Keziah Babu- CUNY York College PA Program
Rotation 9- Internal Medicine NSUH
H&P 1

Identifying Data:
Full name: R.M.
Address: Long Island, NY
Date of Birth: XX/XX/1950
Date & Time: 11/14/2022
Location: NSUH
Ethnicity: Hispanic
Source of Information: Self
Source of referral: Self
Reliability: Fair

HISTORY

Chief Complaint: "I started to feel numb on the left side of my face and arm since last night"

History of Present Illness: 72 year old male with PMH of HLD, HTN, CAD, DMT2 comes to the emergency department with numbness/weakness of the left arm and left face along with right eye pain with visual changes. Patient states that he was watching TV around 3pm the previous day and suddenly felt weakness/numbness in his left arm and face and right eye pain and symptoms resolved within 10 minutes. Similar episodes occurred again at 9:30 pm the same day and 8 am this morning which was when he decided to come to the ED. Each episode lasted approximately 10 minutes. In addition to these symptoms, the patient also experienced dizziness this morning. Patient states that this has never happened in the past. Took Advil without relief. The patient did not take his prescribed aspirin or insulin the night prior because he had run out of his medication.

Upon arrival at the ED, the patient is neurologically intact. His fingerstick was 438 in triage. The patient mentioned that he was having a difficult time controlling his glucose levels and is currently not followed by an endocrinologist. Denies headache, dizziness, numbness, slurred speech, tingling, weakness, chest pain, SOB or cough.

Past Medical History:
CAD, unknown years
Diabetes mellitus, unknown years
Hyperlipidemia, unknown years
Hypertension, unknown years

Immunizations:
Up to Date on childhood vaccinations

COVID x3 (Pfizer)- last booster was 12/2021
Influenza vaccination- still pending

Past Surgical Hx:
Coronary artery bypass- 2019

Medications:
Levemir FlexPen 100 units/mL subcutaneous solution- Last dose taken 2 days ago as per patient he ran out
Aspirin 81 mg PO qd
NKDA

Family Hx:
Family hx noncontributory

Social Hx:
Denies alcohol abuse
Denies tobacco abuse**- Previous 52 pack year smoker**
Denies substance abuse
Occupation:N/A
Travel: No recent travel
Diet: healthy diet
Exercise: moderately active
Sexual history: Patient is a heterosexual male in a monogamous relationship with his wife; denies history of STDs

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: **Admits to headache,** denies migraines, head trauma, vertigo, loss of consciousness, or coma

Eyes: **Admits to blurry vision and pain in the right eye.** Denies corrective lenses, pruritus, photophobia, or 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

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: Denies urgency, polyuria, dysuria, nocturia, hematuria, discharge, lesions, flank pain.

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

Musculoskeletal: 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: 162/58 (162/58-157/67)
HR: 73 (73-75)
Resp: 16 (16-18)
Temp: 36.8 C
SpO2: 96% on RA
Weight: 175 lb
Height: 5’9”

BMI: 25.84

General: 72 year old gentleman in no acute distress who appears stated age, cooperative, good- hygiene, well- developed, alert and oriented x 3
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, pulsations, 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
Abdomen: no rebound tenderness; soft symmetrical; no evidence of guarding, CVA tenderness, or pain out of proportion to the exam
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: Full active/passive ROM of all extremities without rigidity or spasticity. Symmetric muscle bulk with good tone. No atrophy, tics, tremors or fasciculations. Strength 5/5 throughout. No pronator drift noted. Coordination by rapid alternating movement and point to point intact bilaterally, no asterixis.

Labs and Imaging:

CBC:
- Hgb 15.3
- Hct 46.7
- WBC 6.78
- Plt 211

BMP:
- Na 134
- K 5.1
- Cl 98
- CO2 27
- BUN 22
- Cr 0.96
- Glucose 316 (most recent)

Liver Function:
- AST 10
- ALT 10

Alk Phos 73
Total Bilirubin 0.4
Protein 6.9
Albumin 4.1

CT head without IV contrast on 11/14/2022 reveals: stable right MCA territory infarct. No new infarct or development of intracranial hemorrhage

Differential Diagnosis:

1. Stroke (TIA)
2. Uncontrolled Diabetes (peripheral neuropathy)
3. Uncontrolled HTN
4. Chronic SAH/ Brain aneurysm
5. Bell's Palsy

Assessment:

72 yo M PMH HLD, HTN, CAD, DM comes to the Emergency Department with numbness/weakness of L arm and L face, R eye pain/ visual change evaluated emergently by neuro with initial work up negative admitted for further work up.

Plan:

1. Stroke (TIA)
    a. Initial work up negative
    b. Will have a MR brain and MR angio head and neck per neuro recommendations clinically improving neurologically intact
    c. Treat headache with Ibuprofen 200 mg PO q 6 hours
2. Diabetes mellitus (type 2)
    a. Uncontrolled with hyperglycemia
    b. Will consult endo to assess the patient
    c. Start Lantus 20 units at night for now
3. Hypertension
    a. Start valsartan 160 po qd
    b. Continue to monitor
4. Hyperlipidemia
    a. Fasting panel in AM
5. VTE
    a. Start Plavix 75 mg PO qd