Student name: Ariel Niazov
Date of visit: 3/14/23
Patient Name: JG
Address: Brooklyn, NY
Date of Birth: 4/15/66
Location: NYP Queens, Flushing, NY
Religion: Catholic
Source of information: Self
Reliability: Reliable
Source of referral: N/A
Transport: Ambulance

Chief complaint: Pt states he was "freezing outside"

HPI:

56-year-old undomiciled male with PMHx of hypertension presents to internal medicine with coldness everywhere that started today. Pt states he was waiting for a friend out in the cold, but his friend never showed up. Paramedics found him freezing outside shivering and confused. Pt rates his pain an 8/10. He tried warming himself up to relieve his pain to no avail. He denies any cough, nausea, vomiting, loss of consciousness, fall or trauma.

Past Medical History
Present illnesses:
- Hypertension - present
Immunizations: up to date; has not taken anything in the last couple of months

Past surgical history
Patient denies history of surgical procedures, injuries, and/or transfusions.

Medications
- Currently on a hypertension medication – does not know the name

Allergies
- NKDA
- Food allergy: None
- Denies seasonal allergies

Family history
- Mother, deceased, history of hypertension
- Father, deceased, patient denies significant past medical history.
- 3 children, living and well.
- 1 sister, living and well.
- Maternal/paternal grandparents, deceased, pt unsure of their medical history.

Social History
Mr. JG is a divorced man living in a homeless shelter in Brooklyn, NY. Patient was reluctant to answer further questions about his family life.
Habits: denies drinking alcohol, smoking cigarettes, and/or illicit substance abuse. Drinks coffee
Travel: denies recent travel

Diet: Eats whenever he can
Exercise: minimal
Occupation: Does odd jobs
Safety measures: Looks both ways for traffic before he crosses the street
Sleep: reports that his sleep patterns are fine; sleeps at the shelter when he can
Sexual history: denies sexual activity and denies history of sexually transmitted diseases.

ROS
General – Pt admits to having chills from being outside in the cold. Denies fever, fatigue, weakness, recent weight gain or weight loss.

Skin, Hair, Nails – Some hair loss was noted, denies any change in texture, excessive dryness or sweating, discolorations, pigmentations, rashes, or pruritus

Head – Pt stated he was slightly lightheaded. Denies losing unconsciousness.

Eyes - Pt denies wearing contact lenses or glasses. Patient denies visual disturbances, fatigue, lacrimation, photophobia, or pruritus.

Nose/sinus – Pt had some watery discharge d/t being out in the cold. Pt denies obstruction, or epistaxis.

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

Mouth/throat - denies bleeding gums, sore tongue, mouth ulcers, voice changes or denture use.

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

Breast - denies lumps, nipple discharge, or pain.

Pulmonary system - Denies orthopnea, wheezing, hemoptysis, cyanosis, cough, paroxysmal nocturnal dyspnea.

Cardiovascular system – Reports hypertension, does not know which medication it is controlled with. Denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal system - Denies vomiting, decreased appetite, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, constipation, rectal bleeding, or pain in flank.

Genitourinary system - Denies incontinence, change in urine color, or polyuria.

Menstrual/obstetrical – Not applicable

Nervous - Denies weakness, sensory disturbances, seizures, or loss of strength.

Musculoskeletal system – reports some lower back pain and right shoulder pain (both not acute). Denies muscle pain, deformity or swelling, redness, or arthritis.

Peripheral vascular system – reports coldness in his hands and feet; denies intermittent claudication, trophic changes, varicose veins, peripheral edema, or color changes.

Hematologic system - denies easy bruising and bleeding, anemia, lymph node enlargement, blood transfusions, or h/o DVT/PE.

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

Psychiatric - Denies feelings of anxiety or depression, helplessness or hopelessness, lack of interest in usual activities, suicidal ideation, OCT, or history of seeing a mental health professional.

Physical Exam
General: Male, slightly unkempt, and appears his stated age. He is awake, alert, and oriented x 3 and in no acute distress.

Vital signs:
- BP:
- Supine
- R: 136/78
- L: 132/76
- Seated
- R: 140/80
- L: 142/82
- Respiratory rate: 16 breaths/min, unlabored
- Pulse: 78 beats/min, regular
- Temperature: 98 degrees F (oral)
- O2 sat: 98% room air
- Height: 66 inches
- Weight: 156 lbs
- BMI: 25.2

Skin – A brown 0.3cm circumferential macular mole with regular borders was found on the left anterior forearm 4cm from the medial epicondyle. Some dry skin was noted with flaking. Good turgor. Skin was cold to the touch. Nonicteric

Hair – Average quantity and distribution. No nits or lice were seen; no seborrhea was noted

Nails – No clubbing was seen; cap refill was under 2 seconds. Nails were noted to look long and uncut. No splinter hemorrhages nor any beau's lines were noted. Atraumatic.

Head – Normocephalic, atraumatic and non-tender to palpation.

Eyes – Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctive pink.

Visual acuity uncorrected – 20/20 OS, 20/20 OD, 20/20 OU
Visual fields full OU. PERRLA, EOMs intact with no nystagmus

Fundoscopy – Red reflex intact OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.