H+P - Internal Medicine Angelina Gambino

<u>Identifying data</u>:
Full Name: RN
Address: NY, NY
DOB: 88 y/o
Date & Time: 10/2/18 1015AM
Location: NYHQ, Flushing, NY
Catholic
Source of Information: self
Source of Referral: PCP

<u>Chief Complaint</u>: "I am having problems breathing x1.5 months"

<u>HPI</u>: 88 y/o puerto Rican male with PMH of HTN, DM, hypercholesterolemia, non smoker comes to the ER c/o S.O.B for 1.5 months. States he has been admitted for 3 days and was here for S.O.B last month for 3 days. Admits the S.O.B began 1.5 months ago when he noticed it was difficult to breath while sleeping. Admits to orthopnea and states he sleeps sitting up in a reclining chair. States none of his medications have helped. Breathing is worse at night and on exertion. Patient is currently on 2 Liters nasal cannula and BiPAP at night, which has helped ~~a little~~ AG slightly. States there is fluid around his lungs so he is scheduled for a thoracocentesis this afternoon. Denies having this procedure in the past. Admits to dyspnea, SOB, orthopnea, edema/swelling of ankles or feet. Denies cough, wheezing, hemoptysis, cyanosis, chest pain, palpitation, irregular heart beat syncope, known heart murmur, fever, chills, night sweats, fatigue, weakness, loss of appetite, recent weight loss or gain.

Past medical History:

Present illnesses - Hypertension x 15 years, Hypercholesterolemia x10 years
Diabetes x10 years

Past medical illnesses - Hospitalized for S.O.B Sept. 2018 x3 days at NYHQ, Flushing, NY

Childhood illnesses - Chicken pox as a child. Doesn't recall exact age. Denies other illnesses

Immunizations - Flu vaccine yearly. Pneumoccocal vaccine 2017

Past Surgical History:

Denies surgical procedures, injuries or transfusions

Medications:

For edema → (Furosemide) Lasix 40mg IV twice a day, last dose this morning

Eliquis (Apixaban) 5mg 1 tab ~~oral~~ PO daily, not given today

For hyperchdesterolemia → Lipitor (Atorvastatin) 10mg 1 tab ~~ora~~ PO daily, last dose this morning

for HTN → Coreg (Carvedilol) 12.5mg 1 tab PO twice a day, last dose this morning

Plavix (Clopidogrel bisulfate) 1 tab PO daily 75mg, not given today

Entresto (Sacubitril 24mg Valsartan 26mg) 1 tab PO twice a day, last dose this morning for ~~HN~~ HTN

Januvia (sitagliptin) 100mg 1 tab PO daily, last dose this morning for diabetes (type 2)

Allergies:

Pt denies any drug, enviornmental or food allergies

Family History:

Mother - deceased in 1980, natural causes
Father - deceased in 1933, unknown reason
Daughter - age 51, alive and well.
Daughter - age 47, alive and well
Son - deceased in Airforce
Son - deceased in Airforce
Denies family history of cancer.

Social History:
Mr N. is a married male living with his wife of 68 years.
He worked as an engineer, retired 20+ years ago.
Admits to drinking caffinated coffee 1 cup per day.
Denies drinking alcohol, illicit drug use or smoking.
Denies any recent travel.
He eats a well-balanced diet with fruits and vegetables and sleeps 5 hours per night.
He admits to doing landscape at his home as exercise but has not been able to since becoming sick (1.5 months).
Admits to wearing a seatbelt.

Review of symptoms:
General: Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

Skin, hair, Nails: Denies changes in texture, excessive drying or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head: denies headaches, vertigo, lightheadedness or head trauma.

Eyes: Denies no visual disturbances, lacrimation, photophobia or pruritus, Last eye exam 4 years ago. Wears reading glasses. Visual acuity unknown.

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

Nose/Sinuses: Denies discharge, obstruction or epistaxis.

Mouth/Throat: Admits to having upper and lower dentures. Denies bleeding gums, sore tongue, sore throat, mouth ulcers or

voice changes. Last dental exam 7 years ago.

Neck: Denies localized swelling/lumps or stiffness/ decreased range of motion.

Pulmonary system: See HPI

Cardiovascular: See HPI

Gastrointestinal: Admits to regular bowl movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding or blood in stool. Doesn't recall last colonoscopy.

Genitourinary system: Denies freqauency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain, hesitancy, dribbling. Last prostate exam over 10 years ago.

Sexual history: He is not currently sexually active. Denies history of sextually transmitted infections.

Nervous system: denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory or weakness.

Musculoskeletal system: Admits to arthritis in both hands. Denies other muscle/joint pain, deformity or swelling or redness.

Peripheral Vascular system: Admits to edema in lower limbs. Denies intermittent claudication, coldness of trophic changes, varicose veins or color change.

Hematologic system: Admits to easy bruising or bleeding. Denies lymph node enlargement, blood transfusions or history of DVT/PE.

Endocrine system: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, ~~hirt~~ hirsutism, or excessive sweating.

Psychiatric: Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional

Physical

General: Slender male, doesn't appear distressed, neatly groomed, looks stated age of 88 years old.

Vital Signs:

BP:	R	L
Seated	120/80	122/86
Supine	120/76	120/84

R: 16/min unlabored
P: 86, regular
T: 98.4 degrees F (oral)
O_2 sat: 98% 2 L nasal canula

Height: 70 inches
Weight: 150 lbs
BMI: 21

Skin: warm and moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: average quantity and distribution.

Nails: no clubbing, capillary refill < 2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpitations throughout.

Eyes: symmetrical OU / no evidence of strabismus, exophthalmos or ptosis / sclera white / conjunctiva and cornea clear.
Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU)
Visual fields full OU. PERRLA, EOMs full with no nystagmus.
Fundoscopy: Red reflex intact OU. Cup: disk <0.5 ~~Hem~~ A6 1012 OU / no evidence of AV nicking / papilledema / hemorrhage / exudate / cotton wool spots / neovascularization OU

Did not get up to physical exam. Blue ink used