HPPA -502 physical diagnosis #1

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Professor. Sundberg
Physical Diagnosis I (Lab)
February 11, 2025

History of present illness:

Mrs. J.D who is a 68 Y.O South African female who appears to be a reliable source who is married to her spouse, presented at her normal state of health, who is in no immediate distress at the moment. Patient has a Past medical history of hypertension, Diabetes, Hyperlipidemia and Coronary artery Disease with a pertinent surgical history of 2 stents in 02/21/2025. Patient arrived at the emergency room yesterday on 03/10/2025 with her spouse via car and was transferred to the Early treatment of admitted patients suite (ETAP) for overnight observation for congestive Heart failure as per the attending physician. Patient originally presented to the ED with chest pain with Shortness of breath and bilateral lower peripheral edema which began 3 days ago on 03/07/2025 which had progressively worsened yesterday on 03/10/2025. Patient had recently been diagnosed with Coronary Artery disease on 01/19/2025 and was scheduled for a coronary angiogram for installment of 3 stents on 02/21/2025. The Providers were only able to install 2 out of the 3 due to the patient's condition deteriorating during the procedure where she became renally compromised. Patients reported an increased work of breath especially when lying supine. Patient reported she normally sleeps with 2 pillows but now currently sleeps with 5 pillows and must be in a 90 degree angle when sleeping. Patient reported moderate shortness of breath when lying supine which improves when she's seated upright. Patient reported chest pain which remained constant while the pain radiated to her neck and left jaw described the sensation as “pins and needles”. Patient described the chest pain as tightness and pressure to her sternum. Patient reported the pain was originally a 7/10 when first admitted but has reduced to a 4/10 today when seated upright and worsens when lying supine which becomes a 6/10. Patient also reported excess swelling to her feet and ankles radiating to her calf with difficulty walking.patient reported her swelling would temporarily alleviate when wearing Stockings and applying warm compresses. Patient reported pain to her ankles which was rated as a 4/10 while ambulating. Patient Denies any loss of consciousness, Seizures, Headaches, dizziness, denies any changes to vision or gait, nausea, vomiting, diarrhea.

Past Medical History:

Present illness -Coronary artery Disease Unknown Date of diagnosis
Pre- Diabetes – A1C unknown well managed with Januvia unknown date of current Diabetic status
Hypertension - (unspecified if Primary or Secondary) well managed with Losartan
Hyperlipidemia - Unknown diagnosis date for illness well managed with Ezetimibe and Atorvasatin
Coronary Artery Disease - recently diagnosed on 01/05/2025. And is managed with 2 stents implemented on 02/21/2025.

Insomnia - Unknown diagnosis date for illness well managed with 2 mg melatonin OTC.
Immunization - "Up to date" Unknown date of vaccination
Mammogram- 2024, result unknown
Colonoscopy- 2022, normal results
Endoscopy - 2022 normal results

Past Surgical History:
Coronary Stents X2 - 02/21/25 performed at NYHQ
Laminectomy- 1987 unknown date and origin of procedure
Hysterectomy - 1986 unknown date and origin of procedure
Cesarean Section X2 - performed in 1980 and 1984 unknown place of procedure

Medications:
Losartan 50 mg once a day PO for Hypertension
Metoprolol XR 25 mg QD PO for hypertension
Brilinta - 90 mg QD antiplatelet for Coronary Artery Disease
Atorvastatin- 40 mg QD PO for Hyperlipidemia
Ezetimibe - 10 mg QD PO for Hyperlipidemia
Nitroglycerin 0.40 mg PRN SL for stable Angina
ASA 81 mg QD for Coronary artery disease and Hypertension
Probiotics - 1g QD unknown use for medication
B12 vitamin- QID unknown dosage
Dicyclomine - 10 mg q4h for "unspecified Abdominal pain"
Melatonin - 2 mg PRN for insomnia

Pt reports compliance with all medications listed. Last dose was reported this morning .

Allergies: Positive Allergies to Latex materials reports Erythema, wheals and pruritus when in contact with substance. No other reported allergies to medications and food.

Family History:
Mother – Coronary Artery Disease, Primary essential Hypertension, Deceased at age 91 Y.O , Myocardial infarction.
Father – Coronary Artery Disease, primary Essential hypertension, Deceased at age 41 Y.O, Renal Failure
Sister- Hypertension, living 62 Y.O currently hospitalized for Hypertensive Emergency Unspecified
Brother - Primary Hypertension, living 73 Y.O currently hospitalized for Myocardial infarction
Maternal/paternal grandparents – Deceased at unknown age & unknown reasons
Denies family history of cancer.
Son - Unknown medical condition , living 45 Y.O
Daughter - Unknown medical condition , living 41 Y.O

Social History
Travel: Denies any recent traveling outside of the state or country

Marital history: Married currently living with spouse

Occupational history: Retired Elementary Teacher

Alcohol or Drugs: Denies any Drug or alcohol usage

Smoking history: denies any history of smoking

Diet:
Breakfast- Consists of oatmeal, fruits, Coffee X1 and wheat bread (unspecified)
Lunch - Romaine salad with boiled Eggs
Dinner - oven baked Chicken and fish
Reports frequently drinks water 6 times a day

Exercise: she reported the duration of exercise is usually for 10-15 minutes while walking outside. Pt reports typically walking 2-3 blocks before having to stop due to shortness of breath.

Safety measures: Admits to wearing seatbelt when driving with her husband seated in the passenger seat.

Sexual History: Pt currently sexually active with her spouse in a monogamous relationship, reports cessation post-menopause in 1987 due to Hysterectomy

ROS:
General – Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

Skin, Hair and nails - Denies any changes in hair texture, excessive Dryness or sweating, discolorations, pigmentations, moles/rashes, Denies any puritius or changes to hair distribution. Patient reported Edema and erythema to bilateral lower extremities.

Head – Denies headaches or any related head trauma, reported Dizziness however patient has a history of vertigo which she is medicated with meclizine.

Eyes : Denies visual disturbance, lacrimation, photophobia, or pruritus patient, unknown last eye examination

Mouth and throat : patient reported numbness to her Jaw which radiated from her neck. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, denies any loose teeth, dentures or dental implement.

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

Breast: Denies lumps, nipple discharge, or pain

Pulmonary system: reported Shortness of breath on exertion, Patient reports orthopnea which requires 4 pillows behind her back while sleeping. denies any cough, wheezing, hemoptysis, cyanosis.

Cardiovascular system : history of Hypertension, reported chest pain, bilateral edema of the ankles or feet, reported Distended Jugular vein during incident currently Denies any syncope, or any known heart murmur

Gastrointestinal system: Denies any loss of appetite , nausea or vomiting diarrhea , constipation and abdominal pain, denies any Dyspepsia after consumption of meals

Genitourinary system: Denies urinary frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, or flank pain. Unable to determine color of urine and last rectal cervical pap smear examination.

Obstetics/Menstrual - unable to report her last menstrual period. Unknown date of menache period.

Nervous system: denies any seizures, headache, loss of consciousness, sensory disturbances, ataxia, changes in cognition/mental status/memory, or weakness. Reported minimal sleep at 6 hours for most nights due to Insomnia.

Musculoskeletal system : Denies muscle pain, or arthritis patients reported deformity and swelling, redness to bilateral lower extremities distal to the malleus. Patient denies any pain while ambulating. Denies any additional assistance of use of walking devices.

Peripheral vascular system: reported peripheral edema bilaterally to lower extremities distal of the Malleus, reported redness to the lower extremities, denies any intermittent claudication while ambulating or Circumferential swelling to Calf, denies any coldness or trophic changes, varicose veins,

Hematologic system : denies anemia, bleeding disorders, easily bruising or bleeding, lymph node enlargement or history of DVT/PE.

Endocrine System: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism

Psychiatric: Denies depression, anxiety, or feelings of hopelessness. Declined to reply SI/HI.

Physical exam

General: Female, neatly groomed, and appears her stated age. She is awake, alert, and oriented x 3, and in no acute distress at the moment.

Vital signs:

BP:

	Right	Left
Seated:	102/68 mm Hg	106/72 mm Hg
Supine:	106/68mm Hg	102/64 mm Hg

R: 16 breaths/min, unlabored

P: 68 beats/min, strong regular and normal

T:98.0 degrees F (oral)

O2 Sat: 96% room air

Height: 64 inches

Weight: 120 lbs.

BMI: 32.6

Physical examination

Skin: warm and moist good turgor, Nonicteric, with no tattoos, bilateral lower extremities appeared engulfed and erythematous and swelling to the lower extremities. swelling begins along the calf and extends to the malleus process along the ankle. Remainder of the skin assessment was normal.

Hair: Average quantity and distribution. No alopecia, seborrhea, or lice on exam.

Nails : No clubbing, cyanosis, or lesions. Capillary refill < 2 seconds in upper extremities. Lower extremities had an extended capillary refill > 2 seconds

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

Visual acuity (uncorrected) – 20/100 OS, 20/70 OD, corrected lenses -20/20 OU

Visual fields full OU. PERRLA pupils 5 mm in diameter constricting to 2 mm, EOMs full, with horizontal nystagmus
Fundoscopy: red reflex present OU. Cup to disk ratio <0.5 OU. No AV nicking, hemorrhages, exudates, or neovascularization OU

Nose: symmetrical, no masses, lesions, deformities, trauma, discharge. Nares patent bilaterally/nasal mucosa pink & well hydrated. No discharge noted on rhinoscopy: Septum midline without lesions/deformities/injection/perforation. No foreign bodies noted

Sinuses: Non tender to palpation and percussion over bilateral frontal, and maxillary sinuses.

Ears: Symmetrical and appropriate in size. No other lesions, masses, trauma on external ears. No discharge / foreign bodies in external auditory canals AU. Tympanic membrane appears pearly white with intact with light reflex in good position AU.Auditory acuity intact to finger rub test AU. Weber midline / Rinne reveals AC>BC AU.

Mouth and Pharynx:

Lips: Pink, moist; no cyanosis or lesions. Non-tender to palpation.

Oral mucosa: appeared Pink and well hydrated. No presentations of masses or lesions. Non-tender to palpation. No leukoplakia, no visible bleeding airway is patient and unobstructed.

Soft and Hard Palate: appears Pink, with palate remained intact with no lesions, masses, scars no presentation of bleeding.

-Teeth: Good dentition no obvious dental caries noted, no use of dentures were noted

Gingivae: Pink and moist. No gingival hyperplasia masse, lesions, erythema or discharge of purulent or hemorrhagic exudate

Tongue: Pink, well papillated, no masses, lesions or deviation. Non-tender to palpation

Oropharynx: Well hydrated, no injection; exudate; masses; lesions; foreign bodies. Tonsils present with no injection or exudate (grade 2). Uvula pink, no edema, lesions

Neck:
Trachea appears midline. No masses, lesions, scars, pulsations. Supple, non-tender to palpation. No cervical adenopathy noted. Thyroid- Non-tender; no palpable masses no thyromegaly

HPPA-522 Phyiscal diagnosis #2

Professor Wu
History

Chief Complaint: “ I’m here for a surgical consult for a Cesarean Section procedure.

History of Present Illness:

47 Y.O. female who is a 38 week pregnant patient with a past medical history of 3 total pregnancies, one miscarriage, and one full-term normal vaginal delivery. Patient reports a past surgical history of Uterine fibroids, which were excised in 2023. The patient was brought to the pre-admission testing site by her husband in a motor vehicle for a prescheduled consult for a Cesarean section procedure. The patient reported her due date is 09/18/25, the patient's last menstrual cycle was reported on 12/24/24, and she is scheduled to receive a cesarean section procedure. Patients only reported increased nocturia during the later stage of the third trimester, increasing twice a night, and increased exercise-induced intolerance, which was for the patient. The patient denies any complaints, including SOB, chest pain, dizziness, nausea, and vomiting. Denies any diarrhea or constipation, denies any presence of blood in the stool or urine. Denies any recent travel outside the country and reports that she is up-to-date with immunizations. Denies any discharge of blood or spontaneous rupture of the amniotic sac.

Past Medical History:

Present illnesses – 3 total pregnancies, one full-term normal vaginal delivery, one spontaneous miscarriage P3G1T1A1L1

Past medical illnesses – None

Hospitalized – None

Childhood illnesses – Denies any illnesses.

Immunizations – Currently up to date with vaccinations

Screening tests and results – no recent screening tests were reported.

Past Surgical History:

Myomectomy at NYPQ in 2023, with no complications during the procedure. The patient was placed under general anesthesia. No complications during induction or any post op complications

Denies previous past injuries or transfusions.

Medications: Folic Acid, Calcium, Cyanocobalamin, and Iron supplements. Unable to specify the dosage or frequency of consumption of medication

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

Family History:

Mother – Currently Alive, unknown age, has no known medical history.

Father – Currently Alive, unknown age, has no known medical history

Son – 2-year-old male, no known medical history

Paternal grandfather - deceased at the age of 89 years old from Gastric cancer

Paternal Grandmother - deceased at an unknown age due to complications from a hip fracture post-injury.

Social History:

L.F. is a married female living with her husband. Currently a store clerk at a retail store, restocking inventory and managing the cash register.

Habits - Pt denies any drug or alcohol consumption prior to or during pregnancy. Patient reported consumption of caffeine, 12 ounces of coffee once a day , prior to pregnancy, and reported she no longer drinks coffee due to the pregnancy

Travel - Pt denies recent travel.

Diet - Pt reports eating a well-balanced diet including rice, steamed buns, fish, and vegetables (unspecified). Reports consumption of chocolate (unspecified quantity)

Exercise - Pt admits to walking around her neighborhood approximately 7-10 blocks a day. Currently, due to the pregnancy, she has reduced exercise tolerance to 5-6 blocks.

Safety measures - Admits to wearing a seat belt in the passenger seat across the shoulder and lap belt.

Sleep – Pt reports poor quality of sleep, approximately 5-6 hours of sleep due to conflict with her husband, and excessive night awakening due to frequent urination during pregnancy.

Sexual Hx - Pt is currently sexually active with his husband. Reported use of contraceptives, including an IUD insertion in 2008, and was removed in 2018. patient

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 – Denies headaches, vertigo, or head trauma.

Eyes – Pt wears glasses for nearsightedness. Denies recent vision changes, photophobia, and pruritus.

Last eye exam unknown.
Ears – Denies deafness, pain, discharge, tinnitus, or use of hearing aids.

Nose/sinuses – Pt admits to clear watery nasal discharge. Denies obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcer, or voice changes.

The last dental exam was unknown or not reported.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Admits to dyspnea on exertion for prolonged periods of time. The SOB resolves with rest due to the pregnancy. Denies any cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

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

Gastrointestinal system – Regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or
blood in stool.

Genitourinary system – reported nocturia during the pregnancy with frequent awakening twice a night. Denies any pain with urination, denies any discharge of stones or blood.

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status, weakness, or recent onset of memory loss.

Musculoskeletal system – Denies deformity or swelling, redness or arthritis.

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.

Psychiatric – Admits anxiety. Does not see a psychiatrist regularly.

Physical

General: Well-nourished, short-statured male in no apparent distress. Alert and Oriented x3, well-groomed, looking about the stated age of 37. Ambulates without support with no signs of acute distress were noted.

Vital Signs:
BP:

Seated	Supine
R 106/76	104/68
L 112/72	108/70

R:14/min unlabored
P: 91, regular

T degrees 98.4 F (oral)
O2 Sat: 98% Room air

Height: 165 cm
Weight: 194 lbs.
BMI: 33.4

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

Hair: Normal hair distribution and thickness on Pt's head. No lesions, lice, or seborrhea.

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

Head: Normocephalic, atraumatic, non-tender to palpation throughout. No swelling noted.

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

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

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

Fundoscopy- red reflex intact OU. Cup to disk ratio <.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Ears: Symmetrical and appropriate in size. No lesions, scars, scabs, erythema or tenderness present. Ear canal nonerythematous, no masses, foreign bodies present. Cone of light, tympanic membrane noted. Weber midline, Rinne reveals AC > BC. Auditory acuity intact assessed with whisper test.

Nose: Mild watery discharge noted. Symmetrical, no bony deformities, tenderness. Nasal mucosa pink and well hydrated. Septum midline with no perforation or inflammation. No foreign bodies.

Sinuses: Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.

Lips: Pink, moist, and well hydrated.

Mucosa: Pink, no masses, well hydrated, nontender, no leukoplakia.

Palate: Pink, intact with no lesions or scars.

Teeth: Good dentition, no caries noted.

Gingivae: Pink, moist, no hyperplasia, masses, lesions, discharge.

Tongue: Pink, well-papillated, no masses, lesions, or deviations. Frenulum intact.

Oropharynx: No exudates, masses, lesions, foreign bodies. Tonsils present with no exudate.

Uvula pink, no edema.

Neck: Trachea midline. No masses, lesions, scars. FROM, no stridor, 2+ carotid pulse, no thrills, bruits 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.

Breasts L/R : Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable, mobile, non tender, no presence of erythema or swelling

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

Heart: JVP is 3.0 cm above the sternal angle with the head of bed at 30 degrees. Carotid pulses are 2+ bilaterally without bruits. PMI in 5th ICS in 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.

Abdomen: Abdomen round and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all 4 quadrants with no aortic/renal/iliac or femoral bruits. Tender to palpation in the right middle quadrant. Tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.

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.

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 vault. FOB negative.

Assessment

37-year-old female patient who is 38 weeks pregnant with no known past medical history, surgical history of uterine fibroid removal, and three total pregnancies, one full-term normal vaginal delivery in 2023, and one miscarriage in the past of unknown date the previous miscarriage. patient's expected Due date is 9/18/25. The patient's last known menstrual cycle was reported on 12/24/24. The patient reports no new complaints or onset of symptoms. No notable abnormalities on the physical exam. This is consistent with the purpose of today's medical visits , Lab work is currently pending.

Plan

1. Uterine fibroids -

Reasoning: the patient reported a history of Uterine fibroids recently in 2023, which she had a myomectomy in 2023, and reported from her follow-up appointment 6 months post-operation, revealed the presence of polyps during cervical exam. Even though the patient denies any pain or discomfort during the pregnancy, 32 % of patients between the ages of 35 and 42 years old have complications, and an additional 10 % chance of complications if the patient is an asian female. This drastically increases the chance of obstetric complications, such as early preterm labor and birth, fetal malpresentation, and uterine rupture and placental abruption.

Special considerations: offer a trial of labor, and Cesarean section is reserved for obstetric indications, including

2. placenta previa

Reasoning - Placenta previa can be another reason why the patient may require a C-section procedure. Another reason is due to a previous history of uterine fibroids, which can cause malformation during the development of the fetus during the term of gestation for the patient, leading to abnormal attachment of the placenta towards the cervix rather than the abdominal wall.

Special considerations

Blood & surgical prep:

- 2–4 units PRBCs available.

- Surgical expertise + instruments ready for possible cesarean hysterectomy (high PAS risk).

Placenta handling & incision planning:

- Minimize placental disruption when entering uterus.
- Pre/intra-op ultrasound for placental localization to guide hysterotomy site.

Hemorrhage prevention & control:

- Routine oxytocin; may add second uterotonic or tranexamic acid.
- Tourniquets or uterine vessel occlusion (catheter/Penrose drain tied low around uterus).
- Hemostatic square sutures at placental site for focal accreta/poor uterotonic response.
- Local vasopressin injection (4 units in 20 mL saline).

Mechanical interventions:

- Intrauterine balloon tamponade.
- Uterine compression sutures.
- Suction as needed.

3. Breech presentation

Reasoning - the patient has a history of uterine fibroids, which can lead to abnormal growth and position of the fetus in the uterus, leading to a breech presentation.

Special considerations before Cesarean surgery.

- Attempt External cephalic version (ECV) before labor, with a trial of labor if the version is successful. If the maneuver is unsuccessful, proceed to Cesarean Surgery.

4. Prevention of transmitting genital herpes (active infection)

Herpes simplex virus can be transmitted from mother to infant during childbirth. C-section is indicated if the patient has prodromal symptoms and presents with herpetic lesions on physical examination.

Special considerations-

- Limit and minimize neonatal expisre, including no fetal scalp electrodes, rupture of the membrane, use of forceps, or vacuum deliveries

- If exposed, perform cultures, HSV PCR, and treat empirically with antivirals including acyclovir.

4. Macrosomia

Reasoning- the patient's approximated BMI was calculated to be 33.1, which categorizes her as obese, where this is shown to be a potential risk factor for the development of macrosomia, which can lead to shoulder dystocia during delivery, which was found to have a higher proportion of patients with a BMI of greater than 25.

Plan

Pre-operative
- CBC, Type and Crossing
- 2-4 units of Plasma RBCs
- PT/INR & PTT, Coagulation studies
- Pre- and intra-operative ultrasound for placental localization.
- Prophylaxis antibiotics - cefalozin

Intra-operative
- Oxytocin infusion post delivery
- Tranexamic acid
- Use of tourniquet and or uterine artery occlusions
- Interuterine balloon tamponade or compressions sutures.
- Vassopressin
- Maintain a sterile Amniotic sac and avoid or minimize fetal exposure to HSV

Postoperative -

Patient #1 mother
- Measure Urine output
- CBC - blood loss
- CMP - renal function
- Pain management - opioids (fentanyl)
- Early ambulation, Anti-coagulants LMWH ,and compression devices

Patient #2 Newborn

- Assess for possible HSV exposure, Cultures, and HSV PCR
- Consider empirical acylcovoir

Reflection

In **PD1**, my documentation emphasized completeness, resulting in a detailed but dense narrative that occasionally blended elements of the HPI with the ROS and past medical history. While the essential components of the presenting illness were included, the volume of background information sometimes detracted from the primary clinical concern. This reflects an early stage in my development, where thorough data collection took precedence over synthesis, prioritization, and narrative focus.

In **PD2**, my HPI writing demonstrates improved organization, clarity, and clinical reasoning. The purpose of the visit is clearly defined and consistently maintained, with pertinent positives and negatives selected intentionally and presented in a logical, chronological sequence. This progression highlights my growth toward concise, problem-focused HPI documentation that more closely aligns with professional clinical standards and expectations.