H&P 2

Full name: [redacted]

Sex: Female

Race: Hispanic

Language: English and Spanish

Religion: Unspecified

Date of Birth & Age: [redacted]

Marital status: single

Date and time: 5/11/2026, 11:11 am

Location: Metropolitan Hospital, Geriatric primary care

Source of history: Self

Reliability: Reliable

Referral source: Self

Chief of complaint: "I feel constipated" x 2 weeks

History of Present Illness:

83-year-old female with a past medical history of paroxysmal atrial fibrillation, bradycardia s/p pacemaker, osteopenia, HFpEF, aortic stenosis, pulmonary hypertension, hypertension, multiple CVAs, seizure disorder, bilateral epicondylitis/capsulitis, prediabetes, urge urinary incontinence, and anxiety disorder presents for follow up complaining of constipation for the past 2 weeks. She has been taking Senna without significant relief. She describes her stools as hard and pebble-like with bowel movements occurring every 2-3 days. Associated symptoms include abdominal bloating and increased flatulence. Appetite and oral intake remain unchanged, and she reports adequate daily fluid intake. She also reports worsening external hemorrhoid discomfort secondary to constipation. She has been using hydrocortisone 2.5% rectal cream with minimal relief and notes local irritation. She denies fever, chills, abdominal pain, nausea, vomiting, diarrhea, hematochezia, melena, rectal bleeding, unintentional weight loss, chest pain, shortness of breath, dysuria, hematuria, dizziness, or recent medication or dietary changes.

Geriatric assessment:

ADLs: independent in all

IADLs: needs assistance in transportation, shopping and finances

Visual impairment: wears glasses

Hearing impairment: none

Falls in the past year: none

Assistive devices used: rollator

Gait impairment: none

Urinary incontinence: yes, urge urinary incontinence

Fecal incontinence: none

Osteoporosis: DEXA 2022, T-score lumbar spine and femur: - 2.4

Cognitive impairment: none

Mini-cognitive: 5:5, recall 3 out of 3 objects and was able to draw clock

Depression: none

Home safety issues: none

Health care proxy: yes, son is Healthcare proxy

Advance directives: Full code

Past medical history:

- Atrial fibrillation
- Bradycardia s/p pacemaker
- Essential hypertension
- Pulmonary hypertension
- Heart failure with preserved ejection fraction
- Pre-diabetes
- Seizure disorders
- History of multiple CVAs
- Urge urinary incontinence
- Aortic stenosis
- Osteopenia
- External hemorrhoids
- Obesity class I BMI 34.58

Past surgical history:

- Pacemaker placement, 2021
- Cholecystectomy, unknown year

Immunizations:

- Shingrix: 2/13/23, 6/5/23
- COVID 19 Pfizer: 4/5/2021, 4/26/21, 12/1/21, 5/23/22, 12/26/23
- Influenza: 10/1/18, 10/11/19, 9/17/20, 11/1/21, 9/30/24, 9/22/25
- Pneumococcal 13: 12/7/15
- Pneumococcal 23: 12/30/13
- TDaP: 1/29/24

Medications:

- Acetaminophen 500mg PRN
- Amlodipine 5mg for HTN
- Carboxymethlycellulose 0.5% eye drops PRN for dry eyes
- Hydrocortisone 2.5% rectal cream for hemorrhoids
- Lidocaine 4% patch PRN
- Topical Diclofenec PRN
- Levetiracetam 500 mg for seizure
- Sennosides 8.6mg for
- Warfarin 2.5mg Sat and Sun night
- Warfarin 2mg Mon-Fri
- Vibegron 75mg
- Cetirizine 10mg for allergic symptoms PRN

Allergies:

- Morphine – shortness of breath and hot flashes
- Atorvastatin – swelling of face

Family history:

- Father: deceased, cardiac
- Mother: deceased, cardiac
- Siblings: none
- Maternal and paternal grandparents: specifics unknown to patient

Social history:

Tobacco use: none

Alcohol use: none

Illicit drug use: none

Recent travel: none

Sexual activity: sexually inactive, no known STIs

Review of systems:

General: Denies fever, chills, recent weight loss or gain, change in activity

HEENT: Denies dizziness, headache, trauma, vision changes, eye pain, hearing loss, tinnitus, nasal congestion, sore throat

Neck: Denies stiffness, decrease range of motion, localized swelling/lumps

Respiratory: Denies cough, shortness of breath, wheezing, dyspnea on exertion, pleuritic chest pain, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular: Denies chest pain, palpitations, swelling of low extremities, syncope

GI: Reports abdominal distension and constipation. Denies vomiting, diarrhea, hematochezia, melena

Genitourinary: Denies dysuria, hematuria, changes in urine output

Musculoskeletal: Denies joint swelling, trauma, falls, pain

Endocrine: Denies polyuria, polydipsia, polyphagia, goiter

Neurological: Denies change of behavior, seizures, tremors, syncope, weakness, light-headedness, and numbness

Psychiatric: Denies depression, suicidal/homicidal ideations, auditory/visual hallucinations, delusional thinking

Physical:

- Vital signs
  - Temperature (F): 97.5 F forehead
  - Heart rate: 74
  - Respiration rate: 18
  - Blood pressure: 142/60
  - SpO2%: 97% RA
  - Weight: 83 kg
  - BMI: 34.58

General: AAOx3, well-appearing elderly female sitting upright in no acute distress. Well-groomed and appropriately dressed for weather. Does not appear to be in acute distress, ill-appearing, toxic appearing or diaphoretic.

Skin: Warm to touch and flushed pink. Capillary refill < 2 seconds

HEENT: Head is atraumatic and normocephalic. Tympanic membrane normal bilaterally with light reflex. Nasal passage patent.

Eyes: pupils equal, round and reactive to light. No swelling, erythema, discharge noted.

Mouth: Mucous membranes moist. Oropharynx is clear, no exudate or posterior oropharynx erythema noted.

Neck/throat: negative cervical lymphadenopathy. Normal thyroid swallowing test. Neck is supple.

Chest: symmetrical, no trauma, deformities noted.

Cardiovascular: Irregular rhythm. Regular rate. Crescendo decrescendo murmur noted on right sternal border. No gallops, friction rubs.

Pulmonary: Lung sounds clear to auscultation bilaterally. No wheezing, rhonchi, crackles noted. No respiratory distress. No accessory muscle use.

Abdominal: Mildly distended and protuberant abdomen. Soft and non-tender without guarding, rebound, or palpable masses. Normoactive bowel sounds. No CVA tenderness.

Neurological: Patient is alert. No cranial nerve deficit noted. No sensory deficit. No motor weakness. Coordination normal. Gait normal.

Psychiatric: appropriate and congruent mood and affect. No signs of agitation, anxiety or depression

Assessment

83-year-old female with extensive cardiovascular and neurologic history including paroxysmal atrial fibrillation on warfarin, bradycardia s/p pacemaker, HFpEF, pulmonary hypertension, aortic stenosis, multiple CVAs, seizure disorder, osteopenia, and urge urinary incontinence presents with constipation for 2 weeks characterized by hard, pebble-like stools occurring every 2-3 days despite Senna use. Associated symptoms include abdominal bloating and increased flatulence with worsening external hemorrhoid irritation secondary to straining. She denies alarm symptoms including abdominal pain, nausea, vomiting, hematochezia, melena, rectal bleeding, unintentional weight loss, or recent dietary/medication changes. Physical examination is notable for mild abdominal distension without tenderness, guarding, rebound, or palpable masses. Given her age, decreased gastrointestinal motility associated with aging, and reassuring abdominal exam, her presentation is most consistent with chronic constipation

Differential diagnoses

1. **Chronic constipation -** Chronic functional constipation is the most likely diagnosis given the patient's age, symptom presentation, and overall reassuring physical exam findings. The patient reports hard, pebble-like stools occurring every 2–3 days associated with abdominal bloating and increased flatulence, which is consistent with decreased colonic motility commonly seen in elderly patients. Additionally, aging itself is associated with slower gastrointestinal transit and constipation. On physical exam, the abdomen was mildly distended but soft and non-tender without guarding, rebound, or palpable masses. She also denies concerning symptoms such as hematochezia, melena, severe abdominal pain, vomiting, or unintentional weight loss. All of this makes it less likely to be an acute etiology.
2. **Medication induced constipation -** Medication-induced constipation should also be considered. The patient is currently taking amlodipine, which is a calcium channel blocker that can contribute to constipation by decreasing smooth muscle contractility and slowing bowel motility. In elderly patients, polypharmacy itself is also a common contributor to constipation. Although the patient denies any recent medication changes, chronic medication use may still contribute to worsening constipation over time.
3. **Fecal impaction** - Fecal impaction remains a possible differential given the patient's prolonged constipation despite Senna use, associated abdominal bloating, and hard stool consistency. Elderly patients are at increased risk for fecal impaction due to chronic constipation and decreased gastrointestinal motility. However, this diagnosis is less likely at this time because the patient is still having bowel movements every few days and denies nausea, vomiting, or severe abdominal pain. Additionally, bowel sounds were normoactive and abdominal examination was otherwise benign without tenderness or signs of obstruction.
4. **Colorectal malignancy/SBO -** Colorectal malignancy or partial bowel obstruction should also be considered in an elderly patient presenting with worsening constipation. Advanced age is a significant risk factor for colorectal cancer. However, this is less likely

given the absence of alarm symptoms including hematochezia, melena, unexplained weight loss, anorexia, severe abdominal pain, or vomiting. Her abdominal exam was also reassuring without palpable masses or peritoneal signs.

Plan

Labs ordered

- CBC
- CMP
- TSH with FT 4 reflex
- Abdomen XR
- Hemoglobin A1c
- LFTs
- Lipid panel
- PT/INR

Acute condition management

- Hemorrhoids: reports hydrocortisone cream 2.5% causes irritation. Will swtich to 1%.
- Abdominal XR to r/o bowel obstruction/fecal impaction today

Chronic condition management

- Atrial fibrillation: continue warfarin 2mg daily Monday to Fridays. Continue 2.5mg daily on Saturday and Sundays. Repeat INR in 4 weeks.
- Hypertension: continue amlodipine 5mg. Maintain low sodium diet and healthy weight. BMI goal < 25.
- Urge incontinence: advise no coffee or tea after 3 pm. Have frequent scheduled urine breaks and bladder training. Discontinue vibegron due to worsening constipation and polypharmacy.
- Obesity class I: advise aerobic exercise for at least 150 minutes per week with moderate intensity exercise. Counsel of BMI goal of < 25
- Constipation: increase water intake and fiber in diet. Continue Senna daily. Will start miralax daily and can increase to 2 times a day. If symptoms worsen after starting miralax, advise patient to go to ER. Discontinue vibegron and cetirizine d/t potentially worsening constipation and polypharmacy.
- Bilateral epicondylitis and capsulitis: use diclofenac as needed. Continue following current physical therapy plan of 8 sessions starting 3/2026
- Pre-diabetes: HbA1c on 1/5/26 is 6.1. Advise low carbohydrate diet, aerobic exercise, and maintaining healthy weight. BMI goal < 25.
- Seizure disorder: no recent seizure reported. Last followed neurology was back in 9/15/2025. Continue Keppra 500 mg twice daily.
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Referrals/Healthcare maintenance/follow-ups

- Return to clinic in 1 month for PT/INR and review of labs
- Tobacco screening due on 3/10/2027
- TDaP/TD vaccine (every 10 years) due on 1/29/2034