History

Identifying Data:
Full Name: SB
Address: Brooklyn, NY
Date & Time: October 01, 2020 at 13:20 AM
Location: NYC Health + Hospitals/Woodhull
Religion: Baptist
Source of Information: Self, Reliability Good
Source of Referral: Self

Chief Complaint: "I have pain when I use the bathroom" x a few days

History of Present Illness:
71-year-old female, G3P3003 with past medical history of HTN, HLD, DM2, GAD, arthritis and polycythemia. She presents to the clinic c/o dysuria x a few days. She also admits to vaginal burning, itching, and bumps around labia for a few days. She also complains of itchiness around her groin and lower abdomen. She denies ever having a similar episode, and denies seeing another medical professional or using any medication for her symptoms. She also denies any radiating pain. She reports that the pain is worse when urinating. She denies any vaginal discharge, 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 over 10 years and denies any past history of STIs. Her LMP was >20 years, and is postmenopausal.

Past Medical History:
Hypertension
Diabetes mellitus type 2
Hyperlipidemia
Generalized Anxiety Disorder
Polycythemia Vera x 11 years
Chronic Headache
Arthritis
Childhood illnesses – Denies
Immunizations – Up to date; flu vaccine yearly.
Screening tests and results: Denies PPD recently, Colonoscopy - could not recall.

Past OB/GYN History:
NSVD x 3, born full term with no complications.
LMP: None recorded. Patient is postmenopausal x 20 years.
Last Pap smear - could not recall, patient denies any history of abnormal Pap.
Last mammogram: 2019. Results were: normal

Past Surgical History:
Laparoscopic Cholecystectomy 2018, Woodhull hospital, no complications
Total Hysterectomy, unknown hospital or year

Right Knee Joint Replacement, unknown hospital or year

Medications:
Losartan 100 MG tablet, PO daily.
Aspirin 81 MG EC tablet, PO daily.
Atorvasatin 10 MG tablet, PO daily.
Klonopin 0.5 MG tablet, PO TID.
Docusate sodium 100 MG capsule, PO daily.
Duloxetine 60 MG DR, PO daily.
Furosemide 20 MG tablet, PO BID.
Metformin 1000 MG tablet, PO BID with meals.
Glipizide 5 MG tablet, PO daily.
Acetaminophen 500 MG tablet, PO TID prn.
Vitamin D/calcium carbonate 600 MG tablet, PO daily.
Hydroxyurea 500 MG capsule, Take 2 pills PO in morning and 1 pill at night.
Lorazepam 0.5 MG tablet, PO BID prn.
Denies any other herbal or vitamin use.

Allergies:
Penicillin, Rxn – Rash and itching
Ace Inhibitors, Rxn – Chest tightness
Topiramate, Rxn - Rash
Denies any other known drug, environmental or food allergies.

Family History:
Father – Deceased at age 80, from natural cause
Mother – Deceased at age 82, has history of DM and HTN.
Maternal Aunt – History or breast Cancer
Sister – 68, alive, had colon cancer, s/p surgery.
She denies any family history of cervical, or ovarian cancer.

Social History:
Ms. SB is an African American female, who is widowed and lives alone.
Habits –She drinks tea daily. She denies any past or present smoking cigarettes, or illicit drug use, and denies any current alcohol use.
Travel – Denies any recent travel or COVID contacts.
Diet - Consists of rice, bread, chicken, meat, and fried foods.
Exercise - She denies any formal exercise, and sleeps about 7 hours each night.
Sexual Hx – Heterosexual, who is postmenopausal and no longer sexually active for over 15 years. She denies any history of sexually transmitted infections.

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 4 in
Weight: 213 lbs.
BMI: 36.56
Pulse Oximetry: 98% - room air
RR: 18 bpm - unlabored
Pulse: 91 bpm - strong regular rhythm
Temperature: 97.6 F - oral
BP: 148/80 - seated L arm

General: 71-year-old African American female, obese, neatly groomed, appropriately dressed, good hygiene, ambulates with walker and seated in no apparent distress. Alert and cooperative, looks younger than her stated age of 71.

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no tattoos, erythema, swelling, bruises, or masses. Notable vertical scar on right knee.
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, no bruits noted.

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

Lungs: Clear to auscultation bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. 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 tenderness, lumps/masses, lesions, or nipple abnormality.

Abdomen: BS present in all 4 quadrants. Erythematous, slightly tender areas with evidence of rash/candidiasis, satellite papules and pustules along abdominal skin fold. No bruits noted over aortic/renal/iliac/femoral arteries. Symmetrical. 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: Enlarged labia majora secondary to swelling, numerous clusters of ulcerated lesions, tender to touch. No bleeding or discharge noted.
Vagina: mucosa pale pink, smooth rugae, no visible lesions or discharge.
Cervix: Surgically absent
Uterus: Surgically absent
Adnexa: Non-tender, No masses palpable

Labs:
POC Uristix 4 Manual
Status: Final result

	Ref Range & Units	10/1/20 1512
UA Glucose, POC	Negative mg/dL	Negative
UA Protein POC	Negative mg/dL	Negative
UA Nitrite POC	Negative	Negative
UA Leukocyte Esterase POC	Negative	Negative

Assessment:
71-year-old female, G3P3003 with past medical history of HTN, HLD, DM2, GAD, arthritis and polycythemia. She presents to the clinic c/o dysuria x a few days. She also admits to vaginal burning, itching, and bumps around labia for a few days. She also complains of itchiness around her groin and lower abdomen. Examination of abdomen consistent with Candidal intertrigo, and Examination or external female genitalia consistent with Genital herpes outbreak.

Plan:

Candidal intertrigo

- Start Clotrimazole 1% cream, Apply topically two times a day. Patient counseled on proper use and possible side effects.
- Patient counseled on minimizing moisture and friction in the involved area by cleaning skin with a mild cleanser followed by drying of affected area with paper towels or hair dryer on a cool setting. Patient can also apply drying powders daily. Use of absorbent material or clothing, such as cotton or merino wool, to separate skin in folds.
- Patient advised to lose weight for prevention of future episodes and be compliant with medication to control Diabetes.
- Consider Oral Fluconazole if no response or relief.
- F/u in clinic in 2 weeks.

Genital herpes outbreak

- Start Acyclovir 5% ointment topically every 3 hours
- Start Acyclovir 400 mg five times per day for 10 days
- Continue acetaminophen 500 MG tablet, by mouth 3 (three) times a day, as needed for pain.
- Patient reassured that recurrences are generally less severe and shorter than the first episode and that episodic treatment of recurrences, or chronic suppression with antiviral therapy, are available therapeutic options. Educated on the probability of recurrence and risk.
- F/u in clinic in 2 weeks.

Screening:

- Mammogram screening ordered
- Referral for Woodhull Gastroenterology for Colonoscopy screening