Emily Lancia H&P 1 Due 4/3/23

History

Identifying Data:
Full Name: HW
Address: Flushing, NY
Date of Birth: April 16, 1970
Date & Time: March 28th, 2023
Location: NYHQ PAT, Flushing, NY
Religion: Christian
Source of Information: Self
Source of Referral: Unable to recall name of referring surgeon (NYHQ-affiliated)

Chief Complaint: "I'm here to get checked before my surgery" x 0 days

History of Present Illness:
Well-appearing 54 YOF presents to scheduled appointment at PAT for clearance to undergo scheduled R lumpectomy next week. Pt reports she has a 'small mass' in her R breast discovered 3 months ago via routine mammography that requires surgical removal and biopsy. She says the mass was asymptomatic prior to discovery. She reports no changes in the area of the mass since the last evaluation by her provider. Today, she denies breast tenderness, nipple discharge, dermatological changes or vascular changes B/L. Denies pain at any time, rating 0/10 in severity. Denies radiation of pain, denies alleviating or aggravating factors. She has no personal or family history of breast cancer or breast masses. She does not smoke cigarettes or drink alcohol. She states she is recently divorced and has been experiencing a mildly depressed mood that is being monitored by her PCP.

Pt notes URI that began suddenly 2-3 days ago and has improved since onset. She reports intermittent nasal congestion with clear anterior rhinorrhea contributing to intermittent clear posterior rhinorrhea that is worse in the morning and while in supine position. She says symptoms are relieved by expectorating from the nose and mouth. She describes URI symptoms as 2/10 in severity. Denies fever, cough, sinus tenderness, or loss of taste or smell. Denies known sick contacts. She is not vaccinated against influenza or COVID-19, but is UTD on other vaccinations. She has not taken any OTC or Rx medications for symptom relief.

Past Medical History:
Present chronic illnesses – Denies chronic illnesses
Past medical illnesses – Denies past illnesses
Childhood illnesses – Denies childhood illnesses
Immunizations – Up to date, with the exceptions of annual COVID-19 and annual influenza vaccines
Screening tests and results – Screening mammogram 2022, found small mass in R breast. Last PAP smear unknown. Pt has never undergone colonoscopy.

Past Surgical History:
Denies past surgical procedures.
Denies past injuries or transfusions.

Medications:
Denies use of medications.
Denies use of vitamins or supplements.

Allergies:
NKDA
Denies environmental or food allergies.

Family History:
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons
Father – Deceased at age 70, stroke
Mother – 78, alive, hypertensive
Sister – 49, alive and well
Son – 28, alive and well
Denies family history of cancer or diabetes

Social History:
HW is a female recently divorced in late 2022 that lives alone.
She works full-time as a preschool teacher's aid.
She denies drinking any alcohol, smoking cigarettes/cigars, or using illicit drugs.
She has 1-2 cups of green tea daily.
She denies recent travel.
She reports a diet rich in meats and vegetables. She says she does not follow any one specific diet and does not consider the nutritional value of the foods she eats.
She walks to and from work every day, which she estimates to be about .5 miles each way. She is not active otherwise.
She reports getting 8-10 hours of sleep each night, although she states the quality of her sleep has become worse since her divorce.
She is not currently sexually active. Denies history of sexually transmitted diseases.

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 uncorrected.

Ears – Denies changes in hearing, pain, or discharge

Nose/sinuses – Reports nasal congestion and rhinorrhea beginning 2-3 days ago. Denies sinus congestion or tenderness.

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

Neck – Denies swelling, tenderness, or stiffness

Breast – Reports small mass in R breast scheduled for lumpectomy. Denies tenderness, nipple discharge, dermatological changes, or vascular changes.

Pulmonary system – Reports intermittently expectorating mucus. Denies cough, wheezing, or dyspnea.

Cardiovascular system – Denies palpitations, chest pain, or edema.

Gastrointestinal system – Reports chronic constipation beginning about 10 years ago. 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 – G1P1. LMP about 6 months ago. Pt believes she is currently in menopause. Reports hot flashes about once per month, says they have decreased in frequency since their onset.

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 – Reports increased depression/sadness since her divorce last year. She does not see a mental health professional, but she says her PCP is aware of her depressed mood. Denies anxiety.

Physical

Vital Signs:

BP:

	Right Arm	Left Arm
Seated	108/64	108/60
Standing	98/60	100/60

R: 16/min unlabored P: 84, strong and regularly regular

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

Height 63 inches Weight 155 lbs. BMI: 29.2

General:
Well-nourished, middle-aged Asian female, neatly groomed, dressed appropriately for the weather.

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 uncorrected - 20/25 OS, 20/20 OD, 20/20 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:

(+) DISCHARGE ON ANTERIOR RHINOSCOPY (+) ERYTHEMATOUS MUCOSA
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
(+) POSTERIOR RHINORRHEA (+) ERYTHEMA
Well hydrated, with no exudates, masses, 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.

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: PAT

Date of Visit: 3/28/23

Activity performed: H+P vitals skin check ENT exam eye exam

Supervisor:

Name and Credentials: Naeem Sadal, PA-C PRAC

Supervisor Signature: [signature]

Supervisor Comments: