Jeleeta Jolly
H&P 2
Site Evaluator: Naeem Sadat
January 30, 2025

H&P 2- Ambulatory Care

Chief Complaint: "I am having diarrhea and stomach cramping" x 2 days.

History of Present Illness:

Patient A.S. is a 58 year old female with a past medical history of hypertension and Type 2 diabetes who presents to urgent care with complaints of diarrhea and abdominal cramping that began 2 days ago. She reports eating takeout on Friday, in which she tried cheese stuffed wontons from a new restaurant. She noted that her husband ate a different meal and has no symptoms. She reports having several episodes of watery diarrhea the previous 2 days, around 5-6 episodes each day. She denies any blood in her stool. She also reports having mild nausea, but denies vomiting. She reports that she is able to tolerate oral intake of foods and liquids, though her appetite is decreased due to the persistent diarrhea. Additionally, she has been having associated abdominal cramping alongside the diarrhea, rated 6/10 in pain. She admits to temporary relief of pain after having a bowel movement, but states that the cramping remains persistent. She denies radiation of the pain, stating it is localized to the center of her abdomen. She reports taking one dose of Imodium last night with minimal relief.

Currently, she expressed feeling discomfort with the constant diarrhea and cramping. She denies any fevers, chills, bodyaches, cough, congestion, chest pain, shortness of breath, hx of abdominal surgeries, back pain, urinary symptoms, recent illnesses, or recent travels.

Past Medical History

Hypertension x present - managed with medication
Type 2 Diabetes x present - managed with medication
Bipolar disorder x present - managed with medication
Depression x present - managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History

D&C - 2000

Medications

Albuterol HFA 108, 2 puffs every 4-6 hours PRN for asthma, last dose today (1/19/26)
Amlodipine 5 mg oral, QD daily, last dose today (1/19/26)

Buspirone HCl 7.5 mg last dose today (1/19/26)
Lamotrigine 200 mg, QD daily, last dose today (1/19/26)
Metformin 500 mg, QD daily, last dose today (1/19/26)
Ozempic 0.5 mg, once weekly, last dose last week
Patient is compliant with the above medications.

Allergies:
Admits to Azithromycin allergy → unknown reaction

Family History
Mother, deceased at 70, PMHx of DM
Father, deceased at 80, uncertain of PMHx
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, none
Children, 1 son, 32, living and well

Social History
Habits: Denies smoking or alcohol use. Admits to drinking coffee. Denies usage of illicit drugs.

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

Marital History: Married to husband.

Occupational history: Currently working as a teacher.

Home situation: Patient reports living with her husband.

Diet: Patient reports having toast and coffee for breakfast. She states having pasta or rice with chicken for lunch. She reports having salmon, chicken, or takeout for dinner.

Sleep: Average 7 hours of sleep per night.

Exercise: Ambulatory, patient denies actively exercising.

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

Sexual history: Pt is not currently sexually active. Pt denies hx of past STIs. Denies use of barrier methods or contraceptives.

Review of Systems:

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

Skin, hair, nails: Denies excessive dryness or sweating, changes in skin texture, discoloration, pigmentations, moles/rashes, pruritis, or changes in hair distribution.

Head: Denies headache, vertigo or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, or pruritus. Admits to wearing reading 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: Denies sore throat, sore tongue, bleeding gums, mouth ulcers, voice changes, or use of dentures. Last dental exam last year.

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

Breast: Denies lumps, nipple discharge, or pain. Last mammogram 2 years ago, unremarkable.

Pulmonary System: Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Admits to diarrhea, abdominal cramping, and nausea. Denies vomiting, constipation, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool. Last colonoscopy 5 years ago, 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 12. LMP 8 years ago. Menopause at age 50. G1P1001, no complications. Denies bleeding, spotting, or vaginal discharge.

Nervous System: Denies headache, 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: 58 y/o female, well groomed, good posture, in no apparent distress. Patient was found sitting on exam chair, A&O x 3.

Vital Signs:

BP:	R:	L:
Seated:	128/85 mm/Hg	123/84 mm/Hg
RR:	16 breaths/min, unlabored	
P:	84 beats/min, regular	
T:	97.7 ℉, oral	
SpO2	98% room air	
Ht: 5’2”	Wt: 156 lbs	BMI: 28.53

Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. No scars, rashes, or ecchymosis.
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. Nontender to palpation throughout.
Eyes: PERRLA, EOMS intact with no nystagmus. Sclera non-icteric, upper and lower eyelids normal.
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: Symmetrical with no masses or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated.
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
Mouth:
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 midline. Supple and non-tender to palpation. Full range of motion. No palpable cervical adenopathy.
Thyroid: Non-tender, no thyromegaly. No palpable nodules.
Lungs: Mild wheezing bilaterally (improved with nebulizer treatment). Chest expansion and diaphragmatic excursion symmetrical.
Heart: 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: Bowel sounds normoactive in all four quadrants. Soft, non-tender to palpation and tympanic throughout, no guarding or rebound noted. Non-distended, no palpable masses. Negative Murphy's, Rovsing's, and Oburator sign. Negative McBurnery's point. No hernias present, no hepatosplenomegaly.

Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Cranial Nerves:

I – Correctly identifies coffee & alcohol wipe odors bilaterally

II – Visual fields full by confrontation, visual acuity 20/20 OD, 20/20 OS, 20/20 OU corrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena.

III & IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.

V – Face sensation in tact bilaterally, corneal reflex intact jaw muscles strong without atrophy.

VII – Correctly identified sweet, salty and sour tastes. Facial expressions intact, clearly enunciates words.

VIII – Repeats whispered words a 2 feet bilaterally, Weber midline, Rinne AC>BC bilaterally.

IX & X– No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing.

XI – Full range of motion at neck with 3/5 strength and strong shoulder shrug.

XII – Tongue midline without fasciculation, good tongue strength.

Motor: Good muscle bulk and tone. Strength 3/5 throughout.

Cerebellar: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift.

Sensory: Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally.

Reflexes:

	Biceps	Triceps	Brachioradial	Patellar	Ankle/ Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Peripheral Vascular: The extremities have good color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted

Problem List:

- Hypertension
- Type 2 Diabetes
- Diarrhea
- Abdominal cramping

Assessment: 58 year old female with past medical history of hypertension and Type 2 diabetes presents to urgent care with diarrhea and abdominal cramping that began 2 days ago after eating a meal from a new restaurant. She reports 5-6 episodes of diarrhea each day, accompanied with constant abdominal cramping. Symptoms are still persistent currently, with no significant improvement. In office, vitals are within normal limits. Physical exam is unremarkable, with the abdomen being soft, non-tender and normal bowel sounds present. Special tests were all negative. Rapid covid and flu testing were done to rule out upper respiratory infection and were negative. Currently most concerned for acute gastroenteritis.

Differential Diagnoses:

1. Acute gastroenteritis

   The patient's clinical presentation is most consistent with acute gastroenteritis. Her acute onset of diarrhea and abdominal cramping within 48 hours of consuming takeout food from a new restaurant strongly suggests foodborne gastroenteritis. Additionally, the patient's lack of fever, absence of bloody stools, and presence of mild nausea without vomiting suggests a mild infectious process of disease. The crampy abdominal pain with temporary relief following bowel movements is also often present in acute gastroenteritis due to increased intestinal motility, making this diagnosis most likely.
2. Food poisoning due to bacteria/toxins

   Toxins and bacteria are commonly present in specific foods, such as dairy or cream based products. Given that the patient consumed cheese-stuffed wontons, this could be a likely source of toxins or bacteria, such as S. aureus or Bacillus cereus. Her symptoms of cramping, diarrhea, and nausea align very closely with this diagnosis. Although toxin mediated food poisoning commonly presents with fevers and prominent vomiting, it is common for this also not to be a presenting symptom in certain situations.
3. Food intolerance

   New foods containing dairy or high fats can often trigger diarrhea and cramping in patients with a history of intolerance. The patient lacks symptoms of fevers, bloody stools, or systemic symptoms, making this a possible diagnosis. Additionally, the patient reported slight relief of pain after bowel movements, which is also seen. However, the persistent diarrhea over two days suggests that this may be due to a more infectious etiology rather than purely food intolerance. The patient also did not report having a history of food or lactose intolerance in the past, making it less likely.
4. New onset inflammatory bowel disease

   IBD can present with chronic diarrhea, abdominal cramping, and systemic symptoms. Flares are often associated with bloody stools, weight loss, fever, or

other manifestations not seen in this patient. Given the acute onset of symptoms and lack of prior gastrointestinal history, this diagnosis is lower on the list.

5. Early ischemic colitis

   Given the patient's age and comorbidities, such as hypertension and diabetes, ischemic colitis is a diagnosis to be considered. However, bloody diarrhea and signs of systemic illness are more present with this diagnosis, which the patient lacks. Her symptoms lack severe pain and fevers, making this a less likely diagnosis.

Workup/Plan:

- Conduct rapid covid and flu testing (negative)
- Conduct urinalysis (unremarkable)
- Sent patient home with stool kit (ova & parasites, C. diff toxin B, and stool culture) to return
- Start dicyclomine HCl tablet, 20 mg, 1 tablet orally QID for 3 days
- Follow up in one week or sooner if symptoms continue or worsen

Patient Education:

- Advised patient to drink plenty of fluids containing electrolytes and clear fluids
- Educated patient on BRAT diet to help decrease the diarrhea and avoid dairy, high fiber foods, and greasy or spicy foods at this time.
- Avoid alcohol or caffeine and consider probiotics
- Ensured follow-up with patient to review results and if symptoms persist or worsen to come back sooner

/s/ Jeleeta Jolly, PA Student

Jeleeta Jolly
H&P 3
Site Evaluator: Naeem Sadat
January 30, 2025

H&P 3- Ambulatory Care

Chief Complaint: "I am having some dizziness and chest burning that began yesterday".

History of Present Illness:

Patient M.E. is a 71 year old female with a past medical history of hypertension, Type 2 diabetes, hyperlipidemia, and asthma who presents to urgent care with complaints of new onset headache, dizziness, and chest burning sensation that began yesterday. She reports that last night, she experienced a presyncopal event characterized by a sudden onset of room spinning dizziness. During this episode, her husband assisted her into a seated position, after which the dizziness gradually improved. She denies any loss of consciousness. Since that time, she continues to experience persistent but mild dizziness.

She describes her headache as pounding, localized to the frontal region, with a severity of 8/10 last night, currently improved to 2/10. The headache began yesterday and has been intermittent. She reports taking Tylenol, which relieved it minimally. She states that the headache is less severe currently but has not fully resolved.

Additionally, she reports a burning sensation and tightness in the center of her chest that began after eating dinner last night. She rates the pain as 7/10 at its worst, currently rating it 1/10. She recalls a prior history of acid reflux, but denies taking medicine consistently for it. She took one dose of omeprazole last night with minimal relief, but the pain returned shortly after. She denies radiation of pain, shortness of breath, or worsening pain on exertion. This morning, she also noticed a new onset, intermittent mild tremor in her left lower leg, described as a "shaking" sensation lasting a few seconds at a time. She denies current tremor and reports no prior history of similar symptoms. Currently, she expressed feeling discomfort with the chest burning sensation and feeling of dizziness. She denies any fevers, chills, loss of consciousness, photophobia, shortness of breath, radiation of pain, nausea, vomiting, numbness, weakness, hx of personal or family cardiac conditions, recent illnesses, or recent travels.

Past Medical History

Hypertension x present - managed with medication
Type 2 Diabetes x present - managed with medication
Hyperlipidemia x present - managed with medication
Asthma x present - managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History
Cholecystectomy - 2014
Umbilical hernia repair - 2007
Right scapula tear repair - August 2018
Total left adrenalectomy - December 2023

Medications
Albuterol HFA 108, 2 puffs every 4-6 hours PRN for asthma, last dose today (1/23/26)
Amlodipine 5 mg oral, QD daily, last dose today (1/23/26)
Rosuvastatin 10 mg, QD daily, last dose today (1/23/26)
Metformin 500 mg, QD daily, last dose yesterday (1/22/26)
Olmesartan 20 mg, QD daily, last dose today (1/23/26)
Singulair 10 mg, QD daily, last dose today (1/23/26)
Patient is compliant with the above medications.

Allergies:
Admits to corn/nut allergy → anaphylaxis
Admits to Augmentin allergy → hives

Family History
Mother, deceased at 74 due to stroke, PMHx of DM, HTN
Father, deceased at 80, PMHx of asthma
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 1 brother, 67, living and well
Children, 1 daughter, 40, living and well

Social History
Habits: Denies smoking or alcohol use. Denies drinking coffee or usage of illicit drugs.

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

Marital History: Married to husband.

Occupational history: Not working.

Home situation: Patient reports living with her husband.

Diet: Patient reports having eggs and cereal for breakfast. She states having chicken and rice for lunch. She reports having rice with salmon or chicken for dinner.

Sleep: Average 8 hours of sleep per night.

Exercise: Ambulatory, patient denies actively exercising.

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

Sexual history: Pt is not currently sexually active. Pt denies hx of past STIs. Denies use of barrier methods or contraceptives.

Review of Systems:

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

Skin, hair, nails: Denies excessive dryness or sweating, changes in skin texture, discoloration, pigmentations, moles/rashes, pruritis, or changes in hair distribution.

Head: Admits to headache. Denies vertigo or head trauma.

Eyes: Denies visual disturbances, lacrimation, photophobia, or pruritus. Admits to wearing reading 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: Denies sore throat, sore tongue, bleeding gums, mouth ulcers, voice changes, or use of dentures. Last dental exam unknown.

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

Breast: Denies lumps, nipple discharge, or pain. Last mammogram unknown.

Pulmonary System: Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Denies nausea, vomiting, constipation, diarrhea, intolerance to specific foods, dysphagia, pyrosis, flatulence, eructations, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool. Last colonoscopy unknown. Last endoscopy was 2 weeks ago.

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 13. LMP 20 years ago. Menopause at age 51. 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: Admits to lower leg pain bilaterally that has been present for years and patient is currently undergoing physical therapy for it. Denies muscle/joint pain, deformity, or swelling and redness. Denies arthritis.

Peripheral Vascular System: Admits to mild peripheral edema of bilateral lower legs and ankles. Denies intermittent claudication, coldness or trophic changes, varicose veins, 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: 71 y/o female, well groomed, good posture, in no apparent distress. Patient was found sitting on exam chair, A&O x 3.

Vital Signs:

BP:	R:	L:
Seated:	131/90 mm/Hg	121/84 mm/Hg
Supine:	129/87 mm/Hg	126/82 mm/Hg
Standing:	126/87 mm/Hg	129/80 mm/Hg
RR:	16 breaths/min, unlabored	
P:	80 beats/min, regular, sitting 89 beats/min, regular, supine 85 beats/min, regular, standing	
T:	98.4 ℉, oral	
SpO2	98% room air	
Ht: 5'1"	Wt: 161 lbs	BMI: 30.42

Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. No scars, rashes, or ecchymosis.
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. Nontender to palpation throughout.
Eyes: PERRLA, EOMS intact with no nystagmus. Sclera non-icteric, upper and lower eyelids normal.
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: Symmetrical with no masses or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated.
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
Mouth:
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 midline. Supple and non-tender to palpation. Full range of motion. No palpable cervical adenopathy.
Thyroid: Non-tender, no thyromegaly. No palpable nodules.
Lungs: Mild wheezing bilaterally (improved with nebulizer treatment). Chest expansion and diaphragmatic excursion symmetrical.
Heart: 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: Bowel sounds normoactive in all four quadrants. Non-tender to palpation and tympanic throughout, no guarding or rebound noted.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.
Cranial Nerves:
I – Correctly identifies coffee & alcohol wipe odors bilaterally
II – Visual fields full by confrontation, visual acuity 20/20 OD, 20/20 OS, 20/20 OU corrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena.
III & IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.
V – Face sensation in tact bilaterally, corneal reflex intact jaw muscles strong without atrophy.
VII – Correctly identified sweet, salty and sour tastes. Facial expressions intact, clearly enunciates words.
VIII – Repeats whispered words a 2 feet bilaterally, Weber midline, Rinne AC>BC bilaterally.
IX & X– No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing.
XI – Full range of motion at neck with 3/5 strength and strong shoulder shrug.
XII – Tongue midline without fasciculation, good tongue strength.
Motor: Good muscle bulk and tone. Strength 3/5 throughout.
Cerebellar: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift.
Sensory: Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally.
Reflexes:

	Biceps	Triceps	Brachioradial	Patellar	Ankle/ Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Peripheral Vascular: Mild edema of lower legs and ankles bilaterally. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, or cyanosis. No stasis changes or ulcerations noted.

Problem List:

- Hypertension
- Type 2 Diabetes
- Hyperlipidemia
- Asthma
- Headache
- Chest pain
- Dizziness
- Left leg tremor

Assessment: 71 year old female with past medical history of hypertension, Type 2 diabetes, hyperlipidemia, and asthma presents to urgent care with acute onset headache, dizziness, and chest burning and tightness that began yesterday, as well as mild left lower extremity tremor that began this morning. She reports sudden onset of symptoms last night as she experienced a presyncopal event, with symptoms more severe at the time. Symptoms persist currently, but have improved. In office, vitals are within normal limits. Physical exam is unremarkable, with no focal neurologic deficits or cardiopulmonary abnormalities. EKG revealed normal sinus rhythm, with no acute ST changes. Point of care urinalysis and fingerstick glucose were obtained given patient's history of diabetes and presyncopal symptoms and were within normal limits. Currently most concerned for GERD or cardiac pathology given patient's age and cardiovascular risk factors.

Differential Diagnoses:

6. Gastroesophageal reflux disease (GERD)

   The patient's clinical presentation aligns with an acute episode of gastroesophageal reflux disease. Given the patient's prior history of acid reflux and burning chest pain after eating food, this is a likely diagnosis. Additionally, the patient's symptoms mildly improved after one dose of omeprazole and

although they still persisted last night, they improved significantly by the morning. Currently, she denies any significant chest pain. Her EKG did not reveal any signs of cardiac ischemia and on physical exam, she expressed no neurological deficits. In office, she is hemodynamically stable and in no acute distress. Although this diagnosis most likely explains the patient's current symptoms, cardiac etiologies cannot be ruled out at this time.

7. Atypical acute coronary syndrome

   An atypical presentation of acute coronary syndrome can be very common in elderly female patients and is a must not miss diagnosis. The patient's longstanding history of hypertension, diabetes, and hyperlipidemia puts her at an increased cardiovascular risk than patients without these comorbidities. Additionally, her complaints of chest burning and tightness is a common atypical presentation, especially in females. Her presyncopal event the previous night also raises concern for cardiac ischemia. Although the EKG was normal in office, this does not rule out ACS and must require a further workup. Given the symptom improvement, it seems less likely of a diagnosis, however, it is one that cannot be disregarded.

8. Orthostatic hypotension/Presyncope

   The patient's presentation of dizziness and having a presyncopal episode that resolved with sitting could be due to orthostatic hypotension. The patient is elderly with multiple comorbidities, making this a likely diagnosis. Additionally, her symptoms are milder today and have not recurred in the same intensity as the previous night. Factors such as dehydration, medications, or other causes could have contributed to the presyncopal event. The neurological exam was unremarkable as well. Although orthostatic vitals obtained in the office were normal, orthostatic hypotension can be intermittent and are dependent on the patient's status at a specific moment.

9. Vertigo/Vestibular neuritis

   The patient's dizziness and room spinning sensation from the night before could indicate a potential form of positional vertigo or vestibular neuritis. Although her dizziness significantly improved from the previous night, it is still present. Her headache may be secondary to the dizziness that she was experiencing. However, her lack of history of vertigo and no recent viral illness or hearing loss makes this diagnosis less likely. Additionally, it does not explain her burning chest sensation as well.

10. Transient ischemic attack

    The patient's presentation of the brief unilateral lower leg tremor, headache, and dizziness puts this diagnosis as a consideration.This diagnosis is less likely, however, since the symptoms were transient and the patient did not exhibit any focal neurological changes. The patient lacks symptoms of weakness, aphasia,

visual or sensory disturbance. Her neurological exam was normal. Additionally, her advanced age and vascular risk factors also put this diagnosis as a must not miss diagnosis, considering that the patient also has a family history of stroke.

Workup/Plan:

- Conduct point of care fingerstick glucose (127)
- Conduct urinalysis (unremarkable)
- EKG → normal sinus rhythm, no acute ST-T changes
- Refer patient to emergency room (offered ambulance but declined, will proceed to ER with spouse who is driving)
    - Reason: Presyncope in elderly patient, new onset unilateral leg tremor, chest discomfort, inability to r/o life threatening causes in urgent care

Patient Education:

- Educated patient on the need to go to the emergency room. While current symptoms are milder, serious conditions can present in different ways, especially in elderly patients and patients with diabetes. Explained to patient given her age and comorbidities, it would be safer to get a full workup in ED.
- Discussed with patient that ED workup will include more labs, such as serial cardiac enzymes and advanced imaging if needed, to rule out cardiac ischemia or neurologic issues.

/s/ Jeleeta Jolly, PA Student