Amber Shaikh
PD2 H+P 1

History
identification: 1/28/20 9:30 AM
NP, female, Hispanic, 57 years old, divorced, address unknown, catholic
location: NY Presbyterian Queens Internal medicine
informant: self (patient)
reliability: reliable ✓
source of referral: self
mode of transportation: personal vehicle
PCP: Dr. Jones

✓ cheif complaint: "I felt chest pain, burning, and shortness of breath" for 1 week.

HPI:

NP is a 57 year old Female with a past medical history of type 2 diabetes, hypertension, hypercholesternia, and 10 pack year smoking history comes in complaining of chest tightness and a heart burn sensation for 1 week. She states the symptoms came on when she was trying to fall asleep. The pain is localized to her left chest, with sensation of "acid coming up her throat". The pain is intermittent, and she characterizes it as sharp sensation when it comes on. The pain is aggravated by laying down and sitting in certain positions, and is alleviated with walking. She states the pain is localized and does not radiate anywhere. Patient says that when her symptoms are present, she rates it a 7/10, and at baseline a 3/10. She says the pain is now resolved, due to medications (name not recalled) given during her stays. She denys any recent illnesses, travels, or sick contacts. ~~She says she has been eating a healthier diet~~. The same symptoms happend 2 weeks prior when she was sitting on the couch, and she brought herself to the hospital.

ANY RELATION TO FOOD?

WHAT WAS SHE DIAGNOSED WITH AT THIS TIME?

~~She has had EKGs, Xrays, blood work, and a CTA done. The only positive finding was calcium deposits along her vessels.~~ She has never had similar symptoms prior to these two episodes. She has associated shortness of breath, heart burn, and palpitations. She denies any cough, fever, weight changes, jaw/left arm pain, diaphoresis, urinary changes, syncope, myalgia or abdominal pain.

Past medical history

past/present illnesses: Type 2 Diabetes x 30 years
Hypertension x 15 years ✓
High cholesterol x 10 years

✓ childhood illnesses: none
✓ immunizations: flu vaccine 5 months ago, up to date on vaccines
✓ screening: stress test 3 weeks ago; unremarkable finding
mammogram 1 year ago, unremarkable findings

Past surgical history

✓ Gall stone lithotripsy over 20 years ago - NY Presbyterian
no complication
✓ Cholecystectomy 15 years ago - NY presbyterian
no complication OPEN OR LAPAROSCOPIC?
✓ 3 C-section deliveries - (30, 20, 19 years ago) - NY Presbyterian
no complications
✓ no blood transfusion history

medications

✓ Humulin R U-500 - subcutaneous injection 1 unit/kg/day
Type 2 Diabetes - noncompliant, last used: 1 week ago
✓ hydrochlorothiazide - PO 50 mg QD - hypertension
• last taken 3 days ago
Aspirin 75 mg PO QD - hypertension, last taken 1 day ago
UNUSUAL DOSE FOR ASPIRIN, THIS IS USUAL DOSE OF PLAVIX

/ lipitor 20 mg PO QD - high cholesterol last dose 2 days ago
/ lisinopril 40 mg PO QD - hypertension last dose 3 days ago

Allergies
REACTION TO ALLERGENS?
environmental - seasonal allergies, dust + mold
medication - no known medication allergies
food - no food allergies

Family history
mother - Type 2 Diabetes; controlled, alive + well age 79
Father - deceased at 62 from a Myocardial infaction
sister - alive + well, age 53, history of Diabetes.
Daughter - age 30, alive + healthy, no hx
/ Daughter - age 20, healthy, no hx
Son - age 19, healthy, no PMX
Grandmother - deceased at 70. Hx of Diabetes
Grandfather - deceased at 72. Hx of MI

Social history
"SOCIALLY" IS ~~SUBJECTIVE~~ TOO SUBJECTIVE
NP is a divorced 57 year old female who lives with her daughter. She is a customer service representative.
- alcohol - ~~drinks socially~~ - up to 2 drinks per weekend, usually wine. For the past 20 years
/ - smoking - 10 pack year cigarette smoking history; quit 1 year ago denies cigar, hookah or vape use
- illicit drugs - denies ever using any illicit drugs
- caffine - pt drinks 1 cup of coffee every morning
- travel - denies any recent travel outside country
- marital - divorced 20 years ago
- education - bachelor degree from 4 year college
- occupation - customer service representative
- home life - lives with her daughter

Diet = well balanced diet consisting of vegetables, meats and fruits. Patient recently cut out fast food

exercise = walks everyday to work, takes stairs at home

sleep pattern: only gets 5 hours a sleep a night, ~~pt concerned for sleep apnea.~~

safety: wears seat belt, uses sidewalks

sexual history: NP is not currently sexually active. In the past she practiced vaginal sex with male partners. When married, she was only active with her husband. She did not use protection or barrier methods. Denies any hx of STDs. Last tested over 10 years ago. Last time she was sexually active was 5 years ago

ROS

General: denies fatigue, weight changes, fevers, chills, night sweats

Skin, hair, nails: denies changes to hair texture, dryness, discoloration, moles, rashes, changes in pigmentation, growths or changes in hair distribution.

Head: denies headaches, dizziness, vertigo, or head trauma

Eyes: wears glasses for distance. Denies visual changes, photophobia
Last eye exam 5 years ago

Ears: denies deafness, ear pain, discharge, tinnitis, hearing loss or use of hearing aids

nose, sinuses: denies nasal discharge, sinus pain, obstruction or epistaxis

mouth + throat: denies sore throat, gum bleed, ulcers, lip changes, dentures. Last dental exam = 3 years ago = proper hygiene (brushes + flosses 2x/day)

neck: denies pain, swelling, stiffness, decreased range of motion

Breast: denies lumps, pain, or discharge, last mammogram 1 year ago - RESULTS?

pulmonary: (SEE HPI.) Admits to shortness of breath, denies dyspnea, DOE, cough, wheezing, orthopnea, PND, hemoptysis, or cyanosis.

cardiovascular: (SEE HPI.) Admits to chest tightness, heart burn, and palpitations. Denies edema of ankles, syncope, or hx of known heart murmur

GI: denies changes in appetite, food intolerance, nausea, vomiting, dysphagia, diarrhea, constipation, changes in bowel, pyrosis, flatulence, eructations, jaundice, hemorrhoids, rectal bleed, or abdominal pain

GU: denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, color changes of urine, incontinence, flank pain, or waking at night to urinate.

Menstrual + Obstetrical: last period 7 years ago, currently in menopause. Menarche at 13 years old. Denies post coital bleeding, vaginal discharge, dyspareunia, menopause at age 50, no breakthrough bleeding ~~3 pregnancies 3 deliveries~~ (3G, 3P - full term)

USE GP NOTATION

nervous: denies seizures, headaches, loss of consciousness, sensory

disturbance, ataxia, loss of strength, change in cognition, or weakness / ataxia

✓ Musculoskeletal: denies muscle / joint pain, swelling, redness, or arthritis.

✓ Peripheral vascular system: denies varicose veins, edema, cyanosis, intermittent claudication, coldness or trophic changes

✓ hematologic system: denies anemia, bruising or bleeding, lymphadenopathy, Blood transfusions, or history of PE/DVT

✓ Endocrine: Hx of DM II. Denies polyuria, polydipsia, polyphagia Denies heat or cold intolerance, goiter, sweating or hirsutism.

✓ Psychiatric: ~~deplies~~ A.S 1/29 Denies depression or sadness, denies anxiety, OCD, hx of seeing a mental health professional or medications.

Physical Exam

✓ General: well developed Female, average build, well groomed, looks her age. Not in severe distress. Alert and oriented x 3 to person, place & time

Vitals: BP =

	R	L
Seated	136/86	134/82
Supine	140/86	138/80

RR = 16 breaths / min, unlabored

✓ HR = 66 beats / min, regular

O2 sat = 98 % on room air

Temp = 98.6 °F oral

Biometrics = H = 60 inches W = 150 lbs BMI = 29.29

Skin, head, nails: Skin warm, texture dry, good turgor, non icteric no lesions, scars, rashes, moles, or tattoos present.

hair = no baldness, ~~normal~~ EVEN distribution, soft texture ~~(not brittle)~~

nails = no deformities, no lesions, masses, splinter hemorrhage, bars (+), Cap refill <2 seconds on toes + fingers bilat. No clubbing or koilonychia. No ~~paronychia~~ A.C paronychia.

head: normocephalic, atraumatic, non tender to palpation, no scars lesions or trauma to bones.

Eyes: OU symmetrical. No nystagmus, ptosis, or exophthalmos. Bilateral sclera white, clear cornea, pink conjunctiva.

visual acuity: wearing glasses for distance

uncorrected: R (OD) = 20/70 L (OS) = 20/20 OU = 20/40

visual fields: full OU by confrontation

PERRLA: OU with direct + consensual reaction to light

EOMI: intact, no abnormal nystagmus

fundoscopy: red reflex intact OU. Cup to disc ratio <0.5 OU no AV nicking, copper wiring or cotton wool spots

Ears: Avg size bilat, symmetrical. No obvious lesions, masses, battle signs or trauma to external ear.

External ear / tragus - non tender to palpation. No foreign bodies

otoscopic exam: TM pearly white, mild cerumen bilat, cone light reflex intact (7° clock L + 5° clock R) no perforations, swelling or effusion

Whisper: intact bilat

Weber: midline

Rinne: AC > BC bilaterally

nose / sinuses: Symmetrical, no masses or lesions. no step offs, no deformities. non tender to palpation. patent nares, AU. pink + hydrated mucosal membrane. Septum midline no polyps

Sinuses: frontal & maxillary nontender to palpation, no congestion. unremarkable to transilluminescence.

Mouth & pharynx

lips: moist w/ no cyanosis, well hydrated, non tender, no lesion or masses. no ulcers.

palate: pink & hydrated, no lesions

teeth: good dentition, non tender, not loose

gingiva: pink & moist, no hyperplasia or regression

tongue: pink & moist, ~~normal~~ EVEN distribution of papillae, no lesions

oropharynx: hydrated, no injection. Mallampati 3. no lesion, post nasal drip or exudates. uvula rises symmetrically, no edema.

neck: trachea midline, no scars, masses or lesions, no pulsations. Supple non tender, FROM. no stridor, carotid 2+, no thrills or bruits. no lymph enlargement

thyroid: nontender, no masses, no bruit or thyromegaly

thorax & lungs

chest symmetrical, no trauma, scars, lesions, or masses. Resp unlabored no paradoxical respirations or accessory muscle use. LAT:AP=2:1, chest non tender to palpation. symmetrical tactile fremitus. Symmetric expansion. Resonant to percussion at all bases. Clear to auscultation & precussion. Diaphragmatic excursion symmetric, no adventitious sounds.

abdominal

flat with no scars, lesions, striae or pulsations. Bowel sounds normoactive in 4 quadrants; no aortic, iliac or femoral bruit. Non tender to light & deep palpation. Tympanic throughout. no guarding or rebound tenderness. liver span 6 cm, no hepatosplenomegaly to palpation, no CVA tenderness or ascites with fluid wave test.

Cardiovascular: JVP is 2.5 cm above sternal angle w/ bed @ 30° PMI in 5th ICS midclavicular line. Regular rate + rhythm in all values. S1 + S2 are distinct with no murmurs. No S3 or S4 heard. No S2 splitting, venous hums or friction rubs heard. Carotid pulses 2+ bilat without bruit.

Breast: Symmetric, no dimpling, no masses to palpation, nipples symmetric w/o discharge or lesions. No axillary nodes palpable.

Assessment:
NP is a 57 year old female with a past medical history of Type 2 diabetes, HTN, high cholesterol and 10 pack year smoking history presents with 1 week of chest tightness with associated heart burn, shortness of breath and palpitations. Presentation is consistent with angina; rule out Gastroenteritis Reflux Disease (GERD).

Differentials

① Angina Pectoris:
- squeezing like chest pain, acute in nature. Similar episodes in the past. Last short time or comes and goes. May feel like indigestion. Can be relieved w/ rest or medicine

② GERD
- burning feeling in your chest (heart burn). sensation of acid coming up.

③ Acute Pericarditis
- sharp localized chest pain, shortness of breath, palpitations

④ Peptic ulcer disease
- heart burn sensation. Pain can be recurrent

⑤ hiatal hernia
- heart burn, chest pain and shortness of breath.