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:
S. Seligson, J. Yuan &
L. Sanassi
Contact: Jeanetta Yuan
jyuan1@york.cuny.edu

History and Physical Verification Form

Class: Physical Diagnosis II (HPPA 522)

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: NYPD Emergency Department

Date of Visit: 10/21

Activity performed: HTP

Supervisor:

Name and Credentials: Richa Gupta MD

Supervisor Signature:

Supervisor Comments:

York College - Physician Assistant Program
Physical Diagnosis II HPPA 522

Sirat Zafar
Prof. Jeanetta Yuan

Identifying Data:
Full Name:[redacted]
Address:[redacted], NY
Date of Birth: [redacted]
Date & Time: Oct. 21, 2025 8:46 AM
Location: NYPQ
Religion: [redacted]
Source of Information: Self
Source of Referral: Self
Mode of Transport: Ambulance

Chief Complaint: "I had an episode of 'gallstone' pain x last night."

History of Present Illnesses: Mrs. S.B. is a reliable 48 year old Caucasian female with a significant past medical history of cholelithiasis, anxiety, prediabetes, and gastritis, presented to the NYPQ ER at 2:00 am via ambulance with complaint of epigastric pain x 2.5 hours. She describes the pain as sharp, stabbing, and constant in the epigastric region, radiating to the right back. The right-sided back pain was moderate intensity (6/10), while the overall pain was initially rated 9-10/10, now 2/10 at the time of evaluation. She reports mild associated nausea without vomiting, along with abdominal bloating. She also notes a burning sensation consistent with her gastritis that coincides with these episodes. Patient reports experiencing similar episodes over the past 2 months, noting that their frequency has gradually increased from once weekly to multiple times per week. She reports that applying pressure to the epigastric area aggravates the pain, while taking a hot shower with steam typically provides relief; however, on this occasion, the pain was too severe to tolerate. She reports eating dinner around 6:00 PM, consisting of one-quarter piece of Parmesan Chicken and one-quarter cup of pasta. Patient admits to loss of appetite due to GLP-1 therapy and intermittent headaches occurring once a month, typically 4 days a week with mild intensity (4/10) She takes Advil as needed with relief. She denies recent trauma, recent travel, strenuous activity, fevers, chills, chest pain, SOB, jaundice, scleral icterus, changes in bowel movements, urinary symptoms, recent alcohol use, recent use of NSAIDs or sick contacts.

Past Medical History:
Present Illnesses-
Anxiety x (8 years), controlled with oral medications
Gastritis x (2 months), controlled with oral medications
Cholelithiasis x (2 months), uncontrolled
Prediabetes x (2 month), controlled with oral medications
Denies of childhood illnesses.
Immunizations- Patient reports having received all routine childhood vaccinations, COVID vaccine (2 doses, 2020) and Tdap (2023). She routinely declines the annual influenza vaccination.

Screening tests and results- Pap smear/HPV test: Nov 2025, normal results. Mammogram: Feb 2024, normal results. Colonoscopy- 2022, normal results. Endoscopy: Oct 6, 2025, findings consistent with gastritis. Abdominal US: Oct 6, 2025, Cholelithiasis (gallbladder stones).
Last PCP visit 9/8/2025.

Past Surgical History:
Hospitalizations-
Cesarean section (2013)
Denies past injuries and transfusions

Medications:
Lexapro 15 mg PO QD for anxiety, last dose yesterday
Buspar 10 mg PO QD for anxiety, last dose yesterday
Tirzepatide 25 mg PO QW for weight loss and prediabetes, last dose 2 days ago
Nexium 20 mg PO QD for gastritis, last dose yesterday
Currently has an intrauterine device (IUD) in place for contraception.
No holistic preps/vitamins.

Allergies:
Tetracyclines: Blisters, hives, rash, hypotension (↓BP by ~20 mmHg)
Macrobids: Rash
Denies food/environmental allergies.

Family History:
Mother- 78, alive, history of HTN
Father- Deceased at 40, colon cancer
Sister- 47, alive and well
Brother- 45, alive and well
Son- 15, alive and well
Daughter- 11, alive and well
Maternal grandparents- Grandfather: Deceased at 90, kidney cancer; Grandmother: Deceased at 99, unknown reason
Paternal grandparents- Grandfather: Deceased at 85, unknown reasons; Grandmother: Deceased at 85, Alzheimer's disease

Social History:
Mrs. S.B. is a married female currently living at home with her husband, 2 children, and 2 cats. She is a researcher at Weill Cornell Medicine.
Habits- Pt reports occasional alcohol use (once per month) and vaping nicotine for the past 2.5 years. She drinks half a cup of coffee daily and denies use of cigarettes or illicit drugs.
Travel- Pt denies recent travel.
Diet- Patient reports typically having half a cup of coffee for breakfast along with a protein bagel and peanut butter. She usually skips lunch and eats salad with protein for dinner. For snacks, she occasionally eats apples with cream cheese.

Exercise- Patient states walking a few blocks daily for exercise. She sleeps an average of 5-6 hours per night, though she wakes up multiple nights per week for approximately 20 minutes between 3:00- 6:00 am due to pain, after which she returns to sleep within a few minutes.
Safety measures- Admits to wearing a seat belt
Sexual Hx- Heterosexual. She is currently not sexually active, reporting decreased sexual desire over the past six months, which she attributes to perimenopausal changes. She has an intrauterine device (IUD) in place for contraception and denies any history of sexually transmitted infections (STIs)

Review of Systems:
General- Patient reports loss of appetite and a recent weight loss of approximately 28 pounds, which she attributes to Tirzepatide use. She also reports generalized weakness but denies fatigue, fever, chills, and 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 intermittent headaches occurring once monthly with mild intensity (4/10), relieved by Advil. Denies vertigo or head trauma.

Eyes- Denies visual disturbances, lacrimation, photophobia or pruritus. Wears prescription contact lenses for near vision correction (+2.00 diopters OU). Last eye exam July 2025, normal results.

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 July 2025, normal results.

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- Hx of Gastritis, cholelithiasis, and prediabetes. Admits to loss in appetite due to Tirzepatide use. Admits to nausea, abdominal pain, pyrosis, and intolerance to dietary triggers (fatty, fried and spicy foods), which cause abdominal discomfort. Denies dysphagia, unusual flatulence, eructations, jaundice, rectal bleeding, blood in stool or flank pain.

Genitourinary system- Denies urinary frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awaking at night to urinate, or flank pain. Urine is clear/yellow.

Menstrual/Obstetrical- Menarche age 12. Reports irregular cycles consistent with perimenopause. LMP September 2025, described as spotting only. Denies dysmenorrhea, metrorrhagia, menorrhagia, premenstrual symptoms, postcoital bleeding, abnormal vaginal discharge, or dyspareunia.
Obstetrical hx- $G_3P_2(T_1\ P_1\ A_1\ L_2)$ No complications reported.

Nervous system- Denies loss of consciousness, seizures, headaches, numbness, paresthesias, dysesthesias, paresthesias, ataxia, loss of strength, change in cognition, or weakness.

Musculoskeletal system- Denies muscle/joint pain, 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- Hx of anxiety controlled with oral medications. Last mental health professional visit- 9/2025; FU every two months. Denies depression, feelings of hopelessness, lack of interesting in usual activities, suicidal ideations, or obsessive/compulsive disorder.

Physical:
General: 48 y/o female who appears her stated age- good posture, in hospital gown. Patient was found sitting up on the hospital bed, A&O x 4, and in NAD.

Vital Signs: BP:	R	L
Seated	109/49 mmHg	105/70 mmHg
Supine	104/78 *(done on friend)*	107/73 *(done on friend)*

R: 16/min unlabored P: 60 beats/min, regular
T: 97.4°F, oral
SpO_2: 98%, room air
Ht: 64 in. Wt: 190 lbs. BMI: 32.6

Skin Exam:
Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos. Peripheral IV present on the lateral aspect of the left arm below the elbow.
Hair: average quantity and distribution.
Nails: no clubbing, capillary refill <2 seconds in upper and lower extremities.

Head Exam: Normocephalic, atraumatic with no evidence of contusions, ecchymosis, hematomas or lacerations and nontender to palpation throughout.

Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.

Visual acuity: Corrected, 20/20 OS, 20/20 OD, 20/20 OU. Unable to fully assess accuracy as the patient was wearing one nearsighted contact lens in the right eye only.
Visual fields: full OU. PERRLA. EOMs intact with no nystagmus.
Fundoscopy: red reflex intact OU on fundoscopy. Cup to disk ratio < 0.5 OU. No AV nicking, hemorrhages, exudates, or neovascularization OU. *(done on friend)*

Ears: Symmetrical and appropriate in size. No lesions, masses or trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TMs pearly white/intact with light reflex in good position AU. *(done on friend)* Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC > BC AU.

Nose/Sinuses: Symmetrical. No masses, lesions, deformities, trauma or discharge. Nares patent bilaterally. Nasal mucosa is pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No foreign bodies. *(done on friend)*
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.

Mouth & Pharynx:
Lips: Pink, moist. No cyanosis or lesions. Nontender to palpation.
Mucosa: Pink, well hydrated. No masses or lesions noted. Nontender to palpation. No leukoplakia.
Palate: Pink, well hydrated. Palate intact with no lesions, masses, or scars. Nontender to palpation; continuity intact.
Teeth: Good dentition. No obvious dental caries.
Gingivae: Pink, moist. No hyperplasia, masses, lesions, erythema, or discharge. Nontender to palpation.
Tongue: Pink, well papillated. No masses, lesions, or deviation. Nontender to palpation.
Oropharynx: Well hydrated. No injection, exudate, masses, lesions, or foreign bodies. Grade 1 tonsils, present with no injection or exudate. Uvula pink with no edema or lesions. *(done on friend)*

Neck, Trachea, & Thyroid:
Neck: Trachea midline. No masses, lesions, scars, or pulsations noted. Supple, nontender to palpation. FROM, no stridor noted. No thrills, bruits noted bilaterally, or cervical adenopathy noted.
Thyroid: Nontender; no palpable masses; no thyromegaly; no bruits noted.

Thorax & Lungs:
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored/ no paradoxical respiration or use of accessory muscles noted. Lateral to AP diameter 2:1. Non-tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. *(done on friend)* No adventitious sound with no evidence of drooling or stridor noted.

Cardiac Exam: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. *(done on friend)*
PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. 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: The abdomen is flat and symmetric, with no scars, striae, or pulsations noted. Bowel sounds are normoactive in all four quadrants, with no aortic, renal, iliac, or femoral bruits. Predominantly tympanic to percussion, with expected dullness in the right upper quadrant, consistent with the normal liver. The epigastric region is markedly tender to palpation. No guarding or rebound tenderness is noted. No hepatosplenomegaly is appreciated on palpation, and there is no CVA tenderness. Special tests- Murphy's sign: marked tenderness but no inspiratory arrest.

Female Genitalia: External genitalia without erythema or lesions. Vaginal mucosa pink without inflammation, erythema or discharge. Cervix parous (or multiparous), pink, and without lesions or discharge. No cervical motion tenderness. Uterus anterior, midline, smooth, non-tender and not enlarged. No adnexal tenderness or masses noted. Pap smear obtained. No inguinal adenopathy. *(done on practice model)*

Rectal: Rectovaginal wall intact. No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in the vault. FOB negative. *(done on practice model)*

Neurological:
Mental Status: A&O x4, cooperative, thoughts & speech coherent. Conversation progresses logically. Insight, judgement, cognition, memory and attention intact

Cranial Nerves:

- I- Correctly identifies coffee & alcohol wipe odors bilaterally
- II- Visual fields full by confrontation, visual acuity 20/20 OD,OS,OU corrected, red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates or crossing phenomena. *(done on friend)*
- III & IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.
- V – Face sensation in tact bilaterally, corneal reflex intact jaw muscles strong without atrophy *(done on friend)*
- VII – Correctly identified sweet, salty and sour tastes *(done on friend)*. Facial expressions intact, clearly enunciates words. *(done on friend)*
- VIII – Repeats whispered words at 2 feet bilaterally, Weber midline, Rinne AC>BC bilaterally.
- IX & X– No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing *(done on friend)*
- XI – Full range of motion at neck with 5/5 strength and strong shoulder shrug *(done on friend)*
- XII – Tongue midline without fasciculation, good tongue strength *(done on friend)*

Motor: Good muscle bulk and tone. Strength 5/5 throughout.

Cerebellar: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift. *(done on friend)*

Sensory: Pinprick, light touch, position sense, temperature and vibratory sense intact bilaterally. *(done on friend)*

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Reflexes:

	Biceps	Triceps	Brachioradialis	Patellar	Ankle/Achilles	Babinski
Right	2+	2+	2+	2+	2+	Absent
Left	2+	2+	2+	2+	2+	Absent

Problem List:

- Epigastric pain
- Right-sided back pain
- Headaches
- Anxiety
- Prediabetes
- Colilithiasis
- Gastritis
- Obesity, Class 1 (BMI: 32.6)
- Perimenopausal changes

Assessment:

48 year old female with a history of prediabetes, anxiety, cholelithiasis, obesity, and gastritis who presented with epigastric and right-sided back pain x 2.5 hours. Pain was sharp, stabbing and associated with mild nausea, bloating and food intolerance to fatty, fried and spicy foods. Symptoms have been recurrent for the past 2 months, increasing in frequency. Currently improved at time of evaluation.Exam notable for marked tenderness in the epigastric region without guarding or rebound; negative Murphy's sign (tenderness without inspiratory arrest) and cardiopulmonary exam otherwise unremarkable. Patient is currently being counseled by her bariatric surgeon for elective cholecystectomy.

Plan (General):

- CBC and CMP to evaluate for infection, electrolyte abnormalities, renal and hepatic function
- Lipase and amylase to rule out pancreatitis
- RUQ US to assess for gallstones, cholecystitis or biliary obstruction
- H. pylori stool antigen or urea breath test for possible gastritis or PUD
- UA to rule out renal or urinary causes of right-sided pain
- IV PPI (Omeprazole or pantoprazole) for acute gastritis/epigastric pain
- GI cocktail (Antacids or viscous lidocaine) for immediate symptom relief
- IV oral analgesic for pain control
- Ondansetron PRN for nausea.
- Transition to oral PPI and pepcid.
- Dietary modifications: avoid fatty, fried and spicy foods; recommend low-fat, frequent meals, and avoid lying down immediately after eating.
- Patient is currently being counseled by her bariatric surgery team for elective cholecystectomy. Continue symptom management until surgery is performed.
- Counseling: smoking cessation

- ❖ FU w/ GI specialist and possible repeat endoscopy for further evaluation, management and presence of alarming symptoms.

Differential Diagnoses:

1. Biliary colic secondary to cholelithiasis
    a. Patient presents with acute epigastric pain radiating to the right back, associated with nausea and tenderness. History of cholelithiasis and tenderness of RUQ makes this the leading diagnosis. The pain's postprandial onset and relief between episodes is consistent with biliary colic.
        i. Workup- CBC and CMP, RUQ US, Lipase/amylase to r/o pancreatitis
        ii. Tx- IV fluids, analgesics, IV PPI for pain control; GI cocktail for immediate relief. Avoid fatty, fried and spicy food. Patient is currently being counseled by her bariatric surgery team for elective cholecystectomy.
2. Gastritis exacerbation
    a. Hx of gastritis and recent worsening of burning epigastric pain after eating suggest possible inflammation of the gastric mucosa. The patient also reports bloating and fullness, common in these flares.
        i. Workup- H. pylori stool antigen or urea breath test, CBC and CMP.
        ii. Tx- IV PPI, Oral PPI once stable. Avoid triggers like caffeine, NSAIDs and acidic foods.
3. Peptic Ulcer Disease (PUD)
    a. Hx of gastritis and intermittent severe epigastric pain, PUD is the possible diagnosis. However, the absence of hematamesis or melena makes perforation or bleeding less likely.
        i. Workup- H. pylori testing, CBC, Endoscopy if pain persists/worsens.
        ii. Tx- IV PPI, avoid spicy, fatty, acidic foods, avoid NSAIDs and alcohol
4. Pancreatitis
    a. The presence of severe epigastric pain radiating to the back makes acute pancreatitis a possibility, but less likely. There is no vomiting or elevated HR but should not be missed.
        i. Workup- Serum lipase and amylase, CMP, RUQ US for gallstone pancreatitis
        ii. Tx- Supportive care: IV fluids, analgesics, NPO until symptoms improve
5. GERD
    a. The patient reports burning epigastric discomfort worsened after meals and partially relieved by PPIs, consistent with reflux symptoms
        i. Workup- Clinical, consider endoscopy if refractory or new alarming symptoms
        ii. Tx- PPI therapy, Pepcid PRN, elevate head during sleep, avoid late-night meals, caffeine and trigger foods.

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