Darielle Connor 10/25/18

H&P #2

Identifying Data:

Full name: Mrs. C

Address: Flushing, NY

DOB: 3/29/86

Date & Time: 10/23/18 9:00 Am

Location: NY HQ

Religion: Non-Religious

Source of Info: Self

Source of Referral: Hematologist to ED

Mode of Transport: Self, husband drove to Hospital, abulatary

Chief Complaint: "I went to my Hematologist yesterday. And my Hemoglobin is 6.32, so they sent me here."

HPI:

GIPD@4wOd,

Mrs. C is a reliable 32 y/o married, Chinese female, ~~who is 4 weeks pregnant~~, w/ a significant PMHx of Congental Dyserythropoietic Anemia (CDA) (not type 1-3), and asthma, who presented today to the ED with a Hemoglobin of 6.23 She has had an elevated HR, which she takes herself due to her anemia, of 90+ after eating, which didn't get any better and her normal is around 70 BPM. She was at her hematologists office when her hemoglobin was checked, and she was sent to the hospital's Blood Center to receive a transfusion.

The blood center sent her to the ED as they could not give her more than one unit of blood at that time and she needed 2+. She has noticed some fatigue while walking, nausea when eating and after, some pallor, and lightheadedness when standing up, all intermittently over the last 3 weeks. She denies vomiting, dizziness, syncope, CP or SOB. Mrs. C has had this feeling before, many times in her life, due to her anemia and found out this morning that she is pregnant. She is not terribly worried and just wants to remain safe in order to maintain the health of her pregnancy. ✓

great!

PMHx:

Present illnesses: Anemia (CAD) x 25 years +, Asthma x 10 years

Past illnesses: Anemia (CAD), Asthma, Bronchitis in 11/2017 ✓

Childhood illnesses: Anemia (CAD), Chicken Pox ✓

Past surgical Hx: (All lead to Diagnosis of CAD)

Bone Marrow Biopsy x 4: (1996) in LIJ Hospital, (2001, 2006) in Mt. Sinai - Harlem, (2017) in Hematologist's office who is affiliated w/ Mt. Sinai. - All at patient procedures. ✓

Transfusions: Due to the nature of her CAD, this patient has had 20 + transfusions during her life, starting around age 10. ✓

- in 1996, first transfusion in LIJ hospital, Complications noted of coughing, wheezing, hives - given benadryl and tylenol, these transfusions continued for 1x/month x 2 years, intermittent transfusions given after that (unsure of exact # or duration) ✓
- 2016-2017, 4 transfusions received @ NYHQ, benadryl + tylenol

not given during these last 4 transfusions with no complications. She was hospitalized w/ every transfusion as a child, @ LIJ as far as she can remember, w/ the 4 in 2016 being done in NYHQ blood center (Denies complications). She denies any other injuries.

Medications:

- Albuterol (Salbutamol 2.5mg, 0.5mL of 0.5% diluted in a 3mL sterile normal saline) nebulized as needed x 10 years, has not taken it since march 2018*
- Singulair (montelukast sodium 4mg) 10 mg / day per Os, has not taken since March 2018*
- Claritin (loratadine) 10mg / day, per Os, has not taken since March 2018
- Prenatal vitamins of unknown brand and dosage, 1 tablet / day per Os, last dose this morning
- "Chinese herbal supplements" taken for anemia, brewed in a tea. She does not know the names of these or dosages, they were given to her by her mother. Last taken March of 2018*

*. All medications stopped in March 2018 due to trying to get pregnant.

Allergies: NKDA, only reaction during first transfusion @ age 10, seasonal allergies of unknown orgins.

- Denies other animal, drug, environmental or food allergies.

Family Hx:

Mother: Living, 63 y/o, Hx of proteinuria, denies any other known PMHx

Father: Living, 66 y/o, Anemia, Vitaligo, unsure of any other PMHx.

maternal/paternal Grandparents: Alive, all of them, as far as she knows. Live in China w/ limited contact due to time differences and scheduling conflicts. Unsure of ages or PMHx. She assumes one of her "father's parents must also be anemic as [her] CAD is hereditary."

- No Siblings, Denies FHx of Cancer, HTN, CVD, Stroke

Immunizations: up to date and last flu shot 3 weeks ago

Psych Illnesses: Denies any clinically diagnosed psych illnesses, past or present

Screening Tests: Pap smear yearly, denies any abnormal results.

Social Hx:

Mrs. C is a married female, living with her husband and no pets. She works as a Pharmacist in a Flushing CVS.

Habits: Denies alcohol use due to her anemia, even one drink makes her her heart race. She denies cigarette/cigar use or having ever used tobacco products. She sometimes has a cup of coffee in the morning, but not since her symptoms started (3 weeks).

Travel: Last travel to Hawaii w/ husband in May 2018, denies travel since.

Diet: Eats an "average" diet, no raw foods or cold foods as instructed by "Chinese" medicine" and her mother. Denies any other dietary restrictions or measures.

Exercise: She states she doesn't get much exercise lately, she sometimes does yoga and used to play "Dance Dance Revolution" at home w/ her husband about a year ago.

Sleep: She states she usually gets about 7-8 hours of sleep/night. She complains of intermittent insomnia due to having done overnight shifts for a year (stopped end of 2017). She feels she's still adjusting. Denies any other sleeping problems.

Safety: Admits to wearing her seatbelt and crossing @ crosswalks.

Sexual Hx: Admits to being sexually active, one partner (husband). They used condoms + timing methods prior to trying to get pregnant in March of 2018. She denies any Hx of STI's or sexual dysfunction / pain.

ROS:

- General: Admits to fatigue and weakness, loss of appetite today only, recent weight gain of 5 lbs in the last year. Denies any fever, chills, night sweats, weight loss
- Skin, hair, nails: Admits to less hair shedding than usual, dryer lips, some pallor noticed, and white nail spots. Denies changes in hair/skin/nail texture, excessive sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.
- Head: Admits to headaches, intermittently and tolerable, this week only, and lightheadedness. Denies any dizziness, vertigo, LOC, trauma, coma or f/x

- Eyes: Admits to eye fatigue when she's tired. Denies other visual disturbances, photophobia, Lacrimation, pruritis. Last eye exam Feb 2018, wears corrective lenses, not contacts, w/ visual acuity of -6.5 OS and -7.0 OR.
- Ears: Denies any deafness, pain, discharge, tinnitus, or use of hearing aids.
- Nose/sinuses: Admits to "sniffles" and discharge "runny nose" end of September. Denies epistaxis or obstruction, pain in sinuses.
- Mouth/Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or dentures. Last dental exam March of 2017.
- Neck: Denies any localized swelling/lumps, stiffness or decreased range of motion.
- Breast: Denies any tenderness, lumps, nipple discharge, or pain. No Hx of mammograms due to age.
- Pulmonary: Denies any SOB, dyspnea, coughing, wheezing, hemptysis, cyanosis or orthopnea, PND.
- Cardiovascular: Admits to heart racing and palpations at night x 3 weeks. Denies any CP, HTN, edema/swelling of lowerlimbs, syncope, or known Heart murmur.
- GI system: Admits to intolerance/preference of no cold or raw foods, loss of appetite today, mild nausea x 3 weeks and intermittent, slight diarrhea this morning only. Denies any vomiting, dysphagia, pyrosis, flatulance, eroctation, abdominal pain, jaundice, Δ in bowel habits, hemorrhoids, constipation, rectal bleeding, bloody stool, or colon screening.

- GU system: Denies any urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, or flank pain.
- Menstrual/obstetrics: G1 (current) P0. Menarche age 12. LMP 9/12/18. Currently 4 weeks pregnant, found out this morning. Interval of 30-40 days between periods, normal for her, lasting 4 days w/ normal bleeding - not heavy or painful. Denies any dysmenorrhea, menorrhagia, post coital bleeding, vaginal discharge, dyspareunia, or menopause symptoms/breakthrough bleeding.
- MSK: Denies any joint pain, muscle pain, deformity, swelling, redness, or arthritis.
- Peripheral vascular: Denies any claudication, coldness, trophic changes, varicose veins, peripheral edema, or color change.
- Hematologic: Admits to Anemia x25 years, Congenital dyserythropoietic Anemia (CAD) not type 1, 2 or 3, Refer to HPI. Denies any easy bruising or bleeding, lymph node enlargement, Hx of DVT/PE.
- Endocrine: Admits to some polydipsia 3 weeks ago but not now. Denies polyuria, polyphagia, heat or cold intolerance, goiter or hirsutism, or excessive sweating.
- Nervous: Denies any seizures, LOC, sensory disturbances, ataxia, loss of strength, Δ in cognition/mental status/memory or weakness
- Psychiatric: Admits to recent dreams of her teeth falling out and feeling more anxious than usual. Denies depression/sadness or associated feelings, OCD behavior or ever seeing a mental health professional.

Physical:

- General: Average build female, neatly groomed, looks her stated age of 32, not in any acute distress.
- Vitals: BP:

	R	L	Palp
Seated:	108/68	106/68	102 Systolic
Supine:	106/70	104/68	

R: 20/min, unlabored but frequent

P: 102 BPM, regular and strong

T: 98.6° F Oral

O_2 Sat: 96% on Room Air

Height: 5'4" Weight: 158 lbs BMI: 27.1

- Skin: Warm and moist, good turgor, non icteric. no thickness/opacities, no lesions, no rashes, no scars, no tattoos.
- Hair: Average quantity and distribution, no signs of alopecia, lice, or seborrhea.
- Nails: No clubbing (patient wearing nail polish so unable to visualize white lines described by patient or capillary refill.) No infection, capillary refill < 2 seconds throughout.
- Head: normocephalic, atraumatic, non tender to palpation, no apparent facies noted.
- Eyes: symmetrical OU, no evidence of strabismus or ptosis noted, sclera white, conjunctiva pink and moist, cornea clear. Visual acuity 20/20 with corrective lenses OU. Visual fields intact, PERRLA, full EOMI, no nystagmus OU. Red Reflex intact OU, Cup: Disk < 0.5, non remarkable OU.

- Ears: Symmetrical and normal size. No evidence of lesions, masses, trauma, discharge, pain externally AU. No evidence of discharge, pain, erythema, F/B in Auditory canal AU. Tympanic membrane visualized, pearly gray and intact AU. Weber and Rinne exams normal, whisper test normal.
- Nose/Sinuses: Symmetrical, no visualized masses, lesions, trauma, discharge. Bilateral patency. Turbinae pink and moist, no septal deviation, no discharge. no F/B or lesions noted. Sinuses non-tender to palpation.
- Mouth: Lips pink & moist, no evidence of cyanosis, fissures or lesions.
  - Mucosa pink & moist, no evidence of lesions, ulcers, leukoplakia.
  - Palate pink & moist, no evidence of lesions, ulcers, masses.
  - Teeth have good dentition / no obvious caries, missing teeth noted.
  - Gingivae pink & moist, no evidence of hyperplasia, erythema, lesions.
  - Tongue pink & moist, no masses / lesions / deviation noted
  - oropharynx pink & moist, no evidence of exudate, masses, lesions, F/B, tonsils present w/ no evidence of injection or exudate. Uvula pink, no edema, lesions or deviation noted.
- Neck: Trachea midline. No masses / lesions / scars / pulsations noted. Supple & non-tender to palpation. FROM, no Stridor noted. No palpable adenopathy noted in lymph nodes.
- Thyroid: Non-tender, no palpable masses or thyromegaly, no bruits noted.

98.80 F

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History and Physical Verification Form

Class: Physical Diagnosis I (HPPA 502)

Student Expectation:
- Obtain medical history and perform physical exam up to the point covered in class.
- Oral presentation to clinical site supervisor/preceptor

Student: Darielle Connor

Clinical Site: NYP-Q

Date of Visit: 10/23/18

Activity performed: HPI

Supervisor: Marion-Vincent Mempin MD

Name and Credentials:

Supervisor Signature:

Supervisor Comments: Great Attitude