Rachel Freundlich

Professor Yuan

History

Identifying Data:
Full Name: R.J.
Address: Jamaica, NY
Date of Birth: 09/28/1940
Date & Time: 11/21/2023 10:08am
Location: New York Presbyterian Hospital, Flushing, NY Religion: Catholic
Source of Information: Self, with assistance from son
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Ambulance
Chief Complaint: “I fainted while I was in the kitchen this morning”

History of Present Illness:
R.J. is an 83 y/o female with PMH of HTN, DM and Hypercholesterolemia presenting following a syncopal episode. Pt reports the syncopal episode was sudden and denies preceding dizziness, nausea, or lightheadedness. Duration of syncopal episode is unknown. Pt fell backwards and received a laceration to the back of her head. Copious blood was present and was relieved by a bandage at the site of the fall. Pt reports pain at site of laceration is dull, constant and rates it 3/10. Pain is aggravated when palpated and relieved with rest.
Pt denies history of syncope, CVA, CAD or new medications.

Past Medical History:
Present illnesses – HTN, DM, Hypercholesterolemia
Past medical illnesses – None
Hospitalized – None
Childhood illnesses – Denies any illnesses
Immunizations – Up to date; received flu vaccine Oct ‘23; received COVID booster ‘23
Screening tests and results – Colonoscopy ‘21 - normal (hx of polyps)

Past Surgical History:
Denies previous past injuries or transfusions.

Medications:
Losartan, 100 mg, PO daily (HTN)

Amlodipine, 5 mg, PO BID (HTN)
Atorvastatin, 20mg, PO daily (Hypercholesterolemia)
Metformin, 500mg PO daily (DM)

Allergies:
Ciprofloxacin (pruritic rash x5 years ago)
Denies any other food, drug, or environmental allergies.

Family History:
Mother – deceased at age 86 from CVA, hx of DM
Father – deceased at 87 from DM complications, hx of HTN, DM
Twin sons – 60 y/o, both alive and well
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
R.J. is a retired single female living with her son. She previously worked at a supermarket. She does not routinely exercise although she gardens weekly. R.J. spends much of her time cooking and watching TV.

Habits - Pt denies alcohol consumption and marijuana smoking. Pt drinks two cups of coffee each morning.
Travel - Pt denies recent travel.
Diet - Pt reports eating a well-balanced diet. She emphasizes consuming proteins, vegetables and fruit. Pt maintains a low sodium, low carbohydrate diet.
Exercise - Pt denies exercise.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns. Pt reports waking 2-3x per night to urinate.
Sexual Hx - Pt is not sexually active.

Review of Systems:
General – Denies recent changes in weight, 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 – Admits to mild headache and head trauma. Denies vertigo.

Eyes – Pt wears glasses for nearsightedness and farsightedness. Denies recent vision changes, photophobia, pruritis. Last eye exam 1 month ago.

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

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

Mouth/throat – Admits to wearing dentures. Denies bleeding gums, sore tongue, sore throat, mouth ulcer or voice changes. Last dental exam Oct ‘23.

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

Breast – Denies lumps, nipple discharge, or pain.

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

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

Gastrointestinal system – Reduced bowel movements daily (1x every 3 days). Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, rectal bleeding, or blood in stool.

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

Nervous – Admits transient loss of consciousness. Denies seizures, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness or recent onset memory loss.

Musculoskeletal system – Admits arthritis. Denies deformity or swelling or redness.

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, or prior history of DVT/PE.

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

Psychiatric – Denies depression and anxiety.

Physical

General: Appears the stated age of 83. Alert and Oriented x3, appropriately dressed, well-groomed, in no apparent distress. Appears slightly frail. Ambulates with support.

Vital Signs:

BP:	R	L	
	Seated	160/80	160/83
	Supine	155/78	161/85

R: 14/min unlabored P: 70, regular

T: 98.6 degrees F O2 Sat: 96% Room air

BMI: 26.8
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 <2 seconds in upper extremities.
Head: Laceration present in the center of the back of the head. No bleeding noted currently. Slightly tender to palpation. Normocephalic, non tender to palpation in other areas. 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: Mild watery discharge noted. Symmetrical, no bony deformities, tenderness. 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, 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 unlabored/ no paradoxic respirations or 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. Abdomen: Abdomen round and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. Tender to palpation in right middle quadrant. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.
Male Genitalia and Hernia: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. No inguinal or femoral hernias noted.
Anus, Rectum and Prostate: No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate enlarged, smooth and non-tender with palpable median sulcus.
Neuro Exam:
Cranial Nerves: CN I- XII are intact
II, III, IV, VI: visual acuity 20/20 bilaterally. Visual fields normal in all quadrants. PERRLA. EOMS intact without ptosis.
V: Facial sensation intact bilaterally to dull and sharp stimuli.
VII: Facial muscle strength is equal and normal bilaterally.
VIII: Hearing is normal bilaterally.
IX, X: Palate and uvula elevate symmetrically, with intact gag reflex. Voice is normal
XI: Shoulder shrug strong and equal bilaterally.
XII: Tongue protrudes midline and moves symmetrically.
Mental status exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to name, date, time and location. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.
Reflexes: Biceps, brachioradialis, triceps, patellar, and Achilles are 2/4 bilaterally. No clonus. Plantar reflex is downward bilaterally.
Sensation: Sensation is intact bilaterally to pain and light touch. Two-point discrimination is intact.
Motor: Good muscle tone. Strength is 5/5 bilaterally at the deltoid, biceps, triceps, quadriceps, and hamstrings.

Cerebellar: Finger-to-nose and heel-to-shin test normal bilaterally. Balances with eyes closed (Romberg). Rapid alternating movements normal. Gait is steady with assistance. Coordination was unable to be measured.
Peripheral Vascular System: Extremities are warm and without edema. No varicosities or stasis changes. Calves are supple and non-tender. No femoral or abdominal bruits. Brachial, radial, ulnar, femoral, popliteal, dorsalis pedis and posterior tibial pulses are 2+ and symmetric.

Problem list:

- Syncope
- HTN
- DM

Assessment:
83 yo female with PMH of HTN, DM and hypercholesterolemia presents with syncopal episode. Pt has no previous history of syncope. Pt did not experience nausea, dizziness or lightheadedness before syncope. Pt received a laceration to the back of her head upon falling. Copious blood was present and laceration was bandaged on the scene. No labs are available at this time.

Differential Diagnosis:

1. Orthostatic Hypotension

a. The pt's syncopal episode may have been due to orthostatics. Although the pt is typically hypertensive, this does not rule out a possible orthostatic cause.

i. Blood pressure in lying down, sitting, and standing

2. Vasovagal

a. Vasovagal reaction is a common cause of syncope. The pt was cooking in the kitchen when she syncopized and it's possible that the heat from cooking or a multitude of other factors could have caused a vasovagal syncope.

i. This is a diagnosis of exclusion.

3. Subdural hematoma

a. The pt presents with head trauma following a fall. Due to the patient's age and physical exam there is concern for subdural hematoma.

i. Non-contrast head CT

4. MI

a. Although syncope is not a typical initial presentation of an MI, it must be considered. Infarction of the heart can cause a syncopal episode due to decreased perfusion. Furthermore, this patient is 83 and therefore is more likely to present with atypical symptoms of an MI.

i. EKG, cardiac monitor, puls ox, troponin

5. CVA

a. The patient's age and hx of HTN and hypercholesterolemia increase the pt's risk of having a stroke. Although it is not common for a stroke to cause syncope, it must be ruled out in this pt.

i. Non-contrast head CT +/- CTA of head/neck with and without contrast, lactate, cardiac monitor, puls ox

6. Hypoglycemia

a. It is important not to overlook the possibility of hypoglycemia in syncopal episodes. Hypoglycemia can mimic more threatening disease states such as stroke and MI and therefore it is important to check glucose levels. Furthermore, because this pt has a history of DM it is crucial to monitor glucose.

i. POC glucose

Work up:

- BP on 2 arms - lying down, sitting, standing
- EKG
- Non-contrast Head CT
- Cardiac monitor
- Continuous Pulse ox
- POC glucose
- Troponin, CBC, T&S, PT/PTT, INR

Plan:

Syncope

- Workup for orthostatic hypotension
- Workup for MI, CVA, Hypoglycemia
    - Consider vasovagal if above is negative

- Fluids if orthostatic hypotension present

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
S. Seligson, J. Yuan &
L. Sanassi
Contact: Jeanetta Yuan
jyuan1@york.cuny.edu

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: NYPQ

Date of Visit: 11/21/23

Activity performed: H&P

Supervisor:

Name and Credentials: Kathleen Yan, PA-C

Supervisor Signature: Kathleen Yan

Supervisor Comments:
Good H & P interviews, pertinent negatives and positives. She was also able to provide some assessments and plans