Chaya Neufeld
H&P #5 (ED)

Identifying Data
Name: M.C.
DoB: 2-11-1965 (age 54)
Date and time: 11-26-19 8:05 AM
Address: Jamaica, Queens
Location: NYPQ E.D.
Religion: Catholic
Sex: Female
Race: Hispanic
Nationality: Columbian
Marital status: separated
Referral source: self
History source: self
Reliability: reliable

Chief Complaint
"I feel like I have heart palpitations at night" x 1 week.

HPI
M.C. is a reliable 54 year old female, with a past medical history of hypertension, presenting to ED complaining of heart palpitations at night x 1 week. M.C states that the palpitations begin when she is lying down at night and continue intermittenly throughout the night. she feels as if "there is something pounding in my upper chest." The symptoms begin gradually and then get worse throughout the night, with bouts lasting 1-2 hours in 30 minute intervals. M.C. characterizes the palpitations as "throbbing and like my heart is beating too hard." M.C. denies any aggravating of alleviating factors. Denies any associated chest pain, or pain in any other areas of the body, denies radiating pain. Mc. admits that the strongest palpitations began last night, which prompted her to come to the E.D. Admits waking up with chills and having night

sweats, general fatigue, weakness and loss of appetite. Also admits feeling nausea after bouts of palpitations. Denies syncope, chest pain, shortness of breath, light-headedness, dyspnea, tunnel vision, smoking, illicit drug use, prior cardiac history, recent travel, any other chronic medical problems, peripheral edema, or known heart murmur. Denies having similar symptoms in the past. Admits family history of MI, father died from MI at age 60.

Past Medical History

Present Illness: hypertension x 2 years
Past Illness: ~~denies~~ (CN) 11:00 AM colon cancer 2003, in remission
Childhood Illness: denies
Immunizations: up to date
Last flu shot: 1 year ago
Tests and screenings: mammogram 2017 - benign
colonoscopy 2018 - benign

Past Surgical History

colorectal surgery due to colon cancer 2003, no complications
L ankle surgery due to injury to L ankle, extended hospital stay to monitor blood pressure post-op, no further complications, 2018
Denies any other past injuries, surgeries or transfusions

Medications

Vitamin D, 2,000 IU orally, x 1 tablet QAM for low vitamin D
Denies any other medications

Allergies

NKDA, no known food or environmental allergies

Family History

Maternal and paternal grandparents, unknown
Father, deceased at age 60, MI

Mother, deceased at age 42, leukemia
Sister, 56, alive and well
Daughter, 23, alive and well
Son, 26, alive and well

Social History
Denies alcohol use, tobacco use, smoking cigarettes, illicit drug use, caffeine.
Denies recent travel.
Admits attending zumba dance classes on weekends for an hour a week
occupational history - mid level manager at a clothing company
marital status - separated
Home situation - Pt lives with her son and daughter in a house, denies pets.
Diet - Breakfast of oatmeal, lunch of soup, dinner of chicken and rice, chocolate for snack.
sleep patterns: pt admits only getting 3 straight hours of sleep a night.
Sexual history: Denies recent sexual activity or sexually transmitted infections
Safety measures: Admits to wearing seatbelt in car, helmet when biking.

Review of Systems
General: Denies recent weight gain or loss. Admits chills and night sweats, fatigue, general weakness, loss of appetite. Denies fever.
Skin, hair, nails: Admits pale appearance, sweating at night. Denies changes in texture, excessive dryness, discoloration or pigmentation, moles / rashes, pruritus, changes in hair distribution.
Head: Admits nausea associated with palpitations, denies headache, vertigo, head trauma, unconsciousness, coma, facture, light headedness
Eyes: Admits use of glasses, last eye exam x3 years ago.
Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus.
Ears: Admits mild hearing loss in L ear. Denies deafness, pain, discharge, tinnitus, use of hearing aids.
Nose/sinus: Denies discharge, epistaxis, obstruction.
Mouth/throat: Admits frequent dry mouth. Denies bleeding gums, sore tongue, mouth ulcers, sore throat, voice changes, use of dentures, last dental exam x 3 years ago - within normal limits.

Neck: Denies localized swelling, lumps, stiffness, decreased range of motion. CN 11:53
Breast: Denies lumps, nipple discharge, pain. ~~last mammogram 2017- ben~~
Last mammogram 2017- ~~beg~~ CN 11:54 benign
Pulmonary: Denies dyspnea, shortness of breath, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea.
Cardiovascular: Admits hypertension, palpitations. denies chest pain, edema/swelling of ankles or feet, syncope, known heart murmur, Pt is unsure regarding irregular heart beat.
Gastrointestinal: Admits loss of appetite, nausea. Denies intolerance to specific foods, vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, pain in flank
Last colonoscopy 2018- benign.
Genitourinary: Denies frequent urination, incontinence, polyuria, oliguria, abnormal color of urine, foul smelling urine, hematuria, dysuria. Admits waking up approximately 1-2 times a night to urinate.
Menstrual and obstetric
Last normal period: 2014- age 49
menarche: age 14
Pt denies hot flashes, admits vaginal dryness
G2 P2: 1102
Sexual history: Denies recent sexual activity, sexually transmitted infections.
Musculoskeletal: Denies muscle/joint pain, deformity/swelling, redness, arthritis. Pt is still regaining full function of L ankle and walks with slight limp.
Peripheral vascular: Denies intermitten claudication, coldness of trophic changes, varicose veins, peripheral edema, color change
Hematologic: Denies anemia, easy bruising or bleeding, lymph node enlargement, history of DVT/PE.
Endocrine: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism.
Nervous: Denies seizures, headaches, loss of consciousness, sensory disturbance, numbness, paresthesia, dysesthesias, hyperesthesia

ataxia, loss of strength, change in cognition / mental status / memory, asymetrical weakness.
Psychiatric: Denies depression, sadness, anxiety, obsessive compulsive disorder, denies seeing a mental health professional, Medication.

Vital Signs

BP	R	L	
lying down	140/80	136/82	(supine)
sitting up	142/80	138/80	(seated)

R: 16 breaths/min, unlabored
Pulse: 70 bpm, regular rhythm
T: 99.1 °F, oral
O_2 Sat: 96% in room air
Height: 5'3"
Weight: 160 lbs
BMI:

General Survey: 54 year old female, alert and oriented x3, pt apears well nourished, well groomed, in no acute distress, slender build.
Skin: warm and moist, slight tenting with average turgor, nonicteric, no lesions, masses, scars or tattoos noted.
Hair: Average/thin hair with even distribution, smooth texture, no sign of seborrhea, lice or nits.
Nails: No clubbing, pitting, good shape, color, no paronychea. Pt had acrylic nails. capillary refill of toenails <2 seconds Throughout.
Head: Normocephalic, atraumatic, nontender to palpation.
Eyes: Symmetrical OU
No evidence of strabismus, exophthalmos, ptosis. sclera is white, conjunctiva is pink. Visual acuity corrected 20/20 OS, 20/20 OD, 20/20 OU normal visual fields, PERRLA bilateral, EoMs full range of motion, slight nystagmus, good convergence. cup to disc ratio <0.5 OU. No evidence of av nicking, papilledema, copper wiring, exudate, cotton wool

Spots of neovascularization OU.

Nose: symmetrical, no masses, lesions, deformities, discoloration, discharge or trauma. Nares patent bilaterally, nasal mucosa pink and well hydrated. No discharge noted on rhinoscopy. Septum midline, no lesions, injection or perforations, no foreign bodies. good color. Septum is beefy red.

Sinuses: Nontender to palpation of frontal and maxillary sinuses.

Ears: Symmetrical and average size. No evidence of lesions, masses, trauma to external ear. Pinna and tragus non tender to palpation AU. No discharge, foreign bodies in external auditory canals AU. TMS pearly white, intact, no perforations. Cone of light 4:00 AD, 8:00 AS. Auditory acuity intact to whisper test AU. Weber Midline. Rinne AC>BC AU.

Mouth and Pharynx

Lips: Pink, moist, no cyanosis or lesions, nontender to palpation.

Palate: Pink, well hydrated, intact with no lesions, masses, scarring. Nontender to palpation, symmetrical.

Teeth: 32 teeth intact with no sign of dental caries, shaky teeth, chipping.

Gingivae: Pink, moist. No erythema, masses, lesions or discharge. Nontender to palpation.

Tongue: Pink, good distribution of papillae. No masses, lesions, erythema or deviation - to surface or underside of tongue. Nontender to palpation.

Oropharynx: well hydrated, uvula pink, symmetrical, no masses or lesions. tonsills not enlarged, no exudate, masses, lesions, injection.

Neck: Trachea midline, no masses, lesions, scarring. Supple, nontender to palpation, no palpable adenopathy noted. 2+ carotid pulses, no thrills, bruits noted bilaterally.

thyroid: Nontender to palpation, no palpable masses, no thyromegaly no bruits noted.

Thorax and Lungs

Chest: symmetrical, no deformities or evidence of trauma. Respiration unlabored. No paradoxic respirations or use of accessory muscles noted. Lateral to AP diameter 2:1. Nontender to palpation.

Lungs: clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious breath sounds.

Heart: JVP is 3 cm above angle of sternum, head of bed at 30°. PMI is 1cm x 1cm at 5th ICS in midclavicular line. Carotid pulses 2+ bilaterally, no bruits. Regular rate and rhythm. S_1 and S_2 noted, no murmurs, S_3 or S_4. No splitting of heart sounds or friction rubs appreciated.