Identification

Daniel DeMarco PHYS DIAG

11/7/2017, 9:30AM

NM, F, Caucasian, Colombian, DOB: 08/10/1950, Age: 67, Divorced, Christian Orthodox

Princess Drive, Bayside, NY, 11359

PMD: Dr. Jennifer Losquadro

Informant

(4/4)

Self, Reliable

Referral: self

Chief Complaint

(2/2)

"I am having pain in my stomach x 1 week."

History of Present Illness

(27/30)

Ms. M is a reliable 67-year-old female with a past medical history of GERD and Esophageal Cancer presenting to the emergency department with ~~stomach~~ lower abdominal pain x 1 week. Pain is located in suprapubic region described as burning pain ~~which started 1 week ago. It has been a persistent~~ since it started ~~burning pain since then~~. she states that urination alleviates the pain while retention of urine aggravates it. The pain does not radiate and is rated an 8/10 on a pain scale where 10 represents the most severe pain. Ms. M states this occurs twice yearly. she saw her PMD 1 week ago and she was diagnosed with a UTI and treated with Cipro. She presents today to ED because her symptoms are persistent and she had to call out of work because of the severity of the pain. she admits urgency, polyuria, and chills. she denies nausea, vomiting, fever, fatigue, loss of appetite, dysuria, nocturia, or STIs.

Past Medical History

(3/3)

GERD - 2013

ESOPHAGEAL CANCER - 2013, Treated with Radiation q6 mo.

flank pain ?
Sexual Active ?
Vaginal Discharge ?

Past Surgical History

Patient Denies Past Surgical History

Medications

2/2

Nexium (Esomeprazole) 40mg, 1 tab by mouth daily

Allergies

Peanuts, Anaphylaxis

NKDA

No known environmental allergies

3/3

Family History

Paternal Grandfather, Unknown

Paternal Grandmother, Unknown

Maternal Grandfather, Unknown

Maternal Grandmother, Unknown

4/4

Father, Deceased, 82 y/o, Cause of Death: Cancer (unknown type)

Mother, Living, 100 y/o, patient denies PMH

Social History

HABITS

Denies alcohol use, tobacco use, illicit drug use, caffeine use

Travel

Denies out of state/country travel

Marital History

Divorced

8/8

Occupational History

Mail Carrier

Home Situation

Patient lives with her friend.

Diet

Breakfast: Oatmeal

Lunch: Salad

Dinner: Chicken and Vegetables

Exercise

Patient walks >5 miles daily with her job.

Sexual History

Is sexually active, men, monogamous, no history of STIs.

Review of Systems

General

Admits chills

Denies fever, night sweats, fatigue, weakness, loss of appetite, recent weight gain or loss.

Skin, Hair, and Nails

Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritis, changes in hair distribution.

Head

Denies headache, vertigo, head trauma, unconsciousness, coma, fracture

Eyes

Admits glasses use

Denies visual disturbances, fatigue, lacrimation, photophobia, pruritis.

Last Eye Exam: November 2016, Dr. Jacob, within normal limits per patient

Nose/Sinuses

Denies discharge, epistaxis, obstruction

Ears

Denies deafness, pain, discharge, tinnitus, hearing aids

Mouth and throat

Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures,

Last Dental Exam: May 2017, Dr. Jones, within normal limits per patient

Neck

Denies localized swelling/lumps, stiffness/decreased range of motion

Breast

Denies lumps, nipple discharge, pain

Pulmonary System

Denies Dyspnea, SOB, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea (PND)

Cardiovascular System

Denies chest pain, palpitations, edema/swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal System

Admits Abdominal Pain

Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, diarrhea, change in bowel habits, hemorrhoids, constipation, rectal bleeding.

Last colonoscopy: July 2012, Dr. Nesi, within normal limits per patient.

Genitourinary System

Admits increase in frequency, urgency, polyuria

Denies nocturia, oliguria, dysuria, change in color of urine, incontinence, awakening at night to urinate, flank pain

Sexual History

Not sexually active, men, monogamous, no history of STIs.

Menstrual and Obstetrical

Date of Last Normal Period: 17 years ago

Menarche: 13 y/o

Menopause: 50 y/o

G, P (TPAL): 4, 2 (2, 0, 2, 0)

Denies postcoital bleeding, vaginal discharge, dyspareunia.

Nervous System

Denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesias, dysesthesias, ataxia, loss of strength, change in cognition/mental status/memory, weakness.

Musculoskeletal System

Denies muscle/joint pain, deformity or swelling, redness, arthritis

Peripheral Vascular System

Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

Hematologic System

20/20

Denies easy bruising or bleeding, anemia, lymph node enlargement

Endocrine System

Admits polyuria
Denies polyphagia, polydipsia, heat or cold intolerance, goiter

Psychiatric

Denies Depression/sadness, feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideations, anxiety, OCD, psychiatric medications, past history of seeing a mental health professional

General Survey

67 year old female, A/O x3. Patient has a slender build and is sitting up in bed. Patient is dressed in night gown and does not appear distressed.

2/2

Vital Signs

BP:	R	L
seated	116/78	120/82
supine	110/76	108/80

Temperature: 98.6°F (oral)

Respirations: 16 breaths/min, unlabored

Pulse: 62 BPM, strong, regular

8/8

O_2 sat: 98% on Room Air

Height: 63 in.

Weight: 150 lbs.

Skin: Warm and moist, good turgor, Nonicteric, no lesions, no scars, no tattoos, no rash, no petechiae, or ecchymoses noted. (4/4)

Nails: No clubbing, no signs of infection, no lesions and capillary refill <2 seconds throughout

Hair: Average quantity and distribution.

Head: Normocephalic, atraumatic, nontender to palpation throughout.

Eyes: Symmetrical OU; no evidence of strabismus, exophthalmos, or ptosis; sclera white; conjunctiva and cornea clear. Visual Acuity (Uncorrected $\frac{20}{50}$ OS, $\frac{20}{40}$ OD, $\frac{20}{40}$ OU), ($\frac{20}{30}$ Corrected OS, $\frac{20}{20}$ OD, $\frac{20}{20}$ OU). (8/8) Visual Fields full OU. PERRL. Non-accomodating. EOMs full with no nystagmus. Fundoscopy - red reflex intact OU. Cup:Disk <0.5 OU, no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

Ears: Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TM's pearly white and intact with light reflex in normal position AU. (4/4) Auditory Acuity intact to whispered voice AU. Weber midline. Rinne reveals AC > BC AU.

Nose: Symmetrical, no obvious masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pink and well-hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, perforation. No evidence of foreign bodies. (3/3)

Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses. (2/2)

MOUTH AND PHARYNX

Lips: Pink, moist, no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink, well-hydrated. No masses, lesions noted. Non-tender to palpation. No evidence of leukoplakia.

Palate: Pink, well-hydrated. Palate intact with no lesions, masses, scars. Non-tender to palpation. Continuity intact.

Teeth: Several mandibular teeth missing, otherwise good dentition. No obvious dental caries noted.

Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erythema, or discharge. Non-tender to palpation. (10/10)

Tongue: Pink, well-papillated. No masses, lesions, or deviation noted. Non-tender to palpation.

Oropharynx: Well-hydrated. No evidence of injection, exudate, masses, lesions, foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. Full Range of Motion. No stridor noted. 2+ carotid pulses, no thrills, bruits noted bilaterally. No palpable lymphadenopathy noted. (4/4)

Thyroid: ~~Non-tender~~ ~~Non palpable~~, no palpable masses, no thyromegaly, no bruits noted. 11/14/17

Thorax and Lungs

Chest: Symmetrical. No deformities. No evidence of trauma. Respirations unlabored, no paradoxic respirations or use of accessory muscles noted. LAT to AP diameter 2:1. Non-tender to palpation. (4/4)

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile Fremitus intact throughout. No adventitious sounds. → Should Specify Eg. No wheezing, Crackles, Rales, Rhonchi

(5/6)

$\frac{127}{131} = 96.9\%$

Daniel Demarco

Rubric for History of Present Illness

Element	Excellent Performance (3)	Needs Improvement (2)	Unacceptable performance (1)
First Line	Contains age, gender, & imp. pre-existing conditions	Omits some of these variables	Does not include any of these variables
(P)OLD CARTS + What can't you do?	Most or all of relevant elements are present	Only 5-8 are present	Fewer than 5 are present
HPI tells Story of CC	From trigger event to present in orderly fashion& includes all relevant information	Includes most of the relevant information, but is not well organized	Lacks important information
Mechanism of Injury if relevant MA	Includes activity, body part involved, precipitating factors, vehicles/work involved	Lacks some of these or other details important to DX	Lacks this aspect entirely
Hospital course if relevant MA	Is presented with relevant findings, tests, and diagnoses with rationale	Either diagnoses or relevant findings are absent	Hospital course is not included even though relevant
F/U of any serious symptoms elicited in history	Symptoms are explored in depth with follow-up questions	Are noted and somewhat explored	Are noted only
Pertinent positives/negatives	Are addressed thoroughly	Are addressed, but significant items are left out	Are not addressed at all
Relevant information from PMH/ROS	Is "promoted" fully to HPI	Is noted in ROS or PMH with reference to HPI	Is noted in ROS or PMH with no connection to HPI indicated
Succinctness	The story is brief & succinct without extra "content-less" phrases	The story contains extra unnecessary phrases	There are multiple repetitive "content-less" phrases
Grammar/spelling	There are no errors or only minor errors which do not change meaning	There are many errors, but the meaning is clear	There are errors that alter the meaning of the reported information
Drug names	Are spelled correctly with generic names included	Are spelled correctly without including generic names	Are misspelled
Correction of Errors	Any errors are crossed out with a single line and initialed	Errors are crossed out multiple times or not initialed	Writing is squeezed in by writing above the line or in margins

27/30