

Jeleeta Jolly
HPPA 502 - Physical Diagnosis 1 (Lab)
Professor Wu
March 18, 2025

PD H&P 2 - Internal Medicine

Chief Complaint: “I came into the emergency room for severe back pain 9 days ago.”

History of Present Illness:

Mrs. H is a 82 year old female with a PMHx of hypertension, hyperlipidemia, asthma, and newly diagnosed pancreatic cancer who presented to the emergency room on 3/9/25 with back pain that began earlier that day. Patient reports that she felt a sharp, stabbing pain in her back that was constant (rated 9/10). She states her pain started in the center of her back and radiated to her waist bilaterally. She states the pain was very intense, preventing her from being able to stand up and move. She states the pain worsened when sitting or getting up. She states her pain was relieved when she took a dose of Tylenol (dosage unknown). Patient had a recent abdominal stent placed 3 days prior (3/6/25). While arriving at the emergency room, it was found that the source of the patient’s back pain was due to the abdominal stent, causing an infection. She was admitted and underwent an endoscopic retrograde cholangiopancreatography, where she had the abdominal stent replaced. She is currently on Ceftriaxone 2 g daily after developing *E.coli* and *Klebsiella* bacteremia. Patient also had a vasovagal syncope episode while admitted (date unknown). She lost consciousness for about 10 seconds and had a fever of 102 °F. She went back to baseline alert and oriented upon provider assessment but denies recollection of events. A CT head without contrast and routine EEG showed no significant findings. Patient reports that she has begun walking with physical therapy with minimal to no pain. Currently, she denies any pain, but reports feeling a little tired due to lack of sleep the night prior. She denies any trauma, weakness, fatigue, fever, chills, headache, recent travel, or recent sick contacts.

Past Medical History

Present illness - Pancreatic cancer diagnosed 2/20/25

Hypertension x unknown years - managed with medication

Hyperlipidemia x unknown years - managed with medication

Asthma x unknown years - managed with medication

[Denies childhood illnesses](#)

Immunization: Up to date on all immunizations.

Patient reports being hospitalized 30 years ago for an asthma attack (date & hospital unknown).

Past Surgical History

Denies any past surgeries and hx of blood transfusions.

Medications

Losartan 25 mg, 1 tablet QD for hypertension, last dose today (3/18/25)

Diltiazem 240 mg, 1 tablet QD for hypertension, last dose today (3/18/25)

Simvastatin 10 mg, 1 tablet QD for hyperlipidemia, last dose today (3/18/25)

Budesonide-formoterol, 2 puff, inhalation QD, last dose today (3/18/25)

Acetaminophen, 325 mg, Q6 Hrs PRN last dose unknown

Patient is compliant with the above medications.

Allergies:

Admits to having allergies to Penicillins, shellfish, and fish.

Family History

Mother, deceased at 92, uncertain of PMHx

Father, deceased at 99, uncertain of PMHx

Grandparents, (ages uncertain), uncertain of PMHx

Siblings, 3 sisters, (ages uncertain), uncertain of PMHx

3 children, 1 daughter and 2 sons, (ages uncertain), daughter has Type 2 Diabetes, 2 sons are living and well

Social History

Habits: Admits to drinking 1 glass of alcohol at social events every few months. Admits to drinking 1 cup of coffee daily. Denies usage of drugs or smoking history.

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

Marital History: Married to husband.

Occupational history: Retired Board of Education employee.

Home situation: Patient reports living with her daughter.

Diet: Patient reports having coffee, toast, eggs, or a waffle for breakfast. She states having cereal and a banana for lunch. She states having chicken and vegetables for dinner.

Sleep: Average 6 hours of sleep per night.

Exercise: Ambulatory, patient does not actively exercise.

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

Sexual history: Heterosexual, monogamous. Patient is not currently sexually active. Patient denies past history of STIs. Denies use of barrier methods or contraceptives.

Review of Systems:

General: Admits to recent minimal weight loss and loss of appetite. Patient states having loss of appetite after being admitted. Denies weight gain, generalized weakness/fatigue, fever, chills, or night sweats.

Skin, hair, nails: Admits to having dry skin. Denies excessive sweating, discoloration, pigmentations, moles/rashes, changes in hair distribution.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, pruritus. Admits to wearing glasses. Last eye exam was 1 year ago.

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

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

Mouth and Throat: Denies sore tongue, bleeding gums, sore throat, mouth ulcers, or voice changes. Admits to having dentures. Last dental exam December 2024, unremarkable.

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

Breast: Denies lumps, nipple discharge, or pain. Patient is unsure of the last mammogram.

Pulmonary System: Denies shortness of breath or dyspnea on exertion. Denies cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Denies nausea, vomiting, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, or blood in stool. Last colonoscopy unspecified.

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

Menstrual/Obstetrical: [Menarche age 12.](#) LMP 40 years ago. Menopause age unknown. G3P3003, no complications. Denies bleeding, spotting, or vaginal discharge.

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

Musculoskeletal System: Admits to minor arthritis. Denies muscle/joint pain, deformity, or swelling, or redness.

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 transfusion, 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: 82 y/o female, petite, well groomed, good posture, in no acute distress. Patient was found sitting on a hospital chair, A&O x 3.

Vital Signs:

BP:	R:	L:
Seated:	115/71	119/74
Supine:	105/75	104/71
RR:	16 breaths/min, unlabored	

P: 92 beats/min, regular
T: 97.8 °F, oral
SpO2 98% room air
Ht: 5'2" Wt: 95 lb BMI: 17.4

Skin & Head:

Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. Mild ecchymosis on the anterior aspect of the left forearm proximal to the antecubital fossa, due to IV placement.

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.

/s/ Jeleeta Jolly, PA Student