Keziah Babu- CUNY York College PA Program
Rotation 8- OB/GYN Woodhull Hospital
H&P 3

Identifying Data:
Full name: E.O
Address: Bushwick, NY
Date of Birth: XX/XX/1997
Date & Time: 10/06/2022
Location: Woodhull Hospital
Ethnicity: Hispanic
Source of Information: Self (via interpreter)
Source of referral: Self
Reliability: Fair

HISTORY

Chief Complaint: I have been having lower back and pelvic pain since early this morning

History of Present Illness: E.O. is a 25 y/o female, G5P3013, currently 36 weeks pregnant, EDD 11/3/22, who presents s/p slip and fall at a supermarket yesterday at approximately 12pm on 10/05/22. Patient states she was at a supermarket when she slipped on the wet floor and fell onto her buttocks. She denies hitting her head or any other part of her body. Patient states she felt fine after the incident until 12 am this morning when she began to experience a full body tingling sensation. She reports lower back and pelvic pain since 1 am this morning and rates the pain 4/10. States it is constant, sharp, “heavy” and “like period cramping”;pain radiates to her abdomen accompanied by belly tightening. She has not taken any pain medication for her sx. Additionally, she reports a headache since 7:30 am today, but denies nausea, vomiting, or vision changes, hematuria, numbness/tingling or loss of consciousness. Denies hx of complications with her current pregnancy.

Patient admits to normal fetal movement. Denies nausea, vomiting, chest pain, SOB, discharge, itching, dysuria or fever.

OB Hx:
G5P3013; First delivery was induced (2013), second (2015) and third (2018) were NSVD, denies complications with prior pregnancies.

GYN Hx:
LMP was end of January 2022
Menarche at 14 y/o, periods last 7 days
Hx chlamydia 4 years ago, completed course of abx
Reported abnormal PAP smear on April/May 2022, states she was to return for repeat PAP smear after giving birth

Past Medical History:
COVID in January 2022, resolved, no complications

Immunizations:
COVID: Never received
Influenza: refused
All other vaccinations up to date

Past Surgical Hx:
Denies

Medications:
Prenatal multivitamin 28-0.8 mg 1 tablet PO qd
Ferrous Sulfate 325 mg 1 tablet PO qd
NKDA

Family Hx:
Maternal grandmother: hx of diabetes
Mother: Hx of diabetes

Social Hx:
Denies alcohol abuse
Denies tobacco abuse
Occupation: COVID testing center
Social Support: Lives with 3 children and “children’s father”
Travel: Denies recent travel
Diet: Healthy diet
Exercise: active
Sexual history: patient is sexually active and in a monogamous heterosexual relationship with her husband, last sexual activity was 2 months ago, admits to history of STIs
Patient states she feels safe at home

Review of Systems:

General: Patient denies fatigue, weakness, loss of appetite, fever, chills, nausea, vomiting, night sweats

Skin, hair, nails: Denies changes in texture, moisture, discolorations, pigmentations, moles/ rashes, pruritus, changes in hair distribution

Head: Denies headaches, migraines, or head trauma, vertigo, loss of consciousness or coma

Eyes: Denies corrective lenses, pruritus, visual disturbances, photophobia, lacrimation

Ears: Denies vertigo, deafness, pain, discharge, tinnitus, hearing loss

Nose/sinuses: Denies discharge, obstruction, epistaxis

Mouth/throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, hoarseness

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

Breast: Denies pain, lumps, masses, swelling

Pulmonary: Denies cough, dyspnea, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular: Denies chest pain, palpitations, arrhythmias, edema/swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, loss of appetite, dysphagia, pyrosis, unusual flatulence or eructations, hemorrhoids, rectal bleeding

Genitourinary: Admits to sharp pelvic pain since 1 am this morning.Denies urgency, polyuria, dysuria, nocturia, hematuria, discharge, lesions, flank pain. LMP was 01/2022

Nervous: Denies seizures, loss of consciousness, ataxia, loss of strength weakness

Musculoskeletal: admits to lower back pain that radiates to her lower abdomen accompanied by belly tightening; denies instability, deformity, redness, swelling, reduced range of motion

Peripheral Vascular: Denies intermittent claudication, coldness or trophic changes, varicose veins, color changes

Hematologic: Denies bruising, petechiae, purpura, anemia

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

Psychiatric: denies stress, anxiety, depression/sadness; denies ever seeing a mental health professional

PHYSICAL

Vital Signs
BP: 114/60
HR: 102

Resp: 18
Temp: 97.9 F (oral)
SpO2: 99% RA
Weight: 212 lb
Height: 5’2”
BMI: 38.78

General: 25 year old female in no acute distress who appears stated age, cooperative, good-hygiene, well-developed; alert-oriented x 4

Skin: warm and moist, good turgor; nonicteric, no scars or tattoos noted; capillary refill < 2 seconds throughout

Neck: thyroid non-tender, no palpable masses, no thyromegaly; trachea midline, no masses, lesions, scars, pusations, FROM; no lymphadenopathy noted

Chest: symmetrical; no gross deformities or evidence of trauma; no paradoxical respiration or use of accessory muscles noted; contended to palpation

Lungs: breath sounds equal bilaterally with no adventitious sounds

Heart: regular rate and rhythm; S1 and S2 are distinct with no murmurs, S3 or S4; no splitting of S2 or friction rubs appreciated

Breast: non-tender, no palpable masses, skin or nipple changes; no axillary lymphadenopathy noted; symmetrical

Abdomen: Gravid uterus, mild tenderness to palpation in bilateral lower back, no rebound tenderness; soft symmetrical; no evidence of guarding, CVA tenderness, or pain out of proportion to the exam

GU: normally developed external genitalia with no lesions; vagina shows no lesions, inflammation, discharge or tenderness; no cervical motion tenderness; cervix long, 1.5cm dilated posterior

Fetal Assessment:
Movement: present
Dilation: 1.5
Effacement (%): 30
Station: -3
Cervical: 0

Bishop score: 2
Fetal Heart Rate: 125 bpm

Uterine Activity

Flowsheet Row	Most Recent Value
Uterine Activity	
Uterine Contractions	Present filed at 10/06/2022 1156
Mode	Toco filed at 10/06/2022 1156
Contraction Frequency	**q3-5 min** filed at 10/06/2022 1156
Contraction Duration	**40-50** sec filed at 10/06/2022 1156
Contraction Quality	Mild, Moderate filed at 10/06/2022 1156
Resting Tone Palpated	Soft filed at 10/06/2022 1156

Musculoskeletal: no soft tissue swelling, erythema, ecchymosis, atrophy, deformities in bilateral upper and lower extremities; no calf tenderness or edema

Peripheral Vascular: no edema noted in bilateral lower extremities; pulses 2+ bilaterally in upper and lower extremities; no bruits, clubbing, cyanosis, stasis changes, ulcerations, erythema

Neuro: alert and oriented x 4; symmetric muscle bulk with good tone; no atrophy, tics, tremors, fasciculations

Labs and Imaging:
Bedside ultrasound shows fetus is head down and positioned appropriately

No labs drawn at this point

Differential Diagnosis:
Musculoskeletal pain due to mechanical fall
Preterm contractions

Assessment:
25 y/o female, G5P3013, currently 36w0d, presents to triage s/p mechanical fall with lower back pain and pelvic pain which she rates at 4/10. Lower back pain radiates to lower abdomen with associated belly tightening. Uterine activity shows contractions every 3-5 minutes lasting 40-50 seconds.

Plan:
Preterm contractions and Lower Back/Pelvic Pain

- Ensure patient with comfort with pain medication (Acetaminophen)
- IV access with fluid IV hydration
- Order 3rd trimester HIV, GC/CT and UCX
- Recheck vitals in 4 hours

- Check biophysical profile and nonstress test at that time
- Continue to monitor maternal and fetal status
- If patient is stable, dc home, patient can return for scheduled follow up visit