11/20/2

Chaya Newfeld
PD 2 H&P 1 (Internal Med)

Identifying Data
Name: Ms G
DOB 3-12-1937 (age 83)
Date & Time 2-4-20 9:00 AM
Address: Flushing, Queens
Location NYPQ Internal Medicine
Religion: Christian
Sex: Female
Race: Haitian
Nationality: American
Marital status: widow
Referral source: self
History source: self
Reliability: reliable
PCD: unreported

Chief complaint
"My blood pressure was through the roof" x ____

HPI
Ms G is a reliable 83 year old female with past medical history of COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure) and hypothyroidism. She was admitted to the internal medicine department x 3 days ago due to systolic blood pressure rising to 213 mmHg. Ms G denies any associated pain or palpitations at this time, although she admits to having felt sudden weakness and loss of energy beginning 3 hours before she was brought to the hospital and persisting until she was given medication. Denies pain, radiating pain, aggravating or alleviating factors associated with her hypertension, syncope, shortness of breath, lightheadedness, dyspnea, tunnel vision. Ms G admits to being a "heavy smoker" x 20 years ago, and had a pacemaker placed a few years ago

is she compliant w/ her meds?

specifically chest pain.

- If so, is she compliant.
- Is she on BP meds currently?
- Was she stressed about something?
- has this happened before?
- Whats her diet like?

(patient does not recall the date) due to irregular heart rate. Admits brother and sister died in their 50's from heart conditions.

Past Medical History

Present Illness: COPD x ≈ 20 years, CHF x 5 years, hypothyroidism x 30 years
Past Illness: unknown
Childhood Illness: denies
Immunizations: up to date
Last flu shot: October 2019
Last Pneumonia shot: September 2019
Tests and screenings: denies

Past Surgical History

hysterectomy due to post-menopausal bleeding, x 10 years ago, no complications unknown hospital
Pacemaker implantation due to irregular heartbeat, unknown date, no complications, unknown hospital
cataract surgery due to cataracs OU, no complications, unknown hospital, unknown date
Denies any injuries, patient is unsure if transfusions administered during surgery.

Medications

synthroid, unknown dosage, x1 tablet QAM for hypothyroidism
Pulmocort, unknown dosage, inhale 2x daily for asthma due to COPD.
Pt admits to taking blood pressure medications and additional medications but does not recall the name, dosage, or intervals for each.

Allergies

NKDA, no known food or environmental allergies.

Family History

Maternal and paternal grandparents, unknown
Father, deceased at age 57, liver failure
Mother, deceased at age 90, natural causes (old age)
Brother, deceased at 52, heart condition
Sister, deceased at 59, heart condition

Social History

Admits "heavy smoking" (approximately 1 pack a day) ~~40 y~~ x 20 years ago, currently denies alcohol use, tobacco use, smoking cigarettes, illicit drug use. Admits 1 cup coffee per day. Denies recent travel, Denies exercize, currently unemployed (formerly an office cleaner x 20 years ago). Marital status- widow. Home situation- lives with daughter in an apartment building, admits daughter has a dog. Diet- breakfast of cereal, lunch of sandwich, dinner of chicken or fish. Sleep pattern: patient admits sleeping from 1 PM- 6 AM, with frequent waking to use the bathroom.

Sexual history: Denies recent sexual activity or sexually transmitted diseases

Safety measures: Admits to wearing a seatbelt in the car.

7:20 CN 2-9-26 ③ did she quit? when? how many pack years? put in HPI. also.

Review of systems.

General: Admits general weakness. Denies recent weight gain or loss, chills, night sweats, loss of appetite, fever.

Skin, hair, Nails: Denies pale appearance, night sweats, changes in texture, excessive dryness, discoloration of pigmentation, moles/rashes, pruritus, changes in hair distribution.

Head: Denies nausea, headache, vertigo, head trauma, unconsciousness, coma, fracture, light headedness.

Eyes Denies glasses use, last eye exam x 1 year ago, normal results- pt admits cataract surgery "a few years ago". Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus.

Ears: Denies deafness, pain, discharge, tinnitus, use of hearing aids.

Nose/sinus: Denies discharge, epistaxis, obstruction.

Mouth/throat: Admits hoarseness of voice, denies bleeding gums, sore tongue, mouth ulcers, sore throat, use of dentures. Last dental exam "a few years ago"- within normal limits.

7:40 CN ~~Neck~~ Neck: Denies localized swelling, lumps, stiffness, decreased range of motion.

Breast: Denies lumps, nipple discharge, pain, Last mammogram 2012- benign

Pulmonary: Denies dyspnea, shortness of breath, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea. Admits cough and wheezing

due to COPD exacerbations.

Cardiovascular: Admits hypertension, pacemaker use. Denies palpitations, chest pain, edema / swelling of ankles or feet, syncope.

Gastro intestinal: Denies loss of appetite, nausea, specific food intolerance, 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 - pt does not recall.

Genitourinary: Admits urine incontinence, frequent urination. Denies oliguria, abnormal color of urine, foul smelling urine, hematuria, dysuria

Admits ~~AFat~~ CN 7:30 waking up 3-4 times a night to urinate,

Menstrual and obstetric

Last normal period: 1980 (age 43)

Menarche: age 13

Pt denies hot flashes, vaginal dryness

G5P5: 5003

Sexual history: Denies recent sexual activity, STIs

Musculoskeletal: Admits muscle / joint pain due to arthritis and swelling of knuckles. Denies redness. Uses walker to walk.

Peripheral vascular: Denies intermitten claudication, coldness or trophic changes, peripheral edema, color change. Admits varicose veins.

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, change in cognition / mental status / memory, asymetrical weakness.

Psychiatric: Denies depression, sadness, anxiety, obsessive compulsive disorder, denies seeing mental health professional, medications.

Vital signs

| BP | R | L |
|---|---|---|
| Supine | 140/82 | 138/80 |
| Seated | 150/90 | 152/88 |

R: 14 breaths/min, unlabored
Pulse: 70 bpm, regular rhythm
T: 98.8 °F, oral
$O_2$ sat: 96% in room air
Height: 5'2"
Weight: 280 lbs
BMI: 51.2

General survey: 83 year old female, alert and oriented X3, pt appears obese, well groomed, in no acute distress.
Skin: warm and moist, moderate tenting with poor turgor, nonicteric, no lesions, masses, scars or tattoos noted.
Hair: thin, short hair with sparse distribution, rough texture, no sign of seborrhea, lice or nits.
Nails: No clubbing, pitting. good shape, color, no paronychea Capillary refill <2 seconds thraughout finger and toe nails.
Head: Normocephalic, atraumatic, nontender to palpation.
Eyes: symmetrical ou, no evidence of strabismus, exophthalmos, ptosis. sclera is white, conjunctiva is clear. visual acuity 20/40 OS, 20/40 OD, 20/40 OU, normal visual fields. PEARL bilateral, no accomodation noted, EOM full range of motion, slight nystagmus, poor convergence, Cup to disc ratio CO.5 OU. No evidence of av nicking, papilledema, copper wiring, exodate, cotton wool spots or 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. septum 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 nontender 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 sigh of ~~dental c~~ dental caries, shaky teeth, chipping. CN 8:40
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.
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. Nontender to palpation, no palpable adenopathy.
2+ carotid pulses, no thralls, 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. Respirations 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. Dry cough noted.
Heart: JVP is 3 cm above angle of sternum with 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- patient has pacemaker implant. S1 and S2 noted, no murmurs, S3 or S4. Splitting of heart sounds or friction rubs not appreciated.
Breasts: symmetric, no dimpling, no masses to palpation. Nipples symmetric with no discharge or lesions. No axillary nodes palpable.
Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink, no inflammation, erythema or discharge. Cervix multiparous, pink, without lesions or discharge. No cervical motion tenderness.

Uterus anteriar, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. No inguinal adenopathy. Pap smear not obtained.

Rectal: Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present. foB negative.

First line of HPI; what you think the most likely diagnosis is.

Assessment: 83 year old female patient with exacerbation of chronic hypertension secondary to congestive heart failure. She also has COPD, arthritis, hypothyroidism and is a former smoker, and has a pacemaker.

Differential Diagnosis

1. HTN secondary to thyroid disease: pt is on synthroid
   labs: T3, T4, thyroid antibodies

2. HTN secondary to renal failure or chronic kidney disease: complication of aging
   Labs: BUN, creatinine imaging- kidney ultrasound

3. HTN due to obesity: pt is ≥80 lbs

4. Primary hypertension: environmental factors including sedentary lifestyle - pt is elderly and cannot walk well and denies exercising

5. HTN due to coarctation of the aorta
   - measure and compare pulses in the arms and lower extremities.

6. HTN due to noncompliance with medication
   pt admits being on HTN medication.

94.40