Martin Vanegas
03/25/2023
Prof. Jeanetta Yuan
HPPA 502 – Physical Diagnosis I (Lab)

Hospital Visit HPI #1 – Internal Medicine

Identifying Data:
Full Name: A.M.
Address: Valley Stream
DOB: 06/04/1961
Age: 61
Date & time: 03/21/2023, 10:15 am
Location: NYPQ-H
Religion: unspecified
Marital status: Married
Source of information: Self
Reliability: Reliable
Source of referral: Self
Mode of transport: Wife

CC: "Urine infection" x 8 days

HPI: 61 y/o M presents to internal medicine c/o of dysuria. Pt stated that he initially started with acute dysuria and 101.4°F (38.5° C) fever that would not go down with OTC acetaminophen on (03/14/2023). Pt went to a local CityMD Urgent Care as symptoms began. He was diagnosed with a UTI and was sent home on Ciprofloxacin 500mg and took it for 3 days. During this course of time, pts fever subsided but had developed hematuria and lower back pain. Pts wife drove him to NYPQ-H and was admitted to internal medicine on (03/17/2023) for failing outpatient antibiotic treatment for a UTI. Currently (03/21/23), the patient is still reporting consistent dysuria that feels like a burning sensation and is now associated with hematuria, b/L testicular swelling, constipation and diffused lower back pain rated a 5/10. He states that the lower back pain is worse with movement and is less when lying down in bed. Pt denies any radiation of lower back pain, new onset of fever, nausea, vomiting, abdominal pain or rectal bleeding.

Past Medical History:
-Type II diabetes mellitus - controlled with rx.
-Immunizations: Up to date on all immunizations

Past Surgical History:

-Umbilical Hernia repair - (10/2020, No complications)

Medications:
-Metformin 1000 mg BID for DMII - Compliant
-OTC GNC 50+ mens vitamins QD

Allergies:
-NKDA
-Denies food allergies
-Denies environmental allergies

Family History:
-Paternal/maternal grandparents, deceased, unsure of age or their medical history
-Father - Deceased, Age 107, No significant past medical history
-Mother - Deceased, Age 98, No significant past medical history
- 2 children, living and healthy.

Social History:
Status - Pt is married to a single spouse and lives in valley stream.

Occupation - Works in construction as a construction worker.

Habits - Admits to "caffeine" intake with 1-2 coffee/tea drinks on the daily.

Smoking - Denies smoking tobacco or marijuana products

Illicit drugs - Denies any past/present use of illicit drugs.

Alcohol - Former hx of weekend beer drinking 2-3 drinks, has since abstained for 35 years.

Diet - Pt reports eating an overall balanced diet and reports eating homemade bread, vegetables, beans and mixed meats like goat and chicken.

Exercise - Pt exercises 2-3 times per week - walking outside for around 30 minutes each session.

Sleep - Pt states he gets a good amount of sleep every night, about 7-8 hrs. No issues noted.

Travel - Pt traveled to Pakistan on 09/2022 for 10 days.

Sexual - Pt is currently sexually active with spouse only and uses barrier protection (condoms only).

Immunizations

Up to date with all childhood immunizations and COVID-19 Moderna vaccines with no boosters. Does not recall the last time he updated his influenza vaccine.

Review of systems:

General - **Admits recent weight loss of 10-12 lbs d/t current hospital stay**. Denies fever, chills, weakness.

Skin, Hair and Nails - Denies skin, hair, nail changes, discolorations, pruritus, or new moles.

Head - Denies HA, vertigo, head trauma or lightheadedness.

Eyes - **Admits to wearing reading glasses for farsightedness.** Denies photophobia, dryness, blurry vision or vision changes. Last eye exam - unable to recall

Ears - Denies deafness, tinnitus, pain, discharge, or use of hearing aid.

Nose/sinus - Denies pain, discharge, epistaxis, difficulty breathing.

Mouth/throat - Denies sore throat, ulcers, bleeding gums, lesions or use of dentures. Last dental exam - (unknown-month/1997)

Neck - Denies any localized swellings, masses, or decreased range of motion.

Breast - Denies any pain, masses, nipple discharge, gynecomastia, or other changes.

Pulmonary system - Denies SOB, dyspnea, cough, asthma, wheezing or orthopnea.

Cardiovascular system - Denies chest pain, chest tightness, palpitations, irregular heart beat, known heart murmurs, syncope, or edema.

Gastrointestinal System - **Admits to lack of appetite and constipation.** Denis abdominal pain, nausea, vomiting, dysphagia, diarrhea, or rectal bleeding.

Genitourinary system - **Admits to hematuria, dysuria, urinary frequency, urinary urgency, testicular swelling and flank pain.** Denis any oliguria.

Menstrual/obstetrical – Not applicable to patient.

Nervous -Denies seizures, peripheral numbness, sensory disturbances or ataxia.

Musculoskeletal system - **Admits to diffuse lower back pain**. Denies weakness, swelling, arthritis.

Peripheral vascular system - Denies edema, skin changes, or varicose veins.

Hematologic system - Denies any hx of anemia, abnormal bleeding, easy bruising, blood transfusions or hx deep vein thrombosis or pulmonary embolism. .

Endocrine system - Denies heat intolerance, goiter or excessive sweating.

Psychiatric - Denies anxiety, sadness, depression, suicidal ideations.

Physical
General: 61 y/o M laying upright at 45 degrees on hospital bed, A&Ox3 (person, place, time), afebrile, responding to questions without trouble, appears stated age and in no acute distress.

Vital Signs
BP:
Supine: R:122/64 mm/Hg (as per pt) L:118/62 mm/Hg (as per pt)
Seated: R:132/80 mm/Hg (Done on roommate) - L:136/78 mm/Hg (Done on roommate)
RR: 12 breaths/min, unlabored, regular rhythm
Pulse: 80 beats/minute, regular
Temp: 97.7 F, oral
SPO2: 97% room air
Height: 5’7”
Weight:142 lbs
BMI: 22.2

Skin & Head:
Skin: Skin was pink, warm & moist with good turgor. Non-icteric in nature. Normal body temperature.
Hair: Black hair color, normal texture, distribution, and quantity noted.
Nails: Capillary refill on nails was under 2 seconds. No clubbing, erythema, swelling, lesions were noted.
Head: Normocephalic, atraumatic and nontender on palpation.

Eyes: Symmetrical OU. PERRLA, EOMs intact with no strabismus, exophthalmos, or ptosis. Sclera was white, cornea clear, conjunctiva pink and clear.
Fundoscopy - Red reflex intact OU Cup to disk ratio < 0.5 OU. No AV nicking, papilledema, hemorrhages, exudates, or neovascularization OU (Done on roommate)

Ears: Symmetrical and appropriate in size. No lesions or trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's grayish-white, intact, cone of light in normal position AU. Weber midline, AC>BC. (Done on roommate)

Nose: Symmetrical nares. No masses, lesions, trauma, discharge, or deviated septum noted. Nasal mucosa pink. No foreign bodies or nasal septal hematoma noted b/L.

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses. (Done on roommate)

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History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Martin Vanegas

Clinical Site: NYPQ

Date of Visit: 03|21|23

Activity performed: Vitals, Skin, Ears, Eyes, Nose

Supervisor:
Name and Credentials: Bilal Hanif Senior PA

Supervisor Signature: [signature]

Supervisor Comments:

Excellent presentation