Identifying Data:

Name: BE
Address: Forest View Center
Age: 58

Sex: Male
Date: 1/10/2022
Ethnicity: Caucasian
Preferred Language: English
Source of Information: Self and nurse
Reliability: unreliable

CC: Blood in foley bag x1 week

HPI: BE is a 58 y/o Caucasian male with significant past medical history of TBI from an attack in the subway x30 years ago, HTN, DM II, HLD, CAD, hypothyroidism, depression/anxiety, BPH, urinary retention with chronic Foley catheter since October 2021, patient is a long-term resident of Forest View center since November 2021, with complaint of hematuria. Patient is A&O x3 but unreliable historian due to TBI. Patient is continent of bowel and ambulates freely. Nurse noted blood-tinged urine in foley bag twice in the past week. Per patient documents, he has history of UTI and urinary retention prior to admission at Forest View, when he was hospitalized at Northwell in October and d/ced home with foley bag to leg. Patient offers no complaints; states he feels fine. Denies any chest pain, palpitations, fever, chills, suprapubic pain, nausea, vomiting, diarrhea or abdominal pain.

Geriatric Assessment:

ADLs: requires reminders but can perform ADLs independently.
IADLs: dependent in all.
Visual impairment: Not impaired, follows up with ophthalmologist regularly.
Hearing impairment: Hearing intact to whisper test
Falls in the past year: denies
Get up and go: Performed without cane. Steady gait. Patient is not at risk for falling.
Assistive devices used: none
Gait impairment: none
Urinary incontinence: chronic foley catheter due to BPH/ urinary retention
Fecal incontinence: none
Osteoporosis: none
Depression: hx of depression/ anxiety
Health Care Proxy: Father
Advanced directives: Patient does not have

Past Medical History:
Present illness: TBI (x30 years) HTN, DM II, HLD, CAD, hypothyroidism, depression/anxiety, BPH, urinary retention with chronic Foley catheter since October 2021
Hospitalizations:
• Northwell October 2021 (urinary retention)

Unknown hospital 1990 (TBI)

Screening:
•colonoscopy (x5 years ago, benign)
Past Surgical History:
• right ankle fixation (2010)

Medications:
levothyroxine 137 mcg (0.137 mg) oral tablet: Hx, 1 tab(s) orally once a day -Indication: hypothyroidism

hydrALAZINE 50 mg oral tablet: Hx, 1 tab(s) orally every 8 hours -Indication: High Blood Pressure

amLODIPine 5 mg oral tablet: Hx, 1 tab(s) orally once a day -Indication: High Blood Pressure,

losartan 100 mg oral tablet: Hx, 1 tab(s) orally once a day -Indication: High Blood Pressure

metoprolol tartrate 100 mg oral tablet: Hx, 1 tab(s) orally 2 times a day -Indication: HTN,

repaglinide 1 mg oral tablet: Hx, 1 tab(s) orally 2 times a day -Indication: DMII

glyBURIDE 1.25 mg oral tablet: Hx, 1 tab(s) orally 2 times a day -Indication: DM II,

Crestor 5 mg oral tablet: Hx, 1 tab(s) orally once a day -Indication: High Cholesterol,

tamsulosin 0.4 mg oral capsule: Hx, 1 cap(s) orally once a day -Indication: BPH/urinary retention

aspirin 81 mg oral delayed release tablet: Hx, 1 tab(s) orally once a day -Indication: CAD

buPROPion 150 mg/24 hours (XL) oral tablet, extended release: Hx, 1 tab(s) orally every 24 hours -Indication: Anxiety,

Allergies:
No known allergies to drugs, food or environment.

Immunizations:
• Patient is up to date on immunizations, received COVID Moderna vaccine in March

Family History:
Denies any known family history significant for stroke, PE/DVT or bleed

Mother died of MI at 81 years old

Social History:
BE lived at home with his mother until mother had an MI in November 2021. Currently long-term resident of Forest View center. He has been adjusting well to his roommate and the staff. He denies the past or present use of alcohol, cigarettes, tobacco, or and illicit drugs. Patient receives 6-8 hours of sleep each night. Patient is on a diabetic and heart healthy diet. BE is not sexually active. Denies any history of STDs.

Review of Systems:

General: Denies fever, chills, night sweats, fatigue, weakness, loss or appetite, recent weight gain or weight loss.
Skin, hair, nails: denies dry, itchy skin, changes in texture, sweating discolorations, pigmentations, moles or rashes.
Head: Denies headache, vertigo, or head trauma.
Eyes: denies blurry vision, double vision, eye pain, Last eye exam approximately 1 year ago.
Ears: Denies deafness, pain, discharge, tinnitus or use of hearing aids.
Nose/sinuses: Denies discharge, epistaxis or obstruction.
Mouth and throat: Denies bleeding gums, sore throat, sore tongue, mouth ulcers, voice changes or dentures. Last dental exam unknown.
Breast: Denies lumps, nipple discharge or pain.
Pulmonary System: Denies dyspnea, shortness of breath, cough, wheezing, hemoptysis, cyanosis, orthopnea or PND.
Cardiovascular System: Denies chest pain, palpitations, edema/swelling of ankles or feet, syncope or known heart murmur.
Gastrointestinal System: Denies changes in appetite, intolerance to foods, nausea, vomiting, diarrhea, dysphagia, pyrosis or excessive flatulence.
Genitourinary: Patient has chronic foley, admits noted hematuria in foley bag, denies pain/discomfort.
Musculoskeletal System: denies muscle pain, stiffness, limp
Peripheral Vascular system: Denies intermittent claudication and coldness of feet, varicose veins, peripheral edema or color changes.
Endocrine System: Denies polydipsia, polyphagia, polyuria, heat or cold intolerance.
Nervous System: Denies seizures, loss of consciousness, numbness, or tingling.
Psychiatric: Admits depression/anxiety after his mother diet, is on bupropion which helps, does not feel suicidal/homicidal or wish to self-harm

Vitals:
Vital Signs:
Blood Pressure: 123/84 (right arm, supine)
Heart Rate: 74 beats/minute (regular)

Respiration Rate: 18 breaths/minute (nonlabored)
Temperature: 36.7 C (oral)
O2 Sat: 98% (on room air)
Height: 175.3 cm
Weight: 213 lbs
BMI: 31.5

Physical Exam:
General:
58-year-old casually-groomed male lying supine in bed. No indications of acute distress, resting comfortably
Skin:
Warm and moist/dry, good turgor, noncitric, no thickness/opacity, no notable lesions, rashes, or tattoos. Well healed scar to R ankle from previous surgery
Eyes:
Symmetrical OU without evidence of strabismus or ptosis. Sclera white, conjunctiva and cornea clear. EOMI, PERRL.
Ears:
Symmetrical and normal size. No evidence of lesions, masses, or trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TMs pearly gray and intact with light reflex in appropriate position AU
Nose: Symmetrical without obvious masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pale & well hydrated.
Mouth and Pharynx:
Lips: Pink, moist, no evidence of cyanosis or lesion.
Neck: Supple, no JVD, thyroid nontender/not enlarged
Chest: Normal breathing effort. Symmetrical, no deformities, no signs of trauma. Lateral: AP diameter 2:1. Non-tender to palpation.
Lungs: Clear to auscultation bilaterally without rales, rhonchi, or wheezes, breathing unlabored and symmetrical.
Cardiovascular: Regular rate and rhythm (RRR); S1 and S2 are normal. No S3, S4, splitting of heart sounds, friction rubs or other extra sounds
Abdomen: Soft, non-tender, non-distended, bowel sounds present
Genitourinary: +Foley catheter in, pinkish urine in foley bag, however, draining clear urine in tube
Rectal: Not assessed.
Peripheral Vascular: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower, no LE edema. No stasis changes or ulcerations noted.
Musculoskeletal: good motor strength
Neurological: A&O X 3, however, a poor historian, Sensation intact, Cranial nerves grossly intact.

Differential Diagnosis

1. UTI
2. Urethral trauma
3. Kidney or bladder stone
4. Kidney or bladder cancer

Assessment:
58-year-old male PMHx TBI (subway attack >30 years ago), HTN, DM II, HLD, CAD, hypothyroidism, Depression/anxiety, BPH, urinary retention with a chronic Foley since October 2021 presents with hematuria x1 week, Patient's vitals are stable, likely has a UTI

Assessment/Plan:

1) UTI/Chronic urinary retention

c/w tamsulosin

labs: CBC, CMP, urinalysis, urine culture

Imaging: US renal/bladder

Based on results from lab work and imaging, start patient on appropriate antibiotics at facility or follow up with urology/oncology for tx

2) Cardiac prophylaxis

-Hold aspirin as patient has hematuria

3) HTN: c/w Hydralazine 25 mg TID, Losartan 100 mg daily, Metoprolol 100 mg BID, amlodipine 5 mg daily

4) Anxiety/depression: c/w bupropion 150mg daily, continue with psych follow up in facility

5) If labs indicate anemia due to hematuria: start Iron supplements or send to ER for blood transfusion depending on results

6) Hypothyroidism: c/w Synthroid 150 mcg daily

7) HLD: c/w Crestor 5 mg daily

8) DM II: c/w repaglinide 1 mg, glyBURIDE 1.25 mg