Abigail Chen

Chief Complaint:
“I’m here for evaluation before my right knee surgery for knee pain that has been ongoing for 3–4 years”

History of Present Illness:
J.E. is a 74-year-old male with a history of rheumatoid arthritis and well-controlled hypertension, presenting for pre-admission testing in preparation for an upcoming right knee replacement surgery. The patient has experienced chronic right knee pain for the past 3–4 years, which has progressively worsened. He describes the pain as sharp, occasionally dull, and located in the posterior aspect of the knee, with radiation upward along the posterior thigh and laterally toward the hip. He rates the pain at 8/10 on average, with exacerbations triggered by walking, stair climbing, and particularly cold and rainy days. The pain is partially alleviated with rest and medications.He has been prescribed prednisone and Vimovo for rheumatoid arthritis, which provide limited relief. He also uses over-the-counter advil, tylenol and motrin have been used intermittently, though he reports only minimal improvement. He received a cortisone injection 6 months ago, which offered temporary relief. Patient reports no mechanical locking, giving way, or catching is reported. He remains physically active and exercises daily, including light weight training and cardiovascular activity. He denies pain in other joints, fever, chills, weight loss, night sweats, numbness, tingling, weakness, or recent trauma.

Past Medical History:
Rheumatoid arthritis, diagnosed 4 years ago (2021)
Hypertension, well-controlled on losartan
Benign Prostatic Hyperplasia, controlled
Left meniscus tear, diagnosed in 2020; managed conservatively
Hernia, repaired approximately 15 years ago
Hepatitis C, diagnosed 15 years ago, successfully treated and cured with antiviral therapy

Immunizations:
Up to date on all age-appropriate vaccinations including influenza, pneumococcal, shingles, and 3 doses of COVID-19 vaccine (Moderna)

Medications:
Losartan 50 mg PO daily
Prednisone 5 mg PO daily
Vimovo 500–20 mg PO BID
Tamsulosin for BPH 0.4 mg PO daily
PRN: Ibuprofen 400 mg, Acetaminophen 500 mg, or Motrin 220 mg

Allergies:
No known drug, food
Seasonal Pollen- nasal congestion and itchy eyes

Surgical History:

Bilateral cataract surgery 2020 (5 yrs ago), Queens, NY. No complications.
TURP for BPH 2020 (5yr ago), Queens, NY. No complications.
Repeat TURP performed in 2024 for recurrent BPH symptoms (1yr ago),Queens, NY. No complications.

Family History:
Mother: Deceased, breast cancer at age 57
Father: Deceased, cirrhosis, heavy drinker, died at 52
7 Brothers: all living and well; no known PMHx.
2 children: both alive and well
Grandparent: Deceased, unknown age, unknown family history

Social History:
J.E. is a retired 15 year janitor and former mason who worked for over 40 years before retiring. He lives with his wife in a house provided through his work as a cemetery caretaker.

Habits: Denies current tobacco use, alcohol consumption, or any history of illicit drug use. Former smoker with a 25 pack-year history. Smoked 1 pack per day from age 29 to 64; quit 10 years ago.
Travel: No recent travel.
Diet: Patient eats three meals daily. Breakfast usually consists of oatmeal with fruit and black coffee. Lunch is typically a turkey sandwich or salad with grilled chicken. Dinner often includes grilled fish or chicken with vegetables and rice. He snacks on almonds or yogurt and drinks 6–8 glasses of water daily.
Exercise: Goes to gym daily, cardio & weights for approximately 1 to 1.5 hours per session.
Safety Measures: Wears a seatbelt consistently.
Sexual History: Currently sexually active with one partner in a monogamous relationship. Does not use condoms.
Sleep: Reports good sleep quality, averaging 7 hours of sleep per night and waking feeling well-rested.

Review of Systems:

General: Denies weight loss, weight gain, fatigue, fever, chills, night sweats, or changes in appetite.

Skin, Hair, Nails: Denies rashes, itching, dryness, pigment changes, or hair/nail changes.

Head: Denies headache, vertigo, or head trauma.

Eyes: Denies visual disturbances, foreign body sensation, photophobia, or excessive tearing. Does not wear corrective lenses.

Ears: Denies hearing loss, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinus: Denies congestion, rhinorrhea, epistaxis, or sinus pain.

Mouth/Throat: Denies sore throat, bleeding gums, ulcers, hoarseness, or dental issues.

Neck: Denies neck pain, stiffness, swelling, or decreased range of motion.

Breast: Denies lumps, pain, or discharge.

Pulmonary System: Denies shortness of breath, cough, wheezing, sputum production, or hemoptysis.

Cardiovascular System: Denies chest pain, palpitations, edema, syncope, or known murmurs.

Gastrointestinal System: Denies nausea, vomiting, abdominal pain, constipation, diarrhea, or changes in bowel habits.

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

Musculoskeletal System:Reports chronic right knee pain for 3–4 years, described as sharp and worsening with activity such as walking and stair climbing. Also reports stiffness, particularly in cold or rainy weather. No reports of locking, catching, or giving way of the knee. Denies pain in other joints, joint swelling, redness, warmth, or deformity elsewhere. No history of recent trauma or falls. Maintains daily exercise routine with modifications due to knee symptoms.

Nervous System: Denies dizziness, numbness, weakness, seizures, or changes in memory or coordination.

Peripheral Vascular System: Denies claudication, varicose veins, cold extremities, or color changes.

Hematologic System: Denies easy bruising, bleeding, anemia, or history of transfusions.

Endocrine System: Denies heat/cold intolerance, polyuria, polydipsia, or hormonal symptoms.

Psychiatric: Denies depression, anxiety, mood changes, hallucinations, or suicidal ideation.

Physical:
General: Well-developed, well-nourished male, neatly groomed, appears at his stated age of 74 years. Patient is alert and oriented ×3, ambulatory, and in no acute distress.

Physical Exam

General:
74-year-old male, alert, well-developed, well-nourished, appears his stated age. Sitting upright on exam table Neatly groomed and cooperative. No acute distress.

Vital Signs:
Patient tolerated orthostatic vitals in all positions.

BP:
Seated: Right 132/90 mmHg, Left 120/76 mmHg
Supine: Right 124/80 mmHg, Left 122/78 mmHg
Standing: Right 116/74 mmHg, Left 114/72 mmHg

RR: 16/min, non-labored
Pulse: 88 bpm, regular
Height: 67 inches
Weight: 170 lbs
BMI: 26.6, overweight
O2 Sat: 98% on room air
Temperature: 98.4°F oral

Skin Exam: Skin warm, dry, and well-hydrated. Normal turgor. Capillary refill <2 seconds in all digits. No rashes, lesions, or pigment changes. Hair and nail exam within normal limits.

Head Exam: Normocephalic and atraumatic. No evidence of contusions, hematomas, lacerations, depressions, crepitus, or tenderness to palpation.

Eyes: Sclera white and conjunctiva pink. No foreign bodies, tearing, or vascular abnormalities. Pupils 3 mm, equal, round, and reactive to light and accommodation (PERRLA). Extraocular movements intact without nystagmus. Visual acuity 20/20 OU with correction. Visual fields full bilaterally. Fundoscopy reveals sharp disc margins, present red reflex, no AV nicking, hemorrhages, or neovascularization.

Ears: Auricles symmetrical and equal size with no lesions or trauma. External auditory canals clear. Tympanic membranes pearly white and intact with appropriate light reflex. Hearing intact via finger rub. Weber midline; Rinne shows air conduction > bone conduction bilaterally.

Nose/Sinus: Symmetrical with no lesions, trauma, or discharge. Nares patent bilaterally. Nasal mucosa pink and moist. Septum midline, no deviation or perforation. No sinus tenderness over frontal, maxillary, or ethmoid areas.

Mouth & Pharynx:
Lips: Normal pigmentation, no cyanosis or lesions, non-tender.
Mucosa/Palate: Pink, well hydrated, no lesions or masses. Palate intact, non-tender.
Teeth: Intact dentition, no caries or missing teeth. No implants.
Gingivae: Pink, moist, no hyperplasia, lesions, or discharge.
Tongue: Midline, pink, well-papillated, non-tender, no masses or deviation.
Oropharynx: Well hydrated, no injection, exudates, lesions, or swelling. Tonsils present and non-enlarged. Uvula pink and midline.

Neck, Trachea & Thyroid:

Neck supple with full range of motion. Trachea midline. No masses, lesions, scars, or pulsations. No cervical adenopathy. Thyroid non-enlarged, non-tender, and without palpable nodules.

Chest: Symmetrical, no deformities or signs of trauma. Respirations are unlabored with no paradoxical movement or use of accessory muscles. Lateral-to-anteroposterior (AP) diameter is 2:1. Non-tender to palpation throughout.

Lungs: Clear vesicular breath sounds with good air entry bilaterally. Chest expansion and diaphragmatic excursion are symmetrical. Tactile fremitus is equal throughout. Resonant percussion bilaterally. No adventitious breath sounds noted (e.g., wheezes, rales, or rhonchi).

Heart:
Point of maximal impulse (PMI) located at the 5th intercostal space at the midclavicular line. Regular rate and rhythm. S1 and S2 heard clearly without murmurs, rubs, or gallops. No S3 or S4. No heaves or thrills palpated. Carotid upstrokes are brisk without bruits.JVP is 2 cm above the sternal angle with the head of the bed inclined at 30°.