Lisette Romo
Family Medicine - rotation #1

Identifying Data:
Full Name:
Address:
Date of Birth:
Date & Time:
Location:
Religion:
Source of Information:
Reliability:
Mode of Transportation:
Race/ Ethnicity:
Marital Status:

CC: "My back hurts." x1 week
HPI:

R.P is a 60-year-old male with a past medical history of hypertension and hyperlipidemia who presents with a one-week history of right-sided lower back pain. The patient states that the pain occurred gradually without a specific inciting injury and was initially intermittent, but then progressively worsened over the past week and is now constant. He describes the quality of pain as sharp, with radiation down the right leg in a dermatomal pattern, and associated numbness and tingling sensations. Any slight movement of his back aggravates the pain, and lifting, which has caused difficulty with ambulation, resulting in a limp. He reports mild relief when he applied a heating pad, and applied Bengay. He did not take any OTC medication because he thought the pain would resolve on its own.The patient states he works in a factory that requires him to perform frequent lifting and transporting large objects, often including mirrors. He also reports doing rideshare driving for 3 years in his spare time on the weekends, causing him to be sedentary and, at times, have low back pain from sitting down for hours at a time, anywhere from 2 to 6 hours shifts. He has experienced prior episodes of low back pain, but they have resolved with conservative management, and this is a severe episode for him. Currently, his pain is an 8/10. He denies any trauma or urinary retention, bowel/ bladder incontinence, or lower extremity weakness, saddle anasthesia.

Past Medical History:

- Hypertension (6 years ago)
- Hyperlipidemia (4 years ago)
- Vitamin D Deficiency (4 months ago)

Medications:

- Atorvastatin Calcium 20mg oral tablet daily - Taken this morning for Hyperlipidemia
- Losartan Potassium 100mg oral tablet daily - Taken this morning for Hypertension
- Vitamin D3 1.25mg (50000 UT) oral tablet weekly - Taken two days ago for vitamin D deficiency

Denies taking any herbal supplements or other medications otc

Allergies:

No known drug allergies (NKDA)
Denies any known food allergy or environmental allergies

Surgical History:

Appendectomy (1980)

Family History:

- Mother: History of breast cancer, deceased at 87 years old.
- Father: History of hypertension, deceased at 81 years old.
- Son: Alive, age 25, no medical conditions
- No other significant family history

Social History:

- Lives at home with his family in a house in Queens, NY
- Employed as a Factory worker for approximately 10 years

Habits:

- Former smoker (quit 30 years ago, 1 pack-year history; smoked 3 cigarettes per day for 7 years)
- Drinks alcohol occasionally during social events only (~3 beers)
- Denies any illicit substance use
- Travel: Denies any recent travel
- Diet: Patient reports eating at sporadic times that best fit his work schedule. His diet consists of fish, rice, lentils, roti, and curry.
- Exercise: Patient reports he does not exercise, and that his physical activity is limited to only his occupational demands.
- Safety Measures: Wears a seatbelt.
- Sexual History: Reports he only has one current partner, his wife. Denies any prior history of STDs.

Screenings/ Preventative:

Ophthalmologist: Has not seen his eye doctor in 1.5 years (Discussed, and as per patient, he will make an appointment)
Colonoscopy: performed 4 years ago with normal results. A stool card (FIT) was given today in the office for a routine colorectal cancer screening.
Dentist: Went 2 months ago for a routine check-up, normal
PSA screening: declined today
Lung cancer screening: Not indicated (1 pack year, quit 30 years ago)
PHQ 9 Depression screening: Negative in office today.
Audit C: Negative
Dast 10: Negative
Social Needs Screening: Negative

Immunizations:

Influenza: Last received 11/2025 (annual)
COVID-19: 3/2021 (Pfizer-BioNTech); booster 9/2022

Review of Systems:

Constitutional: Denies any fever, chills, night sweats, or unintentional weight loss.

Musculoskeletal: Reports right-sided low back pain with numbness/ tingling sensation and radiation to the right leg. Denies any recent trauma, falls, or injury.

Skin: Denies any rashes, vesicular lesions, erythema, bruising, or signs of infection.

Neurological: Admits to right-sided lower extremity parasthesias and reports difficulty ambulating secondary to pain. Denies any lower extremity weakness or any loss of sensation in the perineal region.

Cardiovascular: Denies chest pain or palpitations

Respiratory: Denies shortness of breath or cough

Genitourinary: Denies any prior history of kidney stones, urinary retention, urinary incontinence, dysuria, or hematuria.

Gastrointestinal: Denies bowel incontinence, constipation, abdominal pain, nausea, vomiting, or changes in bowel habits, loss of anal sphincter tone.

Infectious: Denies recent infections or intravenous drug use.

All other systems were reviewed and were negative.

Physical Examination:

Vital signs:

Height: 5'4 Weight: 162lbs BMI:27.8

BP: 160/93, HR: 90 bpm, RR: 16 breaths/ min, T: 97.5F, SpO2: 98% on room air

General: 60-year-old male appears his stated age, A&Ox3. Upon entering the room, there is a noticeable antalgic gait and limp. Visibly uncomfortable in a seated position and leaning forward to the affected side of pain.

Cardiovascular: Regular rate and rhythm, S1 and S2 heard.

Respiratory: Lungs are clear to auscultation bilaterally, no wheezing, or rhonchi

HEENT: Normocephalic, atraumatic, PERRLA, EOMI.

Neck: Supple, no cervical lymphadenopathy

Abdomen: Soft, non-tender, no CVA tenderness.

MSK: Inspection of the lumbar spine and lower extremities showed no visible deformities, erythema, or swelling. No midline tenderness over the spinous process. Limited lumbar spine range of motion secondary to pain, in particular, forward flexion and extension. Right-sided lumbar paraspinal tenderness to palpation at L4- S1, **Positive straight leg test on the right**

Skin: Warm, no rashes or lesions over the back or lower extremities.

Extremities/ Peripheral Vascular: No deformities or edema noted. Bilateral pedal pulses present +2.

Neuro: CN II-XII intact. Strength 5/5 bilaterally in upper and lower extremities, with movement limited by pain. Sensation grossly intact with a mild decrease in the right lower extremity. Deep tendon reflexes show patellar reflexes 2+ and symmetric bilaterally; the Achilles reflex was 1+ on the right and 2+ on the left.

Differential Diagnosis:

1. **Lumbar Disc Herniation** - This condition presents as unilateral back pain with parasthesias down the leg. If chronic, presents with structural changes, as the most common cause such as disc degeneration, which leads to the herniation of the nucleus pulposus. Axial overloading can also apply force on the vertebral spine. This patient had prior episodes of low back pain that had resolved, but given his age of 60 years, he may now be experiencing degenerative changes. Additionally, he has been working a labor-intensive job for years that requires axial loading from carrying objects. A positive straight leg test was also elicited in this patient. Given his symptoms, history, and physical exam findings, this is the most concerning diagnosis.

2. **Spinal Stenosis** - This is a condition due to the narrowing of the spinal canal, which typically occurs in patients over the age of 60 with low back pain and neurogenic claudication, and can present as pain worsened with standing and walking, along with radiculopathy. However, this improves with forward flexion. Given the patient reports unilateral symptoms and no improvement on flexion, this is less likely.

3. **Lumbosacral sprain/ strain** - Important to consider because it is the most common cause of low back pain; it mainly occurs from strenuous activities and lifting injuries. The patient has a labor intensive occupation requiring frequent lifting. While the patient does have paraspinal tenderness on exam, which can support this diagnosis, it can be ruled out with the absence of radiation/ neurologic symptoms.

4. **Spondylolisthesis** - Presents with anterior slipping of the vertebra over another that causes low back pain and has a clinical manifestation of sciatica. Sciatica is caused by nerve root compression resulting in radiculopathy, and can cause symptoms like weak ankle dorsiflexion. Less likely since this is from hyperextension traumas. An X-ray of the lumbar spine would be appropriate to rule this out in the patient.

Assessment:

A 60-year-old male with a past medical history of hypertension and hyperlipidemia presents with a one-week onset of right-sided low back pain associated with radiating numbness and tingling in the right lower extremity. He describes the pain as sharp, constant, and an 8/10, which is exacerbated through repetitive movement/ lifting. He did not take any analgesics but applied topical Bengay and a heating pad, which temporarily provided relief. He denies any trauma, fever, or weight loss. Physical exam shows a decreased lumbar range of motion secondary to pain, right-sided paraspinal tenderness, and a right-sided positive straight leg test. Overall, this presentation is most concerning for a lumbar disc herniation.

Plan:

Lumbar Disc Herniation →

- No imaging indicated at this time, consider MRI of the lumbar spine if symptoms do not improve in 4 weeks despite treatment.
- Start NSAIDs (Diclofenac 50mg PO BID), take with food
- Take Cyclobenzaprine 10mg PO daily at bedtime PRN, advised to not drive while taking this medication because it has sedative properties
- Apply Lidocaine 5% Patch QD to the affected area
- Continue applying warm compresses with heating pads
- Encourage activity as tolerated
- Physical Therapy referral
- Will consider corticosteroid injection if conservative management fails, as second-line therapy
- Strict ER precautions if neurologic deficits occur, saddle anesthesia, bladder/ bowel dysfunction, worsening weakness

Preventative

- Discussed the importance of eye exams, the patient plans to schedule an appointment, and verbalized understanding
- Reviewed vaccination status, encouraged to keep them up to date with age-appropriate vaccines
- Discussed risks/ benefits of PSA screening, patient declined at this time

Hyperlipidemia →

- Continue taking Atorvastatin 20mg PO daily
- Encourage the patient to exercise and monitor their diet
- Perform annual routine blood work to assess for lipid panel during next visit

Hypertension→

- Continue taking losartan 100mg PO daily
- Encouraged taking blood pressure readings at home, given an elevated reading inthe office, and bring a log to the next visit
- Encouraged lifestyle modifications (diet and exercise)

Vitamin D Deficiency →

- Continue taking Vitamin D3 1.25mg (50000 UT) PO weekly

- Will transition patient to Vitamin D3 1,000–2,000 IU PO daily for a maintenance dose following a recheck of 25-hydroxy vitamin D in 3 months