Alena Rakhman

History

4 **Identifying Data:**
Full Name: MB
Address: Flushing, NY
Age: 93 y/o
Date & Time: October 31, 2017, 9:30 AM
Location: New York Presbyterian / Queens Hospital
Religion: Jewish
Source of Information: Self
Source of Referral: N/A
Mode of transport: pt unaware

2 **Chief Complaint:** "I have been coughing up phlegm" x4 days.

10 **HPI:** Ms. B, a 93 y/o unreliable female due to age, with PMHx of HTN and diabetes, who presented to the ED 1 day ago, c/o productive cough for the past 4 days. The cough is persistent and irritating to the throat, occurring every day at random times throughout the day and night with no particular pattern or duration. The cough has remained consistent and has not changed or worsened acutely. She did not take any medication to alleviate the cough. The cough is not alleviated or worsened by anything, and is not worse at night, but pt reports waking up at night to cough. She says the cough pasisted after she had a cold (pt unsure if resolved) and produces white, thick phlegm. Cough intensity is 7/10 and she denies having pain anywhere. She has also been experiencing weakness and fatigue for the past 4 days when her sxs began. She reports vomiting

- Any new meds?
- GERD can cause cough also → so ask about reflux symptoms.
- Any recent travel
- has this happened before

Usually use this scale for pain.

5 times at night 2 days ago (unaware of color), and has been having diarrhea x5days (does not know number of movements per day and consistency). She has also been feeling nauseous since yesterday morning after eating, and reports having loss of appetite x4 days with moderate (5lbs?) weight loss. She denies throat pain, SOB, wheezing, chest pain, fever, chills, bodyaches, hemoptysis, post nasal drip, nasal discharge, sore throat, abdominal pain, vomiting, headache, dizziness, fainting, lightheadedness, loss of consciousness, h/o smoking, h/o cancer, h/o COPD, h/o asthma, or h/o pneumonia.

9 Past Medical History:
Present illnesses - HTN (pt doesn't know duration)
arthritis (pt doesn't know duration)
diabetes (pt doesn't know duration)
Past medical illnesses - neck pain (received cervical epidural steroid injections).
Hospitalized for triple bypass and vaginal bleeding (see surgeries).
Childhood Illnesses - Mastoiditis (pt does not recall age). Denies other illnesses.
Immunizations - up to date; no recent vaccines (reports getting sick from last vaccine, does not recall name).
Screening tests and results - Screening mammogram about 10 years ago, benign.

Past Surgical History:
Triple bypass - pt does not recall age, St. Mary's Hospital. Due to chest pain, no complications at hospital AR 11/01/17
Transfusion - pt does not recall age, due to

vaginal bleeding (denies miscarriage).
Left wrist fracture - pt does not recall age, healed well.

Medications:
Pt is unable to provide name of medication & last dose.

Allergies:
Seasonal allergies - rhinorrhea.
Had a reaction to a vaccine (pt does not know name) - hair loss.
Denies other drug, environmental or food allergies.

4 Family History:
Father - deceased at 88, MI
Mother - deceased at 84, trauma
Daughter - 65, alive and well
Son - 62, alive and well
Family h/o HTN and diabetes mellitus. Denies family h/o heart disease, lung disease, cancer, allergies, gastrointestinal disease, disease of urinary tract, or psychiatric or nervous disorders.

8 Social History:
Mrs. B is a widowed female, living alone w/o any pets. She is a retired saleswoman and is not currently working. She has 2 health aids that are with her throughout the week.
Habits - She denies drinking any alcohol/beer, smoking cigarettes/cigars, or illicit drug use.

Travel - She denies any recent travel.
Diet - She denies following any specific diet. States that she does not consume cheese because she can't taste it.
Exercise - She uses a walker at home to move around, walks short distances outside. She sleeps well, about 9 hours each night.
Safety measures - admits to wearing a seat belt.
Sexual hx - she is currently not sexually active and has not been for several years (pt does not know duration). AE 11/6/17

ROS:

18 General - states that she has been having loss of appetite, recent weight loss, and generalized weakness/fatigue for the past 4 days; denies recent weight gain, fever or chills, or night sweats. how much?

Skin, hair, and nails - denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritis, changes in hair distribution.

Head - denies headaches, vertigo, head trauma.

Eyes - wears glasses; denies visual disturbance, lacrimation, photophobia, pruritis; does not remember date of last eye exam.

Ears - denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/Sinuses - denies discharge, epistaxis or obstruction.

Mouth and throat - states that she has dentures; denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes; does not remember date of last dental exam.

Neck - denies localized swelling/lumps, stiffness/decreased range of motion.

Breast - denies lumps, nipple discharge, or pain.

Pulmonary System - states that she has a productive cough for the past 4 days; denies dyspnea, dyspnea on exertion, wheezing, hemoptysis, cyanosis, orthopnea or paroxysmal nocturnal dyspnea.

Cardiovascular System - states that she has h/o HTN (duration unknown); denies chest pain, palpitations, irregular heart beat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal System - she has been having diarrhea for the past 5 days (does not know number of movements per day and consistency), loss of appetite for the past 4 days, vomiting 2 days ago (x5 at night, does not know what color), and nausea since

yesterday morning (does not know nature); denies intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, abdominal pain, change in bowel habit, hemorrhoids, melena, constipation.

Genitourinary System - denies urinary frequency, urinary urgency, nocturia, oliguria, polyuria, dysuria, incontinence, flank pain, or awakening at night to urinate.

Menstrual and Obstetrical - G2P2 (NSVD x2), no complications. Menarche at age 12. Does not recall LMP. Menopause at age 54 - denies hot flashes or associated menopausal symptoms. Denies breakthrough bleeding/spotting or vaginal discharge.

Nervous system - states that she was been feeling weak (symmetric) for the past 4 days; denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory.

Musculoskeletal System - states that she has arthritis (duration unknown); denies muscle/joint pain, deformity or swelling, redness.

Peripheral Vascular System - denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change.

Hematologic System- she had 1 blood transfusion due to vaginal bleeding at unknown age, denies anemia, easy bruising or bleeding, lymph node enlargement, or history of DVT/PE.

Endocrine System- denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, hirsutism.

Psychiatric- denies depression/sadness, anxiety, obsessive/compulsive disorder, seeing a mental health professional, taking psychiatric medications.

Physical

1 General: 93 y/o female, A/O x3. Pt is a slender female, neatly groomed, looks her stated age. Pt does not appear to be distressed.

8 Vital Signs: patient refused due to previous unsuccessful attempts by healthcare staff.

(next time make up the vital signs but in a different color) should be done in another color

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.
Hair: average quantity and distribution.
Nails: no clubbing, capillary refill <2 seconds throughout.
Head: normocephalic, atraumatic, non-tender to palpation throughout.

(8)

16

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white, conjunctiva & cornea clear.
Visual acuity (uncorrected - 20/50 OS, 20/50 OD, 20/50 OU).
Visual fields full OU. PERRLA, EOMs full with no nystagmus.
Fundoscopy - Red reflex intact OU. Cup: Disk ≤ 0.5 OU / no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

should be done over color

Ears: Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears. No discharge/foreign bodies in external auditory canals AD. TM's pearly white/ intact with light reflex in normal position AU.
Auditory acuity intact to whispered voice AD. Weber midline/Rinne reveals AC > BC AU.

Nose: Symmetrical, no obvious masses/lesions/ deformities/trauma/discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions/deformities/ injection/perforation. No evidence of foreign bodies.
Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.
Mucosa: Pink; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia.
Palate: Pink; well hydrated. Palate intact with no lesions, masses, scars. Non-tender to palpation.
Teeth: Pt wears dentures.
Gingivae: Pink, moist. No evidence of hyperplasia masses, lesions, erythema or discharge. Non-tender to palpation.
Tongue: Pink, well papillated, no masses, lesions or deviation noted. Non-tender to palpation.
Oropharynx: Injected oropharynx; well hydrated; no evidence of exudate, masses, lesions, foreign bodies. Tonsils present with injection, no evidence of exudate. Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. FROM, no stridor noted. 2+ Carotid pulses, no thrills, bruits noted bilaterally, no palpable adenopathy noted.

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

should be in another color

95%@