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HPPA 522 - Physical Diagnosis 2 (Lab)
Professor Yuan
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PD 2 H&P 1 - ED

Chief Complaint: "I have been having on and off fevers, chest pain, and headaches for 3 days."

History of Present Illness:
Patient Q.L. is a 25 year old female with no significant past medical history who presents to the ED with intermittent fevers, chest pain, and headaches that began 3 days ago on September 6th, 2025. She reports that all symptoms began simultaneously and that the symptoms are constant and have progressively worsened since onset. She experiences chills, night sweats, and feeling "run down" which get aggravated with the fevers. Patient reports a maximum temperature of 103℉ yesterday. She also states having a productive cough with thick, green sputum and reports having had several coughing fits, occasionally with thin streaks of blood. Following the coughing fits, she had two episodes of non-bilious vomiting of less than one cup, which she attributed to drinking large amounts of water beforehand. She denies the presence of any blood in the vomit. Patient describes her chest pain as a "heavy tightness", and an aching sensation. She states her chest pain is exacerbated with deep breaths and during her coughing fits but the pain is absent with normal, shallow breathing. She describes her headache as a "stabbing pain", localized to the right side of her head, involving the forehead and anterior aspect of the head. She rates both the chest pain and headache 10/10 prior to taking Tylenol, which improves to 3/10 afterwards. She states her symptoms worsen with the fevers and gets temporarily relieved after taking Tylenol 500 mg. Patient states her last dose of Tylenol 500 mg was taken at midnight the night prior. She denies ever experiencing similar symptoms in the past.

Today, she reports symptoms similar to prior days, with mild improvement in cough. Chest pain and headache persist, currently rated 5/10. She reports taking one dose of Ibuprofen 800 mg this morning at 6 am, with minimal relief.

Patient denies any recent exposure to sick contacts, recent travels, weight loss or gain, head trauma, syncope, dyspnea, nausea, diarrhea, constipation, or any urinary symptoms.

Past Medical History
Patient was hospitalized on 4/12/2025 for labor and delivery at New York Presbyterian Queens Hospital for 2 days.
Denies any chronic conditions and childhood illnesses.

Immunization: Up to date on all immunizations.

Past Surgical History
Colon polyp removal - 2019, private clinic (location unknown)
Cesarean section - April 12, 2025, New York Presbyterian Queens Hospital

Medications
Denies use of any medications for chronic conditions.

Allergies:
NKDA. Denies any food, seasonal, or environmental allergies.

Family History
Mother, 48, living and well
Father, 50, living and well
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 1 brother, 20, living and well
Children, 1 daughter, 5 months, living and well

Social History
Habits: Denies usage of alcohol, drugs or smoking history. Denies coffee intake.

Travel: Denies any recent travels out of state or country.

Marital History: Engaged to fiancé.

Occupational history: Currently not employed.

Home situation: Patient reports living with her fiancé, daughter, and six dogs.

Diet: Patient reports having oatmeal for breakfast. She states having noodles for lunch. She reports having rice with chicken or fish for dinner.

Sleep: Average 6 hours of sleep per night.

Exercise: Ambulatory, patient denies active exercising.

Safety Measures: Patient admits to using a seatbelt in the car. Patient states feeling safe at home.

Sexual history: Heterosexual, monogamous. Patient is sexually active with her fiancé. Patient denies past history of STIs. Denies use of barrier methods or contraceptives.

Review of Systems:

General: Admits to loss of appetite, generalized weakness/fatigue, fever, chills, and night sweats. Denies recent weight loss or gain.

Skin, hair, nails: Admits to having occasional hives and itching. Denies excessive dryness or sweating, changes in skin texture, discoloration, pigmentations, moles, or changes in hair distribution.

Head: Admits to having headaches. Denies vertigo or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, pruritus. Admits to wearing glasses. Last eye exam was last year (date unknown).

Ears: Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses: Denies discharge, epistaxis, or obstruction.

Mouth and Throat: Admits to having sore throat. Denies sore tongue, bleeding gums, mouth ulcers, voice changes, or use of dentures. Last dental exam was in July 2025.

Neck: Denies localized swelling/lumps, stiffness, or decreased range of motion.

Breast: Denies lumps, nipple discharge, or pain.

Pulmonary System: Admits to having a productive cough with thick, green sputum. Denies dyspnea, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System: Admits to palpitations and chest pain. Denies hx of HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System: Admits to two episodes of nonbilious vomiting. Denies nausea, constipation, diarrhea, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool. Patient had an endoscopy last year, unremarkable.

Genitourinary System: Denies frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, flank pain, dribbling, or hesitancy. Color of urine is yellow/clear.

Menstrual/Obstetrical: Menarche age 11. LMP was 4 days ago (9/5/25). Normal interval between periods, medium flow. G1P1001, no complications. Denies bleeding, spotting, or vaginal discharge.

Nervous System: Admits to headache. Denies seizures, loss of consciousness, sensory disturbances (numbness, paresthesias, dysesthesias, hyperesthesias), ataxia, loss of strength, change in cognition/mental status/memory, or weakness.

Musculoskeletal System: Denies muscle/joint pain, deformity, or swelling and redness. Denies arthritis.

Peripheral Vascular System: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change.

Hematologic System: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric: Denies depression/sadness, feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideations, anxiety, obsessive/compulsive disorder or ever seeing a mental health professional.

Physical Exam

General: 25 y/o female, well groomed, good posture, in no acute distress. Patient was found sitting on hospital bed, A&O x 3.

Vital Signs:

BP:	R:	L:
Seated:	118/84	120/80
Supine:	110/76	116/80

RR:	16 breaths/min, unlabored	
P:	94 beats/min, regular	
T:	99.8 ℉, oral	
SpO2	98% room air	
Ht: 5’3”	Wt: 130 lb	BMI: 23

Skin & Head:
Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. Mild scattered red macules on the anterior aspect of the right and left forearm distal to the wrist.

Hair: Average quantity and distribution. Hair pull test negative. No alopecia, seborrhea, nits, lice, or lesions on exam.

Nails: No clubbing, cyanosis, or lesions. Capillary refill < 2 seconds in upper and lower extremities.

Head: Noncephalic, atraumatic with no evidence of contusions, ecchymoses, hematomas or lacerations. Nontender to palpation throughout.

Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity corrected - 20/20 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: Ears are symmetric and appropriate in size. No lesions, masses, or evidence on external ears. No discharge or foreign bodies in external auditory canals AU. TM’s are pearly white and intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU.

Nose & Sinuses:
Nose: Symmetrical with no masses, lesion, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesion, deformities, or perforation. No foreign bodies.

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

Mouth & Pharynx:
Lips: Pink, moist, no cyanosis or lesions. Nontender to palpation.

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

Palate: Pink, well hydrated, and intact with no lesions or masses. Nontender to palpation, continuity intact.

Teeth: Full mouth dentures. Good dentition with no obvious dental caries noted.

Gingivae: Pink, moist. No hyperplasia or masses.

Tongue: Pink, well papillated. No masses, lesions or deviation. Nontender to palpation.

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

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

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

Thorax & Lungs:
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 2.5 cm above the sternal angle with the head of the bed at 30 degrees. PMI in 5th ICS in midclavicular 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.

Female Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema, or discharge. Cervix parous, pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy.

Rectal: Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative.

Problem List:

- Fevers
- Productive cough
- Chest pain
- Headache

Assessment: 25 year old female with no significant past medical history presents with intermittent fevers, chest pain, cough, and headache that began 3 days ago. No notable abnormalities on physical exam. No labs or imaging to review at this time.

Differential Diagnoses:

1. Influenza
   Rationale: The patient's symptoms of consistent fevers, cough, and headaches can be explained by a viral illness such as influenza. The onset of symptoms began three days ago which is typically the peak for a viral illness. The chest pain may be explained by the severe coughing and inflammation.
   Plan: Obtain a point of care rapid flu test. Start supportive treatment for symptoms (antipyretics, analgesics, IV fluids, hydration, and rest). Can start Tamiflu although outside the window of maximum benefit.
2. Pneumonia
   Rationale: The patient has been having consistent fevers for the past three days, along with a productive cough, and pleuritic chest pain that worsens with

coughing and deep inspiration. The persisting fevers despite the use of Tylenol further indicates that this could potentially be a bacterial pneumonia.

Plan: Obtain a chest xray. Collect sputum cultures. Start on oral antibiotics along with acetaminophen/ibuprofen for the fevers and pain.

3. Acute bronchitis

   Rationale: The patient presents with a productive cough, with thick, green sputum. Acute bronchitis often follows a viral infection, which would explain the fevers and headaches. The chest discomfort can be explained by the frequent coughing fits.

   Plan: Start supportive care, including hydration, rest, antipyretics, and cough suppressants if coughing is still severe.

4. Pulmonary embolism

   Rationale: The chest pain the patient is experiencing may most likely be pleuritic chest pain due to the severe coughing. However, the high fevers could potentially point towards a pulmonary embolism. Although the patient is 5 months postpartum, she has been staying home and has not been actively exercising, increasing the risk for a potential pulmonary embolism. The risk is lower, however, as she has no significant family history of DVT/PE or history of smoking.

   Plan: Order D-dimer and admit for empiric anticoagulation therapy. Monitor for hypoxemia and give IV fluids.

5. Acute bacterial sinusitis

   Rationale: The localized headaches to the right side along with the fevers may be indicative of a bacterial sinusitis. However, this diagnosis seems less likely, as she isn't complaining of purulent nasal discharge or congestion.

   Plan: Start antibiotics and supportive care (analgesics).

Workup/Plan:

- Obtain chest xray to confirm or r/o pneumonia
- Obtain CBC, BMP, UA, urine hCG
- EKG to rule out other causes of chest pain, such as MI
- Sputum cultures
- Start supportive care (IV fluids, antipyretics, pain relief, cough suppressants)

/s/ Jeleeta Jolly, PA Student