Andres Hernandez
Professor Yuan
04/30/2023

Hospital Visit #3 – Internal Medicine

Identifying Data:
Full Name: D.L
Address: Queens, NY
Date of Birth: [redacted]
Age: 66
Date: 04/25/2023, 10:00 am
Location: NYPQ Hospital
Religion: unspecified
Marital Status: Single, Divorced
Source of Information: Self
Reliability: Reliable
Source of referral: Self
Mode of Transport: Lyft

CC: "Fell and hit head on kitchen cabinet" x 2 weeks

HPI
66 y/o female, with PMHx of HTN fell and hit her head against a kitchen cabinet (April 10, ~ two weeks ago). Patient describes fall due to "lower back seizing and legs locking-up" causing her to lose control and fall back. Similar falls have happened recently but never resulted in injury until now. Patient reports being on the floor for an hour before getting up on her own. Patient lives with her sister who witnessed the fall but couldn't aid patient because of shoulder issues. The patient noticed three bumps on the back of her head that became "soft and squishy" within hours of her incident with throbbing pain that maintained localized; pain rated 10/10 severity the day of fall. Two days later head pain persisted, but pain severity improved slightly to 8/10 when patient iced head and took Tylenol or Ibuprofen. Pain also improved when sitting up and laying down made it worse. Six days after fall, patient reported to emergency room because symptoms did not resolve; patient has been admitted to Internal Medicine since last Monday (1 week ago). Patient reports continual headache but denies any bleeding from trauma, any loss of consciousness, seizures, numbness, change in memory.

Past Medical History:
HTN, controlled with rx.
Denies any childhood illnesses.

Past Surgical History:
Nasal polyp surgery, in 1986.
Wrist fracture surgery, 7 years ago.

No history of transfusions.
Denies hip or knee replacements.

Medications:
Losartan (COZAAR), tablet 50mg, PO x daily.
Metoprolol tartate (LOPRESSOR), tablet 50mg, PO x daily.
Acetaminophen, (TYLENOL), tabet 650 mg, PO x PRN /6 hrs.
No vitamins or supplements.

Allergies:
Has seasonal allergies and allergies to Iodine contrast. Denies any medicine allergies or food allergies.

Family History:
Father – deceased, 42 from heart attack, history of valve issues from rheumatic fever.
Mother – deceased, 74, hx of smoking, HTN, lung cancer with brain metastasis.
Grandparents – all deceased does not recall their medical history
Siblings – One sister with a past medical history of breast cancer at age 30 and thyroid removal.
Children – two children, 41 F and 38 M, both alive and well.

Social History:
Pt. is single, divorced and lives in Queens, NY with her sister.
Pt. is retired and not working.
Smoking – Pt. denies smoking cigarettes, but smoked marijuana in the 70's.
Illicit Drugs – Denies use of drugs.
Alcohol –Consumption of alcohol but only socially or occasionally a cup of wine.
Diet – Since her injury relies on quick meals such as avocado sandwiches, tuna sandwiches, and almond butter on whole wheat.
Exercise – Pt. likes going on walks and enjoys being outdoors. However, in the last couple of months has not exercised but hope to get outdoors after recovery and when weather improves.
Caffeine – Pt. drinks decaffeinated coffee once a day.
Sleep – Pt. states 5-6 hours of sleep per a day.
Travel – Pt. denies any recent travel.
Sexual Hx – Pt. is not sexually active. Denies history of STIs.

Immunizations
Pt. admits to childhood immunizations. Denies any recent vaccinations including COVID-19 vaccine and the flu vaccine.

ROS
General–Denies loss of appetite fever, chills, fatigue, night sweats, weakness. Does admit to weight gain due to lack of recent exercise.
Skin, Hair, Nails – Denies skin or hair changes. Denies discolorations, pruritus, or moles.
Head –Denies vertigo. Admits to head trauma and headache.

Eyes – Denies blurry vision or vision changes. Says last eye exam could be years ago.
Ears – Denies ear pain or discharge. Says she could be experiencing weaker right ear hearing.
Nose/sinuses – Denies pain, discharge, epitaxies, or difficulty nasal breathing.
Mouth/Throat – Denies sores, sore throat, or voice changes. Pt. does not recall last dentist.
Neck – Denies swellings. Admits to neck stiffness which could be attributed to pillow used at the hospital.
Breast – Denies any pain, lumps, masses, or nipple discharge.
Respiratory– Denies SOB, dyspnea, cough, or respiratory changes.
CVS – Denies chest pain, palpitations, irregular HR, or lower extremity swelling.
GI –Denies abdominal pain, nausea, constipation, diarrhea, flatulence or change in appetite. Denies any rectal bleeding or hemorrhoids. Pt. does not recall last colonoscopy.
GU –Denies burning, urinary frequency, incontinence, and pelvic pain. Patient denies any flank plain. Pt. denies any STI. Admits to nocturia.
Menstrual/Obstetrical – Not sexually active. Pt. does not recall year of menopause. Pt. denies vaginal discharge.
Peripheral Vascular System – Denies intermittent claudication, edema, skin changes, or varicose veins.
Musculoskeletal – Denies weakness or muscle pain. Denies any osteoarthritis.
Nervous – Denies loss of strength or any seizures. Denies numbness, ringing, or sensory disturbances. Denies change in mental status. Denies any changes in cognition, mental status, or memory.
Hematologic system – Denies easy bruising. Denies bleeding or anemia. Denies blood transfusions.
Endocrine – Pt. denies cold intolerance, excess sweating, or abnormal hair growth in any region. Denies polydipsia.
Psychiatric - Denies any suicidal thoughts or OCD. Doesn't have a history of taking psychiatric medications. Denies seeing a therapist. Does admit to feeling hopelessness and anxiety. Patient wants to get better and attributes these feelings to uncertainty involving future. Looks forward to recovery to regain her independence with daily tasks which will improve overall quality of life.

Physical:
General: Pt. appears of age, laying supine, well-groomed, well-nourished, alert & oriented x 3. Pt. is very sharp, responding to all questions without difficultly. No signs of any distress.

Vitals
BP: 134/86 mmHg left arm, supine.
120/80 mmHg left arm, seated.
118/76 mmHg right arm, supine.
118/80 mmHg right arm, seated.
RR: 14 breaths/min, unlabored, regular breathing.
Pulse: 80 beats/min, regular
Temp: 97.8F, oral
O2 Sat: 99% room air

Height: 5’9”
Weight: 250 lbs.
BMI: 36.9 kg/m2

Skin: Skin is warm & moist. Good turgor. Non-icteric. No lesions, bruising, or scars on the upper extremities and back. No tattoos noted.
Hair: Long black hair. Normal texture, quantity, and distribution. No lice. No seborrheic dermatitis.
Nails: No clubbing, cap refill <2 seconds in both upper extremities. No splinter hemorrhages noted. No signs of trauma or swelling. No Beau’s lines.

Head: Normocephalic, atraumatic. No lesions or discoloration seen on scalp. Non tender to palpation throughout the head. Face symmetrical, no lesions, or unvoluntary movements.

Eyes: Symmetrical OU. PERRLA. EOMs intact with no strabismus, no nystagmus, no lid lag. Normal convergence. No exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink and clear w/o exudates. Visual fields full OU.
Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU.
Fundoscopy - Red reflex intact OU. Cup to disk ratio < 0.5 OU. No AV nicking, papilledema, hemorrhages, exudates, cotton wool spots, or neovascularization OU.

Ears: Symmetrical and appropriate in size. No lesions or trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's pearly gray, intact, cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne AC>BC AU.

Nose: Symmetrical nares; no masses, lesions, trauma, discharge, or deviated septum. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. No foreign bodies or polyps noticed B/L. Septum is midline without lesions, deviation, perforation or inflammation.
Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Mouth/Throat: Lips- Pink and dry; no lesions.
Oral Mucosa - Pink, moist mucosa. No masses, lesions, erythema.
Palate - Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.
Teeth-Good dentition, no loose teeth.
Gingivae -Pink; moist. No hyperplasia, masses, lesions, erythema, or discharge.
Tongue- Pink; well papillated; no masses, lesions, or deviation.
Oropharynx- Well hydrated; no exudate; masses; lesions; foreign bodies. Uvula pink and midline, no deviations, no edema, lesions. Tonsils present, grade 1, with no erythema or exudate.

Neck: Trachea midline. No masses, lesions, scars; pulsations noted. Supple; non-tender to palpation. No carotid artery bruit. No cervical adenopathy noted.
Thyroid- Non-tender, no palpable masses, no thyromegaly.

Chest and Lungs: 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- CTAP 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 the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, no S3 or S4. No splitting of S2 or friction rubs appreciated.