Devora Schapiro History and Physical I + M 9/24/19

History: 9/24/19 9:30 AM

Identifying data:

Name: R.C.

age/DOB: 91, 7/15/28

Sex: Male

marital Status: Widowed (14 years)

race: Caucasian

nationality: Ireland

Address: Jackson Heights, NY

Religion: Denies

Location: New York Presbyterian Queens

Source: self, unreliable

Referral: daughter, patient unable to remember primary care provider name

Chief complaint: "I don't know how I got in here" x1 day

History of present illness:

R.C. is a 91 year old male with a past medical history of hypertension, hyperlipidemia, and coronary artery disease. patient was at first unsure why he came in and when he came in. After denying all symptoms at first patient admitted to difficulty speaking, a quieter voice, unsteady gait, tiredness, weakness. The difficulty speaking came on over a period of several months, was persistent, lasting for several months, patient was unable to describe location, treatment or worsening/alleviating factors. patient admits to past history of high blood pressure. Patient denies headaches, dyspnea, chest pain. Past history of smoking, diabetes and family history of Stroke. Patient was agitated and worried about being alone with no one in his family knowing where he was. Chief PA-C stated daughter brought him to emergency department four days ago after noticing unsteady gait.

any falls? injuries? new meds?

Past medical history:

Present medical illnesses: ✓

~~hyperthy~~ DS hypertension X 30 years ✓

hyperlipidemia- unknown duration ✓

Coronary artery disease- X 30 years ✓

Past medical illnesses: patient ✓ admits to being hospitalized infrequently but does not remember why

child hood illnesses: chickenpox ✓

immunizations: up to ✓ date

Screening tests: Doesn't Know ✓

Post surgical History:

open heart surgery, 30 years ago, Princeton hospital, does not know why, no complications ✓

Admits to "broken knee" 30 years ago, treated at princeton hospital

Patient is unsure about transfusions.

Denies other surgeries

Medications:

Patent does not know names, doses, or when he last took any of his medications. Patient denies ✓ vitamins or supplements.

Allergies:

Patient states he has medication allergies but cannot remember the drug or reaction. Patient ✓ thinks he is allergic to an antibiotic.

Patient denies environmental ✓ and food allergies.

Family history:

Mother- deceased, 95 unknown reason ✓

Father- deceased, 65 unknown reason ✓

8 Children (4 boys, 4 girls) ages ranging 47-61 (does not know specific ages), alive and well ✓

Maternal/paternal grandparents- unknown

Admits to family history of hypertension. Denies family history of allergies, heart disease, lung disease, GI disease, cancer, urinary tract disease, psychiatric, nervous, metabolic, endocrine, thyroid

Devora Schapiro History and physical I IM 9/24/19

Social history:

Habits- admits to occasional glass of wine with dinner, 3 cups of coffee a day, denies smoking and drug use

Travel -denies recent travel, military

Marital- widowed, lives in senior facility.

occupation- retired at 65 years

Home - Senior care facility, no pets

Diet- coffee, egg, cereal, juice

Sleep- Sleeps well at night

exercise- walks with assistance, cane or walker

Safety- does not drive any more

Review of systems:

General: Admits to weakness and generalized fatigue. Denies recent weight loss or gain, loss of appetite, fever, chills, night sweats.

Skin, hair, nails: Denies changes in texture, hair distribution, Denies excessive dryness, Sweating, discolorations, pigmentation, moles, rashes, Pruritus

Head: Admits to head trauma due to falls, unsure how recent. Denies unconsciousness, coma or fracture. Denies headache, vertigo and lightheadedness

Eyes: Denies visual disturbances, laccrimation, Photophobia, Pruritus.

last eye exam - a month ago. wears glasses, doesn't know ~~perscription~~ RS. Prescription.

Ears: Admits to deafness. Normally wears hearing aids. Denies Pain, discharge, tinnitus

Nose: Denies discharge, epitaxis, obstruction

Mouth and throat: Admits to quieter voice. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, use of dentures. Last dental exam approximately 1 month ago, required tooth to be pulled.

Neck: Denies localized swelling, lumps, stiffness, decreased range of motion

Breast: Denies lumps, nipple discharge, pain.

Pulmonary: Admits to cough without expectoration. Denies dyspnea, wheezing, hemoptysis, cyanosis, orthopnea, Paroxysmal nocturnal dyspnea

Cardiovascular:

Admits to hypertension. Denies, Chest pain, Palpitations, Irregular heartbeat, edema, Syncope, Known heart murmur

GI System: Denies any changes in appetite, intolerance, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, Change in bowels, hemorrhoids, constipation, rectal bleeding, blood in stool

Genitourinary system: Admits to frequency, urgency, Denies nocturia, Oliguria, Polyuria dysuria, incontinence, awakening at night to urinate, pain in flank

Denies prostate exam, hesitancy and dribbling

Sexual: not currently sexually active. Previous partner women. Denies impotence, Sexually transmitted infections

~~Nervous System: denies seizures, headaches, loss of consciousness, abc sensory disturbances~~ DS

Nervous System: Admits to loss of Strength, weakness. Denies Seizures, headaches, loss of consciousness, Sensory disturbances, ataxia, Change in cognition.

Musculoskeletal: Denies Muscle/joint pain, deformity, swelling, redness, arthritis

peripheral vascular system: Denies intermittent claudication, coldness, trophic changes, varicose veins, peripheral edema, color change

Hematologic: Admits to easy bruising. Denies anemia, easy bleeding, lymph node enlargement, history of DVT. Patient doesn't know about blood transfusions

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, hirtuism

Psychiatric: Denies depression, Sadness, anxiety, obsessive/compulsive disorder, medications or seeing a mental health professional

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General survey:

Patient is a 91 year old male, alert and oriented X1 to person. Patient has small build, Patient is well groomed and does not appear to be ~~in~~ DS in distress.

Vital signs

Blood pressure:	Right	left
Supine	~~152/76~~ DS 152/76	152/78
Sitting	154/80	158/76

Respirations 17 breaths per minute, unlabored

Heart rate: 69 beats per minute, regular rhythm

Temperature: 37.6°C, orally

Pulse oxygen: 98% on room air

Height: 5 feet 8 inches Weight: 159 pounds BMI: 24

~~Skin: Scar along midline of chest.~~ DS

Skin: Scar along midline of chest. Skin is warm and moist with good turgor, nonicteric, no lesions or ~~tattoos~~ noted

Hair: Sparse and thin

Nails: No clubbing, capillary refill less than 2 seconds

Head: normocephalic, atraumatic, non-tender to palpation throughout