Emily Lancia H&P 3 Due 5/15/23

History

Identifying Data:
Full Name: AK
Address: Flushing, NY
Date of Birth: September 9th, 1992
Date & Time of Encounter: May 9th, 2023, 9:10am
Location: NYHQ ED, Flushing, NY
Religion: Jewish
Source of Information: Self
Source of Referral: None, admitted to ED from home

Chief Complaint: "I had an episode of SVT" x 2 hours

History of Present Illness:
30YOF pmh PSVT presents from home accompanied by her husband with sudden onset of heart palpitations and tachycardia beginning 2 hours ago at 7:10am, as detected by her Apple Watch. She describes a noticeably "pounding, rapid heartbeat" felt only in the left side of her chest at mid-clavicular line, without radiation. It has been constant since onset. PT reports no alleviating factors. She attempted Valsalva maneuver, carotid massage, and modified Valsalva maneuver at home without relief. She says that standing upright and walking around made her feel worse, resulting in dizziness that resolved once she returned to a seated position. She reports 2 cups of black coffee as her only oral intake today. She denies taking any drugs or medications. Pt states this is the most severe episode of SVT she has experienced, rating 10/10 in severity. Her last episode was 7 months ago. She last saw a cardiologist 4 years ago. She has been hospitalized with SVT one other time 4 years ago and was successfully treated with adenosine. Upon arrival to ED today, she was administered adenosine at approximately 9:04am and reports marked relief since then. She currently presents in normal sinus tachycardia. She denies chest pain, headache, or shortness of breath. Denies dizziness at this time. Denies LOC, falls, or recent trauma. Denies illicit drug use. She notes that she has been under increased mental and physical stress lately due to a demanding workload as an ICU resident physician.

Past Medical History:
Present chronic illnesses – PSVT x 4 years
Past medical illnesses – Denies past illnesses
Childhood illnesses – Denies childhood illnesses
Immunizations – Up to date, including annual COVID-19 and annual influenza vaccines
Screening tests and results – Last PAP smear 2022. Pt has never undergone mammography or colonoscopy.

Past Surgical History:

Denies past surgical procedures.
Denies past injuries or transfusions.

Medications:
Denies use of medications.
Vitamins and Supplement – Daily Women's Multivitamin, unknown content, unknown dosage, once a day, last dose yesterday AM.

Allergies:
NKDA
Denies environmental or food allergies.

Family History:
Maternal/paternal grandparents – Deceased at unknown age from natural causes
Father – 65, alive and well
Mother – 54, alive and well
Sister – 25, alive and well
Son – 7, alive and well
Daughter – 4, alive and well
Daughter – 2, alive and well
Denies family history of cancer or diabetes

Social History:
AK has been married to her husband for 8 years. They live together with their three children.
She works full-time as an ICU resident physician.
She denies drinking any alcohol, smoking cigarettes/cigars, or using illicit drugs.
She has 1-2 cups of coffee daily.
She denies recent travel.
She reports a diet rich in meats and vegetables. She says she does not follow any one specific diet, but tries to remain cognizant of the nutritional content of the food she eats.
She reports an active lifestyle, weight-lifting 4-5 days a week and running 2-3 days a week.
She reports getting 5-6 hours of sleep each night. She thinks that her sleep quality could be improved.
She is currently sexually active with only her husband. Denies history of sexually transmitted diseases.
Reports last STD testing was 5 years ago.

Review of Systems:
General – Denies recent weight loss or gain, fever, chills, or fatigue.

Skin, hair, nails – Denies vascular changes, discolorations, or new moles/rashes.

Head – Denies headaches, syncope, or head trauma.

Eyes – Denies changes in vision, discharge, or erythema. Visual acuity 20/25 OU corrected with contact lenses.

Ears – Denies changes in hearing, pain, or discharge.

Nose/sinuses – Denies nasal congestion, sinus congestion or sinus tenderness.

Mouth/throat – Denies sore throat, difficulty swallowing, or voice changes. Last dental exam November, 2022.

Neck – Denies swelling, tenderness, or stiffness.

Breast – Denies tenderness, nipple discharge, dermatological changes, or vascular changes.

Pulmonary system – Denies cough, wheezing, or dyspnea.

Cardiovascular system – (+) Palpitations (now resolved). Denies chest pain or edema.

Gastrointestinal system – Denies change in appetite, nausea, vomiting, diarrhea, abdominal pain, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, dysuria, or flank pain.

Menstrual/Obstetrical – G4P3. LMP about 3 weeks ago, exact date unknown. Reports regular menstrual cycle. Reports ob/gyn assessment annually.

Nervous – Denies weakness, sensory disturbances, ataxia, or loss of strength.

Musculoskeletal system – Reports intermittent lower back pain and stiffness relieved by rest and stretching. Denies swelling, decreased range of motion, or redness.

Peripheral vascular system – Denies varicose veins, peripheral edema, or cold extremities.

Hematological system – Denies easy bruising or bleeding, h/o blood transfusions, or h/o DVT/PE.

Endocrine system – Denies heat or cold intolerance, excessive sweating, or excessive thirst

Psychiatric – Denies anxiety or depressed mood. Notes that her job is stressful, but she feels that she copes adequately with the stress.

Physical

Vital Signs:

BP:

	Right Arm	Left Arm
Seated	108/72	124/84
Standing	108/70	102/70

R: 18/min unlabored P: 120, strong and regularly regular

T: 97.9 degrees F (oral) O2 Sat: 99% Room air

Height 70 inches Weight 145 lbs. BMI: 20.1

General:
Well-nourished, slightly diaphoretic, young white female. Neatly groomed, wearing a hospital gown provided during admission. Appears fatigued, but is attentive and conversational.

Skin:
Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair:
Average quantity and distribution.

Nails:
No clubbing, no discolorations, capillary refill <2 seconds in upper and lower extremities.

Head:
Normocephalic, atraumatic, non tender to palpation throughout.

Eyes:
Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity corrected with contact lenses - 20/25 OS, 20/20 OD, 20/25 OU.
Visual fields full OU. PERRLA, EOMs intact with no nystagmus or lid lag.
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, or exudates OU.

Ears:
Symmetric and appropriate in size. No lesions, masses, or evidence of trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TMs are pearly white and intact with light reflex in a good position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU.

Nose:
Symmetrical with no masses, lesions, deformities, or trauma. Nares patent bilaterally. Nasal mucosa is well hydrated. Septum midline without lesions, deformities, or perforation. No foreign bodies.

Sinuses:
Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips:
Pink, moist, no cyanosis or lesions.

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

Palate
Pink, well hydrated, and intact with no lesions or masses.

Teeth
Good dentition with no obvious dental caries noted.

Gingivae
Pink, moist. No hyperplasia or masses.

Tongue
Pink, moist. No masses, lesions or deviation.

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

Neck:
Trachea midline. No masses, lesions, scars, or visible pulsations noted. Supple and nontender to palpation. No palpable cervical adenopathy.

Thyroid:
Non-tender, no thyromegaly. No palpable nodules noted.

Chest:
Symmetrical, no deformities, no trauma. Respirations unlabored with no paradoxical respirations or use of accessory muscles noted. 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 3 cm above the sternal angle with the head of the bed at 30°. PMI 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:

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, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Assessment

Differential Diagnosis

YORK COLLEGE
The City University of New York

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
S. Seligson, J. Yuan &
L. Sanassi
Contact: Jeanetta Yuan
jyuan1@york.cuny.edu

History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Emily Lancia

Clinical Site: NYHQ ED

Date of Visit: 5/9/23

Activity performed: H+P

Supervisor:

Name and Credentials: Nate Zander Attending

Supervisor Signature:

Supervisor Comments: thorough history good differential