Darielle Connor

Identifying Data:

Full name: Ms. H

Address: Flushing, NY

DoB: 8/9/91

Date & Time: 4/30/19 8:15 Am

Location: NYHQ - PAT

Religion: Christian

Source of info: Self

Source of Referal: Podiatrist to PAT

Mode of Transport: Ambulatory

CC: "I'm getting this bunion removed from my (left) foot. I've had them for years, I don't know how long".

HPI:

Ms. H is a 27 y/o Black, single, female w/ asignificant PMHx of open Heart surg as a child for possible VSD. Ms. H states that she is unsure what exactly the surgery was for and was unable to obtain her records from her pediatric cardiologist. She states she has had no problems w/ her heart since childhood and takes no medications. She Denies any other significant PMHx. she denies smoking. Ms. H states that she's been having pain due to bunions she has bilaterally, she has had these bunions for years and states they run in her family. She came into P.A.T. prior to bunion removal surgery on 5/10/19 for the left foot only. Ms. H did not care to elaborate on her Hx further or

here for bunion removal

this doesn't flow nicely. Talk about the bunion first.

not sure if this is relevant to be in HPI. but I recall the situation this first

her pain quality/type/character. She was a poor historian and refused to answer further questions or allow a full physical to be done on her.

- PMHx:

Present illnesses: "leaking" Heart as per patient, states she was told this by her cardiologist last year. Could not elaborate further.
- Denies any other present illnesses.

Past illnesses: VSD? Denies any other past illnesses

Childhood illnesses: VSD? Chicken pox. Denies any other past illness

Past surgical Hx: Cervical lymph node removal (2016) Mt. Sinai
- Open Heart surgery (1996) NYQH

Hospitalizations: S/P Open Heart surgery (1996)

Transfusions: Denies any past transfusions.

Injuries: Denies any past injuries

Medications: Denies any medication, vitamin or other supplement use

Allergies: Denies any allergies to medications, foods, environmental

Family Hx: Mother - 55 - alive - HTN, father - 49 - died in 2001 of MI, 2 older sisters - alive and well maternal/paternal GPs?

Immunizations: Pt states she is up to date and received her flu shot

Psych illnesses: Denies any Hx of psych illnesses past or present

Screening tests: Pap - 2018 - negative

Social Hx:

Ms. H is a single female, living alone w/ her 2 yorkies. She works for the MTA as a dispatcher for the last 5 years.

- Habits: Admits to "socially" drinking alcohol with friends on the weekends (>4 drinks per sitting) and wine during the week at home (1-2 glasses per sitting). She denies caffine consumption or any kind. smoking? even though you mentioned in the I
- Travel: Denies any recent travel
- Diet: Denies any dietary restrictions, "eats what she wants"
- Exercise: Denies any exercise forms beside walking her dogs
- Sleep: States she sleeps okay, 6-7 hours per night. Denies apnea or snoring
- Safety: Admits to wearing a seatbelt
- Sexual Hx: Admits to being sexually active. Refused to admit # of partners. Admits to using condoms for contraception. Denies any past Hx of STIs or sexual dysfunction/pain.

ROS:

- General: Admits to fatigue, but believes it's due to working long hours. Denies any fever, chills, night sweats, weakness, loss of appetite, or recent weight gain/loss
- Skin, Hair, nails: Denies any changes in texture, excessive sweating or dryness, discolorations, pigmentations, moles or rashes, pruritus or changes in hair distribution
- Head: Denies any Headache, vertigo, Head trauma, unconsciousness, coma or fatigue
- Eyes: Admits to wearing contacts. Denies visual disturbances, fatigue, lacrimation, photophobia, pruritus. Last eye exam in 2018. unknown visual acuity.

- Ears: Denies any deafness, pain, discharge, tinnitus or hearing aids
- Nose/Sinuses: Admits to some nasal stuffiness and drip. denies any discharge, epistaxis, or obstruction.
- Mouth/Throat: Denies any bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes. Last Dental exam 2018?
- Neck: Admits to lymph node removal Right side of neck. Denies any other lumps, localized swelling, stiffness/decreased ROM. normal?
- Breast: Denies any lumps, nipple discharge, or pain.
- Pulmonary: Denies any dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea or PND.
- Cardiovascular: Admits to "leaking" Heart, unable to elaborate on that further. Admits to yearly stress tests and EKG's w/ unknown results. Denies any CP, HTN, palpations, irregular heartbeats, edema/swelling of LE, syncope or known Heart murmur
- GI: Denies any changes in appetite, food intolerance, N/V, dysphagia, PYROSIS, flatulence, eructations, Abd pain, diarrhea, jaundice, change in BM, hemorrhoids, constipation, rectal bleeding, blood in stool or flank pain.
- GU: Denies any changes in urinary frequency, urgency color, incontinence, dysuria, nocturia, oliguria or polyuria
- Sexual Hx: (see social Hx)
- Ob Gyn: LMP 4/12/19 pt normal interval and duration. Admits to some dysmenorrhea, Back pain & cramps w/ MP. Denies any other gynecological changes to health recently. G:1, T:0, P:0, A:1, L:0
- MSK: Admits to cortizone shots in (B) shoulder, neck for pain. Denies any other joint pain, deformities, swelling or redness

- Peripheral vasc: Denies any intermittent claudication, coldness of trophic changes, varicose veins, peripheral edema, or color change
- Hematologic: Denies any anemia, easy bruising, bleeding, lymph node enlargement w Hx of DVT/PE
- Endocrine: Denies any changes or polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter or hirsutism.
- Nervous: Denies any seizures, LOC, sensory disturbances, ataxia, loss of strength, changes in cognition/memory or AMS, or weakness
- Psychiatric: Denies any depression/sadness, lack of interest in activities, suicidal ideation, anxiety, OCD, medications and has never seen a mental health professional

Physical

- General: healthy weight female, neatly groomed, looks her stated age of 27 years, not in any acute distress
- Vitals: BP:

	R	L	Palp
seated:	133/93 (machine)	130/90	130
supine:	132/92	132/90	

R: 14 BPM, unlabored
P: 71 BPM, regular and strong
T: 98.4°F orally
O_2 Sat: 98% on Room Air
Height: 5'6" Weight: 135 lbs BMI: 21.8

- Skin: large tattoo across chest. non icteric, no lesions, scars or rashes. warm and moist, good turgor, no thickness or opacities

- Hair: Average quantity and distribution for age, no signs of ~~Alopecia~~, lice or seborrhea.
- Nails: Pt wearing long acrylic nails. unable to visualize or test for Capillary refill. clubbing not noticed.
- 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 w/o corrective OU. Visual fields intact. Perrla, full EOMs, no nystagmus OU. Red reflex intact OU, cup:Disk ≤0.5, non remarkable OU
- Ears: Symmetrical and normal size AU. 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, intact AU. Weber and Rinne test normal. whisper test normal.
- Nose/Sinuses: Symmetrical, no visualized masses, lesions, trauma or discharge. Bilateral patency. Turbinate pink & moist, no septal deviation, no discharge, no F/B noted or lesions. Sinuses not 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 normal dentition, no caries noted, no missing teeth noted
  - Gingivae pink & moist, no evidence of hyperplasia, erythema, lesions
  - Tongue pink & moist, no masses, lesions, deviations noted
  - Oropharynx pink & moist, no evidence of exudates, masses, lesions, F/B, tonsils present w/ no evidence of injection or exudate. Uvula midline, no edema, lesions or deviations noted. Malampaty score 2+ as per PA.

- 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, non palpable masses or thyromegaly. No Bruits noted
- Chest: Symmetrical, no deformities, no evidence of trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. LAT to AP diameter 2:1. non tender to palpation.
- Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds noted.
- Heart: JVP is 2.5 cm above the sternal angle w/ the end of the bed @ 30°. PMI is in the 5th ICS, in the mid clavicular line. Carotid pulses are 2+ Bilaterally w/o Bruits. RRR. S_1 & S_2 are normal. No murmurs, S_3, S_4, splitting of heart sounds, friction rubs, or other sounds.
- Abdomen: Symmetrical. no evidence of scars, caput medusae, or abdominal pulsations. striae and stretch marks not noted. BS noted in all 4 quadrants, no bruits heard over aortic / renal / iliac / femoral arteries. Tympany to percussion throughout. non tender to light & deep palpation or percussion. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted Bil
- Breast: Symmetrical. No dimpling, no masses, Nipples w/o discharge. No axillary nodes palpable
- GU Female: External - normal pubic hair pattern. No erythema, inflammation, ulcerations, lesions or discharge noted. BUS WNL. Vaginal mucosa w/o inflammation, erythema or discharge Cervix non purous w/o lesions, or discharge. No cervical motion tenderness. Uterus retro-flexed, mobile, non-tender, and of normal size, shape, and consistency. Adnexa w/o masses or tenderness.

- Rectal: No exteral hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal tone. No masses or tenderwesses. Trace brown stool present in vault. FOB negative.
- Peripheal vasc: The extremities are normal in color, size and temperature. Pulses are 2+ Bilaterally in UE & LE. No Bruits noted. No clubbing, cyanosis or edema noted bilaterally (No C/C/E B/L). No stasis changes or ulcerations noted
- MSK Lower: No soft tissue swelling/erythema/ecchymosis/atrophy or deformities in bil UE & LE. Non tender to palpations/No crepitus noted throughout. From in all LE Bil. No evidence of spinal deformities.
- MSK upper: No soft tissue swelling/erythema/ecchymosis/atrophy or deformities in Bil UE & LE. Non tender to palpation/no crepitus noted throughout. From in all UE Bil. No evidence of spinal deformities
- Neuro:
  - mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.
  - Cranial nerves: I - intact, no anosomia
    II - VA 20/20 Bil. Visual fields by confrontation full. Funduscopic & red light reflex OS/OD, discs yellow w/ sharp margins. No Atrophy, hemorrhages or papilledema noted.
    III-IV-VI - PERRLA, EOM intact w/o nystagmus
    V - Facial sensation intact, strength good. Corneal reflex intact Bil
    VII - Facial movements symmetrical and w/o weakness
    VIII - Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC > BC
    IX-X-XII - swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI - shoulder shrug intact. SCM and Trap muscles strong.

- motor/cerebellar - Full active/passive ROM of all extremities w/o rigidity or spasticity. Normal muscle bulk & tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No pronator drift. Gait normal w/no ataxia. Tandem walking & hopping show balance intact. Coordination by RAM and point to point intact B/L. Romberg negative.
- Sensory - intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bil.

Reflexes	R	L		R	L
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinski	neg	neg
Abdominal	2+	2+	clonus	neg	

- meningeal signs - No nuchal rigidity noted. Brudzinski's & Kernig's signs neg.

Differentials: For VSD / open heart surgery since threat of arrhythmia or bunions

- Atrial Septal Defect : murmur, "leaking", surgery needed to correct
- Patent Ductus Arteriosis : murmur, Cyanosis, surgical repair needed
- Ventricular Septal defect : murmur, "leaking", surgical repair needed, cyanosis
- Tetrology of Fallot : murmur, cyanosis, "leaking", surgical repair needed
- Coarctation of the aorta : murmur not heard, cyanosis, surgical repair needed

* all checked by echo cardiogram / US

List in bullets

Plan

① "leaking" heart OR R/O VSD
- cardio
- EKG etc.

Plan:

Patient needs to have cardiac clearance prior to surgery in order to evaluate "leaking" heart. Stress test needed, echocardiogram, EKG done at time of PAT. NPO 12 hours prior to surgery. Pt non-compliant for most part.

Assessment: 27 y/o female w/ cardiac surgery Hx for unknown reason. Needs to be worked up for cardiac clearance prior to bunion surgery of the left foot. ✓

Assess for marginally high BP. UPreg needed.

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