Tara Capo
Professor Jeanetta Yuan
HPPA 502- Physical Diagnosis I
IM Visit Write Up

Date of visit: March 18th, 2025

Source of information: Self
Reliability: Reliable
Source of referral: PCP
Mode of transport: Self

Chief complaint: "I am here for a colonoscopy."

73-year-old female with PMHx of hypertension and type II diabetes mellitus who was sent in by primary care provider as direct admission to internal medicine for rectal bleeding which started 5 days ago. Pt states she has had 3 episodes of blood in her stool, noted on the toilet paper and in the toilet bowl after having bowel movements. Blood is described as bright red, non clotting, and mixed in the stool. Nothing makes the bleeding more or less severe, as the amount is consistently moderate with each bowel movement. Pt has not taken any medications for it and is not on any anticoagulants. She called her PCP with the complaint, and was referred to the hospital today for anemia workup and colonoscopy. Pt reports prior colonoscopy in 2016 for similar complaint of rectal bleeding, which was found to be normal at that time. Pt denies abdominal pain, nausea, vomiting, diarrhea, constipation, weight loss, fatigue, changes in frequency or consistency of bowel movements. She also denies recent sick contacts or trauma.

Past Medical History
- Type II Diabetes Mellitus x present, controlled
- Hypertension x present, controlled
- Immunizations: up to date on all immunizations, including yearly Flu vaccines and 4 total doses of Pfizer COVID vaccines.

Past Surgical History
- Colonoscopy in 2016 at New York Presbyterian Queens, Flushing, NY. No complications.

Medications
- Metformin 1,000 mg PO twice daily for diabetes
- Enalapril 5 mg PO once daily for hypertension
- Metoprolol 100 mg PO once daily for hypertension

Pt is compliant with all medications.

Allergies
Allergic to peanuts and beans, states her face "swells up." Denies environmental or drug allergies.

Family History
- Maternal/paternal grandparents: deceased at unknown ages due to unknown causes; uncertain PMHx
- Mother: deceased at unknown age from old age; PMHx of HTN, DM and previous MI.
- Father: deceased at unknown age from old age; no known PMHx.
- Brother: alive and well; PMHx of DM and "heart problems" (unable to specify).
- No children.

Social History
Habits: denies smoking, substance abuse or illicit drug use. No caffeine intake.
Diet: 2-3 meals per day of varying foods, unable to specify.
Exercise: daily walks for 10-15 minutes.
Travel: no recent travel.
Occupation: retired x 8 years.
Safety measures: admits to wearing seatbelts in car.
Sleep habits: 6-7 hours per night.
Marital status/living situation: single female, currently living by herself.
Sexual history: heterosexual; currently single and sexually inactive. Sexual partners unspecified. Uses barrier protection and denies contraceptive use.

ROS
General: denies weight loss/gain, loss of appetite, generalized weakness, fatigue, fever, chills, or night sweats
Hair, skin, nails: denies rash, itching, excessive sweating or dry skin, new moles, change in existing moles, hair loss, change in hair texture or nail changes
HEENT: denies headache, lightheadedness, dizziness, head trauma, visual changes, double vision or blurriness, change in hearing, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies orthopnea, SOB, cough, sputum, hemoptysis, or wheezing
Cardiovascular: hx of HTN; denies chest pain, palpitations, syncope, heart murmur, or swelling of legs or feet
Gastrointestinal: admits to blood in stool; denies nausea, vomiting, abdominal pain, changes in appetite, change in bowel habits, diarrhea, constipation, heartburn or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Menstrual/Obstetrical – G0P0, Menarche age 13. LMP at age 54. Minimal menopausal symptoms. Currently in menopause – denies hot flashes or associated menopausal symptoms. Denies breakthrough bleeding/spotting or vaginal discharge
Neurological: denies weakness, seizures, LOC, numbness, tingling, memory loss or changes in gait or mental status
Musculoskeletal: denies muscle/joint pain, redness, deformity, or swelling
Peripheral Vascular: denies claudication, coldness or swelling of extremities or color change in extremities
Hematologic: denies anemia, easy bruising, blood transfusions or hx of DVT/PE
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, sleep disturbances, difficulty concentrating or suicidal ideations

Physical Exam
General: 73 year old female in no acute distress, well nourished, well developed and well groomed. Pt appears stated age of 73, found sitting up in bed and AOx3 to person, place and time.

Vital Signs:	Right:	Left:
Blood pressure		
Seated:	130/80 mmHg	130/80 mmHg
Supine:	120/70 mmHg	110/60 mmHg
Standing:	110/70 mmHg	110/60 mmHg
Respiratory rate:	16 breaths/min, regular rate & rhythm, unlabored	
Pulse:	70 beats/min, regular, 2+	

Temperature:	98.6 degrees F, orally
SpO2:	98% on RA
Height:	62 inches
Weight:	110 pounds
BMI:	20.8

Skin & Head:
Skin: warm and moist, good turgor. Nonicteric, no lesions, tattoos or scars
Hair: average quantity and distribution. No alopecia, seborrhea or lice.
Nails: no clubbing. Capillary refill <2 seconds in upper and lower extremities
Head: normocephalic, atraumatic; no tenderness; no ecchymosis, hematomas or lacerations
Eyes: symmetrical OU. No strabismus, nystagmus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity (uncorrected) – 20/40 OS, 20/40 OD, 20/20 OU
Visual fields full OU. PERRLA, EOMs full, with no nystagmus
Fundoscopy: red reflex present OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates, or neovascularization OU
Ears: Symmetrical and appropriate in size. No lesions, masses, trauma on external ears. No discharge or foreign bodies in external auditory canals bilaterally. TM's pearly grey and intact with light reflex in good position bilaterally. Auditory acuity intact to whisper test bilaterally. Weber midline; Rinne reveals AC>BC bilaterally.
Nose/Sinuses:
Nose: symmetrical; no masses, lesions, deformities, trauma, bleeding or discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. No discharge or bleeding on rhinoscopy. Septum midline with no lesions, deformities, injection or perforation. No foreign bodies noted.
Sinuses: non tender to palpation over bilateral frontal and maxillary sinuses.
Mouth/Pharynx:
Lips: pink and moist, no cracking. No cyanosis or lesions.
Mucosa: pink and well hydrated. No masses, lesions or ulcers. No leukoplakia.
Palate: pink and well hydrated. Intact with no lesions, masses or scars.
Teeth: good dentition. No obvious dental carries or missing teeth.
Gingivae: pink and moist. No hyperplasia, masses, lesions, erythema or discharge.
Tongue: pink, well palpillated. No lesions, masses or deviation.
Oropharynx: no injection, exudates, masses, lesions, or foreign bodies. Tonsils without injection or exudate. Uvula pink and midline, no edema.
Neck, Trachea & Thyroid:
Neck: trachea midline. No masses, lesions, scars or pulsations. Supple and non tender to palpation. No enlargement of parotid or submandibular glands. No visible lymph nodes.
Thyroid: non tender, no palpable masses. Thyroid noted to move upward upon swallowing. Isthmus noted upon lateral displacement of thyroid.