Rachel Freundlich
Rotation #5 - Family Medicine

History
Identifying Data:

Chief Complaint: Presents for follow up visit

History of Present Illness:
45 year old F with PMH of Hyperlipidemia, iron deficiency anemia, and dysmenorrhea presents for follow up. Pt has been complaining of pelvic pain x3 months. She received transvaginal ultrasound most recently and presents to review results. No ovarian cyst was noted on ultrasound. Fibroid and adenomyosis seen. Pt endorses heavy menstrual bleeding with a lot of pain, though previous pelvic pain which prompted ultrasound is no longer present. Pt provided referral to OB/Gyn for further management of adenomyosis. Pt reports she was seen by hematology last week due to iron deficiency anemia and will receive iron transfusion in two days. Pt to return to office in 2 weeks as she does not want to have routine blood work done at this time. Pt appears well in office with no acute complaints. Patient denies any fever, chills, nausea, vomiting, abdominal pain, chest pain, shortness of breath, blurry vision, headache.

Past Medical History:
Present illnesses – Hyperlipidemia, iron deficiency anemia, dysmenorrhea
Past medical illnesses – None stated
Hospitalized – None stated
Childhood illnesses – Denies any illnesses
Immunizations – received COVID vaccine 06/18/2021, 07/09/2021
Screening tests and results – Mammogram - 10/31/2023, no evidence of malignancy; US Abdomen - 02/02/2024 - unremarkable examination; Pelvic US - 2/22/2024 - No discrete fibroids. Multiple simple appearing left ovarian cysts; TVUS - 04/12/2024 - Heterogeneous myometrium suggestive of adenomyosis. Suggestion of presence of a fundal right lateral transmural fibroid measuring 4.8x4.2x3.7cm.

Past Surgical History:
Denies past surgical history

Medications:
Ferrous sulfate 325 (65 Fe) MG - 1 tablet orally once a day
Atorvastatin Calcium 20 MG - 1 tablet orally once a day
Aspirin 81MG - 1 tablet orally once a day

Allergies:

Denies any food, drug, or environmental allergies.

Family History:
Mother – deceased at age 72
Father – alive and well
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons

Social History:
N.S. is a married female currently living with her husband. She has one son and one daughter.
Habits - Pt admits drinking one cup of coffee daily. Denies alcohol, tobacco and drug use.
Travel - Pt denies recent travel.
Diet - Pt reports eating a well balanced 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 for farsightedness. Denies recent vision changes, photophobia, pruritus. Last eye exam 02/2023.

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

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

Mouth/throat – Denies bleeding gums, sore tongue, 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 – **Admits iron deficiency anemia.** Denies easy bruising or bleeding, lymph node enlargement, or prior history of DVT/PE.

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

Psychiatric – Denies history.

Physical

General: 45 year old female appears well groomed, dressed appropriately for the weather, A&O x3, looking about her stated age of 45. Pt in no acute distress.

Vital Signs:
BP: Seated: 129/79
HR: 74 BPM
R: 18 min unlabored
T: 98.8F (forehead)
Weight: 177 BMI: 28.57

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:

CBC With Differential/Platelet

Collection Date Collection Time	03/25/2024 10:59 AM
Order Date	03/25/2024
Result Date	03/26/2024
Ordering Physician	Chand, F
Baso (Absolute)	0.0 0.0-0.2 x10E3/uL
Hematocrit	38.4 34.0-46.6 %
WBC	8.7 3.4-10.8 x10E3/uL
Monocytes(Absolute)	0.6 0.1-0.9 x10E3/uL
Hemoglobin	11.8 11.1-15.9 g/dL
Eos (Absolute)	0.3 0.0-0.4 x10E3/uL
MCV	85 79-97 fL
MCH	26.0L 26.6-33.0 pg
MCHC	30.7L 31.5-35.7 g/dL
Platelets	469H 150-450 x10E3/uL
Lymphs	38 Not Estab. %
Monocytes	7 Not Estab. %
Eos	4 Not Estab. %
Basos	1 Not Estab. %
Lymphs (Absolute)	3.3H

Assessment/Plan:

N.S. is a 45 year old F with PMH of Hyperlipidemia, iron deficiency anemia, and dysmenorrhea presenting for follow up. She received transvaginal ultrasound which suggests adenomyosis. Pt recommended to follow up with OB/Gyn and provided a referral. She is also following with hematology and is scheduled to receive iron transfusion in two days. Prescriptions for Atorvastatin, Aspirin and Ferrous sulfate were refilled. Pt will return to office in two weeks for blood work.