Jeleeta Jolly
H&P 1
Site Evaluator: Naeem Sadat
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H&P 1- Ambulatory Care

Chief Complaint: "I am having trouble breathing, productive cough, and my body hurts" x one week and a half.

History of Present Illness:
Patient J.B. is a 79 year old female with a past medical history of asthma, diabetes, and atrial fibrillation who presents to urgent care with complaints of cough, shortness of breath, and body aches that began a week and a half ago. She describes her cough as productive, with clear mucus present. She states that she took Mucinex with no relief. She reports increased shortness of breath that she attributed to her asthma, stating having similar symptoms during a flare up. She reports taking 3 puffs of her emergency albuterol inhaler this morning and a nebulizer treatment before bed with minimal relief. Normally, she uses her albuterol inhaler every morning with relief. However, her symptoms have stayed constant for the past week and a half. She states that walking and movement aggravates her symptoms. Additionally, she reports being exposed to a family member who had the flu one week ago and states taking Theraflu with no relief as well. Currently, she expressed feeling discomfort with the cough and shortness of breath, and her asthma not being controlled with the albuterol. She denies any fevers, chills, weakness, chest pain, hemoptysis, nausea, vomiting, hx of asthma related hospital admissions, or recent travels.

Past Medical History
Asthma x present - managed with medication
Type 2 Diabetes x present - managed with medication
Atrial fibrillation x present - managed with medication

Patient reports being hospitalized in 2025 for a severe illness.

Immunization: Up to date on all immunizations.

Past Surgical History
Patient denies any surgical history.

Medications
Albuterol HFA 108, 2 puffs every 4-6 hours PRN for asthma, last dose today (1/7/26)
Eliquis 5 mg oral, BID daily, last dose today (1/7/26)

Insulin (patient is unsure of name and dosage, not updated in medical chart, patient will find out and follow up with the name and dosage)
Patient is compliant with the above medications.

Allergies:
Admits to tomato allergy → unknown reaction
Admits to seasonal allergies.
NKDA

Family History
Mother, deceased at 84, uncertain of PMHx
Father, deceased at 82, uncertain of PMHx
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, none
Children, 1 son, 35, 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 son.

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

Sleep: Average 8 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: 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: Admits to sore throat. Denies 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: Admits to mild dyspnea, productive cough, and wheezing. Denies hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System: Denies hx of HTN, palpitations, chest pain, irregular heartbeat, edema/swelling of ankles or feet, 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.

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 29 years ago. Menopause at age 50. G1P1001, 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: 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: 65 y/o female, well groomed, good posture, in mild distress. Patient was found sitting on bed, A&O x 3.

Vital Signs:

BP:	R:	L:
Seated:	151/80 mm/Hg	146/75 mm/Hg
RR:	16 breaths/min, unlabored	
P:	65 beats/min, regular	
T:	98.6 ℉, oral	
SpO2	98% room air	
Ht: 5’1”	Wt: 158 lbs	BMI: 29.85

Skin: Warm & moist, good turgor. Nonicteric, with no tattoos. No scars, rashes, or ecchymosis.
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: No discharge or foreign bodies in external auditory canals AU. TM's are pearly white and intact with light reflex in good position
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.
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.
Peripheral Vascular: Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis, or edema noted bilaterally. No stasis changes or ulcerations noted.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact.

Problem List:

- Asthma
- Diabetes
- Atrial fibrillation
- Cough
- Shortness of breath
- Bodyaches

Assessment: 65 year old female with past medical history of asthma, Type 2 diabetes, and atrial fibrillation presents to urgent care with complaints of persistent productive cough, shortness of breath, and body aches that began a week and a half ago. She also states she has been wheezing, with no relief after using her rescue inhaler or cough medication. In office, vitals are normal,

with a slightly elevated blood pressure. Physical exam reveals bilateral mild wheezing throughout the lungs. She was given nebulized albuterol and ipratropium bromide in office, with slight improvement in her symptoms and reduction of wheezing. Will conduct covid, flu, and strep testing to rule out viral infection. Currently most concerned for acute asthma exacerbation.

Differential Diagnoses:

1. Acute asthma exacerbation

   The patient's clinical presentation is most consistent with an acute asthma exacerbation. Given the patient's history of asthma, her shortness of breath, and her physical examination revealing mild wheezing, this diagnosis would be most likely. Typically with asthma, the use of a rescue albuterol inhaler should relieve acute symptoms. Since the symptoms have not been relieved with albuterol, this suggests an exacerbation of the typical asthma symptoms she experiences. The symptoms have been present for more than one week, indicating that a trigger to the exacerbation could have been something viral in nature.
2. Acute upper respiratory infection

   The patient's symptoms of productive cough and body aches could indicate a potential upper respiratory infection. Although most patients with viral respiratory infections take about less than one week to recover, her age and current health conditions may be lengthening the recovery process. Furthermore, a cough may linger for several weeks past the original illness. She was also exposed to a sick family member, also making this diagnosis likely.
3. Acute bronchitis

   The patient has been having a productive cough for more than one week, possibly following a viral infection, which is how acute bronchitis typically presents. Symptoms of bronchitis can last for several weeks in elderly patients, especially in those with a history of asthma or underlying lung disease. With the symptoms of wheezing and shortness of breath, it is possible that bronchitis can worsen typical asthma symptoms, causing her to experience this.
4. Pneumonia

   Given that this patient has had a cough and shortness of breath for over a week, the duration of the illness may suggest early pneumonia symptoms. The symptoms have not improved, even with over the counter Mucinex or albuterol, suggesting that the illness may be worsening. Although she does not have a fever, it is possible for elderly patients to present atypically and may lack classic symptoms of pneumonia. Pneumonia typically presents with high fevers, which she did not have. However, since her physical exam only revealed mild wheezing, with no decreased breath sounds, this diagnosis may not be as likely.

Workup/Plan:

- Do rapid covid, flu, and strep testing (results for all three were negative)
- Start Duo nebulizer treatment in office and evaluate lungs and patient status after 2-3 treatments
- Start budesone-formoterol (Symbicort) 80/4.5 mcg aerosol inhaler, 2 puffs daily
- Start prednisone 20 mg BID for 5 days
- Start omeprazole 20 mg 1 capsule 30-60 minutes before morning meal once daily for 5 days (for protection of the stomach lining since patient will be starting steroids and is on Eliquis)
- Follow up in 48-72 hours for reassessment

Patient Education:

- Advised patient on continuing nebulizer treatment at home as needed
- Ensured follow up with patient in 2 days to monitor symptoms
- Educated patient on if symptoms worsen to go immediately to the emergency room
- Avoid triggers, such as dust, cold air, or smoke and strong smells
- Advised patient to hydrate and get adequate rest

General Health:

- Diabetes: follow up with PCP, keep daily log of blood sugars, fasting and postprandial, continue using insulin as prescribed, monitor diet and incorporate daily walking into routine
- A fib: follow up with cardiologist. Currently uses eliquis, no symptoms at this time.
- Asthma: follow up with PCP and pulmonologist, continue using rescue inhaler, Symbicort, and nebulizer treatment as needed.

/s/ Jeleeta Jolly, PA Student