Punam Patel

History and Physical #1

Name: W.K.
Medical Record #: 3168409
Date of Birth: 5/11/1940
Date/Time: 6/6/2019 9:25 AM
Source of information: Niece
Reliability of patient: Unreliable

Non-Pt

Would add CC

History of Presenting Illness
Mr. W.K. is a 79 y.o. male with PMH HTN and dementia that presents to the ED with acute abdominal pain x 1 day. Patient is accompanied by his niece who is his HCP and makes all of his medical decisions. As per the niece, he had acute onset of severe abdominal pain just before midnight and she brought him to the ED immediately. Niece denies any trauma/fall, episodes of vomiting, hematemesis, bloody stool/melena, cough, chest pain, urethral discharge. Patient is severely demented and is not able to remember much and cannot provide any further information.

Past Medical History

Past Medical History
- Hypertension – over 20 years
- Dementia – unable to recall when diagnosed

Past Surgical History
- Niece denied any surgical history

Social History
- Denies smoking
- Denies alcohol use
- Denies drug use
- Married and living with family

Allergies
- Niece denies any allergies to medication, environment, or food

Medications

Current Medications
- Amlodipine - 5 mg PO one time a day

Review of Systems: based on niece – patient unable to provide additional information
Constitutional: denies any fever or weight changes
Skin/Hair/Nails: denies any rash
Eyes: denies any discharge

Lungs: denies cough, sputum production, hemoptysis
Abdominal: admits to abdominal pain, denies any nausea/vomiting/constipation/diarrhea, changes in stool, jaundice
GU: denies any dysuria, blood in urine
Vascular: denies bilateral leg swelling
Neurological: denies any tremors or paralysis

Physical Exam:
Temp: 99.4 °F
Heart Rate: 103
Resp: 18
BP: 135/86

General: Patient is A/O x 3; not in any 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 RRR; no murmurs/gallops present
Abdomen: tense, diffusely tender and distended; bowl sounds are decreased; guarding and rebound with rigidity present; negative psoas or obturator sign 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:

WBC		
06/06/2019	18.3 (H)	4.5 - 11.0 K/mcL
White Blood Cells Urine		
06/06/2019	7-10 (A)	0 - 4 HPF
HGB		
06/06/2019	15.8	13.5 - 17.5 gm/dL
HCT		
06/06/2019	48.8	41.0 - 53.0 %
MCV		
06/06/2019	93.2	80.0 - 100.0 fL

SODIUM	137
POTASSIUM	3.8
CHLORIDE	99
CO2	21 (L)
BUN	15
CREAT	1.39 (H)
CALCIUM	10.2 (H)

PT	12.4
INR	1.1
APTT	29.8

ALBUMIN	4.1
PROTEIN	7.0
TBILIRUBIN	0.3
DBILIRUBIN	<0.2
ALKPHOS	70
ALTSGPT	11

Imaging:
Dx Acute Abdomen Series With Decub

Result Date: 6/6/2019
EXAM: XR Abdomen, 3 or More Views EXAM DATE/TIME: 6/6/2019 3:13 AM CLINICAL HISTORY: 79 years old, male; 79 male, C/O of abdominal pain and distension x 2 days, +emesis, R/O air fluid levels, R/O obstruction TECHNIQUE: Imaging protocol: Frontal view of the abdomen/pelvis with upright view of the abdomen and one or more additional views. COMPARISON: No relevant prior studies available. FINDINGS: Lower thorax: Basilar atelectasis with no acute pulmonary infiltrate. Gastrointestinal tract: Normal. No bowel dilation. Intraperitoneal space: Normal. No free air. Bones/joints: Unremarkable for age.

Ct Abdomen Pelvis With Contrast

Addendum Date: 6/6/2019
Visualized superior mesenteric artery and celiac artery and branches are patent and normal in caliber. Critical findings of pneumoperitoneum were communicated to and acknowledged by Dr. Winograd.

Result Date: 6/6/2019
EXAM: CT Abdomen and Pelvis With Contrast EXAM DATE/TIME: 6/6/2019 6:38 AM CLINICAL HISTORY: 79 years old, male; Bowel obstruction, high-grade
ABDOMEN: Liver: Small cysts are stable. Liver otherwise enhances homogeneously. Patent hepatic and portal veins. Gallbladder and bile ducts: Distended gallbladder. No biliary ductal dilatation. Pancreas: Normal. No ductal dilation. Spleen: Normal. No splenomegaly. Adrenals: Bilateral thickening is stable suggesting hyperplasia. Kidneys and ureters: Unchanged right renal stones the largest measuring 10 mm the right kidney. Symmetrical enhancement. Small bilateral renal cortical cysts are stable. No hydronephrosis. Stomach and bowel: Stomach is decompressed. There is no dilatation of small and large bowel. Mild thickening of distal small bowel loops. Contrast has reached the distal small bowel. No definite pneumatosis. Appendix: No evidence of appendicitis. PELVIS: Bladder: Unremarkable as visualized. Reproductive: Unremarkable as visualized. ABDOMEN and PELVIS: Intraperitoneal space: Large amount of pneumoperitoneum mostly in upper abdomen. Moderate volume of free ascites. Bones/joints: No acute fracture. No dislocation. Soft tissues/lower chest: Trace dependent pleural effusions and basilar atelectasis. Vasculature: Normal. No abdominal aortic aneurysm. Lymph nodes: Normal. No enlarged lymph nodes.

IMPRESSION: Large volume of ascites and pneumoperitoneum predominantly in upper abdomen concerning for bowel perforation. Exact location is not clear however duodenal ulcer perforation is considered. No significant bowel obstruction. Other chronic findings are stable.

Assessment/Plan:
Mr. W.K. is a 79 y.o. male with PMH HTN and dementia that presents to the ED with acute abdominal pain x 1 day. His symptoms, sign, and labs/imaging are consistent with a perforated bowl.

Perforated bowl
- Admit to general surgery service
- schedule for emergent OR for Exploratory Laparotomy

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- NPO
- Give 100 cc/hr of D5NS
- Give Zosyn 3.375 grams/50 ml NS over 30 mins
- Place Nasogastric tube
- Central line placed at bedside
- Foley inserted in ED
- Strict I/Os – monitor for signs and symptoms of fluid overload
- Heparin SubQ and B/L Stocking compression Devices for DVT ppx

Hypertension

- Continue Amlodipine 5 mg one a day
- Monitor BP

History and Physical #2
Name: A.S.
Medical Record #: 647581
Date of Birth: 10/6/1975
Date/Time: 6/4/2019 11:18 AM

History of Presenting Illness

Ms. S is a 43 y.o. female with pmhx HIV, uterine fibroids, umbilical hernia presenting to ER for abdominal pain since last night. Patient states the pain is generalized and constant and associated with N/V. Patient confirms last BM 3 days prior and has not had any flatus since last night. Last po intake was last night around 10 pm. Patient found out about her umbilical hernia recently when she underwent an MRI for evaluation of her uterine fibroids. Has not had complaints regarding her hernia prior to this except during menses when she noticed a bulge which always spontaneously reduced previously. Denies fever/chills, dysuria, hematochezia, hematemesis, cough, chest pain, SOB. Patient was supposed to undergo a myomectomy today at an ambulatory center in Jamaica, Queens but presented to the ED given her acute abdominal pain. Patient has no prior colonoscopy or EGD. No prior abdominal surgeries. Patient reports she is followed at QHC for her HIV and has been compliant with HIV meds. Last viral load on 12/31/18 was not detectable.

Past Medical History:

- Adenoma of right breast s/p Bx 8/9/12
- Chronic allergic rhinitis 6/30/2016
- Essential hypertension 6/30/2016
- Fibroid uterus
- Genital herpes 6/30/2016
- HIV (human immunodeficiency virus infection) (HCC) 2006

CD4 nadir >200 .atripla from 3/17/08 switched to complera 10/1/12 due to persistant CNS side effects. Switched to Odefsey 6/2016- well controlled.

- PPD positive, treated 06/30/2016 - took INH for one month in 1998 then refused further
- Umbilical hernia
- Vitamin D deficiency 6/30/2016

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Past Surgical History:
Patient denies any past surgical history

Social History:
- Denies smoking
- Denies Alcohol use
- Denies Drug use
- Occupation – Housekeeper
- Single
- Sexually active with one partner

Allergies
Patient has no known allergies.

Medications:
- emtricitabine-rilpivirine-tenofovir alafenamide 200-25-25 MG Tab - Take 1 tablet by mouth daily
- fexofenadine 180 MG tablet- Take 1 tablet by mouth daily

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 shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: denies chest pain and palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: admits to abdominal pain, admits to nausea, vomiting, denies 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 or panic attacks, 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:
Temp: 97.9 °F (36.6 °C)
Heart Rate: 100
Resp: 17
BP: 141/90

General: Patient is A/O x 3; not in any 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 RRR; no murmurs/gallops present
Abdomen: soft, ND, nonreducible 4 cm mass just superior to umbilicus, tender, no skin changes; bowl sounds not appreciated; mostly tympanic to percussion diffusely
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

Will add "Neg ROVsing Psoas Murphy's etc"

Labs:

WBC
11.8 (H)4.5 - 11.0 K/mcL

White Blood Cells Urine
01/14/2019 0-4 0 - 4 HPF

HGB
10.5 (L) 12.0 - 16.0 gm/dL

HCT
34.0 (L) 36.0 - 46.0 %

MCV 76.7 (L) 80.0 - 100.0 fL

SODIUM 139

POTASSIUM	3.6
CHLORIDE	96 (L)
CO2	25
BUN	10
CREAT	0.92
CALCIUM	9.9
ALBUMIN	4.7
PROTEIN	8.5
TBILIRUBIN	<0.3
DBILIRUBIN	<0.2
ALKPHOS	72
ALTSGPT	16
ASTSGOT	19
LDH	233 (H)
GGT	20
LIPASE	21

Imaging:
Ct Abdomen Pelvis With Contrast

Result Date: 6/4/2019
EXAM: CT Abdomen and Pelvis With Contrast EXAM DATE/TIME: 6/4/2019 5:05 AM CLINICAL HISTORY: 43 years old, female; Abd pain, unspecified TECHNIQUE: Imaging protocol: Axial computed tomography images of the abdomen and pelvis with intravenous contrast. Coronal and sagittal reformatted images were created and reviewed. Radiation optimization: All CT scans at this facility use at least one of these dose optimization techniques: automated exposure control; mA and/or kV adjustment per patient size (includes targeted exams where dose is matched to clinical indication); or iterative reconstruction. COMPARISON: Pelvis US 8/9/2012 3:05 PM FINDINGS: ABDOMEN: Liver: Circumscribed cyst in the anterior right hepatic lobe measuring 6.8 x 6.5 cm. Gallbladder and bile ducts: Normal. No calcified stones. No ductal dilation. Pancreas: Normal. No ductal dilation. Spleen: Normal. No splenomegaly. Adrenals: Normal. No mass. Kidneys and ureters: Normal. No hydronephrosis. Stomach and bowel: Diffuse dilated proximal small bowel. Transition point in the umbilical hernia. Distal small bowel loops

are decompressed. No abnormal bowel wall thickening. Appendix: Appendix is normal. PELVIS: Bladder: Unremarkable as visualized. Reproductive: Uterus measures approximately 22 x 17.5 x 10 cm. Enlarged lobulated uterus consistent with fibroid uterus. ABDOMEN and PELVIS: Intraperitoneal space: No free air. No intraperitoneal free fluid. Bones/joints: No acute fracture. No dislocation. Soft tissues: Nodular lesion in the inferior right breast with small calcifications and biopsy clip measuring 1.3 x 1.8 cm. Moderate umbilical hernia containing short loop of bowel and fluid. Vasculature: Normal. No abdominal aortic aneurysm. Lymph nodes: Normal. No enlarged lymph nodes.

IMPRESSION: 1. Findings consistent with complete small bowel obstruction secondary to umbilical hernia. 2. No evidence of bowel perforation. 3. Circumscribed cyst in the anterior right hepatic lobe. Consistent with cyst. No followup is necessary. 4. Enlarged lobulated uterus consistent with fibroid uterus. 5. Nodular lesion in the inferior right breast with small calcifications and biopsy clip. Correlate with history. 6. Additional findings as described. THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED BY SHWAN KIM MD

Assessment/Plan:
Ms. S is a 43 yo F with SBO secondary to incarcerated umbilical hernia, reduction of hernia was attempted but was unable to reduce

SBO secondary to incarcerated umbilical hernia
- Admit to surgery services
- keep patient NPO
- Give 200 cc/hr NS
- NGT placed in ED with 450 cc of bilious output
- Ordered coags, type and screen, lactate
- Give 4 mg of Morphine
- strict I and O's
- Give Omperazole 40 mg via NG tube for GI ppx
- give heparin subq 5000 units q 8 hrs for DVT ppx
- schedule for OR emergently for ex-lap, umbilical hernia repair, possible bowel resection, possible ostomy

HIV
- Patient reports she is followed at QHC for her HIV and has been compliant with HIV meds.
- Last viral load on 12/31/18 was not detectable
- Continue emtricitabine-rilpivirine-tenofovir alafenamide 200-25-25 MG Tab

Very good!

Punam Patel

History and Physical #4
Name: P.D.
Date of Birth: 4/22/1954
Date/Time: 6/2/2019 2:42 AM

Chief Complaint: "stomach pain x 1 week"

History of Presenting Illness
P.D. is a 65 y.o. female with PMH HTN, HLD, DM, and Afib (on Eliquis), diverticulitis presents to the ED for evaluation of abdominal pain x 1 week. She started having RLQ abdominal pain this past Wednesday but it got most severe yesterday. Patient describes the pain as sharp, intermittent, and rated as 10/10. Patient states the pain has slightly improved with OTC pain medication. She has daily bowel movements but admits being more constipated more than usual. Patient denies nausea/vomiting, diarrhea, bright red blood per rectum, hematochezia, cough, fever/chills. Her last colonoscopy was 3/19/18 and had a submucosal lipoma found on the ascending colon.

Past Medical History:
- Asthma
- Cataract
- Chronic knee pain 10/19/2018
- Cyst of soft tissue 2/9/2018
- Diabetes mellitus (HCC) TYPE II
- Glaucoma suspect, both eyes
- Hematoma of left lower extremity 1/5/2018
- HTN (hypertension) 7/1/2016
- Hyperlipidemia 7/1/2016
- Obesity
- Osteoarthritis of both knees 12/23/2016
- Polyp of ascending colon 4/6/2018
- Swelling of limb 1/10/2018
- Vitamin D deficiency 6/29/2017

Past Surgical History:
- . Breast biopsy of Left fibroadenoma
- colonoscopy 10/16/2017

Social History
- Denies Alcohol Use
- Denies cigarette use – former smoker quit 2/15/17
- Denies Drug Use
- Marital status – single
- Not sexually active

Allergies
Denies allergies to drugs/environmental/food

Medications:
- albuterol 108 (90 base) mcg/act inhaler
- apixaban (eliquis) 5 mg tab tablet
- insulin glargine 100 unit/ml solution pen-injector injection
- latanoprost 0.005 % ophthalmic solution
- liraglutide (victoza) 18 mg/3ml solution pen-injector pen
- lisinopril-hydrochlorothiazide (prinzide, zestoretic) 20-25 mg per tablet
- metformin (glucophage) 500 mg tablet
- nifedipine (procardia xl) 90 mg
- rosuvastatin (crestor) 20 mg tablet

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 shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: denies chest pain and palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: admits to some abdominal pain, denies nausea, vomiting, denies 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 or panic attacks, 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

Vaginal Sx?

Physical Exam:

Temp: 100.6 °F (38.1 °C)
Heart Rate: 58
Resp: 18
BP: 164/79
General: Patient is A/O x 3; not in any 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 RRR; no murmurs/gallops present
Abdomen: obese, midline surgical scar well healed. Soft, nondistended and tender with RLQ pain and guarding, No rebound or rigidity. Bowl sounds present; tympanic to percussion

Mcburney, Murphy, etc

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:

WBC
06/01/2019 23.5 (H)

White Blood Cells Urine
06/01/2019 21-50 (A)

HGB
06/01/2019 11.1 (L)

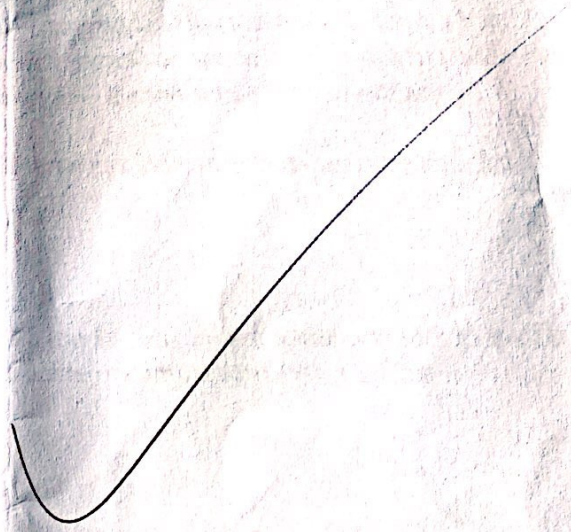
HCT
06/01/2019 35.3 (L)

MCV
06/01/2019 81.6

SODIUM	138	06/01/2019
POTASSIUM	4.0	06/01/2019
CHLORIDE	100	06/01/2019
CO2	23	06/01/2019
BUN	10	06/01/2019
CREAT	0.90	06/01/2019
MG	1.7	01/16/2019
CALCIUM	9.1	06/01/2019
PHOS	4.0	01/16/2019

PT	16.3 (H)	06/02/2019
INR	1.4	06/02/2019
APTT	29.8	06/02/2019

ALBUMIN	3.7	06/01/2019
PROTEIN	6.7	06/01/2019
TBILIRUBIN	0.8	06/01/2019
DBILIRUBIN	0.3	06/01/2019
ALKPHOS	79	06/01/2019
ALTSGPT	10	06/01/2019
ASTSGOT	13	06/01/2019
LIPASE	9 (L)	06/01/2019



Imaging:
Ct Abdomen Pelvis With Contrast

Addendum Date: 6/2/2019
Result Date: 6/2/2019
EXAM: CT Abdomen and Pelvis With Contrast EXAM DATE/TIME: 6/2/2019 12:00 AM CLINICAL HISTORY: 65 years old, female; Abd pain, diverticulitis suspected TECHNIQUE: Imaging protocol: Axial computed tomography images of the abdomen and pelvis with intravenous contrast. Coronal and sagittal reformatted images were created and reviewed. Radiation optimization: All CT scans at this facility use at least one of these dose optimization techniques: automated exposure control; mA and/or kV adjustment per patient size (includes targeted exams where dose is matched to clinical indication); or iterative reconstruction. COMPARISON: DX HIPS AP LATERAL W AP PELVIS BILATERAL 5/1/2017 10:18 AM FINDINGS: ABDOMEN: Liver: 7 mm and 15 mm low-density hepatic lesions with benign features suggesting cyst or hemangioma. (No follow up needed.) Gallbladder and bile ducts: Unremarkable. Pancreas: Unremarkable. Spleen: Normal size. Adrenals: No mass. Kidneys and ureters: Unremarkable. Stomach and bowel: Extraluminal gas and inflammation in fat around cecum. Multiple diverticula throughout colon suggest perforated right-sided diverticulitis as the etiology. No abscess. No bowel obstruction. Appendix: Predominantly gas-filled lumen. No thickening of appendix wall or features suggesting appendicitis. PELVIS: Bladder: Unremarkable. Reproductive: Hysterectomy. No adnexal mass. ABDOMEN and PELVIS: Intraperitoneal space: No pneumoperitoneum or fluid collections. Bones/joints: Severe lumbar facet joint arthritis. No lower thoracic or lumbar compression fractures. Soft tissues: Unremarkable. Vasculature: No aortic aneurysm. Lymph nodes: No adenopathy.

IMPRESSION: Diverticulitis involving cecum with extraluminal gas indicating microperforation. No abscess.

DDx',

Assessment/Plan:
P.D. is a 65 y.o. female with PMH HTN, HLD, DM, and Afib (on Eliquis), diverticulitis presents to the ED for evaluation of abdominal pain x 1 week secondary to acute uncomplicated Diverticulitis

Cecal Diverticulitis
- Admit to general surgery service
- keep patient NPO
- ordered 200 cc of D5NS
- Start Zosyn IV 3.375 g/ 50 ml every 6 hours
- monitor for signs of improvement
- ordered repeat CBC with differential, CMP, LFT, Lipase
- Repeat colonoscopy as outpatient