Kevin Mego H&P 11/19/19

Identifying data

Full name: Mrs. M
Address: Not discussed
Date of birth: 6/1/-
Date & time: 11/19/19 9:00am
location: New York-Presbyterian Queens
Religion: Catholic
source of information: self
Reliability: reliable
Source of referral: self
Mode of transport: self

IT IS UNUSUAL TO STENT VEINS. WAS THERE ALSO AN ARTERIAL OCCCLUSION?

DID SHE PRESENT TO ED AND GET TRANSFERRED TO THE ICU?

Chief complaint

"Both legs have been swelling up for the past 5 days"

BE MORE SPECIFIC THAN "SOME GATORADE"

NO RELATED TO CHIEF COMPLAINT SO DO NOT INCLUDE IN HPI

History of present illness:

62 yr old female with a pmH of Hypertension, diabetes mellitus type II, stage 4 chronic kidney disease, and peripheral vascular disease presented today to the ICU from home with a complaint of bilateral edema located on both legs that initated 5 days ago. pt notes swelling slowly increased until she was unable to walk. shortly after she was admitted to the ICU. No pain is associated with either leg. pt also notes a prior femoral vein thrombosis on the Rt leg of which an angioplasty was performed and 2 stents were put in 2 weeks prior to her current symptoms (pt also notes sensations of nausea that lead to frequent vomiting after the angioplasty procedure. vomiting is described as a dark bluish color that was infrequent with a worsening affect at night) pt also notes fatigue & weakness in both legs shortly after the procedure. pt denies taking any medication for her symptoms besides just hydrating with some gatorade. (pt admits to having anemia for 17 years and is currently on medications & blood transfusion last blood transfusion is noted one week ago with no complications).

ANYTHING MAKE SWELLING BETTER

pt denies fever, chills, night sweats, loss of appetite, recent weight gain or loss, pt denies coldness of trophic changes, Varicose veins, easy bruising or bleeding, lymph node enlargement, Abdominal pain, diarrhea, jaundice,

SIMILAR PRIOR SYMPTOMS?

PMH

Diabetes type II x20 yrs controlled with medication
Hypertension x18 yrs blood pressure controlled & with medication
Anemia x17 yrs under Iron supplements & folic acid
peripheral neuropathy x16 yrs controlled with medication
peripheral Vascular Disease x16 yrs controlled with medication
stage 4 Chronic kidney disease x 6 yrs under medical treatment

Childhood illnesses

pt denies childhood illnesses ✓

Immunizations

pt is up to date / Denies taking flu shots every year ✓

Past surgical history

Angioplasty, 2019 at New York - Presbyterian Hospital, Bilateral les edema ← NOT SPECIFIC ENOUGH... ARTERIAL? VENOUS? LEFT/RIGHT? WHICH VESSEL?
Cholecystectomy, 2017 at Flushing Hospital, No complications
Pancreatomy, 2017 at Flushing Hospital, No Complications
Colon resection, 2009 at Flushing Hospital, No complications > DID THE PATIENT HAVE CANCER? IF SO NEEDS TO BE INCLUDED IN PMH

Medications

Amlodipine 10mg, 1 tab PO at morning for hypertension, last dose this morning
Plavix 75mg, 1 tab Po at morning for prevention of blood clot, last dose this morning
Aspirin 75mg, 2 tab Po at night for prevention of blood clot, last dose this morning
folic acid 1mg, 2 tab PO at morning for anemia, last dose this morning ✓
Iron 325mg, 2 tabs Po at morning & night for anemia, last dose this morning & night
Gabapatin 100mg, 1 tab PO at morning for diabetic neuropathy, last dose this morning
Hydralazine 250mg, 2 tab PO at morning for Hypertension, last dose this morning
Carvedilol 12.5mg, 2 tab PO at morning for hypertension, last dose this morning

~~Allergies~~

pt denies any food allergies

pt denies any medication allergies

pt denies any ~~med~~ K.m 11/12 environmental allergies

Family history

Mother - deceased at age 63, History of HTN

Father - pt denies to talk about

Brother - Alive, 63, history of hyperlipidemia

Children - 3 sons, Alive & well

Social History

Mrs. M is a widowed female, currently living with one son, currently retired from working as a nurses Aide.

Habits - pt denies use of drugs currently or in the past. pt also denies to smoking currently or in the past or use of alternative smoking methods such as Vaping. pt denies use of alcohol or any alcoholic beverages. pt admits to drinking tea (Chamomile) everyday during the morning.

Travel - Jamaica, 2000

Diet - pt notes drinking tea for breakfast along with fried eggs, bacon, and toast. For lunch pt notes eating hamburgers, chicken, beef or pork along with rice and some vegetables. For dinner pt notes eating whatever comes to her mind. pt was advised on healthier eating habits.

Exercise - pt notes not exercising due to pain in leg muscles

Safety measures - pt admits to wearing seatbelts while driving

Sexual history - pt denies current sexual history and describes herself as heterosexual with a hx of monogamous relationships,

Review of systems

General: see HPI. Denies Fever, chills, night sweats ✓, loss of appetite, recent weight gain or loss

Skin, hairs, nails: Denies changes in texture, excessive dryness, or sweating, discolorations, pigmentations, moles / rashes, pruritus ✓, changes in hair distribution

Head: Denies headache, vertigo, head trauma, unconsciousness, coma, fracture ✓

eyes: Denies contacts, visual disturbances, Fatigue, lacrimation, photophobia
pt admits to wearing glasses for long distance
pt admits to pruritus in both eyes after constant use of glasses ✓,
last eye exam was 3 yrs ago, does not know her visual acuity.
pt admits to having Cataracts for 3 years, has not been treated for it
↳ INCLUDE IN PMH

Ears: Denies deafness, pain, discharge, tinnitus, or use of hearing aides ✓

Nose / sinuses: Denies bleeding gums, sore tongue, sore throat, mouth ulcers ✓, voice changes
pt admits to wearing upper and lower dentures
FULL OR PARTIAL?

Neck: Denies localized swelling / lump or stiffness / decreased range of motion ✓

Breast: Denies lumps, nipple discharge, or pain ✓

pulmonary system: Denies Dyspnea, SOB, cough, wheezing, hemoptysis, Cyanosis ✓, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular system: see HPI. Denies chest pain, palpitations, irregular heartbeat, syncope or known heart murmur. ✓
pt admits to hypertension x 15 yrs
pt admits to localized swelling of bilateral ankles and feet

Intestinal system – see HPI, Denies change in appetite, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence, eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool, pain in flank

Genitourinary system – Denies incontinence, dysuria, nocturia, urgency, oliguria, polyuria, awakening at night to urinate or flank pain

Nervous – Denies seizures, headaches, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition, mental status or memory

Musculoskeletal system – see HPI. Denies redness or arthritis. pt admits to muscle/joint pain on both legs prior to the edema that lasted for 15 years. Angioplasty resolved the problem

THIS SHOULD BE IN HPI →

Peripheral vascular system – see HPI. Denies coldness or trophic changes. Varicose veins. pt admits to intermittent claudication that started 16 yrs ago. pt notes cramping pain in legs while walking → How far? ~~Where~~

Hematological system – see HPI. pt denies easy bruising or bleeding even after confirmation of anemia. pt denies lymph node enlargement. pt admits to history of femoral vein thrombosis. Angioplasty was done on 10/29 to correct for this. pt admits to having anemia x 17 yrs. pt admits to blood transfusions. Last blood transfusion on 11/5. No complications

THIS SHOULD BE IN PMH AND HPI →

Endocrine system - Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Psychiatric - Denies depression/sadness, anxiety, OCD, or ever seeing a mental health professional

Sexual history - pt is not sexually active. pt denies current or past impotence, anorgasmia, sexually transmitted infections or use of contraception.

General: slender Female, neatly groomed, looks older than stated age of 62 years, Alert & oriented x3, Does not appear to be in apparent distress ✓

Vital signs: BP	R	L
standing	—	—
supine	150/95	—

(Unable to take R standing or L standing or supine due to patient's request to remain laying down and did not wish to take another BP reading.)

NEVER DOCUMENT YOU WERE UNABLE OR DID NOT DO SOMETHING

HR: 60 bmp O_2 Sat: 98% - ROOM AIR?

T: 36.7 C° ORAL RR: 18 bpm

Height: 5'5" weight: 142 lb BMI: 23.6 (normal)

Skin: ~~Warm & moist~~ km. 11/12 6:32pm pale, dry, Decreased turgor. No lesions noted, No scars, tattoos

Hair: Average quantity and distribution. No sign of seborrhea or lice ✓

Nails: No clubbing, Capillary refill < 2 seconds throughout, No sign of cyanosis ✓

Head: Normocephalic, Atraumatic, Non-tender to palpation throughout ✓

Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea is clear, conjuctiva pink. visual acuity uncorrected 20/70 OS 20/70 OD. 20/70 OU. visual fields full OU. PERRLA, EOMs intact with no nystagmus ✓

Fundoscopy: Red reflex intact OU. Cup to disk ratio < 0.5 OU. No AV nicking / hemorrhages, exudates or neovascularization OU ✓

Ears: Symmetrical and normal size. No lesions / masses / trauma on external ears. No discharge / Foreign bodies in external auditory canals OU. TM's pearly white / intact with light reflex in normal position OU. Auditory acuity intact to whispered voice AU, weber midline / Rinne reveals AC > BC AU. ✓

Nose/sinuses

Nose: symmetrical / no masses / lesions / deformities / trauma / discharge
Nares patent bilaterally / Nasal mucosa pink & well hydrated ✓
No discharge noted on anterior rhinoscopy. septum midline without lesions/ deformities / injection / perforation. No foreign bodies.

sinuses: Non tender to palpation over frontal and maxillary sinuses ✓

Teeth: full dentures noted ✓

Gingivae: pink, moist. No hyperplasia, masses, lesions, erythema or discharge ✓

Tongue: pink, well papillated, no masses, lesions or deviation noted ✓

Oropharynx: well hydrated, No injection, exudates, masses, lesions, foreign bodies tonsils present with no injection or exudate. Uvula pink, no edema or lesions ✓

Neck: trachea midline. No masses, lesions, scars, pulsations noted. supple, non-tender to palpation. No stridor noted. No palpable adenopathy noted ✓

thyroid: Non-tender, NO palpable masses, No thyromegaly ✓

thorax & Lungs

Chest: symmetrical, No deformities, no evidence trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. Lat to ap diameter 2:1. Non-tender to palpation ✓

Lungs: Clear to auscultation and percussion bilaterally. Chest Expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. ✓
No adventitious sounds.

Unable to take examinations past Head examination due to time constraints & patient feeling fatigue & weak.