Identification:

Full name: [redacted]

Sex: male

Race: Asian

Language: English (primary), Taiwanese (secondary)

Religion: [redacted]

Date of Birth & Age: [redacted], 27 YO

Marital status: unmarried

Date and time: 5/10/2025, 4:01PM

Location: patient residence

Source of history: self

Reliability: reliable

Referral source: self

Chief of complaint: "I've been feeling constipated and bloated" x 2 days

History of present Illness:

[redacted] is a 27-year-old male with no significant past medical history who presents with constipation x 2 days and intermittent lower abdominal discomfort. Symptoms began upon waking to use the restroom and have persisted since. He describes the pain as dull, crampy, and "pressure-like". Pain rated as a 3/10, more uncomfortable than painful. Pain is localized to the left lower abdomen, non-radiating, and worsens after meals or when he tries to defecate. Bowel movements occur 1–2 times daily, with stools described as small, hard "pebbles". Last bowel movement was yesterday afternoon. Drinking warm fluids like coffee in the morning provides some relief but the discomfort "comes and goes" throughout his day. He has not used laxatives but is considering doing so if symptoms persist after today. The patient exercises regularly with weightlifting 4–5 times/week and follows a high-protein diet consisting of chicken, eggs, rice, Greek yogurt, protein snack bars, protein shakes and some vegetables. Over the past 4-5 days, he has had reduced physical activity due to his occupation. His meals were take-out food consisting of chicken/steak burritos, grilled chicken burgers, fries, protein snack bars and protein shakes. He admits to a decrease in fruit and vegetable intake as well. He reports feeling bloated but denies flatulence. He noted ~ 2 lbs. of weight gain over the last 3 weeks. Denies weight loss, loss of appetite, intolerance to food, dysphagia fever, nausea, vomiting, recent trauma, straining, mouth ulcers, hematochezia, hematuria, oliguria, dysuria, jaundice, recent travel, family history of colon cancer, or history of STDs. No associated flank pain or generalized weakness.

Past medical history:

- Patient has no significant past medical history

- Patient states no past hospitalization or illnesses in the past besides having a cold.
- Immunization (children/flu/covid boosters) are up to date. Specifics unknown to patient.
- No past screening/imaging tests done

Past surgical history:

- None

Medications:

- None

Allergies:

- Seasonal allergies: pollen
    - Reaction: sneezing and itchy eyes

Family history:

- Mother: 58 YO, alive, PMHx HTN controlled with diet. No medication for HTN as of now
- Father: 60 YO, alive, PMHx HLD controlled with atorvastatin 20 mg x1 daily PO
- Siblings
    - Older sister: 32 YO, alive, PMHx specifics unknown to patient
- Grandparents
    - Maternal grandmother: 76 YO, alive, PMHx osteoarthritis, takes ibuprofen 400mg PO PRN and topical diclofenac.
    - Maternal grandfather: 78 YO, alive, PMHx Diabetes Type 2 controlled with metformin 1000mg twice daily PO
    - Paternal grandmother: 82, alive, PMHx HTN controlled with Amlodipine 5 mg daily PO
    - Paternal grandfather: 72 YO, deceased from MI. PMHx HTN, HLD
- No children

Social history:

- Habits: No smoking, alcohol, or drug use. Drinks morning coffee daily for the past 6 years.
- Travel: No recent travels
- Marital history: Has female partner, unmarried
- Living: lives with his female partner, no pets
- Occupational history: Civil engineer (bridge designer/inspector) – employed. Work hazards include working from heights and use of heavy machinery.
  Diet: 4-5 meals per day. Meals consist of high protein – chicken, eggs, rice, Greek yogurt, some vegetables and protein shakes. Protein bars as snacks. This past week, he has not had many fruits or vegetables. Has been ordering take-out food such as burgers, fries. and burritos
- Sleep patterns: average 7-8 hours, denies any trouble sleeping or take medication for sleep. However, last 4-5 days, average hours of sleep were 5-6 hours due to his occupation demands.

- Exercise: Weightlifting in the gym 1-2 hours, 4-5 times a week. No trouble exercising. No shortness of breath. However, the past 4-5 days, he has not been going to the gym much due to work. Most of his time are spent sedentary in his desk.
- Safety measures: admits to wearing seatbelts while driving and helmet in field work for his occupation.
- Sexual history: Heterosexual male. Monogamous relationship with female partner. Sexually active. Admits to using protection and contraceptives during intercourse. Denies screening for STDs. Denies history of STDs

Review of systems:

General: patient reports a weight gain of ~ 2 pounds in the last 3 weeks. Patient weighs himself every morning. Denies weight loss, loss of appetite, fatigue, weakness, fever, chills or night sweats.

Skin, hair, nails report smooth hair texture, non-flaky, no thinning. Denies skin dryness, discolorations, pigmentation, moles, rashes, pruritus, change in hair distribution.

Head: Denies headache, vertigo, or head trauma.

Eyes: Reports using glasses. Last eye exam was 2.5 years ago. Patient does not recall specifics of last eye exam. Denies blurring, diplopia, scotomas, halos, lacrimation, photophobia, pruritus.

Ears: Denies hearing loss, tinnitus, pain and discharge from ear or use of hearing aids

Nose/Sinuses: Denies discharge, epistaxis and obstruction

Mouth and throat: Denies bleeding gums, sore tongue, mouth ulcers and voice changes. Last dental exam was 6 months ago, specifics unknown to patient. Denies use of dentures.

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

Breast: Denies nipple discharge, pain and breast lumps.

Pulmonary: Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular: Denies chest pain, HTN, palpations, irregular heartbeats, murmurs, syncope, edema, leg swelling.

GI: Reports dull and crampy left lower abdominal pain and “pressured-like” discomfort that is non radiating. Admits to constipation x 2 days. 1-2 bowel movements per day with “pebble-like” stools. Last bowel movement was yesterday afternoon. His diet for the past 4-5 days was low in fiber and high in protein. Denies loss of appetite, intolerance to food, nausea, vomiting, dysphagia, pyrosis, diarrhea, jaundice, hemorrhoids, rectal bleeding, blood in stool. No history of colonoscopy or stool exam.

GU: Reports being sexually active with one female partner. Practices safe sex with protection. Denies impotence and history of STDs. Denies urinary frequency/urgency, nocturia, oliguria, polyuria, blood in urine, dysuria, incontinence, flank pain, awakening at night to urinate. Denies history of prostate exam, hesitancy, and dribbling.

Nervous system: Denies seizures, headache, loss of consciousness, sensory disturbances, changes in cognition/memory, ataxia, loss of strength or weakness

Musculoskeletal: Denies muscle/joint pain, muscle or done deformity, swelling, redness, arthritis or straining.

Peripheral vascular system: Denies varicose veins, color change of lower extremities, claudication, coldness of lower extremities or peripheral edema, peripheral edema

Hematologic system: Denies anemia, easy bruising/bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE

Endocrine system: Denies thyroid gland enlargement, heat/cold intolerance, changes in facial of body hair, excessive hair growth.

Psychiatric: Denies depression, anxiety, suicidal ideations, feeling of helplessness, difficulty concentrating, mood changes, use of psychiatric medication or history of seeing a mental health professional

Physical

General: ███ is a young Asian man of average stature who appears well groomed and in slight distress. His general appearance is consistent with his stated age. He is A&Ox3 awake, alert and oriented.

Vitals:

Blood pressure	Left	Right
Seated	120/70	124/72
Supine	120/74	122/70

HR: 72 beats/min, strong and regular

RR: 18 breathes/min, unlabored and regular

Temp: 97.4 °F, (thermometer)

SpO2: 99% room air

Height: 5 ft 7 in. Weight: 143 BMI: 22.4

Head: Normocephalic, atraumatic with no signs of contusions, ecchymoses, hematomas or lacerations. Nontender to palpation.

Hair: Smooth hair texture. No lice, lesions, moles, scaliness or male pattern baldness noted.

Skin: warm, moist, good turgor. No lesions, moles or scars noted.

Nails: No clubbing, pitting, spooning, cyanosis, lesions. Cap refill < 2 secs upper & lower extremities.

Eyes: symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink. No palpebral lesions, erythema or edema. No swelling or tenderness of lacrimal apparatus.

Visual acuity:

Uncorrected – 20/30 OS, 20/30 OD, 20/30 OU

Corrected – 20/20 OS, 20/25 OD, 20/25 OU

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

Fundoscopy: Red reflex present OU. Cup to disk ratio <0.5 OU. Negative AV nicking, copper wiring, cotton-wool spots, hemorrhages, exudates, or neovascularization OU

Ears: symmetrical and appropriate in size. No external discoloration, lesions, masses, or evidence of trauma. No discharge or foreign bodies in external auditory canals AU. TMs are pearly white and intact with cone of light reflex in good position AU. No perforation, swelling, effusions of TMs AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU

Nose: Symmetrical. No deformities, redness, lesions, swelling. Nasal bridge midline. No external trauma. Nares patent bilaterally. Nasal mucosa pink and well-hydrated. Septum midline with no lesions, deformities, perforation. No foreign bodies noted. No discharge noted on rhinoscopy.

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

Mouth and pharynx

Lips – Pink, moist, no cyanosis or lesions. No tenderness to palpation

Oral Mucosa – Pink, well-hydrated. No masses or lesions or leukoplakia noted. Nontender to palpation

Palate – Pink and well-hydrated. Normal rise of soft palate. No apparent lesions or masses noted. Nontender to palpation and intact

Teeth – Good dentition. No dental caries noted.

Gingivae – Pink and moist. No hyperplasia, masses, discharge, bleeding, erythema or lesions noted. Nontender to palpation.

Tongue – Pink, well- hydrated. Well papillated. No masses, lesions or deviation. Nontender to palpation

Oropharynx – Well-hydrated. No exudates, masses, lesions or erythema. Tonsils are present (grade 2) with no erythema, exudates, masses or lesions Uvula is midline with no lesions, masses. Gag reflex present.

Neck – Trachea midline. No obvious lesions, masses, scars. Supple and nontender to palpation. Full range of motion. No palpable adenopathy noted.

Thyroid – Non tender to palpation, no thyromegaly. No palpable nodules. No bruits noted. Thyroid swallowing test normal.

Thorax & Lungs: Normal regular unlabored breathing rate. Lat: AP diameter is 2:1. No apparent chest lesions, deformities, trauma, or accessory muscle use. Trachea midline. Vesicular lung sounds. Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetrical throughout. NO adventitious sounds bilaterally. Non- tender to palpations.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed inclined at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits or thrills. Regular rate and rhythm noted. Distinct S1 and S2 sounds. No murmurs, gallops noted. No noted S3 or S4. No splitting S1, S2 or friction rubs appreciated. No tenderness on palpations. No large apparent pulsations with heartbeat.

Abdomen: Symmetric but slightly distended. Discomfort on palpation of left lower quadrant. Slightly firm on lower abdomen on palpation. No scars, striae, or apparent pulsation noted. Bowel sounds are hypoactive in left upper & lower quadrant and normoactive in other 2 quadrants. No aortic, renal or femoral bruits. Tympanic throughout, no hepatosplenomegaly to palpation. No CVA tenderness. No rebound tenderness or guarding noted.