Medical History

Taiba Shah

Identifying Data:

Full name: D.G.

Address: Queens, N.Y.

Date of Birth: 06/03/1967

Date & time: February 5.th 2019 8:30am

Religion: christian

Source of Information: self

Referral Source: self no referral

PCP: Pt cannot recall name

Pt is aware competent, and reliable

Cheif Complaint: "I have been vomiting and diarrhea" x3days

not mentioned here.

History of Present Illness:

no past

D.G. is a reliable 52 y/o married African American female, current smoker (5pk yr) with medical history, who presents to the ED complaining of vomiting, abdominal (?) pain diarrhea for 3 days. She states for the past 2 years she had these reoccuring symptoms every 5 months. She had salmon with rice on saturday and had an episode of vomiting and diarrhea 1 hour after, and another episode of vomiting and diarrhea 2 hours after. She had 2 more episodes on the next day with 5 hours in between of both vomiting and diarrhea. On monday she had 1 episode of diarrhea. In total: 5 episodes of diarrhea and 4 episodes of vomiting. She states both her stool and vomits were watery in nature with no distinguishing food particles. The last time she passed stool was on Monday. She also states her abdominal pain started on saturday and has been intermittent over the last 3 days. The pain is in the upper right quadrant, achy and a level 7/10 on the pain scale. It is non-radiating and is aggravated with food and not alleviated by anything. D.G admits to chills, fatigue, dizziness, loss of appetite, recent weight loss, syncope, flatulence, change in bowel habits intolerance to dairy. She denies blood in stool, fever, constipation, recent travel, dysphagia, and hemorrhoids.

Past Medical History

Present illness - denies

Past medical history - denies

Childhood illness : chiken pox - 10 y/o

Immunizations: Refuses flu vaccine, but is up to date with other vaccinations

Screening tests and results : Colonoscopy: denies, Mammogram: 2 years ago; normal; Pap Smear 2 years ago; normal

Past Surgical History

Denies past surgeries

Medications

Denies medications

Allergies

Denies, drug, environmental and food allergies.

Family History

Mother: died from breast cancer 72, HTN, diabetes,

paternal/maternal GPs?

Social history

D.G. is a married female, but currently seperated. living alone with no pets. She works with mental health children usually night shifts.

Habits: She denies drinking alcohol, Admits smoking 1/2 a pack for 10 years (5 pk year). denies illicit drug use. and caffeine intake

Travel: no recent travel.

Diet: 3 meals a day, high in protein, vegtable and fruit shakes often, no dairy intake

Sleep: 5 hours a day, patchy due to her work schedule

Exercise: denies.

Safety: admits to wearing a seatbelt.

Sexual History: sexually active with 1 male partner, her husband. no use of condoms, she denies history of sexually transmitted diseases.

ROS

General: Admits to chills, fatigue, loss of appetite and weight loss. Denies night sweats, weakness and recent weight gain

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

Eyes: Admits to wearing glasses, and fatigue. Denies contacts, visual disturbances, lacrimation, photophobia, puritus last eye exam - does not recall.

Ears: Denies deafness, pain, discharge, tinnitus, use of hearing aids.

Nose / Sinuses: Admits to discharge, denies, epistaxis, obstruction

Mouth and throat: denies bleeding gums, sore tongue, mouth ulcers, dentures voice changes, dental exam 2 years ago: normal

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

Breast: Denies lumps, nipple discharge, pain, last mammogram 2 years ago - normal

Pulmonary system: Admits to cough, wheezing, denies SOB, hemoptysis cyanosis, orthopnea, PND

Cardiovascular: Admits to palpitations, denies chest pain, HTN, irregular heart beat, edema / swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal system: Admits to intolerance to dairy, nausea, vomiting, flatulence, eructations, abdominal pain, diarrhea, change in bowel habits. Denies dysphagia, pyrosis, jaundice, hemmorias, constipation, rectal bleeding, blood in stool, pain in flank, colonoscopy - not done

Genitourinary = Frequency 2-4 times a day, color of urine clear yellow, admits oliguria, incontinece, denies urgency, nocturia, dysuria, polyuria.

Menstrual and obstetrical: date of last normal period Jan 19 2019, menarche 12, interval between periods 28 days, duration and amount of flow 3 pads / 24 hours heavy, clots and size of a nickle, admits menorrhagea, denies dysmenorrhea, premenstral symtoms, postcoital bleeding, vaginal discharge, dyspareunia, menopause associated symptoms and breakthrough bleeding.

Obstetrical history G: 3 T: 2 P: 0 A: 1 L: 2

Musculoskeletal system: Denies muscle joint pain, deformity, swelling redness, arthritis

Peripheral Vascular System: Admits to varicose veins, denies intermittent claudication, coldness of trophic changes, pheripheral edma color change.

Hematologic System - Admits to anemia, easy bruising - Denies bleeding, lymph node enlargement, history of PE / DVT

Endocrine System: Admits to polydipsia, denies polyuria, polyphagia, heat or cold intorance, goiter, hirsutism

Nervous system: Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesia, dysesthesia, hyperesthesia) ataxia, loss of strength, change in cognition/mental status/memory weakness

Psychiatric: Admits to depression and obsessive/compulsive disorder. Denies anxiety, seeing a mental health professional and medications.

Physical Exam

General Survey: Neatly groomed, average height, medium built female, looks her stated age of 52, poor posture, alert and cooperative.

Vital Signs:	BP	R	L
	Seated	128/88	128/88
	Supine	128/88	128/88

R: 18 breaths/min unlabored
P: 72 beats/min regular
T: 98.6 °F (oral)
O2 Sat: 94% room air
Height: 62.4 inches wt: 190 BMI 34.8

Skin: warm and moist, good turgor, non-icteric, several 1-3 mm black well circumscribed nevi on bilateral upper cheeks and posterior neck, 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, exothalamous, or ptosis; sclera white, conjunctiva and cornea clear, visual acuity uncorrected 20/30 OD, 20/30 OS, 20/25 OU. visual fields full OU. PERRLA EMO's full with no nystagmus.
Fundoscopy: Red reflex intact OU: Cup:Disk ≤ 0.5 OU no evidence of AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

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

Nose: Symmetrical no obvious masses/lesions/deformities/trauma/ discharge. Nare patent bilaterally. Nasal mucosa pink and 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.

Mouth and Pharynx: lips: pink moist, no evidence of cyanosis or lesion, nontender to palpation

Mucosa - pink; well hydrated. No masses lesions noted. non-tender to palpation. No evidence of leukoplakia

Palate: pink, well hydrated, palate intact no lesions, masses or scars, non-tender to palpation

teeth: poor dentition / no obvious dental caries noted

Gingiva: 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

T.S. 2-5-19

~~Doc~~ Oropharynx - Well hydrated no evidence of injection: exudate masses, lesions, foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no evidence of lesions

Neck: Trachea midline. No masses, lesions, scars, pulsation noted. supple, nontender to palpation FROM no stridor noted Thyroid non-tender, no palpable masses no thyromegaly No thyroid bruits noted.

Chest: symmetrical, no deformities, no signs of trauma. Respiration unlabored / no paradoxical respiration or use

accessory muscles noted. Lat to AP diameter 2:1 non tender to palpation

Lungs: clear to auscultation and percussion bilaterally. Chest expasion and diaphragmatic excursion. Tactile fremitis intact throughout. No adventitious sounds.

Cardiovascular: JVP is 2.5 cm above the sternal angle with the bed at 30°. PMI in 5th ICS in mid clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm, S1 and S2 are normal. There are no murmurs, S3, S4 splitting of heart sounds, friction rubs or other extra sounds.

Adomen: Flat / Symmetrical / no evidence of scars, striae on hypograstric region, no caput medusae, or abnormal pulsations. hyperactive BS present in all 4 quadrants: No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Non-tender to pression ~~or to light/deep palpation~~. No evidence of organomegaly. Tender to deep palpation in upper left quadrant. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

T.S Oziosh

Female Genitalia: External normal pubic hair pattern. No erythema, inflammation, ulcerations, lesions or discharge noted. BUS wnl. vaginal mucosa without inflammation, erythema or discharge. Cervix nulli / multiparous without lesions or discharge. No cervical motion tenderness. Uterus reto-flexed, mobile, non-tender and of normal size, shape, and consistency. Adnexa without masses or tenderness.

Rectal: No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative

Assessment: D.M. is a 52 y/o female current smoker with no significant past medical history presents to the ED with nausea, vomiting, diarrhea and abdominal pain for 3 days, finds suggest gastroenteritis.

Differentials

1.) Gastroenteritis - pt has nausea, vomiting, diarrhea, and abdominal pain, weight loss fatigue. Physical exam findings showed mild tenderness in LUQ, and a soft abdomen.

2) Irritable Bowel syndrome: abdominal pain, altered bowel habits, diarrhea, reoccuring symptoms.
R/o due to acute abdominal pain, no constipation, and pt is vomiting. use Rome IV criteria, CBC to rule out other diseases
3) Colon Cancer: abdominal pain, anemia, change in bowel habit.
R/o due to vomiting, no rectal bleeding, no masses hematochezia or melena, GI consult + colonoscopy
4) celiac disease - diarrhea, flatulence, weight loss, anemia,
R/o due to vomiting, constipation, acute symptoms/serology testing
5) Diverticulitis: abdominal pain, nausea vomiting, change in bowel habits
R/o due to RLQ pain, no masses, no fever, localized guarding, rigidity or rebound tenderness, CT scan with contrast to rule out.

Plan: 1) Gastro enteritis and dehydration
- IV fluid .9% NaCl solution 1000 mL at 125mL/1hr.
- CBC, CMP, stool guaiac,
- liquid diet. until fluids have been replenished then solid foods with complex carbohydrates such as rice, wheat, bread.
nausea - ondansetron 4mg P.O. PRN

2) Smoking cessation.

99.50