and getting married next year. She currently works as a school preschool teacher and spends most of her time with her fiance.
Habits - Pt admits to drinking alcohol socially. Pt denies smoking cigarettes, hookah, and illicit drug use. Pt drinks four cups of coffee each day.
Travel - Pt denies recent travel.
Diet - Pt reports eating a variation of protein, vegetables and junk food, such as chips, candy, and fast-food.
Exercise - Pt admits to minimal exercise. Pt reports walking up 5 flights of stairs 5 times a day in school.

Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns and no recent changes.
Sexual Hx - Pt is currently sexually active with her fiance and practices safe sex practices.

Review of Systems:
General – Reports significant unintentional recent weight loss (11% body weight). Denies loss of appetite, generalized 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 – Denies recent vision changes. Pt reports she wears glasses for farsightedness. Last eye exam in 2022.

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

Nose/sinuses – Denies nasal discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes. Last dental exam January 2023.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Admits to dyspnea, DOE, wheezing. Denies cough, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – History of HTN, chest pain, palpitations. Denies edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – Admits nausea. Regular bowel movements daily. Denies change in appetite, intolerance to specific foods, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Admits urinary frequency, oliguria. Denies urinary urgency, polyuria, nocturia, dysuria, incontinence, or flank pain.

Menstrual/Obstetrical – G0P000. Menarche age 13. Currently in menopause – admits to hot flashes and associated menopausal symptoms. Denies breakthrough bleeding/spotting or vaginal discharge.

Nervous – 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 – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies 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: Well groomed female, Alert and Oriented x3 looking about the stated age of 47.

Vital Signs: BP:

	R	L
Seated	117/82	115/80
Supine	115/80	114/79

R: 22/min unlabored P: 121, slightly bounding

T: 97.7 degrees F O2 Sat: 95% Room air

Height: 67 inches Weight: 161 lbs. BMI: 25.91

Skin: Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, scars, or tattoos.
Hair: Normal hair distribution and thickness 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.

Eyes: Symmetrical OU. No strabismus, exopthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity -corrected vision 20/20 OD, OS, OU.
Visual fields full OU. PERRLA, EOMs OS intact with no nystagmus.
Fundoscopy- red reflex intact OU. Cup to disk ratio <.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.
Ears: Symmetrical and appropriate in size. No lesions, scars, scabs, erythema or tenderness present. Ear canal nonerythematous, no masses, foreign bodies present. Cone of light, tympanic membrane noted. Weber midline, Rinne reveals AC > BC. Auditory acuity intact assessed with whisper test.
Nose: Symmetrical, no bony deformities, tenderness, discharge. Nasal mucosa pink and well hydrated. Septum midline with no perforation or inflammation. No foreign bodies.
Sinuses: Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.
Lips: Pink, moist, and well hydrated.
Mucosa: Pink, no masses, well hydrated, nontender, no leukoplakia.
Palate: Pink, intact with no lesions, scars.
Teeth: Good dentition, no caries noted.
Gingivae: Pink, moist, no hyperplasia, masses, lesions, discharge.
Tongue: Pink, well papillated, no masses, lesions, deviations. Frenulum intact.
Oropharynx: No exudates, masses, lesions, foreign bodies. Tonsils present with no exudate. Uvula pink, no edema.
Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, no bruits noted bilaterally, no cervical adenopathy noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations slightly labored / no paradoxic respirations. Minimal use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: JVP is 2.5 cm above the sternal angle with head of bed at 30 degrees. Carotid pulses are 2+ bilaterally without bruits. PMI in 5th ICS in mid-clavicular line. Regular rate and rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdominal Exam: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation. Moderate CVA tenderness appreciated.

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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: NYP Queens

Date of Visit: 5/2/23

Activity performed: History and Physical exam

Supervisor: Brian Smith, DO - ER physician

Name and Credentials: ______________________

Supervisor Signature: [signature]

Supervisor Comments: Did a great job! Went above and beyond and did a history and physical exams detailed with no missing information. Pleasure to work with.