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H&P 2
Site Evaluator: Naeem Sadat
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H&P 2 - Family Medicine

Chief Complaint: "I am coughing a lot and I have a sore throat" x 4 days

History of Present Illness:
Patient B.R. is a 57 year old female with a past medical history of hypertension, hyperlipidemia, and diabetes who presents to the primary care clinic with a cough and sore throat that began 4 days ago. She describes the cough as productive, frequently producing thick, yellow sputum. Symptoms began gradually and have persisted without significant improvement. The cough is present throughout the day and appears to be worsening, particularly with prolonged talking or exertion. She also reports associated mild sore throat and hoarseness of voice. She endorses low grade fever, with the most recent temperature of 99.9 degrees Fahrenheit this morning, chills and generalized body aches. She reports recently being exposed to sick coworkers the week prior with similar symptoms. She has not taken any over the counter medications for relief but has tried home remedies including tea with honey with minimal relief. She denies fatigue, chest pain, shortness of breath, abdominal pain, nausea, vomiting, diarrhea, hemoptysis, history of asthma/COPD, or recent travels.

Past Medical History
Hypertension x present - managed with medication
Hyperlipidemia x present - managed with medication
Diabetes x present - managed with medication

Immunization: Up to date on all immunizations.

Past Surgical History
Lumpectomy of right breast - 2021
Cholecystectomy - 2023

Medications
Januvia 100 mg, 1 tablet PO daily
metFORMIN HCl 500 MG, 1 tablet (500 mg) by mouth 1 time every 12 hours
Metoprolol succinate ER 25 mg oral tablet, 1 tablet by mouth daily
Ozempic (1 mg/dose) 4 mg/3mL subcutaneous solution pen-injector, 1 mg subcutaneously weekly
Simvastatin 10 mg oral tablet, 1 tablet by mouth daily

Patient is compliant with the above medications.

Allergies:
No seasonal or food allergies.
NKDA

Family History
Mother, deceased at 90, arthritis
Father, deceased at 67, cirrhosis
Grandparents, (ages uncertain), uncertain of PMHx
Siblings, 2 brothers, 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: Currently employed as a home health aid.

Home situation: Patient reports living with her husband.

Diet: Patient reports having oatmeal for breakfast. She states having fish and vegetables for lunch. She reports having rice with chicken or steak 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: 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 fever and chills. Denies recent weight loss or weight gain, loss of appetite, generalized weakness/fatigue, 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 mild 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 productive cough. Denies dyspnea, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

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

Gastrointestinal System: Denies abdominal pain, 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 was 3 years 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 15. LMP 7 years ago. Menopause at age 50. G0P0. 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: 57 y/o female, well groomed, good posture, in no apparent distress. Patient was found sitting on chair, A&O x 3.

Vital Signs:

BP:		
Seated:	127/84 mm/Hg	
RR:	16 breaths/min, unlabored	
P:	87 beats/min, regular	
T:	99.4 ℉, oral	
SpO2	97% room air	
Ht: 5’3”	Wt: 147 lbs	BMI: 26.0

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.

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: **Mild congestion of the nasal mucosa. Clear nasal discharge in bilateral nares.** Symmetrical with no masses or polyps. Nares patent bilaterally. Nasal mucosa pink & well hydrated.
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.
Oropharynx: **Mild erythema**. Well hydrated, with no exudates, masses, or lesions. Tonsils are present with no 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: **Diffuse wheezing bilaterally, diffuse decreased breath sounds on auscultation throughout lung field**. 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: Abdomen is soft and symmetric. No striae or pulsation noted. Bowel sounds normoactive in all four quadrants. No tenderness, guarding or rebound noted. Non-distended, no palpable masses. No hernias present, no hepatosplenomegaly. No CVA tenderness.
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:

- Hypertension
- Hyperlipidemia
- Diabetes
- Productive cough
- Sore throat

Assessment: 57 year old female with past medical history of hypertension, hyperlipidemia, and diabetes presents with a 4 day history of a persistent productive cough, sore throat, and low grade fevers. Patient reports recent exposure to sick contact one week prior. In office, she is hemodynamically stable. On physical exam, there are diffuse decreased breath sounds and wheezing heard throughout bilateral lung fields. Congestion of the nasal mucosa is noted along with mild erythema of the oropharynx. Currently most concerned for acute URI/bronchitis. Will obtain Covid NAAT and throat cultures, and treat current symptoms.

Differential Diagnoses:

1. Acute bronchitis

   Acute bronchitis is the most likely diagnosis given the patient's 4 day history of worsening productive cough, low grade fever, and recent sick contact. The presence of diffuse wheezing and decreased breath sounds on exam strongly supports involvement of the lower airways, which is characteristic of bronchial inflammation. Her symptoms began gradually and are associated with upper respiratory features, such as sore throat and nasal congestion, suggesting a viral etiology. Additionally, her stable vital signs and absence of focal lung findings make more serious conditions less likely.

2. Upper respiratory infection

   A viral upper respiratory infection remains a strong consideration given her sore throat, nasal congestion, mild fever, and exposure to sick coworkers. The mild erythema of the oropharynx and clear nasal discharge further supports an upper airway process. However, the presence of a significant productive cough and wheezing suggests that the infection has extended beyond the upper airway, making bronchitis more likely. Overall, URI and bronchitis present similarly and often overlap in clinical practice.

3. COVID-19

   Given the exposure to sick coworkers and the symptoms of fever, cough, bodyaches, and sore throat, viral infection, such as COVID-19, is highly probable, particularly in a healthcare related occupation as a home health aid. The presentation is non-specific, and although she does not report typical loss of taste/smell, it could still be a possible diagnosis. In the clinical setting, testing is appropriate to guide isolation and management.

4. Community acquired pneumonia

   Given her age and comorbidities, pneumonia is also a significant differential to consider. The persistent productive cough and low grade fever with body aches could represent forming pneumonia. The wheezing and decreased breath sounds could indicate viral pneumonia. It is lower on the differential list because she lacks persistent high fevers, tachycardia, dyspnea, and crackles on physical exam.

5. Acute sinusitis

   The patient presents with persistent, productive cough, accompanied by a sore throat and hoarseness that can arise from chronic, thick mucus dripping from the sinuses into the pharynx. On exam, there was also mild congestion of the nasal mucosa. However, the lack of facial sinus tenderness and duration of symptoms suggest that this may be more likely due to an upper respiratory infection rather than sinusitis.

Workup/Plan:

- Obtain COVID PCR swab and throat culture
- Start Duo nebulizer treatment in office - improvement in airways and decreased wheezing
- Start benzonatate 100 mg, 1 tablet every 8 hours
- Start Trelegy Ellipta 100-62.5-25 mcg/act, inhale once daily
- Start Ventolin HFA 108 mcg/act aerosol solution, inhale 2 puffs every 6 hours
- Start Zithromax 250 mg

Patient Education:

- Educated patient that symptoms are most consistent with a viral respiratory infection, with a persistent cough that can last up to 2-3 weeks
- Advised patient to take benzontate 100 mg as needed to help with the cough
- Advised patient to use the inhaler as needed, if she experiences wheezing or shortness of breath
- Advised patient to take the Zithromax as directed and to finish the full course of antibiotics
- Educated patient on pending COVID PCR results, advised patient to wear a mask around others, proper hand hygiene, and avoid close contact, especially with high risk patients - offered a work note for a few days
- Encouraged adequate rest and hydration with warm fluids and over the counter medications, such as Tylenol for symptom relief (sore throat, fevers, bodyaches)
- Educated on strict return precautions and advised patient to go to the ER if symptoms worsen (persistent fevers, worsening shortness of breath or difficulty breathing, chest pain)

/s/ Jeleeta Jolly, PA Student