Emily Yeung

H&P #3

4 History

- Identification:

Date: 11/14/17

Time: 9:10 AM

Name: JC

Sex: M

Race: Declined

Nationality: Declined

Age: 66

Marital status: Married

Address: NYP Queens, Internal Medicine

Religion: Declined

- Informant

Source of history: Patient, reliable

- Referral source: PMD Dr. Byrns

- Chief Complaint: "Extreme back pain on right side" x 10 years

12 - Present Illness: 66 year old, obese male current smoker with PMH× of multiple CVA with residual left sided weakness, HTN, dyslipidemia, asthma presents to internal medicine c/o "extreme back pain on right side" x 10 years. He states that the pain has gotten worse in the past month to the point where he cannot get out of bed. Pt experiences constant, throbbing pain with spasms of sudden, sharp pain that last several minutes during sudden, jerky movements like sneezing or coughing. During these spasms, he cannot move or stand until they pass. He rates the pain as 10/10 in severity. The pain sometimes radiates to his right hip. Pt is currently on Neurontin for pain and tried using cold compresses at home with slight alleviation of pain. He was scheduled for an epidural but there were some complications and he was sent to the ER, where he was placed on

You never really localized the pain anatomically, ↓ lumbar Thoracic or both?

morphine. He believes that his back pain results from moving heavy loads from trucks for work many years ago. In the past, pt saw multiple doctors for back pain and an MRI revealed several discs prone to herniation but he chose not to undergo any treatments at that time. Pt admits to pain, numbness, weakness, and loss of strength on right lower back and hip and recent weight loss but denies bilateral lower-extremity weakness or pain, recent infection, nausea, vomiting, fever, chills, or any recent back injury, fall, or trauma.

Does leaning forward make it better? If we are thinking spinal stenosis leaning fwd feels good!

* Because of back pain that has worsened always ask about chest pain of difficulty breathing... abdominal pain urinary complaints. PE ↑s AAA

- Past Medical History

-Hypertension x 20 yrs, dyslipidemia x 20 yrs, multiple CVA x 12 yrs - first stroke unknown, 2nd 2005, 3rd 2005 resulting in residual left sided weakness, asthma x 10 yrs.

- Immunizations up to date.

-Pt denies any childhood illnesses.

hospitalizations?

- Past Surgical History

- Appendectomy - 1980 at Parson's Hospital, no complications

- Denies past transfusions or injuries?

- Medications

- Amlodipine tab 10mg PO daily for HTN, last dose this morning

- Carvedilol tab 25mg PO BID for HTN, last dose this morning

- Enalapril tab 10 mg PO BID for HTN, last dose this morning

- Montelukast tab 10mg PO daily for asthma, last dose this morning

- Tiotropium Inh. 18 ug 1 capsule inhalation pm, pt cannot recall last dose

- Baclofen tab 10mg PO BID for muscle spasms, last dose this morning

- Gabapentin tab 600mg PO TID for pain relief, last dose this morning

- Aspirin tab 81 mg PO daily for blood thinning, last dose this morning

- Atorvastatin tab 80mg PO at bedtime for dyslipidemia, last dose last night

- Morphine sulfate inj. 2mg intravenous Q4h for back pain, last dose last night

- Allergies

- Latex - throat closes

- Tape - hives
- Denies other drug, food, environmental allergies.

4. Family History
- Maternal grandmother – deceased at age 64, due to MI
- Maternal grandfather – deceased at unknown age, due to unknown reason
- Paternal grandmother – deceased at unknown age, due to atherosclerosis
- Paternal grandfather – deceased at unknown age, due to unknown reason
- Mother – deceased at age 80, due to stroke
- Father – deceased at 62, due to lung cancer
- Sister, 70, alive – arthritis
- Sister, 58, alive, COPD

8. Social History
- Admits to smoking cigarettes in the past – 3PPD, 126 pack years. Quit smoking cigarettes in 2005.
- Current smoker of cigars, 1 per week from 2005 to present.
- Denies drinking alcohol, caffeine, or recreational drug use.
- Married, lives with wife, 1 cat
- Occupation: retired; previously worked in vending business moving heavy loads
- Has not traveled out of state/country recently.
- Denies eating a well-balanced diet; eats "whatever tastes good"
- Denies exercising regularly due to back pain
- Admits to sleeping 10 hrs/day without interruptions
- Pt is currently not sexually active. Had 1 partner previously, his wife. Denies any STIs. Did not use contraception.

19. ROS
- General: Admits to recent weight loss of 30-35 lbs over the past year due to loss of appetite and frequent hospitalizations. Denies any weight gain, generalized weakness/fatigue, or fever/chills.

- Skin, hair, nails: Denies any discoloration, moles/rashes, pruritus, changes in hair

distribution, excessive dryness/sweating, change in hair/skin texture.

- Head: Denies any headache, vertigo, head trauma.
- Eyes: Admits to occasional blurring, lacrimation, photophobia. Denies any other visual disturbances, pruritus. Patient wears glasses and his last eye exam was Nov. 2016, he does not recall his prescription.
- Ears: Denies any deafness, pain, discharge, use of hearing aids.
- Nose/sinuses: Admits to nasal drip. Denies any epistaxis, obstruction.
- Mouth/throat: Denies any bleeding gums, sore tongue, sore mouth, mouth ulcers, voice changes, use of dentures.
- Neck: Denies localized swelling/lumps, stiffness/decreased range of motion.
- Breast: Denies any lumps, nipple discharge, pain.
- Pulmonary System: Denies any SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND.
- Cardiovascular System: Denies any chest pain, palpitations, irregular heartbeat, syncope, heart murmur, edema.
- Gastrointestinal System: Pt has not had a bowel movement in 1 week. Admits to loss of appetite, constipation. Denies nausea, vomiting, pyrosis, flatulence, abdominal pain, diarrhea, jaundice, rectal bleeding. Pt has not done a colonoscopy.
- Genitourinary System: Admits to pain on right flank. Denies any frequency, urgency, nocturia, oliguria, polyuria, dysuria, hesitancy, dribbling. Pt's last prostate exam was Nov. 2016, normal.

- Nervous System: Admits to change in cognition, worsened short-term memory, loss of strength, weakness, numbness on right lower back. Denies having headaches, loss of consciousness, sensory disturbances, ataxia.

- Musculoskeletal System: Denies any muscle/joint pain, deformity, erythema, edema, tenderness, arthritis.

- Peripheral vascular system: Denies any peripheral edema / intermittent claudication, varicose veins.

- Hematologic System: Denies any anemia, easy bruising / bleeding, lymph node enlargement, blood transfusions.

- Endocrine System: Denies any polyuria, polydipsia, goiter, excessive sweating, hirsutism.

- Psychiatric: Denies depression, anxiety, OCD. Patient has not seen a mental health professional before.

1 - General Survey: Well-developed male, large build, neatly groomed, looks older than stated age of 66, in some distress. A/O x 3.

6 - Vital Signs
- Pulse: 65 beats per minute, regular
- Respiratory rate: 16 breaths per min, unlabored
- BP: 113/76, right arm, sitting, Both arms, 2 positions
- Height: 69 inches
- Weight: 219 lbs
- BMI: 32.3

Temp: ?

1 - Physical Examination (Pt refused additional PE due to excessive pain.)
- Skin: Warm and dry. Good turgor. Nonicteric, no lesions, scars, tattoos.
- Hair: Avg. quantity / distribution.
- Nails: No clubbing, capillary refill < 2 seconds throughout.

- Head: Normocephalic, atraumatic, no specific facies, non tender to palpation throughout.
- Eyes: Symmetrical OU, no evidence of strabismus, exophthalmos, ptosis, sclera white, conjunctiva + cornea mostly clear. Visual acuity 20/20 OU. Visual fields full OU. EOMS full, no nystagmus. Fundoscopy - rcd, reflex intact OU. Cup: disk ratio <0.5. No evidence of copper wiring, AV nicking, papilladema, hemorrhage, cotton wool spots, exudates, neovascularization, OU.

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- Ears: Symmetrical, normal size. No evidence of lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. Tympanic membrane pearly white, cone of light intact in normal position AU. Auditory acuity intact with whispered voice AU. Weber midline and Rinne revealed air > bone conduction AU.
- Nose: Symmetrical with no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa pink, well-hydrated. No discharge on anterior rhinoscopy. Septum at midline without any lesions, deformities, infection, perforation. No foreign bodies.
- Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
- Lips: Pink, dry, no evidence of cyanosis or lesions.
- Mucosa: Pink, well-hydrated. No masses, lesions noted. No evidence of leukoplakia.
- Palate: Pink, well-hydrated. Palate intact with no lesions, masses, or scars.
- Teeth: Good dentition, no obvious dental carries noted.
- Gingivae: Pink, moist. No evidence of masses, lesions, erythema, discharge, hyperplasia.
- Tongue: Pink, well-papillated. No masses, lesions, deviation noted.
- Oropharynx: Well hydrated. No evidence of masses, lesions, foreign bodies, infection, exudates. Tonsils present with no evidence of infection or exudate. Uvula pink, no lesions or edema.
- Neck: Trachea midline. No masses, lesions, scars, pulsations, stridor noted. Supple, non-tender to palpation. No thrills, bruits noted bilaterally, no palpable adenopathy.
- Thyroid: Non-tender to palpation, no palpable masses, no thyromegaly, no bruits noted.
- Chest: Symmetrical, no deformities, trauma. Respirations unlabored. No use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.

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- Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout, no adventitious sounds.

- Assessment: 66 y/o obese male, current smoker with PMH x multiple CVA with residual Lt sided weakness, HTN, dyslipidemia, asthma presents to IM with severe back pain on right side x 10 years.

Differential Diagnosis

- Spinal stenosis
- Herniated disc
- Back strain
- Osteoporosis
- Spinal neoplasm

- Plan

very Good!!!

- Back pain: suspect spinal stenosis. Start Gabapentin tab 600mg PO TID and Morphine sulfate Inj. 2mg intravenous for pain. Pain management consult. Order thoracic spine and lumbar spine MRI. Neurologist consult.
- Multiple CVA: stable. Continue Aspirin tab 81mg PO daily.
- HTN: BP stable at this time. Monitor BP. Continue Amlodipine tab 10mg PO daily, Carvedilol tab 25mg PO BID, Enalapril tab 10mg PO BID.
- Dyslipidemia: Stable. Continue Atorvastatin tab 80mg PO at bedtime.
- Asthma: under good control. Continue Montelukast tab 10mg PO daily, Tiotropium INH 18 ug / capsule inhalation prn.
- Current smoker: Smoking cessation discussed with patient at this time, pharmacologic alternatives discussed. Pt at this time does not express desire to quit smoking, continue to evaluate.

For plan try to list the solutions to the problems for example:

1. Back pain - suspect spinal stenosis
   - start gabapentin 600mg po TID
   - start morphine sulfate inj. 2mg IV
   - pain management consult
   - order thoracic / lumbar spine MRI
   - Neuro consult

92% (8)

2. . . etc: . . . .