Student name: Ariel Niazov
Date of visit: 5/2/23
Patient Name: MQ
Location: NYP Queens, Flushing, NY
Source of information: Self
Reliability: Reliable
Source of referral: Self
Transport: Car

Chief complaint: "Nausea" X 2 weeks

HPI:

69-year-old female with PMHx of hypothyroidism, rheumatoid arthritis and bronchitis presents to internal medicine with nausea that started two weeks ago. She states she cannot keep any food down but is tolerant to water and other fluids. She says she is nauseous all the time, that her appetite is poor and rates her severity to the nausea an 8/10. Pt states she has taken nothing to relieve the pain in the past couple of days. Patient admits to losing about 10lbs in the last two weeks that he hasn't eaten. Pt states this is the first instance of nausea she has had. She denies any cough, vomiting, fever, headache, abdominal pain, any sick contacts or recent travel.

Past Medical History
Present illnesses:
- Hypothyroidism – controlled with Rx
- Rheumatoid arthritis – controlled with Rx
- Bronchitis – controlled with Rx

Immunizations: up to date; Covid vaccine Moderna X 3; Flu vaccine 10/2022; PNA vaccine 03/2023

Past surgical history
Left Knee Implant – (06/2008 – No complications – Done at NYPQ)

Medications
- Fluticasone – 2 sprays – compliant
- Levothyroxine – 100 mcg QD – compliant
- Montelukast – 10mg QD – compliant
- Pantoprazole – 40mg BID – compliant
- Prednisone – 50mg QD - compliant

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

Family history
- Mother, living, 89 years old
- Father, deceased, pancreatic cancer. Died at 85 y/o
- 4 children, living and well.
- Maternal/paternal grandparents, deceased, pt unsure of their medical history.

Social History
Ms. MQ is a woman living in a one-bedroom apartment. Patient was reluctant to answer further questions about her family life.
Habits: denies drinking alcohol, smoking cigarettes, and/or illicit substance abuse. Drinks coffee
Travel: Traveled to Peru in middle of January 2023 for two weeks.
Diet: Before the nausea, she used to cook many dishes for herself including chicken and beef dishes as well as making salads
Exercise: Walks around her apartment and around the block for 30-60 minutes a day
Occupation: Currently retired but used to work as a cook in a Peruvian restaurant
Safety measures: Puts on her seatbelt when she drives in a car
Sleep: reports that her sleep patterns are fine
Sexual history: denies sexual activity and denies history of sexually transmitted diseases.

ROS
General – Admits to recent weight loss of 10 pounds. Denies fever, fatigue, and weakness

Skin, Hair, Nails – Denies any change in hair texture, excessive dryness or sweating, discolorations, pigmentations, rashes, or pruritus

Head – Denies losing unconsciousness or being lightheaded.

Eyes – Admits to wearing glasses. Patient denies visual disturbances, fatigue, lacrimation, photophobia, or pruritus.

Nose/sinus – Denies obstruction, discharge 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 – Denies chest pain, palpitations, irregular heartbeat, hypertension, edema/swelling of ankles or feet, syncope, or known heart murmur.

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

Genitourinary system – Denies incontinence, change in urine color, polyuria, dysuria or nocturia

Menstrual/obstetrical – G4P4A0L4. Menopause age 52 y/o. Denies any vaginal bleeding.

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

Musculoskeletal system – Denies muscle pain, deformity or swelling, redness, back pain, or arthritis.

Peripheral vascular system – 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: Well-dressed older female, who is dressed appropriately for the weather and appears her stated age. He is awake, alert, and oriented x 3 and in no acute distress.

Vital signs:
- BP:
- Supine
- R: 110/62 mm/Hg
- L: 110/60 mm/Hg
- Seated
- R: 109/58 mm/Hg
- L: 111/60 mm/Hg
- Respiratory rate: 18 breaths/min, unlabored
- Pulse: 58 beats/min, regular
- Temperature: 98.3 degrees F (oral)
- O2 sat: 99% room air
- Height: 60 inches
- Weight: 98 lbs
- BMI: 19.1

Skin – A dark colored 0.5 cm X 0.2 cm bruise with regular borders was found on the right posterior forearm 2cm from the medial epicondyle. Good turgor. No tenting. Normal body temperature was noted. 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. No splinter hemorrhages, lesions, swelling 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 – 20/30 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.

Ears – Symmetrical and appropriate in size. No lesions, masses or trauma on external ears. No discharge, bleeding or foreign bodies in external auditory canal AU. Some cerumen was noted. TM's pearly-white, intact with cone of light in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline and Rinne test reveals AC > BC.

Nose – Symmetrical nares with no masses, lesions, deformities, trauma or discharge. Nares patent bilaterally. Nasal mucosa pink. No discharge noted on anterior rhinoscopy. Septum midline without any lesions, deformities or perforation. Some crusting from blood was noted on the left septum. No foreign bodies.

Sinuses – Non tender to palpation and percussion over bilateral frontal and maxillary sinuses.

Lips – Pink, moist with no cyanosis or masses noted. Non-tender to palpation.

Oral Mucosa – Pink and well hydrated. No masses, lesions or leukoplakia noted.

Palate – Pink and well hydrated. No masses or lesions noted.

Teeth – Good dentition with a couple of filled cavities noted.

Gingivae – Pink and moist. No hyperplasia or masses.

Tongue – Pink, well papillated. No masses, lesions or deviation noted.

Oropharynx – Well hydrated with no erythema, exudates, masses, or lesions. Tonsils are present with no erythema or exudates. Uvula midline with no lesions noted.

Neck – Trachea midline. No masses, lesions, or scars noted. Supple and non-tender to palpation. Full range of motion. No palpable cervical adenopathy.

Thyroid – Non-tender, no thyromegaly. No palpable nodules nor any bruits noted.

Chest – Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout

Lungs – clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds

Heart – JVP is 2 cm above the sternal angle with the head of the bed at 30 degrees. PMI is in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen – Flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout with no guarding or rebound noted. No hepatosplenomegaly to palpation and no CVA tenderness appreciated.