Punam Patel
History and Physical 1

Name: K.E.
DOB: 08/21/1997
Date and Time: 05/02/2019 @ 4:00 pm
Location: NYPQ hospital Pediatric ED
Information Source: Patient/mother
Reliability: Reliable

Chief Complaint: abdominal pain x 1 day

History of Present Illness:

Mr. E is a 21 year old male with PMHx of type 1 diabetes, gastroparesis, is on multiple medications including Novolog, followed at Columbia for his DM, ate last night at 2am, and woke up with epigastric diffuse abdominal pain that is described by the patient as being dull non radiating but is associated with nausea, vomiting and diarrhea. Patient states that he had 4-5 episodes of non-bloody, non-bilious vomiting, and a few episodes of non-bloody diarrhea. Family was concerned because of his preexisting medical conditions and brought him to the ED for evaluation. Patient was last seen here on 3/9/19 for abdominal pain, vomiting, diarrhea, inability to eat, had negative workup and was discharged home with outpatient follow up with endocrinology. Patient denied any chest pain, fever/chills, SOB, constipation, sick contacts, and recent travel.

Past Medical History:
- type 1 diabetes
- Gastroparesis

Past Surgical History - Denied

Immunizations:
Patient is up to date on immunization

Family History:
- Family History: Noncontributory

Social History:
Patient states they live at home with family
Denies any cigarette use, alcohol use, or illicit drug use

Allergies:
No Known Allergies

Medications:
- Lantus 100 units/mL subcutaneous solution: Hx, Status: Active, 40 unit(s) subcutaneous once a day
- NovoLIN 70/30 subcutaneous suspension: 1 unit for every 10g of carbohydrates
- Prilosec 40 mg oral delayed release capsule - 1 cap(s) orally once a day

· ondansetron - 10 milligram(s) orally every 8 hours

Review of Systems:
CONSTITUTIONAL: denies fever, chills, generalized weakness
HEENT: denies head trauma, discharge, ear pain, eye pain, epistaxis
Respiratory: Denies SOB, wheezing, difficulty breathing, cough
Cardiac: Denies chest pain, palpitations
GI: admits to abdominal pain and N/V/D; denies melena
MSK: denies joint pain, joint swelling
Neurological: denies headache, loss of sensation, paresthesia
Hematological: Denies any swelling, easy bleeding/bruising

Physical Exam:
Vitals: Temp: 36.5 HR 81 BP 118/96 RR 20 SpO2 96%
GENERAL: Well-nourished, well-developed, appears tired and nauseous.
EYES: PERRL, sclera non-icteric and not red, no conjunctival injection, no eye discharge.
HEAD: Normocephalic, atraumatic
EARS: TMs with no erythema, no effusion, no masses or lesions or discharge noted
OROPHARYNX: Moist mucus membranes. No erythema, no ulcers, no exudate.
NECK: Supple, no masses, FROM
CARDIOVASCULAR/HEART: Regular rate & rhythm, normal S1/S2, no murmurs, no rubs, no gallops, normal peripheral pulses.
RESPIRATORY/CHEST: Chest clear to auscultation bilaterally, no retractions, no wheezing/rales/rhonchi
GI/ABDOMEN: Normoactive bowel sounds, soft, non-tender, non-distended, no masses.
SKIN: No rash with good turgor noted; no masses or lesions noted
MUSCULOSKELETAL: no clubbing, no cyanosis, no edema; no swollen joints.
LYMPHATIC: No swollen lymph nodes.
NEUROLOGIC: Alert. Normal tone. Normal gait. Patient able to ambulate well with steady balance

Assessment & Plan:
Mr. E is a 21 year old male with PMHx of type 1 diabetes, gastroparesis, is on multiple medications including Novolog, followed at Columbia for his DM, ate last night at 2am, and woke up with epigastric abdominal pain that was associated nausea, vomiting and diarrhea most likely secondary to DKA without coma.

Abdominal pain/Nausea/Vomiting – most likely secondary to DKA

- Reglan
- Normal saline bolus 1 Liter IV – F/U with patient for response to treatment
- CBC with differential, BMP, Beta hydroxybutyric acid, Hemoglobin A1C, Lipase, LFT, UA, Fingerstick Glucose, VBG
- Monitor vital signs
- Endocrine consult

Punam Patel
History and Physical 2

Name: F.H.
DOB: 02/12/1953
Date and Time: 05/13/2019 @ 11:00 am
Location: NYPQ hospital ED
Information Source: Patient
Reliability: Reliable

Chief Complaint: left eye redness x 1 week

History of Present Illness

Mr. H is a 66 y/o male with a past medical history of HTN, HLD, DM came into the ER with complaint of left eye redness x 1 week. Reports the symptom first started 1 week ago with a periorbital extremely pruritic rash that has since spread to the left face and left sided scalp. Patient endorses left eye swelling and pain as well as slight blurring of vision and painful left parotid gland swelling. Patient went to his PMD the day before and was started on Valtrex. Patient has only taken the Valtrex for one day and decided to come to the ER on his own accord. Denies headache, fever, neck stiffness, nausea, vomiting, diarrhea.

Past Medical History:
· gastric CA for tumor 20 yrs ago, HTN HLD DM

Past Surgeries:
Denies any past surgical history

Family History:
· Grandmother – Type II diabetes

Social History:
· Smoking: No
· Alcohol Use: No
· Drug Use: No

Allergies:
No known drug/environmental allergies

Home Meds / Current Meds Review:
Valtrex 1 gram TID PO
Ramipril – patient unable to recall dosage
Metformin – patient unable to recall dosage

REVIEW OF SYSTEMS:
General: Denies fever, weakness, weight loss

Eyes: admits to swelling of left eye, admits to blurry vision, and left eye redness and itchiness, admits to blurry vision in left eye
HENT: denies congestion, sore throat, ear pain
Respiratory: denies cough, SOB,
Cardiovascular: denies chest pain, palpitations
GI: denies nausea, vomiting, abdominal pain, and diarrhea
GU: Denies dysuria, hematuria, urinary frequency
Musculoskeletal: denies other aches or pains, joint swelling
Endocrine: denies generalized weakness, easy bleeding or bruising
Neurological: denies numbness or tingling, headache, dizziness
Psychiatric: denies emotional stress, seeing a mental health professional

Physical Exam:
Vitals: HR 65 BP 176/89 SpO2 97% RR 19
General: Patient is awake, alert, and in no acute distress.
Skin: warm, dry with good turgor; no cyanosis; there are erythematous vesicular rash over left face, partially erupted.
head: multiple cluster of clear to yellow vesicles noted on left sided scalp extending from frontal aspect to occipital aspect of left sided scalp; mild tenderness to palpation on left sided scalp and face
eyes: swelling and tenderness to palpation to left eyelid observed, left eye conjunctival injection, no scleral icterus, EOM intact and PERRLA intact; Visual acuity: OS 20/40 OD 20/30 OU 20/30
ENT: no erythema; airway patent; Trachea midline; no stridor noted; mucous membranes moist
neck: no tenderness or stiffness noted
respiratory: symmetrical rise of chest upon inspiration; lung sounds present in all lung fields; no rales, rhonchi, or wheezes noted
cardiovascular: S1 and S2 RRR; no murmurs, thrills or gallops noted
abdomen: soft mildly protuberant non tender abdomen noted; no tenderness, guarding, rebound
extremities: No deformity, no edema, no tenderness, Active full range of motion, equal pulses present in upper and lower extremities
Neuro and psych: A/O x3; Cranial nerves grossly intact; strength grossly intact. Sensation grossly intact.

Assessment and Plan:
Mr. H is a 66 y/o male with a past medical history of HTN, HLD, DM came into the ER with complaint of left eye redness, swelling, and clusters of vesicular rash most likely consistent with Herpes ophthalmicus

Herpes ophthalmicus
- CMP, CBC w/ differential, ESR and CRP
- Fluorescein exam shows no evidence of ulcer or keratitis.
- Patient is already on Valtrex 1 g BID – continue Valtrex
- Appreciate ophthalmology consult for close follow-up – evaluation of possible deeper eye infection

HTN
- Patients BP slightly higher than normal – patient states he his morning dose of HTN medication
- Advised patient to take medication regularly – education and counseling provided
- Continue to monitor BP and continue current regimen of Ramipril

DM
- Monitor finger stick glucose
- Start patient on sliding insulin scale

Punam Patel
History and Physical 3

Name: E.P.
DOB: 10/04/1930
Date and Time: 05/13/2019 @ 1:00 pm
Location: NYPQ hospital ED
Information Source: Patient/Daughter
Reliability: Reliable

Chief Complaint: abdominal pain x 10 am

History of Present Illness:

Mr. P is an 89 y/o male with PMHx BPH, HTN, recent history of obstructive jaundice s/p ERCP with 2 stents, presents due to abdominal pain since 10 am today. Patient reports this morning he suddenly developed sharp, severe and constant RUQ pain that does not radiate but is associated with 3 episodes of vomiting and nausea. Patient states his symptoms feel similar to the pain he had on his prior hospitalization. Patient was hospitalized 1 month ago and states that his gallbladder was not removed but rather stented and he was diagnosed with SMA stenosis and celiac trunk dissection. Patient endorses being able to pass flatus and reports having a normal bowel movement today. Patient has not yet followed up with his doctor for stent removal x 1. Patient denies having diarrhea, constipation, blood in stool, melena, dysuria, fever/chills

Past Medical History:
· Hypertension
· gallbladder disease

Past Surgeries:
ERCP stent placement x 2

Family History:
· patient denies any family history
Social History:
· Smoking: No
· Alcohol Use: Socially
· Drug Use: No

Allergies:
· No Known Allergies

Home Meds / Current Meds Review:
· Protonix 40 mg oral delayed release tablet: Rx, 1 tab orally 2 times a day
· Diltiazem Hydrochloride ER 120 mg/24 hours oral capsule, extended release: Rx, 1 cap(s) orally once a day
· glucosamine 500 mg oral capsule: Hx, 1 cap(s) orally once a day

REVIEW OF SYSTEMS:
General: Denies fever, weakness, weight loss
HENT: denies congestion, sore throat, ear pain
Respiratory: denies cough, SOB
Cardiovascular: denies chest pain, palpitations
GI: admits to nausea and vomiting and abdominal pain; denies diarrhea, melena, changes in bowl movements, blood in stool
GU: Denies dysuria, hematuria, urinary frequency
Musculoskeletal: denies other aches or pains, joint swelling
Endocrine: denies generalized weakness, easy bleeding or bruising
Neurological: denies numbness or tingling, headache, dizziness
Psychiatric: denies emotional stress, seeing a mental health professional

Physical Exam:
Vitals: Temp 36.6 Oral HR 87 BP 149/93 SpO2: 98% RR 16
General: Patient is awake, alert, and mild distress due to pain
Skin: warm and dry with good turgor; no cyanosis; no rash.
Head: no scalp swelling or tenderness.
Eyes: no conjunctival pallor, scleral icterus; EOM and PERRLA intact
ENT: no erythema; airway patent: trachea midline; no stridor; mucous membranes moist.
Neck: no tenderness or stiffness
Respiratory: symmetrical rise of chest; breath sounds equal in all lung fields; no rales, rhonchi, wheezes
Cardiovascular: S1 and S2 RRR; no murmurs, thrills or gallops noted
Abdomen: slightly distended soft abdomen with tenderness paraumbilical with no guarding or rebound tenderness; murphy sign negative
Extremities: no obvious deformity, no edema, no tenderness, full active range of motion, equal pulses present in upper and lower extremities
Neuro: A/O x 3; Cranial nerves grossly intact; strength grossly intact. Sensation grossly intact.

Assessment and Plan:
Mr. P is an 89 y/o male with PMHx BPH, HTN, recent history of obstructive jaundice s/p ERCP with 2 stents, presents due to abdominal pain since 10 am today with associated nausea and vomiting x 3 mostly consistent with SMA stenosis

SMA stenosis
- *Normal saline bolus 1L IV*
- *CBC with differential, CMP, LFT, PT/INR, aPTT, UA, Troponins, EKG*
- *Ultrasound abdomen*
- *Chest Xray*
- *GI consult*

HTN
- *Well controlled on his current medications – continue current medications and monitor BP*

Obstructive jaundice
- *Monitor LFTs and watch for signs and symptoms of jaundice and hepatic injury*

Name: E.A.
DOB: 04/10/1997
Date/Time: 05/19/2019 @ 6 pm
Source of information: Patient
Reliability: Reliable

Chief Complaint: Feeling dizzy x 2 days

History of Present Illness:

Ms. A presents today with no pmhx with complaint of feeling dizzy x 2 days s/p s/p lipo suction of bilateral arms and abd in Dominican Republic on May 3rd 2019. Recent catheterization for surgery. recent travel back today, arrived this morning. Patient states she had one episode of fever on Wednesday but that has resolved since. Today is having complaints of worsening whole-body pain, extremities swelling, and abdominal pain around incision sites. Currently endorsing body pain specifically in arms, stomach, and hips. Besides the fever denies any other post op complications. Does endorse some urinary discomfort and increased frequency but endorses being catheterized for surgery. Patient states she was given post-op prophylactic antibiotics after procedure. Currently denying shortness of breath, chest pain, nausea, vomiting, and diarrhea. Denies using OCPs or possibility of pregnancy, last LMP 05/10/19.

Past medical history:

- Patient denies any past medical history

Past surgical history:

- Lipo suction – May 3 2019 with no intra-op complications and only fever during post-op for one day

Family history:

- Non contributory

Social history:

- Patient lives at home independently
- Denies any tobacco use
- Admits to social use of alcohol
- Denies any illicit drug use

Allergies:

- No known allergies to drugs or environmental

Medications:

- Multivitamins – unknown dosage or brand

Review of systems:

Constitutional: admits to weakness, denies fever, chills, night sweats, weight change
Skin/Hair/Nails: admits to tenderness over incision sites, denies any rash, itching, changes in texture of skin/hair/nails
Eyes: denies any changes in vision, blurry vision, double vision, discharge
Lungs: denies any shortness of breath, wheezing, cough, sputum production, hemoptysis
Cardiac: denies any chest pain, hypertension, palpitations, dyspnea on exertion
Abdominal: admits to abdominal pain, denies any nausea/vomiting/constipation/diarrhea, changes in stool, jaundice
GU: denies any dysuria, blood in urine, frequency, urgency, nocturia
Vascular: admits to bilateral leg swelling, denies claudication, thrombosis
MSK: denies any muscle weakness, joint pain, joint stiffness, decreased ROM
Neurological: denies any loss of sensation, numbness, tingling, tremors, paralysis

Physical exam:
Vitals: BP 104/56 HR 81 RR 17 SpO2 98% Temp. 37C
General: A/O x 3, well developed and well-groomed African American woman, ambulatory without assistance, not in any apparent distress
Skin: Multiple incision sites measuring 0.5cm surgical incisions on bilateral posterior triceps, bilateral lateral ribs at T4 level, RLQ (some drainage and exudate) and LLQ. None of these had any induration or erythema but were all tender. not noticeably erythematous or warm to touch
Heart: S1 and S2 present RRR, no murmurs/gallops/thrills/heaves noted
Lungs: symmetrical rise of chest; lung sounds present in all lung fields with no adventitious lung sounds appreciated
Abdomen: soft, ND, diffuse tenderness, very tender; two open incision sites noted w/ left lateral incision site more tender than the right with some purulent drainage in left lateral incision site ; bowl sounds present in all quadrants; voluntary guarding present; no rebound tenderness or rigidity noted; negative psoas or obturator sign
Neuro: AOx3; sensation intact in all extremities; strength 5/5 upper and lower extremity; CN II-IV intact

Labs:

Assessment and Plan:
Ms. A presents today with no pmhx with complaint of feeling dizzy x 2 days s/p s/p lipo suction of bilateral arms and abd in Dominican Republic on May 3rd 2019 with multiple incision sites measuring 0.5cm surgical incisions on bilateral posterior triceps, bilateral lateral ribs at T4 level, RLQ (some drainage and exudate) and LLQ. Patient's symptomatology of diffuse extremity edema, fever, and abdominal pain and objective lab results consistent with cellulitis.

Cellulitis
- Normal saline bolus
- CT abdomen and pelvis with contrast – r/o abscess or peritonitis
- Toradol 10 mg IV – Pain control
- Tylenol 325 mg PRN – Fever control
- Blood cultures - r/o bacteremia or sepsis
- Consult ID

- Start Emperic antibiotic treatment – Keflex 500 mg QID x 5 days and Bactrim 400/80 mg BID PO x 7 days

Patient 2
Name: F.A.
DOB: 12/17/1943
Date/time: 5/22/19 @ 8 am
Source of information: Patient's proxy
Reliability: unreliable

CC: Altered mental status x 12:30 pm

History of Present Illness:

Patient is a 75 year old male with PMHx of CVA with left sided weakness, aphasia, HTN, HLD, DM, Afib, CHF, CAD presents to the emergency room with altered mental status from nursing home. According to the proxy, patient has been lethargic and confused for the past 3 days and was found today to be minimally responsive. Patient was evaluated by the nursing home facility and was advised to bring patient into ER. Proxy denies patient having any fever, chills, vomiting, cough, recent illnesses. Proxy admits to new onset of proximal abdominal distension.

Other than the symptoms associated with the present events, the following is reported with regard to recent health: General: (-) fever. HENT: (-) congestion. Respiratory: (-) cough. Cardiovascular: (-) chest pain. GI: (-) abdominal pain. GU: (-) urinary complaints. Musculoskeletal: (-) other aches or pains. Endocrine: (-) generalized weakness. Psychiatric: (-) emotional stress.

Past Medical History:
- CHF
- Diabetes
- Hypertension
- Hyperlipidemia
- PVD
- pressure ulcer

Past surgical history
- Unknown

Family History:
- noncontributory

Social History:
- Lives in a nursing home
- Smoking: No
- Alcohol Use: No
- Drug Use: No

Allergies:
· No Known Allergies

Meds:

- Losartan: Hx, 25 milligram by gastrostomy tube once a day
- hydralazine 25 mg oral tablet - 1 tab(s) by gastrostomy tube 2 times a day
- apixaban 5 mg oral tablet - 1 tab(s) orally 2 times a day
- escitalopram 10 mg oral tablet - 1 tab(s) orally once a day
- aspirin 81 mg oral delayed release tablet - 1 tab(s) by gastrostomy tube once a day
- terazosin 5 milligram(s) by gastrostomy tube once a day
- Metoprolol Tartrate 50 mg oral tablet - 1 tab(s) by gastrostomy tube 2 times a day
- levothyroxine 25 mcg (0.025 mg) oral capsule - 1 cap(s) by gastrostomy tube once a day
- atorvastatin 40 mg oral tablet - 1 tab(s) by gastrostomy tube once a day (at bedtime)
- Vitamin C 1000 mg oral tablet - 1 tab(s) orally once a day
- Novolog FlexPen 100 units/mL injectable solution - 4 unit(s) injectable 3 times a day
- Senna 8.6 mg oral tablet - 1 tab(s) by PEG tube once a day (at bedtime)
- Lantus 100 units/mL subcutaneous solution - 30 unit(s) subcutaneous once a day (at bedtime)
- levetiracetam 750 mg oral tablet - 1 tab(s) by gastrostomy tube/orally 2 times a day

Review of systems:
Unable to obtain, patient is not awake, alert, and non-responsive

Physical exam:
Vitals: BP 94/ 72 HR 88 RR 18 SpO2 97% Temp. 37C
General: A/O x 0, obese obtunded male on nasal canula responds to painful stimulus
Skin: no masses/lesions/rashes noted; slightly diaphoretic
Heart: S1 and S2 present RRR, no murmurs/gallops/thrills/heaves noted
Lungs: symmetrical rise of chest; lung sounds present in all lung fields with coarse breath sounds appreciated; crackles noted in left lower lung field
Abdomen: soft slightly distended non tender abdomen, bowl sounds present in all quadrants; PEG tube present with no surrounding erythema or induration; no rebound tenderness or rigidity noted;
Extremities: thready pedal pulses; bilateral 2+ pedal edema noted; no deformities; tenderness
Neuro: AOx0; unable to complete full neuro exam due to patient's obtunded status; responsive to painful stimulus

Labs:
135 | 95 | 44.0
----------< 207 Ca: 8.7 Anion Gap: 7
6.4 | 33 | 0.59

WBC: 6.54 / Hb: 9.8 (MCV: 86.6) / Hct: 34.8 / Plt: 174
Diff: N:89.00%Bands:3% L:4.00% Mo:4.00%

PT: 22.4 / PTT: 34.3 / INR: 2.00
Prot: 6.6 / Alb: 3.0 / Bili: 0.3 / AST: 33 / AlkPhos: 228

CXR: There is cardiomegaly with moderate pulmonary vascular congestion and small left effusion. Median sternotomy wires from prior cardiac surgery are present. Right shoulder arthroplasty present.

Assessment:
Patient is a 75 year old male with PMHx of CVA with left sided weakness, aphasia, HTN, HLD, DM, Afib, CHF, CAD presents to the emergency room with altered mental status most likely consistent with CHF exacerbation vs infectious etiology.

Plan:

- Transthoracic Echocardiogram
- CT Head with contrast
- Lactate, blood cultures
- Lasix drip
- Hyperkalemia cocktail – insulin, kayexalate, albuterol
- Consult internal medicine for possible admission

Patient 3: Atrial Flutter

Name: B.B. 4253521
DOB: 04/10/1960
Date/time: 5/14/2019 @ 3 pm
Source of information: Patient
Reliability: reliable

CC: chest pain x 1 week

History of present illness:
Ms. B is a 59 y/o female former smoker with a pmhx of anxiety who presents today with complaint of chest pain x 1 week. Patient describes the pain as being on the left sided non radiating and intermittent in character. Pain was worse 2 days before and has slightly improved now. States that this did not feel like her usual anxiety attacks. Patient visited her PMD who sent her to ER for further evaluation. Patient also endorses weakness, SOB, dizziness, and intermittent palpitations. Denied any recent travel, sick contacts, fever, chills, nausea, and diarrhea.

Past medical history:
Anxiety

Past surgical history:
Appendicitis

Family history:
Father – alive 78 – Hx of MI in 30s

Mother – 57, deceased, sudden death of MI
Brother – alive with heart disease

Social history: Former cigarette use quit 6 months ago, occasional wine use, no illicit drug use

Allergies: no known allergies to medications/environment

Medications: Alprazolam – could not recall the dosage

Review of Systems:
Constitutional: admits to generalized weakness, denies fever/chills, weight loss
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R
ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: admits to shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: admits to chest pain and palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: No abdominal pain, no nausea, vomiting or hematemesis; no constipation or diarrhea; No melena or hematochezia
Genitourinary: No dysuria, frequency or hematuria; no flank pain R; no flank pain; no suprapubic pain
MSK: denies limitations or weakness in joints
Psychiatry: admits to bouts of anxiety, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: HR 130 BPM BP 114/76 mmHg RR 20 SpO2 98%
General: Patient is A/O x 3 but slight mild distress
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; no adventitious sounds
Cardiovascular: S1 and S2 present; slightly tachycardic; no murmurs/gallops present
Abdomen: non tender soft abdomen; no masses or lesions noted; no guarding; no rebound tenderness
Extremities: no presence of deformities, edema, tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

Labs/Imaging:
CBC
WBC 10.02
Hemoglobin 13.8
Hematocrit 41.4
MCV 98.1
Platelet count 266
BMP
Sodium 139
Potassium 5.8
Chloride 99

CO2 22
BUN 13.6
Creatinine 0.86
Glucose 93
Anion gap 18
BUN/Cr 16
Liver function test
AST 33
ALT 25
Albumin 4.1
Alkaline phosphate 83
Total bili 0.7
Indirect bili 0.5
Direct bili 0.2

BNP 1,577
PT 11.1
PT/INR 0.99
Thyroid profile
TSH 1.350
T4 7.3
T3 1.06
Troponin <0.010
VBG
pH 7.55
pCO2 25
pO2 34
HCO3 21.8
Magnesium 1.7

- CHEST X-RAY
  - No evidence of focal airspace infiltrate or consolidation. Left upper lung 9 mm nodular density, which may represent a calcified granuloma versus pulmonary nodule. Follow up chest x-ray or CT of chest in 3 months recommended
- EKG
  - Heart rate 134 bpm
  - Possible atrial flutter with RVR
  - 2:1 AV block
  - Inferior infarction - age undetermined
  - Marked left axis deviation
  - Q waves in inferior leads
  - T wave inversion

Assessment and Plan:
Ms. B is a 59 y/o female former smoker with a pmhx of anxiety who presents today with complaint of chest pain x 1 week with associated symptoms of palpitations, SOB, and dizziness most likely consistent with atrial flutter with a 2:1 block based on history, physical exam, and labs/imaging.

Atrial flutter
- Patient symptomatic and plan to rate control patient
- give Cardizem 0.25 mg/kg IV push
- Close monitoring of HR, BP, and respiratory status
- Electrophysiology consult placed
- Considering anticoagulation – will discuss with EP
- Echocardiogram ordered

Anxiety
- Continue Alprazolam at current dosage
- Advised patient to follow up with mental health professional

Patient 4
Name: Chen, Tsai 4063064
DOB: 06/14/1947
Date/time: 5/20/19 @ 11 pm

Source of information: Patient
Reliability: reliable

Chief Complaint: difficulty breathing and elevated BP

History of Present Illness:

Patient is a 71 year old male with PMHx of DM, HTN, CKD on hemodialysis (Tue,Th,Sat). Presents with his nephew with difficulty breathing and elevated BP since yesterday. Patient states he has been compliant with his medications and dialysis. last dialysis was Tuesday. Upon further questioning patient did not take his anti-htn medications today. Patient states that he was at home watching TV after dinner that he started feeling he was having difficulty breathing and later in the night noticed that he had a coughing spell that led to him coughing up small amount of blood. Admits to having leg swelling. He denies any fever/chills, hx of TB infections, recent illnesses, sick contacts, recent travel, chest pain, dizziness, nausea, vomiting, abdominal pain.

Past Medical History:

- Diabetes, ESRD , Hypertension Hyperlipidemia, left forearm shunt, GERD, BPH

Past surgical history:

- Artificial AV fistula placement

Family History:

- noncontributory

Allergies:

- No Known Allergies

Medications:

- amoxicillin-clavulanate 500 mg-125 mg oral tablet - 500 milligram(s) orally once a day
- hydrALAZINE 50 mg oral tablet: Rx, 1 tab(s) orally every 8 hours –Indication
- amLODIPine 10 mg oral tablet: Rx, 1 tab(s) orally once a day
- gabapentin 300 mg oral capsule: Rx, 1 cap(s) orally Monday, Wednesday, and Friday
- cloNIDine 0.3 mg oral tablet: Rx, 1 tab(s) orally every 12 hours
- losartan 100 mg oral tablet: Rx, 1 tab(s) orally once a day
- tamsulosin 0.4 mg oral capsule: Hx, 1 cap(s) orally once a day (at bedtime)
- Artificial Tears ophthalmic solution: Rx, 1 drop(s) in each eye 4 times a day x 30 days
- Restasis 0.05% ophthalmic emulsion: Hx, 1 drop(s) to each affected eye every 12 hours
- finasteride 5 mg oral tablet: Hx, 1 tab(s) orally once a day
- Fiber Lax 625 mg oral tablet: Hx, 1 tab(s) orally once a day
- latanoprost 0.005% ophthalmic solution: Hx, 1 drop(s) to each affected eye once a day (in the evening)
- Proctozone HC 2.5% topical cream: Hx, Apply topically to affected area 3 times a day
- Combigan 0.2%-0.5% ophthalmic solution: Hx, 1 drop(s) to each affected eye every 12 hours

- betamethasone dipropionate 0.05% topical cream: Hx, Apply topically to affected area 2 times a day
- diphenhydrAMINE 25 mg oral tablet: Hx, 1 tab(s) orally once a day (at bedtime)

Review of Systems:
Constitutional: denies generalized weakness, denies fever/chills, weight loss
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R
ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: admits to difficulty breathing, admits to slight dry cough, denies wheezing or hemoptysis.
Cardiovascular: denies chest pain or palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: No abdominal pain, no nausea, vomiting or hematemesis; no constipation or diarrhea; No melena or hematochezia
Genitourinary: No dysuria, frequency or hematuria; no flank pain R; no flank pain; no suprapubic pain
MSK: denies limitations or weakness in joints
Psychiatry: denies anxiety, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: HR 89 BPM BP 205/108 mmHg RR 18 SpO2 93%
General: Patient is A/O x 3 resting comfortably
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; bilateral crackles noted
Cardiovascular: S1 and S2 present RRR; no murmurs/gallops present
Abdomen: non tender soft abdomen; no masses or lesions noted; no guarding; no rebound tenderness
Extremities: AV fistula noted on left arm, no edema, tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

Labs/Imaging:

CXR: Right-sided tunneled catheter line is visualized in unchanged position with tip projecting from the superior cavoatrial junction. There is indistinctness of the pulmonary vessels suggesting mild pulmonary interstitial edema. Superimposed pneumonia cannot be excluded. There is a hazy retrocardiac opacity obscuring left hemidiaphragm border, possibly due to atelectasis versus pneumonia. Patchy right basilar opacities are also noted. No pleural effusion or pneumothorax. The cardiac silhouette is within normal limits. No acute osseous abnormality.

CT Lung: Multiple scattered airspace opacities within both upper lobes and the right lower lobe suggestive of aspiration, or multifocal pneumonia in the appropriate clinical setting. Short interval

follow-up after completion of treatment is suggested to ensure for resolution as malignancy cannot be excluded. Unchanged borderline prominent right paratracheal lymph nodes measuring up to 1.0 cm noted, also amenable to further characterization on follow-up exam. Mild bilateral pleural effusions. Mild to moderate pericardial effusion. 3 mm nonobstructing calculus of the upper pole of the right kidney.

Assessment:
Patient is a 71 year old male with PMHx of DM, HTN, CKD on hemodialysis (Tue,Th,Sat). Presents with his nephew with difficulty breathing and elevated BP x 1 day. Signs and symptoms most likely correlated with non compliance of anti-htn medications and cough consistent with pneumonia vs aspiration.

Plan:

- Give hydralazine 50 mg tablet – observe BP in hour
- Educate and counsel on proper medication compliance
- Consult urology for possible in house dialysis
- Obtain CBC, CMP, and sputum culture – r/o aspiration pneumonia

Patient 5:
Name: Macancela, Frank 4255334
DOB: 01/07/1997
Date and time: 5/21/19 @ 2 pm
Source of information: patient
Reliability: reliable

CC: Chest pain x 3 days

History of Present Illness:

Patient is a 22 yo male with no pmhx presenting with chest pain x3 days. Patient describes the pain as left sided pain that is radiating to left arm, but not associated with nausea, vomiting, or diaphoresis and non exertional in nature. States that there are no aggregating, or alleviating factors. pain is constant and sharp in nature. Patient reports no injuries to the chest area. Patient states he was also having burning chest pain yesterday. Patient admits to neck pain but denies numbness or tingling in extremities, fever/chills, SOB, n/v/d, dizziness, syncope, palpitations, abdominal pain, headache, recent travel, or sick contacts.

Past Medical History:

- Patient denies any past medical history

Past Surgical history:

- Patient denies any past surgical history

Family history

- Father – DM II
- Mother – none

Social history:

- Patient denies smoking tobacco, alcohol use, or illicit drug use

Allergies:

- No Known Allergies

Medications:

- Denies any medication use·

Review of Systems:
Constitutional: denies generalized weakness, denies fever/chills, weight loss
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R
ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: denies difficulty breathing, denies cough, denies wheezing or hemoptysis.
Cardiovascular: admits to chest pain, denies palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: No abdominal pain, no nausea, vomiting or hematemesis; no constipation or diarrhea; No melena or hematochezia
Genitourinary: No dysuria, frequency or hematuria; no flank pain R; no flank pain; no suprapubic pain
MSK: denies limitations or weakness in joints
Psychiatry: denies anxiety, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: HR 75 BPM BP 118/75 mmHg RR 16 SpO2 100%
General: Patient is A/O x 3 resting comfortably
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, no neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; no adventitious lung sounds
Cardiovascular: S1 and S2 present RRR; no murmurs/gallops present; left chest wall tender to palpation
Abdomen: non tender soft abdomen; no masses or lesions noted; no guarding; no rebound tenderness
Extremities: no deformities, no edema, no tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

Labs/imaging:

EKG: normal sinus rhythm with normal axis and normal interval, no ST elevations or depressions noted

Assessment:

Patient is a 22 yo male with no pmhx presenting with chest pain x3 days most likely consistent with musculoskeletal pain.

Plan:

- Give Toradol 10 mg IM
- Ordered CBC, CMP, CXR, troponin
- Educate and consul patient to follow up with primary care doctor
- Pending discharge once labs come back