Khizra Shafiq

March 14, 2023

HPPA 502 – Physical Diagnosis I

Prof. Seligson

History

Identifying Data:

Full Name: Mr. J

Address: Queens, NY

Date of Birth: 01/27/1981

Date & Time: 03/14/2023 10:00 AM

Location: New York Presbyterian Queens, Flushing, NY

Religion: Catholic

Source of Information: Self

Reliability: Reliable

Source of Referral: Self

Mode of Transportation: Self

Chief Complaint: “My left side is numb” x 8 days

History of Present Illness:

42 year old male with a PMHx of diabetes was admitted to the hospital on 03/09/2023 due to left side numbness. Patient reports that pain began on 03/06/2023 when he woke up, started in his left shoulder and radiated to his neck. He describes it as a “pins and needles” sensation, rated a 7/10, which resulted in persistent left side numbness. He denies any previous episodes. He states he is currently on Metformin 1000 mg 1x/day for his diabetes. He denies any exacerbations or improvement in his condition, stating that no medications, such as Tylenol 800 mg or Morphine (unsure of dose) have helped so far. He also endorses a “burning” eye sensation upon movement of his eyes, rated a 5/10, which began when admitted to the hospital. Patient denies fever, slurred speech, loss of balance, limited range of motion of extremities, and vision loss. He denies recent travel or sick contacts. Patient reports a family history of high cholesterol and hypertension.

Past Medical History:

Present Illnesses – Diabetes x 2 years, takes Metformin 1000 mg PO 1x daily

Immunizations: Fully up to date, flu vaccines yearly.

Screening tests & Results: N/A

Childhood illnesses: None

No past hospitalizations.

Past Surgical History:

No past surgical history.

Medications:

Metformin – 1000 mg PO 1x/day, for Diabetes

Tylenol – 800 mg PRN, for pain

Morphine – PRN in the hospital (unsure of dose)

Allergies:

No known drug allergies

No known environmental allergies

No known food allergies

Family History:

Mother – 81, alive with comorbidities: hypertension

Father – 83, alive with comorbidities: high cholesterol

Maternal Grandmother – deceased, from myocardial infarction

Maternal Grandfather – deceased, from congestive heart failure

Paternal Grandmother – deceased, aging

Paternal Grandfather – deceased, aging

Two children – alive and healthy

Two Siblings – alive and healthy

Social History:

Mr. J is a married male living in his home with his wife and his 11 year old son. He works part time as a contractor and dishwasher.

Habits: Denies alcohol consumption since 4 years ago. Denies history of illicit substance use. Denies smoking/marijuana use. Admits to consuming 1 cup of coffee daily.

Travel: Denies recent travel

Diet: Admits to a well balanced diet, his wife is healthy and cooks for him.

Exercise: Plays soccer every Saturday and Sunday for 4 hours each day.

Safety measures: Admits to using seatbelt in moving vehicles.

Sexual history: Sexually active. Heterosexual. Admits to use of condoms. Denies history of STIs.

Review of Systems:

General – Denies weight loss, fever, malaise, weight change, or night sweats.

Skin, hair, nails – Denies rash, pruritus, excessive sweating, skin changes, and hair changes.

Head – Endorses headache and dizziness, denies trauma, fainting, and Hx of vertigo.

Eyes – Endorses diplopia and eye pain. Denies visual changes, discharge, and photophobia. Last eye exam: January 2023.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/Sinuses – Endorses sinus pressure. Denies epistaxis, nasal congestion, discharge, swelling.

Mouth/Throat – Denies dysphagia, sore throat, hoarseness, cough. Last dental exam: unknown

Neck – Endorses pain with movement, stiffness. Denies swollen glands and trouble swallowing.

Breasts – Denies skin changes, lumps, nipple discharge.

Pulmonary System – Denies cough, SOB, DOE, wheezing, hemoptysis or cyanosis.

Cardiovascular System – Denies chest pain, palpitations, edema. Last EKG: unknown.

Gastrointestinal System – Endorses loss of appetite. Denies changes in stool, abdominal pain, hemorrhoids, constipation, rectal bleeding or diarrhea.

Genitourinary System – Denies oliguria, frequency, urgency, nocturia, incontinence or flank pain.

Sexual History – Sexually active with his wife, uses condoms. Denies history of STIs.

Nervous – Denies dizziness, sensory disturbances, paresthesia, or changes in cognition/mental status.

Musculoskeletal system – Denies joint pain, muscle soreness, reduced mobility, bone deformity, swelling/stiffness.

Peripheral vascular system – Endorses pins and needles. Denies edema, calf pain, varicosities, cyanosis.

Hematological System – Denies Hx of DVT/PE, lymph node enlargement, blood transfusions, anemia, clotting.

Endocrine system – Endorses diabetes x 2 years. Denies heat or cold intolerance, excessive hunger/thirst.

Psychiatric – Denies changes in mood, suicidal ideations, irritability, and changes in eating habits.

Physical

General: Well groomed male, with proper posture, appearing as his stated age of 42 years, with medium build. Appears tired but no signs of acute pain. Appears awake, alert, oriented to person, place, time and situation. Is cooperative and appears to be a reliable source of information.

Vital Signs:

BP: Seated – (R) 118/72; (L) 117/70

Supine – (R) 122/77; (L) 119/75

R: 16 breaths/min, unlabored

P: 63 beats/min, regular

T: 97.8F (Tympanic)

O2 Sat: 98%, room air

Height: 66 inches Weight: 163 lbs BMI: 26.3

Skin, Hair, Nails:

Skin: Cool and moist. Good turgor. No tattoos, no lesions, no masses, no bruises, no ulcerations.

Hair: Low quantity but even distribution. Color is dark brown, and the texture is normal. No visible dandruff or lice.

Nails: No clubbing, pitting, signs of infection. Presence of lunula on all nails. Capillary refill < 2 seconds in upper/lower extremities.

Head: Normocephalic atraumatic, non-tender to palpation.

Eyes:

Eyes appear symmetrical. Eye lashes are well distributed. No strabismus, lid lag, or ptosis noted. Sclera white, cornea clear with no signs of abrasion, conjunctiva is clear. Visual acuity corrected 20/20 OS, 20/20 OD, 20/20 OU. Full visual field. PERRLA and EOM intact with no nystagmus.

Fundoscopy: Red reflex intact in both eyes. Cup to disc ratio <0.5 in both eyes. No AV nicking, hemorrhages, exudates, or cotton wool spots in both eyes.