Khizra Shafiq
April 29, 2023
HPPA 502 – Physical Diagnosis I
Professor Seligson

History and Physical

Identifying Data:

Full Name: Mr. C
Address: Queens, NY
Date of Birth: 10/01/1956
Date & Time: 04/25/2023 10:00 AM
Location: New York Presbyterian Queens, Flushing, NY
Religion: Buddhist
Source of Information: Self but used Interpreter, from Mandarin to English
Reliability: Reliable
Source of Referral: Self
Mode of Transportation: Self

Chief Complaint: "My right knee hurts" x 7 years

History of Present Illness:

A 67 year old male with a PMHx of hypertension and GERD presented to PAT on 04/25/2023 due a right knee replacement scheduled for 5/5/23. He was in a motor bike accident 42 years ago which resulted in knee surgery (unsure of type). However, his mobility was still not great so he repeated the surgery around 20 years ago. The patient reports that pain began again about 10 years ago. He describes it as a constant, soreness sensation rated a 7-8/10, which radiates up the femur. He denies any exacerbations or improvement in his condition, stating that no OTC medications, such as pain killer patches, have alleviated any pain. The patient endorses the inability to walk up two flights of stairs, limited range of motion, and swelling and stiffness in the right knee. Patient denies any fever, chills, recent trauma or falls. He denies recent travel or sick contacts.

Past Medical History:

Present Illnesses – Hypertension and GERD

Immunizations: Fully up to date

Screening tests & Results: N/A

Childhood illnesses: None

Past Hospitalizations: Abscess on upper back 2 years ago, Jamaica Hospital

Past Surgical History:

Right knee surgeries (unsure of what kind of surgery) – 42 years ago, unsure of name of hospital

Right knee surgeries (unsure of what kind of surgery) – 20 years ago, unsure of name of hospital

Wound VAC – January 2023, Jamaica Hospital

Medications:

Losartan 50 mg PO 1x daily

Atenolol 100 mg PO 1x daily

Famotidine 20 mg PO 2x/day

Fluticasone IN 1x/day (unsure of dose)

Allergies:

Environmental Allergies – Pollen

No known drug allergies

No known food allergies

Family History:

Mother – deceased at 78, unsure of cause

Father – deceased at 81, unsure of cause

Maternal Grandmother – deceased, from unknown cause

Maternal Grandfather – deceased, from unknown cause

Paternal Grandmother – deceased, from unknown cause

Paternal Grandfather – deceased, from unknown cause

No children

No siblings

Social History:

Mr. C is a single male living in a home with his two friends. He is retired but used to be a delivery driver.

Habits: Denies smoking. Denies smoking marijuana recreationally. Denies alcohol consumption. Denies illicit drug use. Denies consumption of coffee.

Travel: Denies recent travel

Diet: Admits to a well balanced diet

Exercise: Denies any exercise due to limited knee mobility.

Safety measures: Admits to using seatbelt in moving vehicles.

Sexual history: Not sexually active. Heterosexual. Denies history of STIs.

Review of Systems:

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

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

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

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

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

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

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

Neck – Denies pain with movement, stiffness, 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 – Denies loss of appetite, 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 inactive. Denies history of STIs.
Nervous – Denies dizziness, sensory disturbances, paresthesia, or changes in cognition/mental status.
Musculoskeletal system – Endorses swelling/stiffness, joint pain, muscle soreness, reduced mobility, bone deformity in the right knee.
Peripheral vascular system – Denies pins and needles, edema, calf pain, varicosities, cyanosis.
Hematological System – Denies Hx of DVT/PE, lymph node enlargement, blood transfusions, anemia, clotting.
Endocrine system – Denies diabetes, 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 67 years, with small 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) 140/85; (L) 139/82
Supine – (R) 135/87 (L) 138/89
R: 15 breaths/min, unlabored
P: 64 beats/min, regular rate and rhythm
T: 99.1F (Tympanic)
O2 Sat: 99%, room air
Height: 68 inches Weight: 170 lbs BMI: 26.9

Skin, Hair, Nails, Head:

Skin: Warm and moist. No discoloration. Good turgor. No tattoos, no masses, no bruises, no ulcerations. Visible scarring from previous knee surgery.
Hair: Low quantity, even distribution. Color is black, 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 or nodules. Conjunctiva is clear with no foreign bodies. Visual acuity uncorrected 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. Disk to cup ratio 2:1 in both eyes. No AV nicking, hemorrhages, exudates, or cotton wool spots in both eyes.

Ears

Symmetrical and appropriate in size and shape. No lesions/masses/trauma on external ears. Cerumen present bilaterally, with no discharge or foreign bodies in the ear canal. Tympanic membranes appeared intact, pearly gray/white, with a well positioned cone of light and handle of the malleus. No effusions/pus noted. Whisper test demonstrated intact auditory acuity. Weber midline, Rinne normal bilaterally, indicating AC>BC.

Nose/Sinus

Nose symmetrical with no evidence of masses/lesions/deformities/trauma/discharge. Mucosa pink and well hydrated. Nares patent bilaterally. Septum appears midline with no perforations/inflammation or deviation. Inferior and middle turbinates appreciated. No foreign bodies noted. Frontal and maxillary sinuses are non tender to palpation. Sinuses were clear upon trans-illumination.

Mouth/Neck/Pharynx

Lips: Pink, moist, no cyanosis, no lesions or edema.

Buccal Mucosa: Pink, well hydrated, no masses, lesions or ulcerations, or leukoplakia.

Palate: Pink, well hydrated, no lesions, scars or ulcerations present.

Teeth: Good dentition, no dental caries present, no plaque buildup.

Gingivae: Dark discoloration noted. Moist, with no bleeding, ulcerations, or hyperplasia.

Tongue: Pink, well papillated. Symmetrical with normal texture.

Oropharynx: Well hydrated, no exudates, masses, lesions or foreign bodies. Tonsils Grade I with no edema, injection or exudate. Uvula pink, midline elevation, no lesions or ulcerations.

Neck: Trachea midline. No masses, lesions, scars or pulsations noted. Non-tender to palpation.

Thyroid: Non-tender, no palpable masses, no enlarged thyroid. Noted symmetrical movement of thyroid when swallowing, visually and upon palpation.

Thorax/Lungs

Clear to auscultation and percussion bilaterally. No adventitious sounds. Tactile fremitus symmetric throughout. Chest expansion and diaphragmatic excursion symmetrical. Chest was symmetrical with no signs of deformities or trauma. Respirations were unlabored and no accessory muscle use was noted. Mildly tender to palpation throughout.

Heart

Jugular venous pressure is 2.5 cm above the sternal angle with the head of the bed at 30°. Regular rate & rhythm. Distinct S1/S2 with no murmurs, splitting, friction rubs, or S3/S4 appreciated. Carotid pulses are 2+ bilaterally, no bruits present. Point of maximal impulse located at 5th intercostal space at midclavicular line.