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H&P 2
February 20, 2026

H&P 2- Emergency Medicine

Chief Complaint: "I am feeling very dizzy" x 4 days

History of Present Illness:

J.A. is a 67 year old female with a past medical history of hypertension, Type 2 diabetes, and prior CVA who presents to the emergency room with complaints of new onset dizziness and emesis that began on Sunday (2/8/26). She described the dizziness as a room spinning sensation. She stated that she also had one episode of vomiting on Sunday, non-bilious non-bloody but has had no episodes since then. Throughout the week, she reported feeling mild intermittent dizziness. However she woke up at 3 AM today with worsening symptoms, reporting severe dizziness that prevented her from standing or walking without assistance. The dizziness has been constant since onset and is also associated with a pounding sensation in her head. Her symptoms are alleviated by lying down, but worsens with any kind of movement or position changes.

She reports recent changes to her medication. She has been taking Ozempic and Jardiance but missed Ozempic last month due to insurance issues and restarted it last Friday. Her primary care provider also initiated Farxiga, though her cardiologist later advised that Jardiance and Farxiga are similar and that she should continue only one of them. She is unsure whether her symptoms are related to restarting Ozempic or the recent medication changes. She has not tried anything over-the-counter to help with the dizziness. She denies any fevers, chills, hearing loss, chest pain, shortness of breath, any changes in vision, any recent illness or travel, diarrhea, constipation, or urinary symptoms.

Past Medical History
Hypertension x present - managed with medication
Type 2 Diabetes x present - managed with medication
CVA 2021- managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History
Open heart surgery 2021 - QHC

Medications
Amlodipine 5 mg oral, QD daily, last dose today (2/11//26)
Ozempic 0.5 mg, once weekly injection, last dose last week
Jardiance 10 mg, QD daily, last dose today (2/11//26)

Patient is compliant with the above medications.

Allergies:
NKDA
No food or seasonal allergies.

Family History
Mother, deceased at 80 PMHx of DM, HTN
Father, deceased at 85, PMHx of HTN

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 and son.

Sleep: Average 8 hours of sleep per night.

Exercise: Ambulatory, patient denies actively exercising.

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.

HEENT: Admits to headache. Denies trauma, vision disturbances, pain or redness. Denies ear pain, deafness, nasal congestion, discharge, or sore throat.

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

Pulmonary System: Denies dyspnea, cough, or wheezing.

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

Gastrointestinal System: Admits to nausea and vomiting. Denies abdominal pain, diarrhea, constipation, jaundice, change in bowel habits, hemorrhoids, rectal bleeding, or blood in stool.

Genitourinary System: Denies frequency, nocturia, urgency, dysuria, hematuria, or flank pain.

Menstrual/Obstetrical: Denies bleeding, spotting, or vaginal discharge.

Nervous System: Denies weakness, numbness, loss of strength, or change in cognition/mental status/memory.

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

Peripheral Vascular System: Denies peripheral edema, coldness, or trophic changes.

Hematologic System: Denies anemia, easy bruising or bleeding, or lymph node enlargement.

Endocrine System: Denies heat or cold intolerance, excessive sweating, thirst, or urination.

Physical Exam

General: 67 y/o female, well groomed, in mild distress. Patient was found lying down on hospital bed, A&O x 3.

Vital Signs:

BP:	159/81 mm/Hg
RR:	20 breaths/min, unlabored
P:	82 beats/min, regular
T:	98.1℉, oral
SpO2	96% room air
Ht: 5’1”	Wt: 54.3 kg

Skin: Warm & moist, good turgor. No scars, rashes, or ecchymosis.
HEENT: Noncephalic, sclera no-icteric, oropharynx well hydrated, moist, non-erythematous, neck is supple with no lymphadenopathy.

Lungs: Clear to auscultation bilaterally, no wheezing, rhonchi, or rales.
Heart: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, gallops, or friction rubs.
Abdomen: Soft, flat, bowel sounds normoactive in all four quadrants. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. No CVA tenderness.
Extremities: No peripheral edema, distal pulses 2+ and symmetric.
Neurologic Exam: A&O x3, cooperative, thoughts & speech coherent. Conversation progresses logically.
Cranial Nerves:
I – Correctly identifies coffee & alcohol wipe odors bilaterally
II – Visual fields full by confrontation, red reflex present.
III & IV & VI – Extraocular movements intact, and reactive to direct & consensual light & accommodation, no ptosis.
V – Face sensation intact bilaterally, jaw muscles strong without atrophy.
VII – Facial expressions intact, clearly enunciates words.
IX & X– No hoarseness, uvula midline with elevation of soft palate, 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. **Unstable gait, unable to ambulate without assistance.**
Sensory: Light touch, position sense, temperature sense intact bilaterally.

Problem List:

- Hypertension
- Type 2 Diabetes
- Prior CVA
- Dizziness

Assessment: 67-year-old female with past medical history of hypertension, diabetes, and prior CVA presents to the emergency room with new onset dizziness that began 4 days ago and worsened this morning around 3 AM. She reports a room spinning sensation with one episode of vomiting on Sunday. Symptoms have been persistent with no improvement. Also reports recent medication change and restart of Ozempic after not taking it for one month. On exam, she displays no focal neurological deficits, however she has an unsteady gait, unable to ambulate on her own. Given her past history of CVA, would like to rule out neurologic/cardiac etiology. Most concerned for BPPV or medication related side effects. Will obtain EKG, labs, and CT head to further assess. Will closely monitor patient. Will treat symptoms and reassess.

Differential Diagnoses:

1. Benign Paroxysmal Positional Vertigo (BPPV)

   The patient's clinical presentation aligns with peripheral vertigo. The sudden onset of room spinning sensation, worsening with movement, and improvement when lying still is classically seen in BPPV. The inability to ambulate due to positional dizziness also strongly suggests vertigo as the primary diagnosis. The lack of neurologic deficits, hearing loss, or infectious symptoms rules out other more dangerous conditions or causes of the dizziness.
2. Vestibular Neuritis

   Persistent vertigo lasting days with severe imbalance and nausea and vomiting can indicate vestibular neuritis, even without a clear preceding viral illness. This condition causes continuous dizziness rather than brief positional episodes, which could explain why she has felt symptomatic throughout the week.
3. Medication Related Dizziness

   The patient recently had medication changes involving Farxiga and Jardiance, both SGLT2 inhibitors. These medications can cause dehydration, electrolyte imbalances, and dizziness/lightheadedness. Although her dizziness is more likely due to vertigo, medication related side effects could also be exacerbating her symptoms.
4. Central Vertigo due to Posterior Stroke

   Given her risk factors of HTN, DM, and prior CVA, a cerebellar stroke must be ruled out. Posterior strokes may present with only vertigo, vomiting, and inability to walk. Although she exhibits no focal neurological deficits, the inability to stand up or ambulate is concerning and requires evaluation to rule out a central cause.
5. Migraine

   The patient also described a head pounding sensation, along with room spinning sensation, which could indicate new onset of migraine. These episodes may cause vertigo and imbalance. However, the patient lacks severe headaches, with the prominent symptoms being dizziness, leading to vertigo being more likely as the primary diagnosis.

Workup/Plan:

- Labs
  - CBC w/ diff. → r/o infection, inflammation, anemia
  - BMP → to assess dehydration, fluid losses, electrolyte abnormalities
  - Troponin - r/o cardiac ischemia
    - Findings: < 6
  - UA → to evaluate hydration, infection
  - POC glucose → r/o hypo or hyperglycemia
  - VBG w/ lactate → to assess perfusion and metabolic status

- Imaging
    - EKG → normal sinus rhythm, no ST-T changes, no acute ischemia
    - CT head → r/o ischemic/hemorrhagic stroke
        - Findings: small lacunar infarct, possibly from prior CVA
    - CT angiography of head and neck → if normal CT head, r/o posterior stroke
- Management
    - IV fluids (sodium chloride 0.9% 1000 mL)
    - Give IV metoclopramide 10 mg for nausea and vomiting
    - Give IV meclizine 25 mg for dizziness
    - Consult neurology for evaluation
    - Reassess gait → if no improvement, admit to EDOU
    - Educated patient on staying hydrated, moving slowly when changing positions. Also told patient that if symptoms are not improving and if patient still cannot stand or walk, may need to be admitted to the ED observation unit to conduct more testing and evaluate for worsening of sxs.

/s/ Jeleeta Jolly, PA Student