Rachel Freundlich
Rotation #5 - Family Medicine

History

Identifying Data:
Full Name: C.C.
Address: South Richmond Hill, NY
Date of Birth: 01/30/1969
Date & Time: Wednesday, May 29, 2024 2:00pm
Location: AllCare Family Medicine
Religion: Not stated
Source of Information: Self
Reliability: Reliable
Source of Referral: Self
Mode of Transport: Public Transportation
Chief Complaint: Presents for follow up visit

History of Present Illness:
55 year old F with PMH of HTN, Hyperlipidemia, GERD presents today for follow up visit. She was recently seen by cardiology due to heart palpitations and reports she had a normal exercise stress test. She is scheduled to follow up with them in 6 months. Pt is also due for a mammogram as well as a Pap smear. She states she will schedule to have the Mammogram completed and will complete the Pap smear in the office at her next visit. Pt had positive FOBT at her last visit and was recommended to follow up with GI then. She reports she has not done so yet. It was reiterated to the Pt that it is extremely important for her to continue this workup and she states she will contact them when she gets home to schedule an appointment. She denies any acute complaints today. Patient denies any fever, chills, nausea, vomiting, abdominal pain, chest pain, shortness of breath, blurry vision, headache.

Past Medical History:
Present illnesses – HTN, Hyperlipidemia, GERD
Past medical illnesses – None stated
Hospitalized – None stated
Childhood illnesses – Denies any illnesses
Immunizations – received COVID vaccine 1/08/2022, 01/30/2022
Screening tests and results – FOBT - Positive, April 2024

Past Surgical History:
Denies past surgical history

Medications:
Atorvastatin Calcium 20 MG - Tablet 1 tablet Orally Once a day
Lisinopril 20 MG - 1 tablet Orally Once a day
Aspirin 81 MG Tablet Delayed Release - 1 tablet Orally Once a day
Metoprolol Tartrate 25 MG - 1 tablet with food Orally Twice a day

Allergies:
Denies any food, drug, or environmental allergies.

Family History:
Mother – alive and well
Father – alive and well
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
C.C. is a married woman currently living with her husband. She works at the local pharmacy.
Habits - Pt admits drinking one cup of coffee daily. Denies alcohol, tobacco and drug use.
Travel - Pt denies recent travel.
Diet - Pt reports attempting to reduce fast food from her diet.
Exercise - Pt denies consistent exercise routine.
Safety measures - Admits to wearing a seat belt.
Sleep – Pt reports regular sleep patterns.
Sexual Hx - Pt is currently sexually active with her husband.

Review of Systems:
General – Denies loss of appetite, weight gain/loss, generalized fatigue, fever or chills, or night sweats.

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

Head – Denies headaches, vertigo or head trauma.

Eyes – Pt wears glasses. Denies recent vision changes. Next upcoming eye exam in June 2024.

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

Nose/sinuses – Pt denies nasal discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore throat.

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

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

Cardiovascular system – Denies chest pain, edema, syncope or known heart murmur.

Gastrointestinal system – Denies epigastric pain, nausea, diarrhea, change in appetite, rectal bleeding, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructations, jaundice, hemorrhoids, constipation, hematemesis.

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

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 back pain, arthritis.

Peripheral vascular system – Denies peripheral edema.

Hematological system – Denies easy bruising or bleeding, lymph node enlargement, or prior history of DVT/PE.

Endocrine system – Denies polydipsia, polyphagia, heat or cold intolerance,.

Psychiatric – Denies history.

Physical

General: 55 year old female appears well groomed, dressed appropriately for the weather, A&O x3, looking about her stated age of 55. Pt in no acute distress.

Vital Signs:
BP: Seated: 138/84
HR: 68 BPM
R: 16 min unlabored
T: 98.7F (forehead)
Weight: 150 BMI: 33.39

Physical Exam:
Skin: Non diaphoretic. Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, unhealed scars, or tattoos.
Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, no bruits noted bilaterally, no cervical adenopathy, JVD noted.
Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.
Chest: Symmetrical, no deformities, no trauma. Respirations mildly labored with audible occasional wheezing.
Lungs: Chest expansion and diaphragmatic excursion symmetrical. Bilateral crackles auscultated with decreased breath sounds.
Heart: No JVP present. Regular rate, regular rhythm. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Nontender, nondistended abdomen. No CVA tenderness appreciated. No striae or pulsations noted. Normoactive bowel sounds present with no aortic/renal/iliac or femoral bruits. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation.
PVS/MSK: 2+ pulses bilaterally, no edema noted. FROM bilaterally upper and lower extremities.

Labs: No labs discussed at this visit

Assessment/Plan:
55 year old F with PMH of HTN, Hyperlipidemia, GERD presents today for follow up visit. Her recent exercise stress test was normal. Pt to complete Pap smear at next visit. She will schedule a mammogram and contact GI to schedule an appointment for positive FOBT. Pt was reminded to monitor blood pressure at home and contact the office if blood pressure is above 140/90. Pt was also advised to consume a diet consisting of whole foods and reduce fried, fatty and processed foods. She was recommended to begin incorporating walking into her routine. Metoprolol, Lisinopril, Aspirin and Atorvastatin were refilled during this visit. Pt will return to the office in two weeks for fasting blood work and Pap smear.