History

Identifying Data:
Full Name: AS
Address: Queens, NY
Date & Time: June 6th, 2020 4:10 PM
Location: Centers Urgent Care
Religion: Unknown
Source of Information: Self, Wife, Reliability Good
Source of Referral: Self
Mode of Transport: Car

Chief Complaint: "I have a headache and feel weak" x 14 hrs

History of Present Illness:
74 y/o male, with PMHx of HTN, COPD, and 60 pack year smoking history presents to Urgent Care c/o headache and general malaise after falling from tripping 14 hours ago. Pt states that he fell and hit his right posterior-head and describe his pain as a constant dull headache, which does not radiate. Pt states he did not take any medications to relieve headache and nothing makes it better or worse. He states it is a 7 out of 10 pain. He denies headache as being the worse he ever felt. Pt's wife stated that he had no LOC, or confusion after fall. Pt went to his primary doctor yesterday, 06/05/2020 c/o fever x 3 days and was diagnosed with bronchitis. Pt admits to loss of appetite, wet cough with clear phlegm, weakness, ambulating with a cane. Pt denies any other trauma, chills, night sweats, fatigue, recent weight gain or loss, vertigo, dizziness, unconsciousness, coma, or fractures. He also denies any visual disturbances, dyspnea, SOB, hemoptysis, cyanosis, orthopnea, PND, chest pain, palpitations, irregular heartbeat, known heart murmur, syncope, muscle/joint pain, deformity or swelling, seizures, sensory disturbances, loss of strength, or change in cognition/mental status/memory.

Past Medical History:
HTN x 20 years
COPD x 18 years
Osteoarthritis x 30 years
Childhood illnesses – Denies
Immunizations – Up to date, flu vaccine yearly.
Screening tests and results: Denies PPD recently

Past Surgical History:
Denies any surgeries.

Medications:
Augmentin, 500 mg PO daily for Bronchitis, last dose yesterday
Amlodipine, 5 mg PO daily for HTN, last dose yesterday morning
Lisinopril, 10mg PO daily for HTN, last dose yesterday morning
Meloxicam, 15 mg PO daily for osteoarthritis, last dose yesterday morning

Hydrochlorothiazide, 12.5 mg PO daily for HTN, last dose yesterday morning
Denies herbal vitamin and supplement use

Allergies:
Denies any allergies. Denies other drug, environmental or food allergies.

Family History:
No significant family history.

Social History:
Mr. S is a married male, living with his wife of 40 years and is retired MTA worker.
Habits – He admits to smoking 2 packs per day x 30 yrs, and quit 15 yrs ago. He denies any past/present alcohol use or caffeine. He denies any past/present illicit drug use.
Travel – Denies any recent travel.
Diet – He states his meals consist of cereal, bagels, vegetables, chicken. He has a well -balanced diet and tries to minimize salt and sugar intake.
Exercise - He denies any formal exercise, sleeps about 7 hours each night.
Safety measures - Admits to wearing a seat belt, walking with a cane, has smoke detectors in home, and uses sunscreen when outdoors.
Sexual Hx – Heterosexual, Denies any current sexual activity and Denies history of sexually transmitted diseases.

Review of Systems:
General – See HPI.

Skin, hair, nails – Denies changes in texture, excessive dryness, oiliness, or sweating, discolorations, pigmentations, moles/rashes, pruritus, lesions, easy bruising, or changes in hair distribution.

Head – See HPI.

Eyes –Denies any blurry vision, diplopia, scotoma, halos, pain, discharge, injury, lacrimation, photophobia, or pruritus. Last eye exam unknown.

Ears – Denies any deafness, decrease hearing, pain, discharge, tinnitus, infection, and use of hearing aids.

Nose/sinuses – Denies any discharge, epistaxis, obstruction, unusual odors, sinus infections, pain, injury, frequent sneezing, or loss of smell.

Mouth/throat – Denies bleeding gums, sore throat, excessive salivation or dryness, discharge, lesions, change in taste or texture, sore tongue, mouth ulcers, dysphagia, voice changes, loss of/trouble speaking or use of dentures. Last dental exam October 2019, unremarkable.

Neck – Denies localized swelling/lumps, pain, or stiffness/decreased range of motion, or soreness.

Pulmonary system – See HPI.

Cardiovascular system – See HPI.

Gastrointestinal system – He has regular bowel movements daily. Denies intolerance to specific foods, nausea, vomiting, hemoptysis, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, kidney stones, or lumbar/flank pain

Nervous system – See HPI.

Musculoskeletal system – See HPI. Pt. Admits to walking with a cane. Denies gout, neck pain, herniated disc, or redness.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, blood clots, cramping in legs, ulceration of extremities, hair loss or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system – Denies tremors, polydipsia, polyphagia, polyuria, heat or cold intolerance, excessive sweating, hirtuism, or goiter

Psychiatric – Denies insomnia, excessive sleep or sleep disturbances, disorientation, mood extremes, hallucinations, delusions, depression/sadness, anxiety, OCD or seeing a mental health professional.

Physical

General: Well developed male, neatly groomed in no apparent distress. Alert and cooperative, looks younger than his stated age of 74.

Vital Signs: BP:

	R	L
Seated		
Supine	148/80	

R: 16 breath/min, unlabored P: 85 beats/min, regular

T: 37.3 degrees C (oral) O2 Sat: 95% on 3L O2 via NC

Height: 66 inches Weight: 172 lbs. BMI: 27.8

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: average quantity and distribution, color grayish white.
Nails: clubbing noted, capillary refill <2 seconds throughout.
Head: normocephalic, tender to palpation on right posterior aspect of head.

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva pink & cornea clear.
Visual acuity (Corrected - 20/20 OS, 20/20 OD, 20/20 OU).
Visual fields full OU. PERRLA, EOMs full with no nystagmus
Fundoscopy – Red Reflex intact OU, Cup: Disk <= 0.5 OU, no evidence of copper wiring, A-V nicking, cotton wool spots, papilledema, hemorrhage, exudate, or neovascularization.

Ears: Symmetrical and unremarkable size. No evidence of lesions/masses/trauma on external ear. No discharge/foreign bodies in external auditory canals AU. TM's pearly white/ intact with light reflex in normal position AU. Auditory acuity intact to whisper test AU.

Nose and Sinus Exam: Nose symmetrical, no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally, nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No evidence of foreign bodies.

Sinuses: Non tender to palpation over bilateral frontal and maxillary sinuses.

Lips - Pink, moist; no evidence of cyanosis or lesions.
Mucosa - Pink ; well hydrated. No masses; lesions noted. No evidence of leukoplakia.
Palate – Pink; well hydrated. Palate intact with no lesions; masses; scars.
Teeth - Good dentition, no obvious dental caries noted.
Gingivae – Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge.
Tongue – Pink; well papillated; no masses, lesions or deviation noted.
Oropharynx - Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

Neck: Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. FROM, no stridor noted. No thrills, bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Chest: Symmetrical, no deformities, no evidence trauma. Respirations unlabored, no paradoxic respirations or use of accessory muscles noted. Lateral to AP diameter 2:1. Non-tender to palpation.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. No adventitious sounds noted.

Heart: Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and

S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Breasts: deferred.

Abdomen: Flat, symmetrical, no evidence of scars, striae, masses, caput medusa or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Male Genital: Deferred.

Anus, Rectum, and Prostate: Deferred.

Peripheral Vascular:
The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally and No stasis changes or ulcerations noted.

Motor/Cerebellar
No soft tissue swelling, erythema, ecchymosis, atrophy, fasciculations, abnormal movements or deformities in bilateral upper and lower extremities. Upper and lower extremities are non-tender to palpation and normal muscle bulk, countour, and tone. FROM of upper and lower extremities bilaterally, and 2+ symetric reflexs. No tenderness to palpation of the lumbar spine. No evidence of spinal deformities. Rapid alternating movements and point-to-point movements intact b/l, no asterixis, gait normal, Romberg and pronator drift negative.

Assessment:
74 y/o male, with PMHx of HTN, COPD, and 60 pack year smoking history presents to Urgent Care c/o headache and general malaise after falling from tripping 14 hours ago,

Differential Dx:
Traumatic Brain Injury
Community acquired Pneumonia
Orthostatic Hypotension
Fall secondary to Polypharmacy
Subarachnoid Hemorrhage

Plan:
Pt medication reviewed. Pt referred to Emergency Room for further evaluation, to rule out any intracranial bleeding. Pt and wife verbalize understanding. EMS transport offered but declined, as wife states she will take him immediately. Follow-up with PCP after discharge.

- Viral -
- UTI

3rd rotation LTC
Surgery

* Antibody tests * 45 a day
- phlebotomy
- Imaging reviews
- slips / falls
- loc repairs
- referrals
- injections Im / SQ

16/18
see pt → Hx → exam → present
ekg / xray
3pt preceptor / day
3 days / 36 hours a week

S: Pt is a 35 y/o female with PMH of a pelvic kidney, high cholesterol, and pre-diabetes. She presents to urgent care c/o dysuria, urinary urgency, frequency and cloudy urine x 3 days. She states that she gets frequent UTIs because se was born with one kidney that is located in her pelvis. She states she follow-ups with a nephrologist but was unable to get an appointment due to the pandemic. She denies any radiating pain or taking any medication for the UTI symptoms. Pt denies any fever, chills, night sweats, weakness, fatigue, weight loss/gain, n/v/d, HA, or blurred vision. She also denies any pain, cough, CP, SOB or abdominal pain.

O: Vitals – T 98.7, BP - 119/76, HR – 72/min, RR – 16/min, SpO2 – 96%

General: Alert, seated on bed, well groomed and good hygiene, in no apparent distress.

Eyes: PERRLA

Ears: Unremarkable

Nose: nares patent, no lesions

Throat: pharynx normal

Lymph Nodes: no lymphadenopathy

Heart: RRR, S1 and S2 normal, no murmurs

Chest/Lungs: Respirations unlabored, nontender to palpation, clear to auscultation bilaterally

Abdomen: BS present in all four quadrants, soft, nontender, nondistended.

Labs:

U/A – LEU – 3+, NIT – 0, pH – 5.5, Blood – +-, SG – 1.025, Ket - 0

A: Pt is a 35 y/o female with PMH of a pelvic kidney, high cholesterol, and pre-diabetes. She presents to urgent care c/o dysuria, urinary urgency, frequency and cloudy urine x 3 days. Findings consistent with a Urinary Tract Infection.

P: Urinary Tract Infection

- Start Ciprofloxacin HCL Tablet, 250 Mg, 1 tablet, Orally, every 12 hours, for 10 days. 20 tablets, 0 Refills.
- D/c instructions reviewed and discussed
  - Continue medications as prescribed and side effects reviewed and discussed
  - Advised to Increase fluid intake
- Advised patient to proceed to ER if fever, chills, flank pain, abdominal pain, nausea, vomiting, or any other concerning signs and symptoms occur.
- Patient in no acute distress and ambulated from clinic.

Patient was seen and examined with PA Shaw.

S: Pt is a 32 y/o F denies any significant PMHx. She presents to Urgent Care c/o swelling around both eyes x 1 day. She state she had presented to Urgent Care on 05/31/2020 for an allergic reaction secondary to eating sushi, for which she was prescribed prednisone. She admits to finishing the steroids, which helped. She states that the swelling and redness around her eyes started last night. She admits to restarting a retinoid cream for her face. Pt also admits to itching and swelling. She denies any new foods or use of soaps, recent travel, and sick contacts. She denies wearing glasses or contacts, blurriness, ptosis, or acute vision loss. She also denies any fever, chills, night sweats, HA, dizziness, CP, SOB, n/v/d, or other symptoms.

O: Vitals – T: 98.5, BP - 137/88, HR - 92, RR – 16, SpO2 – 98%

General: Alert, seated on bed, well groomed and good hygiene, in no apparent distress.

Skin: Pt has tattoos along both arms, skin Warm and dry, no scars, and bruises.

Eyes: RERRLA, positive swelling and redness around both eyes. Pt is able to open eyelids and has FROM with visual fields intact.

Ears: Unremarkable

Nose: nares patent, no lesions

Throat: pharynx normal

Lymph Nodes: no lymphadenopathy

Heart: RRR, S1 and S2 normal, no murmurs

Chest/Lungs: Respirations unlabored, nontender to palpation, clear to auscultation bilaterally

Abdomen: BS present in all four quadrants, soft, nontender, nondistended.

A: Pt is a 32 y/o F denies any significant PMHx. She presents to Urgent Care c/o swelling around both eyes x 1 day. She finished a round of steroids for and allergic reaction to sushi. History and examination demonstrates a rash and nonspecific skin eruption.

P: Rash and nonspecific skin eruption

- Give IM Dexamethasone Sodium Phosphate 4 mg, on left deltoid.
- Start Prednisone Tablet, 20 Mg, 1 tablet, Orally, once a day for 5 days, 5 Tablets, 0 Refills
- D/C instructions reviewed and discussed
    - Continue medications as prescribed and side effects reviewed and discussed
- Advised patient to proceed to ER if sudden change in rash, fever, throat, closing, lip swelling, difficulty breathing or other concerning symptoms arise.
- Patient in no acute distress and ambulated from clinic.

Patient was seen and examined with PA Shaw.

S: Pt is a 27 y/o M who denies any significant PMH. He presents to Urgent care c/o midsternal chest pain and SOB x 1 day. He states that the pain came about last night during rest and describes it as a pressure that radiates from the midsternum outwards. He denies taking any medication for the pain and pain on position change. He rates the pain a 7 out of 10 that lasts for a few minutes. He admits to and episode of SOB and HA that started this morning. He denies taking any medication to relieve symptoms, and denies the HA radiating anywhere else. Pt admits to unintentional weight loss of about 40 lbs. over the last 6 months. He states that he works as a supervisor at UPS but had to start doing deliveries due to workload, so he admits to lifting boxes and on his feet all day. He also states he eats when he can and knows he has not been eating healthy. He denies any fever, chills, night sweats, cough, active CP, palpitations, murmurs, DOE, edema, or difficulty breathing. He also any dizziness, wheezing, n/v/d, abdominal pain or any tingling/numbness.

O: Vitals – T: 98.3, BP - 121/77, HR – 56/min, RR – 16/min, SpO2 – 98%

General: Alert, seated on bed, well groomed and good hygiene, skinny, in no apparent distress.

Skin: Warm and dry, no scars, bruises, and suspicious lesions.

Eyes: PERRLA

Ears: Unremarkable

Nose: nares patent, no lesions

Throat: pharynx normal

Lymph Nodes: no lymphadenopathy

Heart: RRR, S1 and S2 normal, no murmurs, rubs, gallops

Chest/Lungs: Respirations unlabored, nontender to palpation, clear to auscultation bilaterally

Abdomen: BS present in all four quadrants, soft, nontender, nondistended.

Musculoskeletal: no acute abnormality noted, FROM with no pain.

ECG: Abnormal ECG with T wave inversions and LVH.

A: Pt is a 27 y/o M who denies any significant PMH. He presents to Urgent care c/o midsternal chest pain and SOB x 1 day. Pts abnormal ECG, chest pain, and clinical findings require further cardiac workup.

P: Chest Pain, Unspecified.

- Pt advised to go to Emergency Room immediately as chest pain is concerning because of his age, bradycardia, and ECG findings and needs further evaluation, Pt verbalize understanding. EMS transport offered but declined, as patient states he will go immediately. Patient agrees with plan and understands reason for Emergency Department evaluation. Advised to Follow-up with PCP after discharge.

Patient was seen and examined with PA Shaw.

S: Pt is a 70 y/o F with PMH of HTN and osteoporosis. She presents to urgent care c/o right elbow laceration and shoulder pain x 2 hrs after a fall. She reports that she was walking with her husband when she tripped and fell on the concrete. She fell on her right elbow and shoulder from standing height. She rates the pain on her elbow and shoulder was a 4 or 5 out of 10 and denies any radiating pain. She states that she cleaned the wound with water and put a bandage on. However she noticed that the laceration was still bleeding an hour later. She admits to taking aspirin daily. She denies any foreign body, bruising, swelling, loss of sensation, tingling/numbness, head trauma, joint stiffness, or decrease ROM. She also denies any fever, chills, night sweats, weakness, fatigue, n/v/d, abdominal pain, CP, SOB, palpitations, or other symptoms.

O: Vitals – T: 98.7, BP - 178/81, HR - 78, RR – 16, SpO2 – 96%

General: Alert, seated on bed, well groomed and good hygiene, well nourished, in no apparent distress.

Skin: 1 cm laceration noted along right posterior elbow with no active bleeding or foreign body noted. Warm and moist throughout, no scars, bruises, and other suspicious lesions.

Eyes: PERRLA

Heart: RRR, S1 and S2 normal, no murmurs, rubs, gallops

Chest/Lungs: Respirations unlabored, nontender to palpation, clear to auscultation bilaterally

Musculoskeletal: Right Shoulder: no acute abnormality noted, FROM with no pain.

Right Shoulder x-ray: No acute fracture or dislocation

Right elbow x-ray: No acute fracture or dislocation, No foreign objects noted.

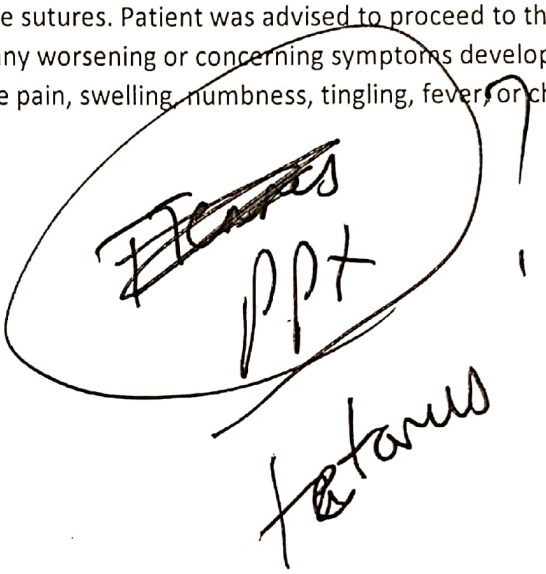
A: Pt is a 70 y/o F with PMH of HTN and osteoporosis. She presents to urgent care c/o right elbow laceration and shoulder pain x 2 hrs after a fall. X-rays found no fracture or dislocation of right shoulder and elbow. History and physical consistent with Acute pain of right Shoulder, right elbow pain, laceration of right elbow.

P:

1) Acute pain of right shoulder and elbow
   - Discharge instructions reviewed with patient
   - Patient advised to take Tylenol/Motrin as needed for pain and/or swelling.
   - Patient given RICE instructions and advised to avoid strenuous activities with extremity at this time.
   - Patient advised to follow-up with PCP and/or Orthopedics as soon as possible.
   - Patient was advised to proceed to the nearest Emergency Department if any worsening or concerning symptoms develop, including but not limited to increase pain, swelling, numbness, tingling, fever, or chills.
   - Patient had opportunity to ask questions and presented a good understanding of instructions and follow-up.
   - Patient ambulated in clinic freely in no acute distress. Patient in good appearance and in no distress at the time of discharge.
2) Right Elbow Laceration

- Patient consent: Laceration repair risks and benefits were explained. The patient appears to understand and granted permission to perform procedure. Verbal consent obtained.
- Anesthesia: Local, Lidocaine 1%, 10 mL. Preparation: area cleaned, prepped, and draped using sterile technique, Betadine, Debrided/undermined, Irrigated/washed with saline, Explored, no foreign material found, Draped in a normal sterile fashion. Distal NVT: Neuro and vascular status intact.
- Procedure: Area cleaned and bandaged, patient tolerated the procedure well. Using 3 sutures place, Suture type used: 5-0 propyprolene.
- Post procedure: Bacitracin placed over laceration, non-absorbable pad covered site and then wrapped with kerlix .
- Patient instructed to clean area every 12 hrs and cover, avoid rubbing and sun exposure. Patient had opportunity to ask questions and presented a good understanding of instructions and follow-up.
- Return to clinic in 12 days to remove sutures. Patient was advised to proceed to the nearest Emergency Department if any worsening or concerning symptoms develop, including but not limited to increase pain, swelling, numbness, tingling, fever, or chills.

Patient was seen and examined with PA Shaw.



Maximal dose	Bacterial infection – 500 mg PO q6-8h x 7-14 days Amebic liver abscess – 500-750mg PO q8h x5-10 days PID – 500 mg PO q12h x 14 days (part of muti drug tx or w/ azithromycin Bacterial vaginosis – 500 mg PO q12h x 7 days Trichomoniasis – 500 mg PO q12h x 7 days

Good preceptor
good hours
education opportunities

venipunctures galore
strep test
splinting
15 - 20 each day
presenting pt to preceptor