H&P. Jinjin Lin.

Identification:

Patient name. Mr. B

DOB: 76 years old

Gender: Male

Race: Asian

Location: New York Presbyterian Queens. Flushing. NY.

Date and time: 3-27-18. at 9:05 am.

Informant: Self. Reliable.

CC: "My chest hurts a lot" x 1 day.

HPI:

A 76 years old male with PMH of CVD, HTN and hyperlipidemia admitted to hospital with chest pain for 1 day. He states that the pain began when he was doing work in the yard. The pain is described as a sharp pain and lasts about 20 seconds and followed by a dull pain which lasts about 18 minute. The patient reports the pain has 8/10 severity and accompanied with SOB. The pain is located over his left chest area, and it does not radiate to anywhere, and he feels better when he sits down and rests. He doesn't have any reoccurrences of chest pain until this morning. The pain is in the same area and does not increase in intensity or severity. Mr. B reports dizziness and Fatigue, and he denies palpitation, irregular heartbeat, edema, sycope, known heart murmur, cough, fever, sweat, wheezing, cyanosis, orthopnea or PND.

PMH:

CVD x 20 years.

HTN x 20 years.

Hyperlipidemia x 26 years.

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The patient had immunizations up to date. He had pneumonia shot in Sep. 2017. and Flu shot in Feb. 2018. The patient denies any hospitalizations or childhood illnesses.

Past Surgical History:

Mr. B had cataracts surgery about 15 years ago, and he cannot recall any details about it. The patient denies any injuries or transfusion.

Medications:

Aspirin 81mg P.O. qd.

Atorvastatin 10mg P.O. qhs.

Carvedilol 3.125 mg P.O. q12h.

Heparin. 5000 unit inj subcutaneous q12h.

Levofloxacin 250 mg. P.O. q24h.

Last dosage took last night around 9 pm.

Allergies:

The patient denies any drug, food or environmental allergies.

Family History:

Parental grandfather - die at 80's. HTN. natural cause.

Parental grandmother - die at 80's. natural cause.

Maternal Grandfather - die at 70's, natural cause.
Maternal Grandmother - die at 60's, car accident.
Father - die at 80's, natural cause
Mother - die at 60's, Breast Cancer.
5 Brother - 71 Alive, HTN.
Son - 42, Alive and well
Son - 38 Alive and well.
Granddaughter - 11 alive and well.

Social History:
Mr. B lives alone in Queens, NY after his wife passed away 4 years ago. He drinks 2-3 bear each week. He has a large coffee every morning. He usually sleep well, walks about 40 mins every day, and he tries to balance his diet. The patient is retired and he used to be a plumber and his highest education level is associated college. The patient denies recent travel, smoking, OR past OR present illicit drug use.
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ROS.
General: The patient reports Fatigue. and he denies recent weight loss OR weight gain, loss of appetite, generalized weakness, Fever, chills OR night sweats.
Skin, Hair and nails: The patient denies texture changes., excessive dryness or sweating, discoloration, pigmentations, moles, rashes, pruritus, OR change in hair distribution.
Head: The patient denies headache, vertigo, head trauma OR Fracture.
Eyes: The patient denies visual disturbance, Lacrimation, photophobia, pruritus OR last eye exam.

Ears: The patient denies deafness, pain, discharge, or tinnitus.
Nose/Sinuses: The patient denies discharge, epistaxis, or obstruction.
Mouth and throat: The patient denies bleeding gums, sore tongue, last dental exam, sore throat, or mouth ulcers.
Neck: The patient denies localized swelling or lumps, stiffness or decreased range of motion.
Breast: The patient denies lumps, nipple discharge or pain.
Pulmonary system: The patient reports SOB and denies cough, wheezing, hemoptysis, cyanosis, orthopnea or PND.
Cardiovascular system: The patient reports chest pain and denies palpitations, edema, syncope or $\bar{s}$ known heart murmur.
Gastrointestinal system: The patient denies change or loss appetite, intolerance to specific foods, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel movement, hemorrhoids, constipation, rectal bleeding, blood in stool, or stool guaiac.
Genitourinary system: The patient denies change in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, pain, hesitancy, dribbling or PSA, exam of prostate.
Nervous system: The patient denies seizures, headache, loss of consciousness, sensory of disturbances, ataxia, loss of strength, change in cognition, mental status, memory, or weakness.
Musculoskeletal system: The patient denies muscle pain, joint pain, deformity or swelling, redness or arthritis.
Peripheral vascular system: The patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color change

Hematologic system: The patient denies anemia, easy bruising, or bleeding or lymph node enlargement.

Endocrine system: The patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance, or goiter.

Psychiatric: The patient denies depression, sadness, anxiety, obsessive, compulsive disorder, see a mental health professional, or taking medications.

Physical Examination:

General: 76 years old male is alert and cooperative. The patient has a small build and doesn't appear to be distressed.

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Vital signs:

BP: supine left 110/60. Right 106/60.

HR: 72 regular BPM

RR: 12 not labored

Temp: 96.7°F (oral) Note: Temp was take last night around 11pm.

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O_2 sat = 96% Room Air.

Height: 155cm Weight: 98 lbs BMI: 19.1

Skin: warm and dry. Poor skin turgor. Nonicteric, no lesions, scars, tattos noted.

Hair: Average quantity and distribution.

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Nonmocephalic/atraumatic. Nontender to palpation throughout.

Eyes: Symmetrical OU. no strabismus, exophthalmos.

sclera white with splotches of pigment. Conjunctiva, cornea clear.

visual acuity with glasses (20/20 O.S. 20/20 O.D. 20/20 OU).

visual field full OU. Pupil equal, round and reactive to light.

But not accomodating. EOM Full with no nystagmus.

Fundoscopy - Red reflex intact OU.

Cup: Disk < 0.5 OU. No AV-nicking, papilledema, hemorrhage, exudate, cotton wool spots OR neovascularization OU.

Ears: Symmetrical and unremarkable size. No lesions, mass, trauma on external ears. No dischage OR Foreign body in external auditory canals AU. TM's pearly white cone of light at 4 o'clock in right ear, 7 o'clock in the left ear. Auditory acuity intact to whispered voice AU. Weber midline and Renne reveals AC>BC AU.

Nose: symmetrical with no masses, lesions, deformation or trauma.

Nasal mucosa pale pink, no discharge, polyps, or foreign Body. Anterior septum deviated to left. No lesions, masses OR perforations.

Sinuse: Non tender to palpation over Frontal sinus and maxillary sinus.

Lips: pink, dry, no cyanosis OR lesions.

Mucosa: Light pink, dry, no masses, lesions noted. No Leukoplaka.

Palate: Pink, hydrated poorly. No lesions, masses.

Scars: Non-tender to palpation. Continuity intact.

Teeth: Missing a few teeth on both sides of top. Not wearing dentures.

Gingivae: Pink, no masses, lesions ~~OR deviation noted~~ JL erythema OR discharge.

Tongue: pink. no masses, lesions, OR deviation noted.

Oropharynx: hydrated. no injection, exudate, masses, lesions, OR foreign Body.

Tonsil present with no injection OR exudate. Uvula pink, no edema OR lesions.

Neck: No masses, lesions OR scars.

Trachea midline. pulsation noted. supple non-tender to palpation.

2+ carotid pulse. no thrills, bruits noted bilaterally.

No palpatable adenopathy noted.

Thyroid: Non-tender, no palpatable masses, no thyromegaly. No Bruits noted.

Chest: symmetrical. no deformations. No trauma. respirations unlabored.
LAt to AP diameter 2:1. Non-tender to palpation. ✓ Good

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursions symmetrical. Tactile fremitus intact throughout. No wheezes, rales or crackles.

Heart: RRR. S1, S2 without murmur, gallop, rub. NO S3. S4 NO JVD.
Carotid pulses are 2+ bilaterally without Bruits. Chest pain elicited at left chest (I would write tender to palpation if that's true to exam or non-tender if not) PMI?

Abdomen: Flat. symmetrical. no scars, striae, caput medusae or abnormal pulsations. Bowel sounds in All 4 Quadrants. NO Bruits noted. Tympany to percussion throughout. Non-tender to percussion or to light and deep palpation. No masses noted. no guarding or rebound tenderness. NO CVAT noted bilaterally.

Male Genitalia and Hernias: Circumcised male. No penile discharge or lesions. No scrotal swelling or discoloration. Testes descended bilaterally, smooth and without masses. Epididymis nontender. NO inguinal or femoral hernias noted.

Peripheral vascular: The extremities are normal in color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No Bruits noted. NO clubbing, cyanosis or edema noted bilaterally. NO stasis changes or ulcerations noted.

Neurological system:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Though coherent. No dysarthria, dysphonia or aphasia noted.

Cranial Nerves:

I - intact, no anosmia.

II - VA 20/20 bilaterally. Visual fields by confrontation full. Funduscopic + Red reflex OS/OD. discs yellow with sharp margins. NO AV nicking. hemorrhages or papilledema noted.

III. IV VI - PERRLA. EOM intact without nystagmus.

V - Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII - Facial movements symmetrical and without weakness.

VIII - Hearing intact to whispered voice bilaterally. Weber midline. Rinne AC > BC.

IX. X. XII - Swallowing and gag reflex intact. Uvula elevates midline.
Tongue movement intact.

XI - shoulder shrug intact. Sternocleidomastoid and trapezius muscles intact.

Motor/cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle tone and bulk. No atrophy, tics, tremors, or fasciculations. Strength equal and appropriate for age bilaterally. No pronator drift. Gaits normal without ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinski	neg	neg
Abdominal	2+/2+	2+/2+	Clonus	negative	

✓ Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's sign neg.

Assessment:

5 76 years old male with PMH of CVD, HTN and hyperlipidemia admitted to hospital with chest pain for 1 day. Maybe include a little more here, like neatly groomed and also after doing what's I usually do a summary of the main points in 2 lines

DDx:

(more likely) ① Angina patient feels dullness/tightness of chest, his age, History of hyperlipidemia also put him at risk. He had 2 episodes, one with mild exertion (works in yard) and one without exertion (morning). It's more likely be a unstable angina.
EKG, troponin and CK-MB needed to rule out MI first.

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(most severe) ② MI patient has history of HTN, CVD, and hyperlipidemia, and his age also a risk factor. Patient has chest pain, But doesn't radiate, it's not substernal, no nausea vomiting, palpitations, sweating, diaphoresis. EKG, cardiac enzyme tests (troponin) needed to rule out MI. Also, EKG and cardiac enzyme need to repeat in 6-8 hours to make sure a MI will not be missed.

(less likely) ③ Pericarditis patient will typically has chest pain, friction rub and ~~wide~~ JL chest pain usually pleuritic in nature. in this case, patient doesn't have friction rub sound, and the chest pain doesn't seem to be pleuritic in nature. EKG needed.

(less likely) ④ pulmonary Embolism. Risk factors for PE include immobilization, recent surgery, malignancy, DVT, and PE patients will present with SOB, pleuritic chest pain, cough hemoptysis, tachypnea, rales heard in physical Examination, fever, S4 sound. In this case, patient less likely have PE. Tests can be ordered include D-Dimer, BNP, troponin, CXR.

(less likely) ⑤ Aortic dissection. patient has history of HTN, which is an important factor for aortic dissection, But patient doesn't has a tearing chest pain, not complain about back pain, pulses take from left arm and right arm do not support aortic dissection. can order EKG, CXR, chest CT, cardiac Enzyme to rule out aortic dissection.

Also look up HEART score

Plan:

- Chest pain.

The probability that Mr.B is having an acute cardiac or other life-threatening event is low. But cardiac enzyme (troponin. CK-MB) and EKG must be repeated. CXR should also be orderd. LAB order include CBC. CMP. also. when?

why?

A nuclear stress test is helpful to identify possible coronary artery cause of chest pain, like angina. But stress test need to be done after pattient is stabled.

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- HTN

continue pattients medication, Carvedilol. 3.125mg P.O. q12h.

- Hyperlipidemia.

continue Atorvastatin 10 mg. P.O. qhs.

- CVD

continue Aspirin. 81mg. PO. qd.

Again, look up HEART score.

Good job overall!