Medical History

Taiba Shah

Identifying Data

Full name: D.N

Address: Queens N.Y

Date of Birth: 01-06-1937

Date & Time: 10-30-2018 9:34 am

Religion: Catholic

Source of Information: Self

Refferal Source: PCP

PCP: Dr. Jones

Patient is aware and competent, and questionably reliable

Cheif Complaint: "My blood report came back, and my doctor said my kidneys are not working properly" x3 weeks

History of Present Illness:

D.N. is a questionably reliable 81 y/o Italian female with significant past medical history of diabetes type 2, hypertension, ulcerated colitis and hyperlipidemia, who is in internal medicine c/o abnormal test results that her doctor said showed kidney dysfunction. She states that she had no pain or discomfort, she received a call from her PCP 1 month ago that her blood and urine tests showed that her kidneys were not functioning properly, and her PCP told her to go to the ER. She has been in the hospital for 1 month. She has no pain or discomft while in the hospital. D.N. states she had 2 blood transfusions, 1-2 treatments of chemotherapy, 5 treatments of dialysis. She was told she had a rare kidney disease but was unable to recall the name. D.N. admits fatigue from being in the hospital and her various treatments; denies fever, chills, night sweats, weakness, back pain, loss of consciousness, vomiting, diarrhea, headache, dizziness. Pt admits to anemia and easy bruising while in the hospital. Pt

due to unreliable HPI is acceptable.

admits to polyuria, frequency 6-7 times. color of urine was dark yellow before coming to the hospital, but since she has been in the hospital it has been clear; admits to incontinece, nocturia, pt wears adult diapers, lower leg edema, denies dysuria, urgency, oliguria and blood in urine.

Past Medical History

Present illness = Ulcerative Colitis x 60 years. hyperlipidemia x 10 years. Diabetes Type II x 10 years. HTN x 10 years. macular degeneration x 10 years.

Past medical history = 2 hernias 2 years ago. Cataracts 10 years

Childhood illness: Scarlet fever 10 y/o, measles 11 y/o; mumps 12 y/o

Immunizations: up to date. Last Flu Shot September 2017

Last pneumococcal 2009

Screening Tests & results: mamogram: December 2017 unremarkable, colonoscopy: 2 years ago (negative?)

Past Srgical History = Tonsilectomy at 3 y/o New York Hospital Queens. no complications.

Appendactomy - 2008 St. John's Hospital, due to appendicitis complications, pt was in a coma for 2 weeks, pt is not sure what went wrong in the surgery.

Cataract surgery - Jan 2009, March 2009 in Manhattan Eyes Ears an Throat Hospital due to cataracts. no complications.

Medications:

Atenolol 50mg P.O. daily 1 tablet (HTN) last dose this morning.

Losartan 50 mg P.O. daily 1 tablet (HTN) last dose this morning.
Lovastatin: 10 mg P.O. daily 1 tablet (hyperlipidemia) last dose last night.

Allergies: N.K.D.A. Denies environmental and food allergies.

Family History:
Mother - Deceased at 80 due to Lymphoma
Father - Deceased at 90, HTN, cause of death. Stroke.
No children
Brother - living Mitral Valve regurgitation
Paternal Grandparents HTN - Deceased at unknown age and unknown cause
Maternal Grandparents Deceased at unknown age and unknown cause.

Social History: DN is a single female living alone with no pets. She used to be a secretary and has been retired since 1991.
Habits: She has 1 small glass of wine on weekends, denies smoking, and smoking in the past, 1 cup of decafe coffee every morning. She also denies illicit drug use
Travel - no recent travel
Diet - eats 3 meals a day, mainly Italian foods like pasta, likes to have hamburgers and salmons on the weekends.
Sleep - 4 hours of sleep while in the hospital, 6 hours at home.
Exercise: Pt walks 1-3 blocks a day with a cane, denies any other forms of exercise.

Saftey measures: denies wearing a seat belt.
Sexual History- Pt is not sexually active currently denies history of STIs ✓

Review of Systems: Admits fatigue, denies fever, chills, night sweats, weakness, loss of appetite recent ✓ weight gain or loss.

Skin hair nails: Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles / rashes, pruritus, changes in hair distribution. ✓

Head: admits to being in a coma in 2008 after a surgery for 2 weeks, denies headache, vertigo, head trauma, fracture ✓

Eyes: Admits to using reading glasses, fatigue, denies visual disturbances, lacrimation, photophobia. Pruritus, last eye exam: June 2017, discussed surgery for macular degeneration, pt can't recall other results.
Ears: Admits left ear deafness intermittent for 2 years denies pain, discharge tinnitus, ✓ use of hearing aids.

Nose / Sinuses: Denies epistaxis, discharge, ✓ obstruction

Mouth / Throat: Denies bleeding gums, sore.. tongue sore throat, mouth ulcers, voice changes, dentures last dental exam September 2017. ✓
(normal?)

Neck: Denies swelling/lumps, stiffness/decreased range of motion ✓

Breast: Denies Lumps, nipple discharge pain last ✓ mamogram: December 2017 (benign?)

Pulmonary System: Denies dyspnea, SOB, cough, wheezing hemoptysis, cyanosis, orthopnea, PND. ✓

Cardiovascular System: Admits HTN, heart murmur at age of 6 denies chest pain, irregular heartbeat, edema/ swelling of ankles or feet, syncope. ✓

Gastrointestinal system: Admits hemmorids, denies appetite changes, intolerance to foods, nausea and vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, change in bowel habits, constipation, rectal bleeding, blood in stool, stool guaiac pain in flank, colonoscopy done 2016 ✓ (benign?)

Genitourinary: Frequency 6-7 times, color of urine dark yellow before coming to the hospital, clear while in the hospital, admits incontinence, nocturia, polyuria, denies, dysuria, urgency, oliguria. ✓

Menstural and obstetrical: admits menopause, dat of cessation late 40's no symptoms. Manarch age 11 LMP- late 40's denies hot flashes or associated menopausal symptoms. Denies break through bleeding / spotting or vaginal discharge. ✓
Obstetrical history: G1O ✓

Musculoskeletal system: Admits swelling of knees bilaterally, denies muscle joint pain, deformity, redness arthritis. ✓

Peripheral vascular System: Admits to peripheral edema since being in the hospital, no pain, slightly sensative, denies intermittent claudication, coldness of thropnic changes, varicose vein ✓

Hematologic System: Admits anemia since being in the hospital, easy bruising, denies bleeding, lymph node enlargement, history of DVT/PE ✓

Endocrine system: Admits polyuria, denies polydipsia, polyphagia heat or cold intolerance, goiter, hirsutism.

Nervous System: Admits loss of strength for the past 6 months. Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia) ataxia change in cognition / mental status / memory, weakness (asymmetric) ✓

Psychiatric - Denies depression sadness feelings of helpness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation) axiety, obsessive / compulsive disorder, Denies seeing a mental health professional and medications.

Physical Exam

General Survey: Neatly groomed, average height, medium built, female. looks younger than her stated age of 81. good posture alert and cooperative. ✓

Vital Signs BP: R L

	R	L
Seated	158/72	160/70
Supine	158/72	160/70

R: 16 breaths/min, unlabored ✓
P: 76 beats/min, regular ✓
T: 98.24 °F (oral) ✓
O2 Sat: 96% room air ✓
Height 64 inches Wt 176 pounds
BMI 30.2

Skin: Several 1-3 cm round sharply circumscribed grey nevi on bilateral arms, chest. Multiple 2-5cm deep purple bruises on anterior bilateral arms from venipuncture and hospital treatments. warm and moist, poor 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
Eyes = symmetrical OU. no evidence of strabismus, exophthalmos or ptosis; sclera white conjunctiva & cornea clear visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU) visual feilds full OU. PERRLA EMOI full with no nystagmus
Fundoscopy - Red reflex in tact OU: Cup : Disk ≤ 0.5 OU/no. evidence of A-V nicking, papilledema, hemorrhage exudate, cotton wool spots or neovascularization OU.
Ears: Symmetrical and normal size, No evidence of lesions masses / trauma on external ear. No discharge / foreign bodies in external auditory canals ALL. TM's pearly white/ intact with light reflex in normal position ALL. Auditory acuity intact to whispered voice ALL. Weber midline/Rinne reveals AC > BC ALL

Nose: Symmetrical / no obvious masses / lesions / deformaties / trauma / discharge. Nares patent bilaterally / Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline w/o lesions / deformaties / injection / perforation. No evidence of foreign bodies.

Sinus - non tender to palpation and percussion over bilateral frontal, ethmoid & maxilary sinuses. ✓

Mouth and Pharynx.
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 - good dentition / no obvious dental caries noted.
Gingivae - Pink; moist. No evidence of hyperplasia; masses; erythema or discharge non-tender to palpation
Tongue: Pink, well papilated: no masses, lesions or deviations noted. non-tender to palpation.
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. 2+ Carotid pulses; no thrills; bruits noted bilaterally; no palpable adenopathy noted. ✓
Thyroid:
non-tender; no palpable masses; no thyromegaly no bruits noted.

great! 100 ✓