Keziah Babu- Family Medicine Rotation (HPI #1)

History

Identifying Data:
Full Name: R. Montalvo
Address: Far Rockaway, New York
DOB: 8/30/1965
Date and TIme: 1/10/22
Location: South Shore Family Medicine, PC
Source of Information: Self
Reliability: Reliable
Source of Referral: Self

Chief Complaint: "I've been throwing up and I feel dizzy"

History of Present Illness: 56 year old woman with PMH of asthma and HLD comes to the office complaining of dizziness and vomiting x 1 day. Patient reports receiving the second dose of the Pfizer vaccine 3 days ago. She reports experiencing pain at the injection site 2 days ago, followed by an episode of vomiting yesterday morning. Patient reports becoming dizzy last night, and feeling as if the room was spinning. The dizziness persisted this morning, upon wakening and has since improved. Patient denies fever, chills, changes in weight, night sweats, chest pain, SOB, changes in vision, tinnitus, hearing loss, diarrhea, constipation, abdominal pain, numbness or tingling, changes in sensation or any other complaints.

Past Medical History
Denies childhood illnesses
Immunizations- Up to date; has not received flu shot

Past Surgical History
Right breast biopsy- 2009

Medications
Ibuprofen 800 mg- 1 tablet with food or milk as needed orally qd
Ergocalciferol 1.25 mg- 1 capsule orally weekly
Flovent HFA 110 MCG/ACT Aerosol- 1 puff bid
Albuterol Sulfate (2.5 MG/3 ML) nebulization solution as needed tid
Ventolin HFA 108 (90 Base) MCG/ACT Aerosol solution- 2 puffs as needed inhalation every 4 hrs
Singulair 10 mg tablet- 1 tablet in the evening orally qd
Gabapentin 300 mg capsule- 1 capsule orally qd
Omega 3 1000 mg capsule- 1 capsule orally bid
Lipitor 10 mg tablet- 1 tablet orally qd
Fenofibrate 145 mg tablet- 1 tablet with food orally qd
Carboxymethylcellulose Sodium 0.25% solution as directed

Allergies
No Known Drug Allergies

Family History
Father: deceased
Mother: deceased

Social History
R. Montalvo is a single female, living by herself. She socially drinks 1 glass of wine on the weekends. Denies present and past tobacco use. Drinks 1 cup of coffee a day
Travel- She has not traveled recently
Diet- She diet consists of carbohydrates and fried foods. States she has been trying to incorporate more vegetables
Exercise- She does not exercise regularly
Sexual Hx- She is heterosexual, but has not been sexually active in the past year. She denies ever having an STD

Review of Systems
General- Denies generalized weakness and fatigue. Denies recent weight loss or gain, loss of appetite, fever or chills, or night sweats

Skin, hair, nails- Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair distribution

Head- admits to dizziness but denies headaches or head trauma

Eyes- Denies visual disturbances. Does not wear glasses.

Ears: Denies tinnitus or hearing changes

Nose/Sinuses- Denies obstruction, post nasal drip or epistaxis

Mouth/throat- Denies bleeding gums, sore throat, sore tongue, mouth ulcers, voice changes or use of dentures.

Neck: Denies swelling, tenderness, pain or difficulty swallowing

Pulmonary system- Denies dyspnea. Denies cough, sputum production, wheezing, hemoptysis, or orthopnea.

Cardiovascular system- Denies palpitations and diaphoresis. Denies chest pain, hypertension, edema in the ankles/ feet, syncope or known heart murmur.

Gastrointestinal system- Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructation, abdominal pain, diarrhea, jaundice, constipation, rectal bleeding or blood in stool.

Genitourinary system- Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain

Nervous- Denies weakness. Denies seizures, , loss of consciousness, loss of strength, or change in cognition/ mental status/ memory,

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 changes

Hematological system- Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusion, or history of DVT/PE

Endocrine system- denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric- Denies depression/ sadness, anxiety.

Physical

Physical

BP:	R	L		R:	16 breaths/min, unlabored
Seated	120/78	120/74		P:	84 beats/min, regular
Supine	118/80	120/78		T:	98.6 degrees F (oral)
Height 63 inches		Weight 136 lbs.	BMI: 24.09	O2 Sat: 98% Room air	

General: Awake, alert and oriented. No acute distress. Well developed, hydrated and nourished. Appears stated age.
Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: Average quantity and distribution.
Nails: No clubbing, capillary refill <2 seconds in upper and lower extremities
Head: Normocephalic, atraumatic, non tender to palpation throughout
Ears: Symmetrical and appropriate in size. No lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU. Negative Dix Hallpike maneuver
Nose: Symmetrical / no 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 foreign bodies.
Sinuses: Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.
Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink. Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA, EOMs intact with no nystagmus.
Fundoscopy: Red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Lips: Pink, moist; no cyanosis or lesions. Non-tender to palpation.
Mucosa: Pink ; well hydrated. No masses; lesions noted. Non-tender to palpation. No leukoplakia.
Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.
Teeth: Good dentition. No obvious dental caries noted.
Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.
Tongue: Pink; well papillated; no masses, lesions or deviation. Non-tender to palpation.
Oropharynx: Well hydrated; no injection; exudate; masses; lesions; foreign bodies. Tonsils present with no injection or exudate (give grade of tonsils). Uvula pink, no edema, lesions
Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no cervical adenopathy noted.
Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated
Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.
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 in vault. FOB negative.
Breasts: Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable
No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

CN I Correctly identified coffee and mint odors bilaterally
CNII Visual fields full by confrontation, visual acuity 20/200 OD, 20/100 OS, uncorrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena
CNIII, IV, & VI Extraocular movements intact, pupils 3mm OU and reactive to direct and consensual light and accommodation, no ptosis
CN V Face sensation intact bilaterally, corneal reflex intact, jaw muscles strong without atrophy
CN VII Correctly identified sweet, salt and sour tastes (bitter not tested), facial expressions intact, clearly enunciate words

CN VIII Repeats whispered words at 2 feet bilaterally, Weber – no lateralization, Rinne – AC>BC
CN IX and X No hourseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing
CN XI Full range of motion at neck with 5/5 strength and strong shoulder shrug
CN XII Tongue midline without fasciculations, good tongue strength

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis
Sensory: Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally

Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Reflexes:
Normal: 2+ throughout, negative Babinski, no clonus appreciated

	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

Peripheral vascular: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally (no C/C/E B/L) No stasis changes or ulcerations noted.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Full active range of motion with no crepitus in all upper and lower extremities bilaterally. Full spinal range of motion with no deformities.

Mental Status Exam

APPEARANCE: The patient's appearance was awestruck; bewildered; clean but bizarre clothing; somewhat agitated.

ATTITUDE: The patient's attitude towards the evaluator was obliging initially and more belligerant as time went on.

MOVEMENTS: The patient's movements were characterized by athetoid aytypical bland calm

AFFECT: The patient's affect was anxious; appropriate; bland; blunted

MOOD: The patient's mood was depressed and nearly despairing.

SPEECH: The patient's speech was barely audible and monotone.

SENSORIUM: The patient's Sensorium was characterized as A&O x 3 (Person, Place, & Time) but did not fully appreciate her situation.

ATTENTION & CONCENTRATION: The patient's attending skills and concentration were clouded; dazed; distracted.

THOUGHT CONTENTS: The patient's thought contents were characterized by poverty of thought

FORM OF THOUGHTS: The patient's form of thought was characterized by coherent; concrete; derailment; disordered thoughts

PERCEPTION: The patient's perceptions were characterized as depersonalization; distorted; hallucinations

INTELLECT: The patient's mental ability was estimated as being above average based on her prior work history (officer in a business) and educational attainment (college graduate).

MEMORY: The patient's memory was characterized by STM impaired, LTM intact.

INSIGHT: The patient's insight into her illness was estimated as being limited.

JUDGMENT: The patient's judgment was estimated as being dubious impaired inaccurate lacking.

Assessment
56 year old woman with PMH of asthma and HLD comes to the office complaining of dizziness and vomiting x 1 day

Differential Diagnosis
Vertigo due to BPPV

Orthostatic hypotension

Dizziness secondary to vomiting

Stomach virus- possible cause of the vomiting, however the patient had stopped vomiting by the time she came to the office

Symptomatic reaction to Pfizer vaccine

Plan

BPPV - conduct dix hallpike maneuver, was negative. Told patient to return if dizziness didn't resolve after medication for further evaluation

Orthostatic hypotension- checked blood pressure in different positions (sitting and standing), with no change to BP

Dizziness secondary to vomiting- educated the patient on staying hydrated and resting. Prescribed Meclizine HCl 25 mg 1 tablet as needed orally qd

Asthma- continue Singulair qd as well as Ventolin and Albuterol nebulizer when needed

HLD- educated patient on the need to change her diet to include more fruits and vegetables and less fried foods. Encouraged patient to exercise daily. Instructed patient to continue Lipitor and Fenofibrate as prescribed

Keziah Babu- Family Medicine Rotation (HPI #2)

History

Identifying Data:
Full Name: Y. Kerner
Address: Far Rockaway, NY
DOB: 8/27/1946
Date and Time: 1/20/2022
Location: South Shore Family Medical, P.C.
Source of Information: Self
Reliability: Reliable
Source of Referral: No referral

Chief Complaint:
"I have a cough and sore throat"

History of Present Illness:
75 year old woman with a PMH of asthma, hypothyroidism, hyperlipidemia, and HTN comes to the office for medicare wellness visits and medication refills. She complains of a sore throat and cough for the past 3 days after receiving COVID booster shot last Friday. (1/13/2022). Notes minimal improvement in her cough and sore throat. She had not taken any medications to help with her cough or sore throat. She denies fever, chills, chest pain, shortness of breath, weakness, dizziness, n/v/d

Past Medical History
Hypertension
Hyperlipidemia
Goiter- stable
Hx of MRSA infection

Past Surgical History
Hysterectomy- 5/2007
L knee surgery, torn ligament- 9/2009
L shoulder fracture- 10/2013

Medications
Albuterol Sulfate (2.5 mg/ 3 mL) 0.08 nebulization solution 3 mL Inhalation qid
Losartan Potassium 25 mg tablet 1 tablet orally once a day
Omeprazole 20 mg Capsule Delayed Release 1 capsule orally once a day
Synthroid 25 mcg tablet 1 tablet every morning on an empty stomach orally once a day
Fenofibrate 67 mg capsule 1 tablet with a meal orally once a day
Zetia 10 mg tablet 1 tablet orally once a day
Coenzyme Q10 150 mg capsule 1 capsule with a meal orally once a day
Symbicort 80-4.5 mcg/ ACT aerosol 2 puffs inhalation once a day
Ventolin HFA 108 (90 base) mcg/ act aerosol solution 2 puffs as needed inhalation every 6 hrs
Mobic 15 mg tablet 1 tablet orally once a day

Hydrocortisone 2.5% cream 1 application externally once a day
Multivitamin 1 tab orally daily
Vitamin B12 1000 mcg tablet externally once a day
Ergocalciferol 5000 Unit Capsule 1 capsule orally once a week
Calcium + D
Folic Acid 800 mcg tablet 1 tablet orally once a day
Omega 3 1000 mg capsule 1 capsule orally once a day

Allergies
Strawberries
Tomato sauce Pollen
Grass
Oranges
Milk

Family History
Father: deceased, CHF
Mother: deceased, DM

Social History
Y. Kerner is a married female, living with her husband. She socially drinks 1 glass of wine on the weekends. Denies present and past tobacco use. Drinks 1 cup of coffee a day
Travel- She has not traveled out of state recently
Diet- She does not eat a balanced diet and eats mainly fast food and protein
Exercise- She does not exercise regularly
Sexual Hx- She is sexually active and does not use protection

Review of Systems
General- Denies generalized weakness and fatigue. Denies recent weight loss or gain, loss of appetite, fever or chills, or night sweats

Skin, hair, nails- Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair distribution

Head- denies headaches, dizziness or head trauma

Eyes- Denies visual disturbances. Does not wear glasses.

Ears: Denies tinnitus or hearing changes

Nose/Sinuses- Denies obstruction, post nasal drip or epistaxis

Mouth/throat- Denies bleeding gums, sore throat, sore tongue, mouth ulcers, voice changes or use of dentures.

Neck: Denies swelling, tenderness, pain or difficulty swallowing

Pulmonary system- Denies dyspnea. Denies cough, sputum production, wheezing, hemoptysis, or orthopnea.

Cardiovascular system- Denies palpitations and diaphoresis. Denies chest pain, hypertension, edema in the ankles/ feet, syncope or known heart murmur.

Gastrointestinal system- Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructation, abdominal pain, diarrhea, jaundice, constipation, rectal bleeding or blood in stool.

Genitourinary system- Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain

Nervous- Denies weakness. Denies seizures, , loss of consciousness, loss of strength, or change in cognition/ mental status/ memory,

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 changes

Hematological system- Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusion, or history of DVT/PE

Endocrine system- denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric- Denies depression/ sadness, anxiety.

Physical

Physical

BP:	R	L		R:	16 breaths/min, unlabored
Seated	136/86	134/86		P:	84 beats/min, regular
Supine	136/86	136/82		T:	97.2 degrees F (oral)
Height 65 inches		Weight 262 lbs.	BMI: 43.59	O2 Sat: 98% Room air	

General: Awake, alert and oriented. No acute distress. Well developed, hydrated and nourished. Appears stated age.
Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: Average quantity and distribution.
Nails: No clubbing, capillary refill <2 seconds in upper and lower extremities

Head: Normocephalic, atraumatic, non tender to palpation throughout
Ears: Symmetrical and appropriate in size. No lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU. Negative Dix Hallpike maneuver
Nose: Symmetrical / no 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 foreign bodies.
Sinuses: Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.
Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink. Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA, EOMs intact with no nystagmus.
Fundoscopy: Red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.
Lips: Pink, moist; no cyanosis or lesions. Non-tender to palpation.
Mucosa: Pink ; well hydrated. No masses; lesions noted. Non-tender to palpation. No leukoplakia.
Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.
Teeth: Good dentition. No obvious dental caries noted.
Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.
Tongue: Pink; well papillated; no masses, lesions or deviation. Non-tender to palpation.
Oropharynx: Well hydrated; no injection; exudate; masses; lesions; foreign bodies. Tonsils present with no injection or exudate (give grade of tonsils). Uvula pink, no edema, lesions
Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no cervical adenopathy noted.
Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated
Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.
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 in vault. FOB negative.
Breasts: Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable
No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

CN I Correctly identified coffee and mint odors bilaterally
CNII Visual fields full by confrontation, visual acuity 20/200 OD, 20/100 OS, uncorrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena
CNIII, IV, & VI Extraocular movements intact, pupils 3mm OU and reactive to direct and consensual light and accommodation, no ptosis
CN V Face sensation intact bilaterally, corneal reflex intact, jaw muscles strong without atrophy
CN VII Correctly identified sweet, salt and sour tastes (bitter not tested), facial expressions intact, clearly enunciate words

CN VIII Repeats whispered words at 2 feet bilaterally, Weber – no lateralization, Rinne – AC>BC
CN IX and X No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing
CN XI Full range of motion at neck with 5/5 strength and strong shoulder shrug
CN XII Tongue midline without fasciculations, good tongue strength

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis
Sensory: Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally
Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Reflexes:
Normal: 2+ throughout, negative Babinski, no clonus appreciated

	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

Peripheral vascular: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally (no C/C/E B/L) No stasis changes or ulcerations noted.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Full active range of motion with no crepitus in all upper and lower extremities bilaterally. Full spinal range of motion with no deformities.

Mental Status Exam

APPEARANCE: The patient's appearance was awestruck; bewildered; clean but bizarre clothing; somewhat agitated.

ATTITUDE: The patient's attitude towards the evaluator was obliging initially and more belligerant as time went on.

MOVEMENTS: The patient's movements were characterized by athetoid aytypical bland calm

AFFECT: The patient's affect was anxious; appropriate; bland; blunted

MOOD: The patient's mood was depressed and nearly despairing.

SPEECH: The patient's speech was barely audible and monotone.

SENSORIUM: The patient's Sensorium was characterized as A&O x 3 (Person, Place, & Time) but did not fully appreciate her situation.

ATTENTION & CONCENTRATION: The patient's attending skills and concentration were clouded; dazed; distracted.

THOUGHT CONTENTS: The patient's thought contents were characterized by poverty of thought

FORM OF THOUGHTS: The patient's form of thought was characterized by coherent; concrete; derailment; disordered thoughts

PERCEPTION: The patient's perceptions were characterized as depersonalization; distorted; hallucinations

INTELLECT: The patient's mental ability was estimated as being above average based on her prior work history (officer in a business) and educational attainment (college graduate).

MEMORY: The patient's memory was characterized by STM impaired, LTM intact.

INSIGHT: The patient's insight into her illness was estimated as being limited.

JUDGMENT: The patient's judgment was estimated as being dubious impaired inaccurate lacking.

Assessment

75 year old woman with a PMH of asthma, hypothyroidism, hyperlipidemia, and HTN comes to the office complaining of a cough and sore throat onset 3 days ago, with minimal improvement.

Differential Diagnosis

Viral infection
Cough and sore throat secondary to COVID booster
Cough secondary to Asthma exacerbation
Cough secondary to GERD

Plan

Educated patient that cough and sore throat may be due to viral infection, which would not require antibiotic therapy. Will prescribe Guaifenesin syrup 100 mg/ 5mL, 10 mL as needed, orally, every 4 hours for 10 days to help alleviate the cough

Asthma- continue Symbicort 2 puffs qd, Ventolin and Albuterol nebulizer treatment as needed

GERD- Continue Omeprazole 20 mg 1 capsule qd, educated patient on avoiding spicy and fatty foods, and to eat at least 3 hours prior to going to bed

Hypothyroidism- Continue Synthroid 25 mcg 1 tablet every morning on an empty stomach

Hyperlipidemia- Continue Fenofibrate 67 mg, 1 tablet with a meal orally qd. Continue Omega 3 1000 mg 1 capsule qd. Continue Zetia 10 mg, 1 tablet qd. Continue Coenzyme Q10 capsule 150 mg 1 capsule with a meal qd

Hypertension: Continue Losartan 25 mg, 1 tablet qd

Morbid obesity- educated patient on benefit of weight loss through diet and exercise

Keziah Babu- Family Medicine Rotation (HPI #3)

Identifying Data:
Full Name: M. Luciano
Address: Far rockaway
DOB: 4/25/1962
Date and Time: 1/20/2022
Location: South Shore Family Medical, P.C.
Source of Information: Self
Reliability: Reliable
Source of Referral: No referral

Chief Complaint:
" I've been experiencing memory loss for a while now"

History of Present Illness:
59-year-old woman with a PMH of diabetes, HTN, HLD, Insomnia and anxiety comes to the office for blood work and medication refills. States she takes her medications everyday and is compliant. She has been experiencing episodes of memory loss since 2000, which has worsened to daily episodes for the past 4 months. She states her episodes of memory loss range from constantly misplacing household items to not remembering what she had said a minute ago. She has not been referred to a specialist for her memory loss. She also notes intermittent dizziness while walking for months now. Denies fever, chills, chest pain, SOB, weakness, trauma, n/v/d

Past Medical History
Thyroid nodule found on 6/2017- biopsy was negative
DM
HLD
Osteoarthritis
Cervical radiculopathy

Past Surgical History
None

Medications
Claritin 10 mg tablet 1 tablet orally qd
Vitamin D 50000 unit capsule 1 capsule orally once a week
Xanax
Hydrochlorothiazide 12.5 mg tablet 1 tablet in the morning orally once a day
Valsartan 160 mg tablet 1 tablet orally once a day
Omeprazole 40 mg capsule delayed release 1 capsule 30 min before morning meal orally daily
Murine Tears for Dry Eyes 5-6 mg/mL solution as directed
Gabapentin 300 mg capsule orally once a day
Crestor 5 mg tablet 1 tablet orally once a day

Aspirin 81 mg tablet delayed release 1 tablet orally once a day
Diclofenac Sodium 75 mg tablet delayed release 1 tablet with food or milk twice orally
Ubrelvy 100 mg tablet 1 tablet may take second dose at least 2 hours after first dose as needed orally once a day
Metformin HCl 1000 mg tablet 1 tablet with a meal orally twice a day
Glimepiride 1 mg tablet 1 tablet with breakfast or first main meal of the day orally once a day
Vitamin B-650 mg tablet 1 tablet orally once a day

Allergies
Meclizine- causes chest pain

Family History
Father: deceased
Mother: deceased

Social History
M. Luciano is a married female, living with her husband. She does not drink alcohol. Denies present and past tobacco use. Drinks 1 cup of coffee a day
Travel- She has not traveled out of state recently
Diet- She tries to eat a balanced diet with protein, vegetables and fruit
Exercise- She does not exercise regularly
Sexual Hx- She is sexually active and does not use protection

Review of Systems
General- Denies generalized weakness and fatigue. Denies recent weight loss or gain, loss of appetite, fever or chills, or night sweats

Skin, hair, nails- Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair distribution

Head- admits to dizziness, denies headaches or head trauma

Eyes- Denies visual disturbances. Does not wear glasses.

Ears: Denies tinnitus or hearing changes

Nose/Sinuses- Denies obstruction, post nasal drip or epistaxis

Mouth/throat- Denies bleeding gums, sore throat, sore tongue, mouth ulcers, voice changes or use of dentures.

Neck: Denies swelling, tenderness, pain or difficulty swallowing

Pulmonary system- Denies dyspnea. Denies cough, sputum production, wheezing, hemoptysis, or orthopnea.

Cardiovascular system- Denies palpitations and diaphoresis. Denies chest pain, hypertension, edema in the ankles/ feet, syncope or known heart murmur.

Gastrointestinal system- Admits to constipation. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructation, abdominal pain, diarrhea, jaundice, rectal bleeding or blood in stool.

Genitourinary system- Admits to nocturia. Denies urinary frequency or urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain

Nervous- Denies weakness. Denies seizures, , loss of consciousness, loss of strength, or change in cognition/ mental status/ memory,

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 changes

Hematological system- Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusion, or history of DVT/PE

Endocrine system- denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric- admits to anxiety.

Physical

Physical

BP:	R	L		R:	16 breaths/min, unlabored
Seated	120/86	124/86		P:	80 beats/min, regular
Supine	120/86	122/82		T:	97.5 degrees F (oral)
Height 64 inches		Weight 193 lbs.	BMI: 33.12	O2 Sat: 98% Room air	

General: Awake, alert and oriented. No acute distress. Well developed, hydrated and nourished. Appears stated age.
Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: Average quantity and distribution.
Nails: No clubbing, capillary refill <2 seconds in upper and lower extremities
Head: Normocephalic, atraumatic, non tender to palpation throughout
Ears: Symmetrical and appropriate in size. No lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU. TM's pearly white / intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU. Negative Dix Hallpike maneuver

Nose: Symmetrical / no 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 foreign bodies.
Sinuses: Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.
Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink. Visual acuity uncorrected - 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA, EOMs intact with no nystagmus.
Fundoscopy: Red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.
Lips: Pink, moist; no cyanosis or lesions. Non-tender to palpation.
Mucosa: Pink ; well hydrated. No masses; lesions noted. Non-tender to palpation. No leukoplakia.
Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.
Teeth: Good dentition. No obvious dental caries noted.
Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.
Tongue: Pink; well papillated; no masses, lesions or deviation. Non-tender to palpation.
Oropharynx: Well hydrated; no injection; exudate; masses; lesions; foreign bodies. Tonsils present with no injection or exudate (give grade of tonsils). Uvula pink, no edema, lesions
Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no cervical adenopathy noted.
Thyroid: Non-tender; no palpable masses; no thyromegaly; no bruits noted
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Abdomen: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated
Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.
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 in vault. FOB negative.
Breasts: Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable

CN I Correctly identified coffee and mint odors bilaterally
CNII Visual fields full by confrontation, visual acuity 20/200 OD, 20/100 OS, uncorrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena
CNIII, IV, & VI Extraocular movements intact, pupils 3mm OU and reactive to direct and consensual light and accommodation, no ptosis
CN V Face sensation intact bilaterally, corneal reflex intact, jaw muscles strong without atrophy
CN VII Correctly identified sweet, salt and sour tastes (bitter not tested), facial expressions intact, clearly enunciate words

CN VIII Repeats whispered words at 2 feet bilaterally, Weber – no lateralization, Rinne – AC>BC
CN IX and X No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing
CN XI Full range of motion at neck with 5/5 strength and strong shoulder shrug

CN XII Tongue midline without fasciculations, good tongue strength

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculation. Strength 5/5 throughout. Rhomberg negative, no pronator drift noted. Gait steady with no ataxia. Tandem walking and hopping show balance intact. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis
Sensory: Intact to light touch, sharp/dull, and vibratory sense throughout. Proprioception, point localization, extinction, stereognosis, and graphesthesia intact bilaterally
Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Reflexes:
Normal: 2+ throughout, negative Babinski, no clonus appreciated

	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

Peripheral vascular: Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally (no C/C/E B/L) No stasis changes or ulcerations noted.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Full active range of motion with no crepitus in all upper and lower extremities bilaterally. Full spinal range of motion with no deformities.

Mental Status Exam

APPEARANCE: The patient's appearance was awestruck; bewildered; clean but bizarre clothing; somewhat agitated.

ATTITUDE: The patient's attitude towards the evaluator was obliging initially and more belligerant as time went on.

MOVEMENTS: The patient's movements were characterized by athetoid aytypical bland calm

AFFECT: The patient's affect was anxious; appropriate; bland; blunted

MOOD: The patient's mood was depressed and nearly despairing.

SPEECH: The patient's speech was barely audible and monotone.

SENSORIUM: The patient's Sensorium was characterized as A&O x 3 (Person, Place, & Time) but did not fully appreciate her situation.

ATTENTION & CONCENTRATION: The patient's attending skills and concentration were clouded; dazed; distracted.

THOUGHT CONTENTS: The patient's thought contents were characterized by poverty of thought

FORM OF THOUGHTS: The patient's form of thought was characterized by coherent; concrete; derailment; disordered thoughts

PERCEPTION: The patient's perceptions were characterized as depersonalization; distorted; hallucinations

INTELLECT: The patient's mental ability was estimated as being above average based on her prior work history (officer in a business) and educational attainment (college graduate).

MEMORY: The patient's memory was characterized by STM impaired, LTM intact.

INSIGHT: The patient's insight into her illness was estimated as being limited.

JUDGMENT: The patient's judgment was estimated as being dubious impaired inaccurate lacking.

Assessment

59-year-old woman with a PMH of diabetes, HTN, HLD, chronic rhinitis, insomnia and anxiety has been experiencing episodes of short-term memory loss since 2000, which has worsened to daily episodes for the past 4 months.

Differential Diagnosis

Memory loss due to:

- Alzheimer's dementia
- Anxiety
- Lack of sleep (patient has a PMH of insomnia)
- Medication-induced memory loss (ex: long-term use of Gabapentin can cause memory loss)

Plan

Memory Loss

- Neuro referral to determine underlying cause of memory loss

Essential (primary) Hypertension

- Continue hydrochlorothiazide tablet, 12.5 mg, 1 tablet in the morning orally
- Continue Valsartan tablet, 160 mg 1 tablet orally

Type 2 Diabetes mellitus

- Continue Glimepiride tablet, 1 mg, 1 tablet with breakfast or the first main meal of the day

Hypercholesterolemia

- Continue Crestor tablet, 5 mg, 1 tablet orally once a day
- Continue aspirin tablet delayed release, 81 mg, 1 tablet orally once a day

Insomnia

- Insomnia is due to an underlying medical condition and is stable
- Continue Xanax

Vitamin D Deficiency

- Continue Vitamin D 5000 UNIT, 1 tablet orally once a week

Chronic rhinitis

- Continue Claritin 10 mg, 1 tablet orally, once a day

Constipation

- Continue Docusate Sodium Capsule, 100 mg, 1 capsule as needed, orally