Erik Oatman
HPPA 502 - PD1
Prof. Malouet

Hospital HPI #2:

Identifying Data:

Name: JD
Address: LIC, NY
DOB: 2/18/56 (62 y/o)
Date & Time: 11/13/18, 10:00AM ✓
Location: NYP-Q, Internal Medicine
Religion: Unspecified
Source of Info: Self, Reliable
Source of Referral: Podiatrist
Mode of Transport: Self, personal vehicle ✓

Q0

DID PAIN START BEFORE SURGERY OR DID SURGERY MAKE IT WORSE? HPI UNCLEAR

Chief Complaint: (R) foot pain x 1 wk

IS THIS STATEMENT RELATED TO CHIEF COMPLAINT OR JUST GIVING PAST MEDICAL HX?

HPI:

62 y/o male c PMH of DM2, HTN, and hyperlipidemia c/o (R) foot pain x 1 wk (status post debridement of diabetic ulceration of 2nd phalanx of (R) foot.) Reports sudden onset of throbbing 7/10 pain x 1 week. Denies any aggravating or alleviating factors. Denies radiation of pain from ulcer but reports generalized neuralgia in all extremities. Throbbing pain has been generally consistent, varying between 5 and 7/10 over last week. Reports pain worsened at 7/10 post debridement.

PRE-OP OR POST-OP?

WHAT WAS HE DOING?

SHOULD HAVE MUSCULOSKELETAL + NEUROLOGIC ROS? "NEURALGIA"

NEURALGIA IS DIFFERENT FROM PAIN PARESTHESIA? ANESTHESIA?

PMHx:

- DM2 for last "couple decades"; last A1C 6.7 2 wks ago
- HTN for 15 years
- Hyperlipidemia for 15 years
- Up to date on vaccinations. Denies blood transfusions.

Allergies: • Tylenol and contrast for angiograms - pallor and hypotension,
• Denies food or ~~ENT~~ environmental allergies.

Medications: • Humalog, 3 units SQ daily, last dose today
• Tanjeo (Insulin Glargine), 30 units SQ daily at bedtime, last dose last night
• Gabapentin, 100 mg PO TID, last dose this morning
• Amlopril, 10 mg PO daily, last dose yesterday
• Metoprolol XL 25 mg daily

Addendum to Rx provided by Susan Denn, PA-C 11/13/19 (SO)
• Vancomycin, 100 mg
• Atorvastatin, 40 mg/daily
• Cefepime, 1gm 28hrs x 7 days
• ~~Clopidorel, 7 mg daily~~ (SO) • Clopidogrel, 7 mg daily
• Enoxaparin, 40 mg SQ daily
• Furosemide, 20 mg daily
• ASA, 81 mg PO daily
• D5W, 200mL/hr IV BD x 7 days

Surgical Hx: • Partial (L) foot amputation 2° to DM, 12/29/2014. Hospitalized 1 month, 3 weeks rehab. ~~Denies~~ (SO)
• (L) foot ulcer debridement 2016, hospitalized 10 days. Denies sequelae.

Past Hospitalization: • 2016 - 1wk post (L) foot ulcer debridement 2° to DM.
• 2014 - 1 month post (L) foot partial amputation 2° to DM.

INCLUDED IN PSH, DO NOT NEED TO REPEAT.

Family Hx: • Father - deceased 64 y/o, MI.
• Mother - deceased 68 y/o, CVA.
• Brother - ~~deceased~~ alive (SO) 58 y/o, Hx of (SO) pancreatic CA.
• Sister - ~~alive, H~~ (SO) deceased, 46 y/o, breast CA.

Social Hx: Admits 40 pack-years (cigarettes (SO)), quit >10 years ago. Drinks beer, 3-4 beers x 2-3 times/week, denies any drinking for last month. Retired carpenter as of 2014. Only 1 female sexual partner this year as of 6 months ago. Unable to exercise. No dietary restrictions, but tries to minimize sugar and processed carbohydrates. HISTORY OF ILLICIT DRUG USE?

ROS:
~~V/S: BP - 142/102 mm Hg~~ (SO)
~~HR - 60 bpm~~

•General - Denies weight loss or gain, loss of appetite, generalized weakness, fatigue, fever, 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, vertigo, or trauma.

•Eyes - Denies lacrimation, pruritis, photophobia, or other visual disturbances. Reports myopia, doesn't know prescription, hasn't seen optometrist in over 10 years. Doesn't use glasses.

✓ Nose/Sinuses - Denies discharge, obstruction, or epistaxis. Denies anosmia

✓ Mouth/Throat - Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures. Does not recall last dental exam.

✓ Neck - Denies localized swelling/lumps. Reports stiffness from neck arthritis x 12 years.

↑ "ARTHRITIS - 12 YEARS LOCALIZED IN NECK" SHOULD BE INCLUDED IN PMH

✓ Breast - Denies lumps, nipple discharge, or pain.

✓ Pulmonary System - Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

✓ Cardiovascular System - Denies palpetations, chest pain, irregular heartbeat, edema/swelling, syncope, or known heart murmur. PMHx of HTN.

FORMER BROWN

GI System - Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, ABD pain, diarrhea, jaundice, hemorrhoids, 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.

- Musculoskeletal System - Denies muscle pain, deformity, swelling, or redness. Reports arthritis in neck and carpel tunnel syndrome x 12 years.

DID HE HAVE SURGERY FOR THIS? AGAIN INCLUDE IN PMH ADD PSH IF SO

- Nervous System - Denies seizures, headaches, loss of consciousness, ataxia, or changes in cognition / mental status / memory. (Reports loss of strength in Ⓡ arm since childhood but sensation intact.)

THIS NEEDS ⟷ TO BE EXPLORED MORE AND DOCUMENTED BETTER

- Peripheral Vascular System - Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes. (See PMHx of DM ulceration on Ⓡ foot.)

- Hematological System - Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or hx of DVT/PE. (Hx of HTN and hyperlipidemia.)

CARDIO ROS

- Endocrine System - Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

- Psychiatric - Reports stress and anxiety. Denies depression, OCD, or ever seeing a mental health professional.

Physical:

- General: Pt A/Ox3, reliable and cooperative. Appears to be of average size and development for 62 y/o male. Good hygeine.

- Vital Signs: - BP 142/102 b/lat, semi-Fowler's position
  - PR: 60 bpm, RRR
  - RR: 12 bpm, unlabored
  - Height: 5'11"
  - Weight: 200 lbs
  - BMI (calculated): 27.9
  - Unable to obtain temp. or O_2 Sat.

- Skin: Warm, dry, good turgor. Non icteric. No tattoos.
  (L) Anterobrachial hematoma, purple, 3 cm diameter.

- Hair: Grey, full thickness and distribution

- Nails: No clubbing, cap refill < 2 secs.

- Head: Normocephalic, atraumatic, nontender on palpation.

- Eyes: Symmetrical OU; no evidence of strabismus or exopthalmus. No ptosis; Sclera white, conjunctiva and cornea clear. No crescent shadows OU.
  Visual Acuity (uncorrected): 20/10 OD, 20/10 OS, 20/10 OU.
  Visual Fields fully intact. Pupils equal, round, reactive to light. Slow accomodation. EOMs full. Mild nystagmus OU.

Fundoscopy - Red reflex intact OU. Unable to visualize optic disc OU. Positive copper wiring OU. No evidence of A-V nicking, exudates, or cotton wool spots OU. ✓

- Ears: Symmetrical and good size. No evidence of lesions/masses/tumors/trauma on external ears. No discharge/foreign bodies in EAM AU. TM pearly white, intact, cone of light in ~~normal~~ good position AU. ✓ Auditory acuity intact to whisper test. Weber midline. Rinne test AC > BC AU.

- Nose - Symmetrical, no masses/lesions/deformities/trauma or discharge. Nares patent bilat. Mucosa pink, dry. No discharge on rhinoscopy. ✓ Septum midline, no lesions, injections, or perforations. No foreign bodies.

- Sinuses: Non tender to palpation. Unable to assess transillumination. ✓

- Neck: Supple, even pigmentation throughout. Trachea midline. No JVD. No bruit on auscultation of carotid arteries or thyroid. No evidence of lymphadenopathy on palpation. ✓