Emily Lancia H&P 2 Due 5/9/23

History

Identifying Data:
Full Name: SI
Address: Flushing, NY
Date of Birth: May 17th, 1949
Date & Time of Encounter: May 2nd, 2023, 10am
Location: NYHQ Internal Medicine, Flushing, NY
Religion: Jewish
Source of Information: Self
Source of Referral: None, admitted to ED from home on 4/30

Chief Complaint: "My fingers and toes have been numb" x 2 months

History of Present Illness:
74YOM ppmh controlled DM2 and prostate cancer presents with worsening hypoesthesia of distal extremities B/L beginning 2 months ago. Pt is right-hand dominant and first noticed reduced sensation in his R 1st, 2nd, and 3rd fingertip pads (anterior aspect distal to DIPJs) at home while picking up a drinking cup. Concerned, he tested the sensation of his other phalanges by purposefully manipulating objects, and he noticed reduced sensation in all 10 fingertip pads distal to DIPJs. He describes "numbness" without tingling or pain and says that he senses a lesser degree of pressure in his fingertips than he did previously. He reports the same complaint in the plantar aspect of his toes distal to DIPJs B/L beginning about one month ago. He estimates his mechanoreception to be about half of its baseline in all affected areas. It has not diminished more severely since onset. Hypoesthesia is only noticeable while external pressure is applied to affected areas. It is constant and reproducible with external pressure or palpation. Pt reports it is most noticeable while manipulating objects with his fingertips and while standing upright applying pressure to plantar toes. He says a cold environment makes the diminished sensation more severe, but that a warm environment does not make it better. He reports no alleviating factors. He reports normal sensation proximal to DIPJs of all digits B/L. He denies complete loss of sensation at any point. Denies recent head trauma, denies weakness, denies tremor, denies HA, denies cognitive decline. Denies recent vaccination. Denies skin changes of affected areas.

Beginning 1 week ago, Pt reports intermittent loss of balance while standing. He believes it to be secondary to his lower extremity hypoesthesia. He says that about twice a day, he becomes "unsteady on his feet" and must immediately sit down from a standing position because he feels like he is going to fall. Sitting and "resting his feet" for 2-3 minutes allows him to get up to walk again. He says the bouts of imbalance have not changed in frequency or severity since onset. Pt reports they happen more frequently in the morning than in the evening. He has an active lifestyle and says that his daily life has become affected by his fear of falling. He has been walking with a 4-point walker provided to him by a friend. He says that using the walker improves the imbalance. Pt denies recent fall or trauma, denies

antalgic gait. Denies ataxia, denies incontinence, denies LOC. Denies otalgia, denies tinnitus, denies dizziness.

Past Medical History:
Present chronic illnesses
–HTN x 34 years
–Hyperlipidemia x 34 years
–DM2 (controlled) x 17 years
–Unknown CAD x 6 years
–Prostate Cancer x 5 years
Past medical illnesses – Denies past medical illnesses
Childhood illnesses – Denies childhood illnesses
Immunizations – Up to date, including annual COVID-19 and annual influenza vaccines
Screening tests and results – Last colonoscopy 2022

Past Surgical History:
Coronary Angioplasty, age 69, Weill Cornell, New York, NY. For CAD, no complications.
Partial Prostatectomy, age 71, NYHQ, Flushing, Queens. For prostate cancer, no complications.
Denies past injuries or transfusions.

Medications:
Insulin for DM2, unknown dose, BID, last dose this morning. Pt notes he normally takes Metformin at home, but has been given Insulin instead while in the hospital.
Jenuvia for DM2, unknown dose, BID, last dose this morning.
Unknown medication for HTN, unknown dose, unknown frequency, last dose this morning.
Unknown medication for hyperlipidemia, unknown dose, unknown frequency, last dose this morning.
Aspirin for CAD, 81mg, QD, last dose this morning.
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 78, pancreatic cancer.
Mother – Deceased at 94, natural causes. H/o DM2.
Sister – 65, alive and well.
Son – 54, alive and well.
Son – 50, alive and well.
Daughter – 48, alive and well.
Son – 47, alive and well.

Daughter – 45, alive and well.

Social History:
SI is a 74YOM who lives with his wife. They have been married for 54 years.
He works part-time as a driving instructor.
He has a 60 pack year history.
He denies drinking alcohol or using illicit drugs.
He has 1-2 cups of coffee daily.
Within the last year, he has traveled to Israel and Costa Rica. He reports an extensive travel history throughout his life.
He describes his diet as "Mediterranean." He reports eating mostly meats and whole fruits and vegetables. He tries to avoid foods high in cholesterol and sodium.
SI reports a very active lifestyle, stating he typically walks about 4 miles a day.
He reports getting 8-10 hours of high quality sleep each night.
He is currently sexually active with only his wife. 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 20/30 OU corrected with glasses.

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

Nose/sinuses – Denies nasal congestion, foreign body sensation, 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 – Denies tenderness, nipple discharge, dermatological changes, or vascular changes.

Pulmonary system – Denies cough, wheezing, or dyspnea.

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

Gastrointestinal system – Reports intermittent constipation beginning about 5 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.

Nervous – Reports diminished mechanoreception in all distal extremities. Denies weakness, ataxia, or tremor.

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 some anxiety d/t his condition and hospitalization. Denies depressed mood.

Physical

Vital Signs:

BP:

	Right Arm	Left Arm
Seated	144/86	140/82
Standing	112/88	108/78

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

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

Height 72 inches Weight 155 lbs. BMI: 21.0

General:

Lanky, elderly white male with unkempt facial hair but otherwise neatly groomed, dressed appropriately for the weather. Well-appearing with no signs of acute distress. He is cheerful, engaged, and enthusiastic to respond to my questions, which he does appropriately.

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 glasses - 20/30 OS, 20/30 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, 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.

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 Internal Med

Date of Visit: 5/2/23

Activity performed: H+P CNT Cardiac Vitals Resp

Supervisor:

Name and Credentials: Marina Katanova PA-C

Supervisor Signature: [signature]

Supervisor Comments: Emily has very good bedside manner!!