YORK COLLEGE
The City University of New York

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
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History and Physical Verification Form

Class: Physical Diagnosis I (HPPA 502)

Student Expectation:

- Obtain medical history and perform physical exam up to the point covered in class.
- Start formulating differential diagnosis and treatment plan.
- Oral presentation to clinical site supervisor/preceptor.

Student: Sirat Zafar

Clinical Site: New York Presbyterian Queens (IM)

Date of Visit: 2/18/25

Activity performed: H & P (skin exam)

Supervisor:

Name and Credentials: Memona Ali PA-C

Supervisor Signature:

Supervisor Comments:
Good bedside manner. Through history taken.

York College - Physician Assistant Program
Physical Diagnosis HPPA 502

Sirat Zafar
Prof. Natalia Wu

Identifying Data:
Fall Name: [redacted]
Address: [redacted], NY
Date of Birth: [redacted]
Date & Time: February 18, 2024 10:05 AM
Location: New York Presbyterian Queens Hospital
Religion: [redacted]
Source of Information: Self
Source of Referral: Self
Mode of Transport: Ambulance

Chief Complaint: "I had a seizure episode yesterday, now I'm having a headache since this morning."

History of Present Illness:
Ms. Y.X is a reliable 24-year-old Chinese female with a significant PMHx of seizures, social anxiety, headaches, IBS, depression, and insomnia, currently recovering from a seizure episode at NY Presbyterian Queens Internal Medical Unit. She presents with a chief complaint of headache since this morning. She describes the headache as splitting and diffuse, associated with a "cloudy" sensation, which began gradually upon waking and has persisted throughout the day. She reports experiencing similar episodes multiple times a week since being diagnosed with chronic seizures at age 14. Sounds, bright lights, eating, and her newly prescribed seizure medication, Lamotrigine (75 mg PO daily, started January 29, 2025), exacerbate the headaches, while restful sleep eliminates them upon waking. She has not tried any medication for symptom relief. Additionally, she admits to mild fatigue, lightheadedness, blurry vision, nausea, vomiting (three nonbilious, non-bloody episodes since starting Lamotrigine), loss of appetite, abdominal pain secondary to IBS, and numbness/tingling in her extremities due to chronic seizures. She denies recent travel, strenuous activity, trauma, fever, chills, weight loss, GI bleeding, palpitations, chest pain, SOB, neck stiffness, diarrhea, constipation, dysuria, or swelling in extremities.

Past Medical History:
Present Illnesses-
Seizures x (11 years), controlled with oral medications
IBS x (8 months), uncontrolled
Insomnia x (6 years), controlled with oral medications
Depression x (6 years), controlled with oral medication, hospital administered
Social Anxiety x (2 years)
HA x unknown years (patient reports since childhood)

Childhood illnesses- Seizures x (11 years), Headache x unknown duration
Immunizations- Pt claims she did not receive any childhood vaccines. Pt reports receiving flu vaccine (November 2024), Pfizer COVID vaccine (2 doses, 2022)
Screening tests and results- No pap smear, mammogram or skin exam.

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Past Surgical History:
Hospitalizations- no surgeries
Seizure 2022, NYU Langone, Manhattan, NY
Seizure 2013, NY Presbyterian Queens, NY
Denies any surgeries. Denies past injuries and transfusions

Medications:
Oxcarbazepine (Trileptal) 750 mg PO daily - 250 mg AM, 500 mg PM for seizures (hospital administered 300 mg AM, 600 mg PM, lose dose this morning)
Clobazam (Onfi) 10 mg PO QHS for seizures, last dose last night
Lamotrigine (Lamictal) 75 mg PO daily- 25 mg AM, 50 mg PM for seizures, last dose this morning
Zolpidem (Ambien) 5 mg PO QHS for insomnia, last dose last night
Mirtazapine (Remeron) 15 mg PO QHS for depression, administered by hospital
Ativan 2 mg IV given routinely for DVT/PE prophylaxis, administered by hospital
No birth control/ holistic preps/ vitamins

Allergies: NKDA, denies food/environmental allergies.

Family History:
Mother- 46, Alive and well, Headache
Sister- 26, alive and well
Father- 52, alive and well, Diabetic, HTN
Maternal/paternal grandparents- Deceased at unknown age & unknown reasons
Denies family history of cancer

Social History:
Ms. Y. X. is a single female currently living at home with her mother, sister and dog. She works at a retail store as a sales associate.
Habits- Pt denies drinking alcohol, smoking cigarettes, illicit drug use and caffeine intake.
Travel- Pt denies recent travel.
Diet- Patient follows a pescaterian diet, consuming one meal per day (dinner) consisting of carbohydrates (i.e, noodles, rice) with seafood. She does not eat breakfast or lunch and primarily drinks water. Patient eats chips and drinks bubble tea for occasional snacking.
Exercise- Patient states she does not exercise. She has inconsistent sleep habits but typically sleeps around 12 hours most days.
Safety measures- Admits to wearing a seat belt
Sexual Hx- Patient claims she has never been sexually active with no history of STIs.

Review Of Systems:
General- States she has loss of appetite and generalized weakness/fatigue which she attributes to both her seizure disorder and side effects of Lamotrigine. Denies recent weight loss or gain, fevers, chills, or night sweats.

Skin, Hair and Nails- Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head- Admits to chronic headaches exacerbated by lack of sleep and lightheadedness due to side effects of Lamotrigine. Denies head trauma or fractures.

Eyes- Admits to visual disturbances of blurring and fatigue with use of eyes due to seizure disorder and Lamotrigine but denies diplopia, scotoma and halos. Denies lacrimation, photophobia or pruritus. Last eye exam was more than 10 years ago, no use of glasses.

Ears- Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses:- Denies discharge, epistaxis, or obstruction.

Mouth/ throat- Denies use of dentures, bleeding gums, sore tongue, sore throat, or mouth ulcers. Last dental exam 2022, normal findings.

Neck- Denies localized swelling/lumps or stiffness/decreased range of motion.

Breast- Denies lumps, nipple discharge or pain.

Pulmonary system- Denies cough, dyspnea, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system- Denies HTN, chest pain, palpitations, irregular heartbeat, edema, syncope or known heart murmur.

Gastrointestinal system- Admits to loss in appetite, nausea, vomiting due to Lamotrigine. Admits to abdominal pain due to IBS. Denies dysphagia, pyrosis, unusual flatulence, eructations, jaundice, rectal bleeding, blood in stool or flank pain.

Genitourinary system- Denies urinary frequency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate or flank pain.

Menstrual/Obstetrical- Menarche age 11. Reports regular menstrual cycles lasting 5-6 days. LMP February 6, 2025. Denies dysmenorrhea, metrorrhagia, menorrhagia, premenstrual symptoms, postcoital bleeding, abnormal vaginal discharge, or dyspareunia.

Nervous system- Admits to seizures and headaches due to chronic seizure disorder. Denies loss of consciousness, numbness, paresthesias, dysesthesias, paresthesias, ataxia, loss of strength, change in cognition, or weakness.

Musculoskeletal system- Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Hematological system- Denies easy bruising and bleeding, anemia, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system- Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism or goiter.

Psychiatric- Admits to social anxiety, depression and insomnia. Admits to feelings of helplessness, hopelessness, lack of interest in usual activities, suicidal ideation but denies intent, means or plan. Last mental health professional visit November 2024.

Physical:
General: Slender female, neatly groomed, looks her stated age of 24 years old. She is awake, alert, and oriented x 3, and in no acute distress.

Skin Exam:
Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos. Nevi 1 mm on left wrist and benign nevi 1 mm on right palm.
Hair: average quantity and distribution.
Nails: no clubbing, capillary refill <2 seconds in upper and lower extremities.
Head: Normocephalic, atraumatic, non tender to palpation throughout.