Jessica Brown

10/31/17

History + Physical

Identification: 10/31/17 at 9:30AM
MV, male, Caucasian, American, 65 Y/o, Single, 121 150th St, Forest Hills, NY 10211, Protestant.

Informant: The patient himself is a semi-reliable, noncompliant historian.

4/4

Referral Source: PMD: Dr. R. Duke; urologist: Dr. Steven Tillem

Chief Compliant: " UTI x 1 week"

2/2

Can say "Failed outpt Tx for UTI" or "Recurrent UTI" or "Persistent Frequency".

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Present Illness: MV is a 65 year-old obese male with a significant past medical history of a urethral stent (placed 1 year ago), DM, Afib, CKD, PVD who presented to the ED yesterday ~~via~~ from Long Island Nursing care with a [multi-drug resistant urinary tract infection.] Patient reports a one week history of increased frequency of urination but denies any pain or burning with urination. Patient notes no change to the color or odor of his urine + denies taking any medication to help alleviate his UTI prior to arrival. Patient treated with Meropenem 1g IV in the ED/IM floor + admitted for further evaluation with pre-scheduled urethral stent removal today. Awaiting further assessment from infectious disease, PMD, urology + diagnostic findings

This is a Dx. Should be in plan.

Does this mean no prior Abx? How do we know it is a recurrent/persistent UTI?

Plan

Could say → Received Abx (meropenem) & admitted for further management/workup.
Pt currently feels much better? worse? the same?

to rule out sepsis before proceeding with stent removal. Otherwise; patient denies fevers, chills, nausea, vomiting, abdominal pain or hematuria. → This should go higher up as pertinent positives & negative for frequency

plan

4/4

Past Medical History: DM x 10 years, AFib x 2 years CKD x 2 years, PVD x 8 years. Patient notes he was hospitalized at Mt. Sinai one year ago for one week. Reports immunizations are up to date.

2/2

Past Surgical History: urethral stent placed October 2016 for an obstruction. Denies any transfusions or complications.

5/5

Medications: aspirin 81 mg oral, lasix 20mg oral, Levemir FlexPen 100 units/mL, Metroprolol tantarate 25 mg oral, Polymyxin B sulfate 500 units, simvastatin 20 mg oral, Heparin Inj 5000 unit, Insulin Glargine Inj, Ferrous Sulfate Oral 325 mg, Folic Acid 1mg Oral, Tamsulosin 0.4 mg oral at bedtime.

It is unclear from HPI, how urinary frequency became multidrug resistant UTI

2/2

Allergies: NKDA, denies any food/environmental allergies.

4/4

Family History: Patient lives in a nursing home, Long Island Care.
Father: 57, deceased, MI
Mother: 77 deceased, MI.
No siblings. unable to provide details on grandparents.

5/6

Tobacco → alcohol

Social History: Denies smoking, drinking or illicit drug use. Denies any recent travel but reports some difficulty sleeping intermittently. Patient does not work or exercise and eats all meals as provided by his nursing home.

Review of Systems:

General: Patient denies recent weight loss/gain, loss of appetite, generalized weakness/fatigue, fever, chills or night sweats.

Skin, hair and nails: Patient denies any change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution.

Head: Patient denies any headaches, vertigo, or head trauma.

Eyes: Patient denies any visual disturbance, lacrimation, photophobia, pruritus or use of glasses. Pt doesn't know when his last eye exam was.

Ears: Patient denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction.

Mouth + Throat: Patient missing teeth 1-3; 14-16, 17-19, 30-32. Denies bleeding gums, sore tongue, dental hygiene, sore throat, mouth ulcers, voice changes or use of dentures.

Neck: Denies any localized swelling/lumps, stiffness/decreased ROM.

Breast: Denies any lumps, nipple discharge or pain.

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Pulmonary System: Denies dyspnea, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea or PN.

Cardiovascular System: Denies any chest pain, HTN, palpitations, irregular heartbeat, edema of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System: Denies any change in appetite, intolerance to specific foods, nausea or vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation or rectal bleeding.

Genitourinary System: Reports increased urinary frequency ~~of urination~~. Denies nocturia, urgency, oliguria, polyuria, dysuria, change in color, incontinence, flank pain or awakening at night to urinate. Last Prostate Exam: September 2016, unremarkable. Denies hesitancy + dribbling.

Sexual History: Pt. no longer sexually active as of 2012 but was active with women. Denies impotence or STIs.

Nervous System: Denies seizures, headaches, loss of conciousness, sensory disturbances, ataxia, loss of strength, change in cognition or weakness.

Musculoskeletal System: Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral Vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change.

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions or history of DVT/PE.

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating or hirtusim

Psychiatric: Denies any depression, sadness, anxiety, OCD or medications. Denies ever having seen a mental health professional.

General Survey: 65 year old male, A/O x 3. Patient is obese but appears to be of stated age and is in no acute distress.

4✓

8/8

Vital Signs

BP: seated, Right arm: 124/82 mmHg

R: 18 breaths/min, unlabored

P: 92 beats/min, regular

T: 37 C (oral)

O_2: 98% on NC

Height: 5'10" Weight: 300 lbs BMI: 43.0

Physical Exam

6/6

Skin: warm + dry, good turgor. Nonicteric, no lesions noted, no scars, no tattoos.

Hair: limited quantity, average distribution

Nails: no clubbing, capillary refill < 2 seconds throughout

Head: NC/AT nontender to palpitation through[illegible]

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis | sclera white; conjunctiva + cornea clear.

6/6

Visual Acuity: 20/20 OS, 20/20 OD, 20/20 OU

Visual fields full OU. PERRLA. EOMI with no nystagmus. Fundoscopy - red reflect intact OU. Cup: disc ≤ 0.5 OU | no evidence of AV nicking | papilledema | hemorrhage | exudate | cotton wool spots | neovascularization OU.

(3/3)

Ears: Symmetrical + normal size. No evidence of lesions / masses / trauma on external ears. No discharge / Foreign bodies in external auditory canals AU. TMs pearly white / intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC > BC AU.

(3/3)

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

(2/2)

Sinuses: Non tender to palpation + percussion over bilateral frontal, ethmoid + maxillary sinuses.

(10/10)

Lips: pink, moist; no evidence to cyanosis or lesions.
Mucosa: pink; well hydrated. No masses; lesions noted. No evidence of leukoplakia.
Palate: Pink; Well-hydrated. Intact with no masses, lesions, scars.
Teeth: No obvious dental caries noted. Missing teeth 1-3, 14-19, 30-32. Dentition not intact.
Gingivae: Pink, moist. No evidence of hyperplasia, masses; lesions; erythema or discharge.
Tongue: Pink; well papillated; no masses, lesions or deviation noted.
Oropharynx: Well-hydrated; no evidence of injection; exudates masses; lesions or 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 ROM; no stridor noted 2+ carotid pulses, no thrills, bruits noted bilaterally, no palpable adenopathy noted

3/3

Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted. 6/1

2/2

All Exam should be done bilaterally

$\frac{120}{124}$ = 96.8 %

Brown, Jessica

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 N/A	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	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 most	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 / missing info	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

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

Course Instructors:
H. Persaud, MS, PA-C
M. Malavet & S. Shami
(718) 262-2839 or 2823
Fax: (718) 262-2504

History and Physical Verification Form

Class: Physical Diagnosis I (HPPA 502)

Student Expectation:
- Obtain medical history and perform physical exam up to the point covered in class.
- Oral presentation to clinical site supervisor/preceptor

Student: Jessica Brown

Clinical Site: New York Presbyterian - Queens

Date of Visit: 10/31/17

Activity performed: H+P, Physical Exam

Supervisor:

Name and Credentials: Susan Denn, PA-C

Supervisor Signature: Susan Ann Denn, PA-C, MPAS
Administrative Chief Physician Assistant
Department of Medicine

[signature] PA-C, MPAS

Supervisor Comments:

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