History

Identifying Data:
Full Name: SP
Address: Brooklyn, NY
Date & Time: September 29, 2020 at 10:40 AM
Location: NYC Health + Hospitals/Woodhull
Religion: Baptist
Source of Information: Self, Reliability Good
Source of Referral: Self

Chief Complaint: "I have blisters around my vagina" x a few weeks

History of Present Illness:
42-year-old female, G5P3023 with past medical history of HTN. She presents to the clinic c/o warts to her genital area x few weeks. She stats that she first noticed them on her vulva a year ago but did not seek any medical attention. She has growing concerns because new lesions are "popping up" most notably on her "right lip" and they are growing. She describes the lesions as painful, uncomfortable and notices bleeding sometimes with an odor in her genital area. She reports buying any over the counter cream, but cannot recall the name which provided no relief. She rates the pain a 5-6 out of 10, but denies any radiating pain. She says the lesions do not disappear and she wants them removed. She denies any itching, vaginal discharge, dysuria, frequency, urgency, hematuria, or incontinence. She also denies any fever, chills, HA, CP, SOB, N/V/D, or abdominal pain. States she's been celibate for a year due to embarrassment and discomfort. She also admits to previous history of Chlamydia in her 20's. Her LMP was 09/10/2020.

Past Medical History:
Hypertension x 8 years
Childhood illnesses – Denies
Immunizations – Up to date; flu vaccine yearly.
Screening tests and results: Denies PPD recently, Colonoscopy - not due, Last Mammography – could not recall. Last Pap smear - could not recall.

Past OB/GYN History:
NSVD x 3, born full term with no complications; SA x 2
LMP: 09/10/2020, normal, consistent, lasts about 5 days

Past Surgical History:
Right shoulder surgery secondary to an MVA, no complications

Medications:
Losartan 100 MG Tablet, PO daily.
Denies past/ present herbal or vitamin use.

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

Family History:
Father – Deceased at age 72, from Cancer, unknown
Mother – Alive, has history of DM and HTN.
Sister – 46, alive, has DM.
She denies any family history of breast, cervical, or ovarian cancer.

Social History:
Ms. SP is an African American female, who is widowed and lives with her three children.
Habits –She coffee daily. She denies any past or present smoking cigarettes, and denies any past/present illicit drug use. She admits to drinking alcohol very rarely, mostly during occasions.
Travel – Denies any recent travel or COVID contacts.
Diet - Consists of rice, bread, meat and fried foods.
Exercise - She denies any formal exercise, and sleeps about 7 hours each night.
Sexual Hx – Heterosexual, who had two partners since her husband died 5 years ago and has history of Chlamydia in her 20's but denies any other history of sexually transmitted infections. Uses Condoms sometimes.

Review of Systems:
General – good general state of health, no weight loss or gain, no weakness, no fatigue, no fever.

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

Head – Denies headache, vertigo, head trauma, loss of consciousness, coma, and fainting.

Chest/Breast – Denies any lumps, nipple discharge, tenderness, masses, deformity, changes in nipple or skin, or pain.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – She has good appetite and formed brown bowel movements daily. Denies intolerance to specific foods, heartburn/reflux, nausea, vomiting, hemoptysis, pyrosis, unusual flatulence or eructation's, abdominal pain, diarrhea, jaundice, constipation.

Genitourinary system – See HPI. Denies nocturia, oliguria, polyuria, kidney stones, or lumbar/flank pain, and no hernias.

Physical

Vital Signs:
Height: 5 ft 7 in
Weight: 210 lbs
BMI: 30.86
Pulse Oximetry: 98% - room air
RR: 16 bpm - unlabored
Pulse: 95 bpm - strong regular rhythm
Temperature: 98.3 F - oral
BP: 142/76 - seated L arm
Pain Scale: 6

General: 42-year-old African American female, overweight, neatly groomed, appropriately dressed, good hygiene, seated in no apparent distress. Alert and cooperative, looks her stated age of 42.
Hair: average quantity and distribution.
Nails: no clubbing noted, capillary refill <2 seconds throughout.
Head: normocephalic, atraumatic, non-tender to palpation throughout
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, and no bruits noted.

Chest: Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation.

Lungs: Clear to auscultation bilaterally. No adventitious sounds.

Heart: Regular rate and rhythm (RRR); S1 and S2 are normal. There are no JVD, no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds. Carotid pulses are 2+ bilaterally without bruits.

Breasts: symmetric, no lumps/masses, or lesions.

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

Female Genital:
Vulva: Notable 1 x 2 cm raised verrucous lesion at distal end of right labia minus. Smaller warty lesion in perineum and perivaginal area totaling about 7. Larger mass slightly tender when pulled. No bleeding.
Vagina: mucosa pink, unremarkable rugae, no visible lesions
Cervix: No lesions noted, no CMT

Uterus: Small, not enlarged, nontender
Adnexa: No masses palpable

Assessment:
42-year-old female, G5P3023 with past medical history of HTN. She presents to the clinic c/o warts to her genital area x few weeks. She describes the lesions as painful, uncomfortable and notices bleeding sometimes with an odor in her genital area. Examination of external female genitalia consistent with Condyloma Acuminata.

Plan:
Condyloma Acuminata
-Start Trial of Imiquimod (Aldara) 5% cream, Apply topically on Monday, Wednesday, Friday at night and wash off in morning about after 6-10 hours. Wash hands prior to and following application. Patient counseled on proper use and possible side effects such as redness.
-Consider excision of larger lesion for comfort
-Patient also informed to avoid sexual contact while the cream is on skin as it might weaken condoms and diaphragms and irritate partner's skin.
-Counseled on the importance of condom usage, as condoms have been shown to protect against HPV infection, which causes genital warts. Condom usage can also prevent the transmission of other communicable diseases, as well.
-Hep C, Syphilis, HIV testing done
-Pap offered but declined to be done at next visit.
-F/U 1-2 wks

Essential (primary) hypertension
-Continue Losartan 100MG PO daily
-F/u with PCP
-Educated patient on importance of adherence and Counseled on need for exercise, dietary changes such as a low salt diet.