History

Identifying Data:
Full Name: AW
Address: Brooklyn, NY
Date & Time: October 02, 2020 at 14:20 AM
Location: NYC Health + Hospitals/Woodhull
Religion: Unknown
Source of Information: Self, Reliability Good
Source of Referral: Self

Chief Complaint: Routine Prenatal follow up

History of Present Illness:
19-year-old female, G2P1001, Estimated Date of Delivery: 10/25/20 @ 36w5d. Pt has past medical history of asthma with last attack over 5 years ago and denies any prior hospitalizations or intubations. She presents to clinic for Routine Prenatal follow up appointment. She reports daily and active fetal movement; she denies any vaginal bleeding or spotting, no cramping or contractions, no ROM, no headaches or blurred vision. She reports that she stopped taking prenatal vitamins and iron supplements because "pills are nasty and too big, and the gummies didn't taste good." reports last used a few months ago. She lives with her partner and her 2 y/o daughter, with support from her parents. States she is ready for labor and delivery and comfortable with parenting. She denies any itching, vaginal discharge, dysuria, frequency, urgency, hematuria, or incontinence. She also denies any fever, chills, dizziness, CP, SOB, N/V/D, or abdominal pain.

Past Medical History:
Mild intermittent asthma without complication, No hospitalization or intubation
Childhood illnesses – Denies
Immunizations – Needs MMR, Rubella non-immune; Nonimmune to hepatitis B virus.
Screening tests and results: Quantiferon Plus TB - Negative.

Past OB/GYN History:
NSVD x 1, born full term, 6 lbs 11 oz with no complications at Kings county Hospital
LMP: 01/18/2020.
STI: Has history of Chlamydia.

Past Surgical History:
Denies any past surgeries.

Medications:
None
Denies any current herbal or vitamin use.

Allergies:

Denies any known drug, environmental or food allergies.

Family History:
Father – Alive, age 50
Mother – Alive, age 45
She denies any family history of breast, cervical, or ovarian cancer.

Social History:
Ms. AW is an African American female, who lives with her partner and 2 y/o daughter. Denies intimate partner violence. Has support from partner and her family.
Habits –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 – States she has a healthy diet of fruits and vegetables, but admits to fast food.
Exercise - She denies any formal exercise, and sleeps about 7 hours each night.
Sexual Hx – Heterosexual, who reports only sexually active with one partner. Has history of chlamydia.

Review of Systems:
General – good general state of health, no weight loss, no weakness, no fatigue, and 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 –Denies dysuria, vaginal discharge, frequency, urgency, hematuria, incontinence, nocturia, oliguria, polyuria, kidney stones, or lumbar/flank pain, and no hernias.

Physical

Vital Signs:

Height: 5 ft 6 in
Weight: 153 lbs.
BMI: 24.7
Pulse Oximetry: 99% - room air
RR: 16 bpm - unlabored
Pulse: 90 bpm - strong regular rhythm
Temperature: 98.1 F - oral
BP: 124/74 - seated L arm

Fetal Assessment:
Fetal Heart Rate: 141
Fundal Height (cm): 36 cm
Movement: Present
Presentation: Vertex
TWG about 27 lbs

General: 19-year-old African American female, neatly groomed, appropriately dressed, good hygiene, seated in no apparent distress. Alert and cooperative, looks her stated age of 19.

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos, erythema, swelling, bruises, or masses.
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: Deferred.

Abdomen: BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries. Symmetrical and Gravid Uterus. No caput medusae or abnormal pulsations. Non-tender to palpation. No evidence of organomegaly. No masses or hernias noted. No evidence of guarding or

rebound tenderness.

Female Genital: Deferred.

Assessment:
19-year-old female, G2P1001, Estimated Date of Delivery: 10/25/20 @ 36w5d. Pt has past medical history of asthma with last attack over 5 years ago and denies any prior hospitalizations or intubations. She presents to clinic for Routine Prenatal follow up appointment. She reports daily and active fetal movement. Fundus 36 cm, FH 141, vertex position.

Plan:
1. RTC weekly x3 for check up.
2. Sonogram scheduled on 10/5/20- pt is aware
3. Labs: CBC And Differential, Chlamydia/ G.C. Amplification - only urine, Hemoglobin A1C, Cystic Fibrosis, Carrier Screening, HIV AG/AB Screen
4. Vaginal/rectal culture - Positive for GBS on 07/2020, Pt aware and will receive PCN G prophylaxis during Labor
5. Rubella vaccine Post partum
6. Hepatitis B Vaccine Post partum
7. Breastfeeding encouraged. Pt desires to pump. Not comfortable with baby actually latching. Discussed benefits.
8. Birth control discussed. Pt desires Patch- understand cannot get patch immediate Post Partum
9. Visiting policy discussed