Devora Schapiro History and physical II PAT 10/29/19

History: 10/29/19 8:20 AM

Identifying Data: ~~G~~ DS

Name: G.P.

Age/DOB: 50, 10/11/1969

Sex: Female

Marital Status: Married

Race: Black

Nationality: Haiti

Address: Jamaica, NY

Religion: ~~Did~~ DS Denies

Source: Self, reliable

Referral: gynecologist, Suzette Robinson, MD

Chief complaint: "hysterectomy for fibroids" X 2016

History of present illness:

G.P. is a 50 year old female who denies any past medical history. Patient admits to uterine fibroids that were discovered in 2016. Patient admits to lower left quadrant abdominal pain, when anything touches the area for the past three years. Pain is 8/10, lasts for the duration of contact, nothing exacerbates or alleviates the pain. Patient denies taking anything for pain. Patient has regular menstrual periods that come every 26-27 days, and last for 6. Date of her last period was october 9. Patients gynecological history includes G3, P2012, her last child a daughter was born via C-section in April 2018. The growth of fibroids was discovered during her last pregnancy. Patient admits to constipation, urinary frequency and urgency, and fatigue in the morning. great Patient denies any abnormal vaginal bleeding, pelvic pain, urinary retention, back pain, Painful sex, loss of appetite, swelling in legs, heavy menstruating, headaches, and vaginal discharge. Patient states the reason for coming in ~~to~~ DS for procedure now is that her gynecologist said the fibroids were getting too big. Patient had not wanted to take care of it before because of her new baby.

Past medical history:

Present illnesses: Single kidney cyst x 1 month

Past medical illnesses: Denies

Childhood illnesses: denies, up to date on immunizations

Immunizations: denies flu shot

Past Surgical History:

C- section, April 2018, NY Presbyterian Queens, fibroids

Denies past injuries, blood transfusions or complications in C-section

Medications:

Patient denies any medications, contraception, Vitamins, supplements

Allergies:

Drug: Chloroquine (itchiness)

Environmental: Flowers (sneezing, watery eyes)

Patient denies allergies to food

Family History:

Mother- alive, age 75, stroke, hypertension, knee surgery

Father- deceased, 79, hypertension

brother - 52, hypertension (alive)

Sister- alive, 54, hypertension

Son- 12, alive and well

daughter- 18 months alive and well

maternal/paternal GPs.

Patient admits to family history of high blood pressure, heart disease.

Denies history of lung disease, gastrointestinal disease, cancer, urinary tract disease, psychiatric or nervous disorders, metabolic disorders, and thyroid disorders.

Social History:

Habits- Admits to drinking wine once a year, coffee once a week

denies smoking or drug use

Travel- Last year, Haiti

Marital- married

occupation- home health aid

Home- husband, children, no pets

Social History continued:

Diet- hot cereal (oatmeal), rice, chicken, fish, broccoli, carrots

sleep- sleeps through the night except when baby wakes her up

exercise- none, gets short of breath when walking up steps

Safety- wears seatbelts

Review of Systems:

General: Admits to fatigue in the morning. Denies recent weight loss, gain, loss of appetite, weakness, fever, Chills, night sweats

Skin, Hair, Nails: Denies changes to texture, hair distribution, excessive dryness or sweating, discolorations, Pigmentations, moles, rashes, pruritus ~~Wounds~~ DS

Head: Denies headaches, vertigo, lightheadedness, head trauma

Eyes: patient admits to blurry vision, has glasses but doesn't know the prescription. ~~Denies double~~ PS Denies other visual disturbances, lacrimation, pruritus,

Ears: Denies deafness, pain, discharge, tinnitus, hearing aids USE OF

Nose/Sinus: Denies discharge, epistaxis, obstruction

mouth and throat: Has top row dentures, Denies bleeding gums, Sore tongue, Sore throat, mouth ulcers, voice changes. Last dental exam 6 months ago

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

Breast: Denies nipple discharge, lumps, pain. Last mammogram 2 months ago. Results?

Pulmonary: Admits to SOB/dyspnea when going upstairs. Denies cough, wheezing, hemoptysis, Cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular: Denies chest pain, hypertension, palpitations, irregular heart beat, edema/swelling ankles, Syncope, Known heart murmur

~~Gastrointestinal system: Denies Changes to appetite~~ DS

Gastrointestinal System: Admits to constipation. Denies changes in appetite, intolerance to food, nausea and vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, Rectal bleeding, melena, colonoscopy

Genitourinary System: Admits to frequency (every 30 minutes), nocturia, urgency, Polyuria, awakening at night to urinate, Denies oliguria, dysuria, incontinence, pain in flank

sexual: sexually active with husband, one partner, Denies anorgasmia, sexually transmitted infections, use of contraception

Menstrual: Date of last normal period, October 9, 2019, Interval 26-28 days, medium flow, clot size smaller than a dime, Admits to pre menstrual symptoms of pain in the breasts. Denies dysmenorrhea, metrorrhagia, menorrhagia, post coital bleeding, dyspareunia, vaginal discharge, menopause

Obstetrical history: G3 P2012 pap smear?

Nervous System: Denies seizures, headaches, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition, mental status, memory, weakness

Musculoskeletal System: Denies muscle/joint pain, deformity, swelling, redness, arthritis

peripheral vascular: Denies intermittent claudication, coldness, trophic changes, Varicose veins, peripheral edema, color changes

Hematologic: ~~Denies any~~ Admits to anemia and easy bruising. Denies lymph node enlargement, blood transfusion, history of DVT/PE

Endocrine: Admits to polyuria, denies polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, hirtuism

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

Physical exam and General Survey:

General survey: patient is a 50 year old Female, alert and oriented x3 to person, place, time. Patient has a large build, appears well groomed, good posture, good gait.

Vital signs:

Blood pressure:

	Right	Left
Sitting	132/88 OS	130/86
Supine	132/84	128/84

Respirations: 16 breaths per minute, unlabored

Heart rate: 73 beats per minute regular rhythm

Temperature: 98.1° F (orally)

O_2 Saturation: 100%, Room air

Height: 5'3 weight: 176 lbs. BMI: 31.2

Skin: C-section scar, transverse in pelvic area. Skin is warm and moist with good turgor, non-icteric, no lesions, or tattoos noted.

Hair: average quantity and distribution, coarse texture

Nails: no clubbing, capillary refill <2 seconds throughout

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

Eyes: Symmetrical no evidence of strabismus, exophthalmos, Ptosis. Sclera white, conjunctiva pink, cornea clear.

Visual acuity 20/40 OS, 20/40 OD, 20/30 OU, uncorrected

Visual fields full OU, PERRL, EOMs full with no signs of nystagmus

Fundoscopy: Red reflex intact OU, cup:disk @ OS <0.5 OU no evidence of AV nicking, papilledema, hemorrhage, exudates, cotton wool OS spots, or neovascularization

Ears: Symmetrical and normal size. No lesions, masses/trauma on external ears. No discharge, foreign bodies in external auditory canal. TMs pearly white/intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline / Rinne reveals AC>BC AU

Noses symmetrical/no masses/lesions/deformities/trauma/discharge.
Patent bilaterally, nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy, Septum midline without lesions, deformities, injection, perforation. No foreign bodies
Sinus: Non tender to palpation over bilateral frontal and maxillary sinuses.
Lips: pink, moist no cyanosis or lesions
Oral Mucosa: pink, well hydrated, no masses, lesions, leukoplakia
Palate: Palate pink, well hydrated, no masses, lesions, scars
Teeth: TOP row dentures, good dentition bottom row, no obvious caries
Gingivae: pink, moist, no hyperaplasia or atrophy, no masses, lesions, erythema, discharge
Tongue: pink, well papillated, no masses, lesions, deviation noted
Oropharynx: well hydrated, no injection, exudates, masses, lesions, foreign bodies
Tonsils present, no injection or exudates, Uvula rises midline on phonation pink, no edema, lesions
Neck: Trachea midline, No masses, lesions, scars, pulsations noted, supple non-tender to palpation, lymph nodes non palpable
Thyroid: Non tender, no palpable masses, thyromegaly

99.50