Khizra Shafiq
November 14, 2023
HPPA 522 – Physical Diagnosis II
Professor Yuan

History and Physical

Identifying Data:

Full Name: Mrs. K
Address: Queens, NY
Date of Birth: 06/22/1943
Date & Time: 11/14/2023 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: "I have a UTI" x 1 day

History of Present Illness:

An 80 year old female with a PMHx of COPD, CHF, nephrolithiasis presented to IM with an asymptomatic UTI x 1 days. The patient explains that she had to undergo a removal of a right ureter stent on 11/21, but urinalysis and culture results came back positive for a UTI. She endorses cloudy urine and urinary frequency due to Furosemide. She must wait to treat the UTI before she can undergo the removal. She denies fever, chills, pain, hematuria, dysuria, incontinence, flank tenderness, abdominal pain, nausea, vomiting, itching or erythema of the genitalia. She denies sexual activity and changes in vaginal discharge.

Past Medical History:

Present Illnesses – COPD, CHF, nephrolithiasis
Immunizations: Fully up to date

Screening tests & results: None

Childhood illnesses: None

Past hospitalizations:

Right Ureter Stent Treatment for Kidney Stone 1 week ago, NYPQ

Hospitalized for CHF exacerbation 2 months ago, at NYPQ

Hospitalized for COPD exacerbation 6 months ago, at NYPQ

Past Surgical History:

Right Ureter Stent Treatment for Kidney Stone 1 week ago, NYPQ

Medications:

Furosemide, did not know dose

Iron, did not know dose

Lexapro, did not know dose

Isosorbide, did not know dose

Oxygen, did not know dose

Vitamins – D3, Folic Acid, did not know dosage

Allergies:

Morphine, Codeine – reaction: dizzy, lightheaded

No known food allergies

Family History:

Mother – deceased from CAD and HTN

Father – deceased from CAD and HTN

Maternal Grandmother – deceased, from unknown cause

Maternal Grandfather – deceased, from unknown cause

Paternal Grandmother – deceased, from unknown cause

Paternal Grandfather – deceased, from unknown cause

2 children – daughters, alive and healthy

Social History:

Ms. R is a widowed female living in a home with her daughter, grandson, and dog. She used to work as an administrator for an Italian food importer, but retired at 72.
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 poorly balanced diet consisting of fast food, majority carbohydrates, less fruits and vegetables.
Exercise: Denies any exercise.
Safety measures: Admits to using seatbelt in moving vehicles.
Sexual history: Denies being sexually active since husband was deceased 5 years ago. 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: 3 months ago.
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: upon admission on 11/13/23.

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

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

Sexual History – Denies being currently sexually active. Denies history of STIs.

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

Musculoskeletal system – Denies swelling/stiffness, joint pain, muscle soreness, reduced mobility. Denies tenderness to palpation and erythema.

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 female, with proper posture, appearing as her stated age of 80 years, with large build. She appears awake, alert, oriented to person, place, time and situation. Is cooperative and appears to be a reliable source of information. She is in no acute distress.

Vital Signs:

BP: Seated – (R) 140/81; (L) 139/80

Supine – (R) 140/81 (L) 139/80

R: 19 breaths/min, unlabored

P: 84 beats/min, regular rate and rhythm

T: 98.9 F (Tympanic)

O2 Sat: 97%, room air

Height: 5’2 inches Weight: 185 lbs BMI: 33.8

Skin, Hair, Nails, Head:

Skin: Warm and moist. No discoloration. Good turgor. No tattoos, no masses, no bruises, no ulcerations. No visible scarring.

Hair: Regular quantity, even distribution. Color is blonde, 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: Normal dentition, no dental caries present, no plaque buildup.

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

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

Coarse crackles noted upon auscultation and percussion bilaterally. 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. Non 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.

Abdomen

Abdomen is symmetrical. Striae present. Normoactive bowel sounds in all four quadrants with no bruits or pulsations appreciated. Nontender to palpation, no guarding, rebound, hepatosplenomegaly, masses, or costovertebral tenderness noted. Tympanic throughout.

Breast & Axillae

Breasts were symmetric with no evidence of dimpling. No masses to palpation. Nipples were symmetric. No piercings, lesions, or discharge. Axillary nodes were non-palpable.

Female Genitalia & Rectum

No inguinal adenopathy. External genitalia without erythema, lesion or masses. Vaginal mucosa pink, cervix parous, pink, and without discharge. Uterus anterior, midline, smooth and not enlarged. No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses, uterine cervix non-tender. Stool brown, no fecal blood.

Neuro Exam

Mental Status: A&O x3, cooperative, thoughts & speech coherent.

Cranial Nerves:

I – Correctly identifies coffee & alcohol wipe odors bilaterally

II – Visual fields full by confrontation, visual acuity 20/20 OD,OS,OU corrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena.

III & IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.

V – Face sensation intact bilaterally, corneal reflex intact jaw muscles strong without atrophy

VII – Correctly identified sweet, salty and sour tastes. Facial expressions intact, clearly enunciates words.

VIII – Repeats whispered words at 2 feet bilaterally, Weber midline, Rinne AC>BC bilaterally.

IX & X– No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing

XI – Full range of motion at neck with 5/5 strength and strong shoulder shrug

XII – Tongue midline without fasciculation, good tongue strength

Motor: Good muscle bulk and tone. Strength 4/5 throughout.

Cerebellar: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift.

Sensory: Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally.

Reflexes:

	Biceps	Triceps	Brachioradial	Patellar	Ankle/Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Peripheral Vascular System

Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted. No calf tenderness bilaterally, equal in circumference. Homan's sign is not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy.

Upper & Lower Extremity

No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of all upper and lower extremities bilaterally. No evidence of spinal deformities.

Assessment

A 80 year old female with PMHx of COPD, CHF, and nephrolithiasis presents with an incidental finding of a UTI before removal of a right ureteral stent. She denies related symptoms despite frequent urination. Physical exam demonstrates abdomen nontender to palpation, no flank pain or costovertebral tenderness, along with external genitalia appearing without erythema, lesions or masses. Vaginal mucosa pink and without copious discharge. Patient has been admitted and is being treated with Bactrim.

Differential Diagnosis

1. **Urinary Tract Infection**
    a. The patient presents with an asymptomatic UTI which is common in the elderly. Urine culture reveals findings consistent with UTI. My plan would be to order a urinalysis and urine culture to assess for leukocyte esterase, nitrates, and WBC/RBCs.
2. **Pyelonephritis**
    a. The patient presents with urinary frequency. Findings such as CVA tenderness and flank pain would increase the suspicion of pyelonephritis. My plan would be to order a urinalysis to detect the presence of WBCs, RBCs, and bacteria.
3. **Sexually Transmitted Infection**
    a. Some sexually transmitted infections, such as chlamydia and gonorrhea, can cause symptoms similar to a UTI. My plan is to perform specific tests for STIs, such as nucleic acid amplification tests (NAATs) or cultures of genital or urinary specimens. These tests can identify the presence of bacteria responsible for STIs.
4. **Nephrolithiasis**
    a. Given the patient's history of nephrolithiasis, she may be having symptoms due to kidney stones. My plan is to order an abdominal ultrasound to identify the presence of kidney stones.
5. **Diabetes Mellitus**
    a. Uncontrolled diabetes can lead to frequent urination and increased susceptibility to infections. My plan is to measure blood glucose levels through fasting blood sugar or oral glucose tolerance tests.

Plan

- Administer antibiotics such as Bactrim to treat UTI
- Urinalysis – to detect presence of white blood cells, red blood cells, bacteria
- Urine Culture – identify bacteria causing infection
- POC glucose – rule out diabetes
- CBC – assess for signs of infection
- CMP – assess kidney function and electrolytes

- Ultrasound – assess the urinary tract for structural abnormalities, kidney stones, or complications like abscess
- Patient education – proper hygiene, voiding before/after intercourse, avoiding irritants, antibiotic compliance for treatment, urination habits