Identifying Data:
Full Name: M.W
Address: Flushing, NY
Date of Birth: 01/12/2012
Date & Time: January 6, 2026, 13:00
Location: Queens Hospital Center
Religion: Christian
ethnicity: Trinidadian
Source of Information: sef
Reliability: Reliable
Source of Referral: self
Mode of Transport: car

Chief Complaint:
I felt dizzy and passed out X 2 hours ago

History of presenting illness:

Past Medical History:

Present illnesses – no known past medical history

Hospitlization - No known prior hospitalization

Childhood illnesses – Denies any illnesses.

Immunizations –up-to-date with immunization

Screening tests and results – none were reported recently.

Past Surgical History: - No known surgeries were reported

Medications: No medications were reported

Allergies: Denies any food, drug, or environmental allergies.

Family History:

Mother – currently alive, 45 years old - Hyperlipidemia, hypertension, Diabetes mellitus 2
Father – currently alive, 55 years old - primary essential hypertension, Diabetes mellitus 2, Hyperlipidemia

Siblings - no known medical history

Paternal grandfather & grandmother - unknown

Social History:

Occupation - unemployed

Travel - denies any recent traveling outside of the country.

Diet - breakfast - eggs, bacon, bread, orange juice, lunch- beef, vegetables, corn, onion, apples, cherries, dinner - chicken, water

Exercise: denies any anaerobic exercise or weight training.

Safety measures - Admits to wearing a seat belt in the rear passenger seat.

Sleep – reports approximately 7-8 hours of sleep per night.

Review of Systems:

General – Denies recent changes in weight, loss of appetite, generalized fatigue, fever or chills, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Head – normochephalic head, denies any headache or trauma.

Eyes – Pt does not wear any glasses. Denies recent vision changes, photophobia, and pruritus. Vision was 20/20 OS, 20/20 OD, 20/20 OU.

Last eye exam unknown.

Ears – Denies deafness, pain, discharge, tinnitus, no blood behind the tympanic membrane,discharge of fluids in the external canal

Pulmonary system – denies any Shortness of breath, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or sleep apnea.

Cardiovascular system: Denies chest pain. Denies irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Nervous – reported a headache on the left temporal region after falling from a standing height onto the wooden floor, which was witnessed by school staff. Patient was unarousable for approximately 1 minute and regained consciousness. Denies seizure-like activities, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness, or recent onset of memory loss.

Peripheral vascular system – Denies coldness or trophic changes, varicose veins, peripheral edema, or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, or prior history of DVT/PE.

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

Physical

General:

Vital Signs:
BP: Seated R 122/78 L 114/82
R:14/min unlabored
P: 82, regular

T degrees 98.6 F (oral)
O2 Sat: 99% Room air

Height: 170 cm
Weight: 209 lbs.
BMI: 33.9

Skin: Warm and moist, with good turgor. Nonicteric, no erythema, pigmentation, lesions, scars, or tattoos.

Nails: No clubbing, lesions of infection. Capillary refill <2 seconds in upper extremities.

Head: Normocephalic head with no headache or signs of trauma.

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

Visual acuity - 20/20 OD, 20/20 OS, 20/20 OU.

Visual fields are complete OU. PERRLA, EOMs OS intact with no nystagmus.

Ears: Symmetrical and appropriate in size. No signs of discharge from the external canal or presentation of battle signs. No lesions, scars, scabs, erythema, or tenderness present. Ear canal nonerythematous, no masses, foreign bodies present. Cone of light, no presence of blood behind the tympanic membrane noted.

Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, Bruit noted bilaterally, no cervical adenopathy noted.

Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Chest: Symmetrical, no deformities, no trauma. Respirations unlabored/ no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation
Throughout.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic
Excursions are symmetrical. Tactile fremitus is symmetric throughout. No adventitious sounds.

Heart. Carotid pulses are 2+ bilaterally without bruits. PMI in the 5th ICS mid-clavicular line. Regular rate and rhythm. S1
and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Mental status exam:

Patient is well-appearing, with good hygiene and neat grooming. Patient is alert and oriented to name, date, time, and location. Speech and language ability intact, with regular quantity, fluency, and articulation. Patient denies mood changes. Conversation progresses logically. Insight, judgement, cognition, memory, and attention intact.

Neurologic exam:

Cranial Nerves:

I – Correctly identifies coffee & alcohol wipe odors bilaterally.

II – Visual fields complete by confrontation, visual acuity 20/20 , 20/20 OD and 20/20 OU corrected lenses, Red reflex present, cream colored discs with sharp borders, no hemorrhages, exudates, or crossing phenomena.

III & IV & VI – Extraocular movements intact, pupils 3 mm OU and reactive to direct & consensual light & accommodation, no ptosis.

V– Face sensation intact bilaterally, corneal reflex intact, jaw muscles intense without atrophy

VII–Correctly identified sweet, salty, and sour tastes. Facial expressions intact, clearly enunciates words.

VIII – Repeats whispered words a 2-foot bilaterally, Weber midline, Rinne AC>BC bilaterally.

IX & X – No hoarseness, uvula midline with elevation of soft palate, gag reflex intact, no difficulty swallowing

XI – Full range of motion at the neck with 5/5 strength and strong shoulder shrug

XII – Tongue midline without fasciculation, good tongue strength

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

Cerebellar: RAMs and point-to-point movements intact. Stable gait. Negative Romberg & pronator drift.

Sensory: Pinprick, light touch, position sense, temperature, and vibratory sense intact bilaterally.

Reflexes:

Arms	Biceps	Triceps	Patellar	Ankles/Achilles	Brachioradial	babinski
Left	+2	+2	+2	+2	+2	Absent
Right	+2	+2	+2	+2	+2	Absent

Assessment:

Currently, she is alert, oriented ×3, and hemodynamically stable. Physical exam reveals no focal neurologic deficits, clear lungs, and a normal cardiac rhythm without murmurs. Patient has no acute complaints and reports no distress.

Plan