YORK COLLEGE
The City University of New York

York College
Physician Assistant Program
94-20 Guy R. Brewer Blvd SC-112
Jamaica, NY 11451

Course Instructors:
S. Shami, J. Yuan &
M. Malavet
(718) 262-3793
Fax: (718) 262-2504

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: Ruth Schreiber

Clinical Site: Internal Medicine

Date of Visit: 11/6/18

Activity performed: Obtain H+P

Supervisor:
Name and Credentials: Susan Ann Denn, PA-C, MPAS
Administrative Chief Physician Assistant
Department of Medicine

Susan Ann Denn PA-C, MPAS

Supervisor Signature:

Supervisor Comments:

Ruthie Schreiber
Hospital H+P #2

- ID: Joseph R., 02/16/59, African American, Atheist, 11/6/18, Male, 59 y/o, American, Divorced, 9:18am
- Informant: Patient; Questionable Reliability
- Referal Source: Self; PCP: Dr. Johnson
- CC: "I can't see" x 8 days
- HPI: 59 year old African American male, current smoker, with no significant PMH presents to the hospital from home with an 8-day history complaint of lack of vision in left eye. Patient admits to abrupt onset of the vision loss which began in the morning upon waking up. Admits to starting to see faint shadows + spots 3 days ago. Patient ranks this disorienting blindness at onset at 10/10, + 8/10 currently. Denies taking anything to alleviate the situation. Denies specific time of day when blindness is more prevalent, as it comes + goes randomly. Admits to burning, fatigue with use of eyes, scotoma, last eye exam 2 days ago, + use of reading glasses. Denies recent weight loss/gain, loss of appetite, generalized weakness/fatigue, fever, chills, diplopia, halos/lacrimation, lacrimation, photophobia, pruritus
- Past Medical History: Denies present/past illnesses. Denies receiving the Influenza vaccination, admits to being up to date on other immunizations
- Past Surgical History: Denies surgeries, transfusions
- Medications: Denies use of medications

(1)

- Allergies: Denies any drug/environmental/food allergies
- Family History: Mother, MI @ 48, mental illness
  Father, stroke @ 66, HTN
  Sister, alive + well, 62, lupus
- Social History: Admits to past/present smoking of cigarettes (48 pack years). Admits to illicit drug use of cannabis, cocaine, marijuana, THC, acid, opium, + heroin. Rehabilitation for drug abuse (1994). Admits to occasional drinking of 1 beer on holidays. Admits to well-balanced diet + hours sleep/night, current exercise of walking + strength training, following safety procedures, living with cousin, occupation in business. Denies any recent travel, caffeine use, + any form of sexual activity.
- Review of Systems:
  - General: Denies recent weight loss/gain, loss of appetite, generalized weakness/fatigue, fever, chills, night sweats
  - Skin/Hair/Nails: Denies any change in texture, excessive dryness/sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution
  - Head: Denies headache, vertigo, light-headedness, head trauma, unconsciousness, coma, fracture
  - Eyes: Denies diplopia, halos, lacrimation, photophobia, pruritus. Admits to blurring, fatigue with use of eyes, scotoma, last eye exam 2 days ago, use of reading ② glasses

Ruthie Schreiber

→ Ears: Denies deafness, pain, discharge, tinnitus, hearing aids
→ Nose/Sinus: Denies discharge, epistaxis, obstruction
→ Mouth/Throat: Denies bleeding gums, sore tongue, sore throat, mouth sores, voice changes, dentures. Admits to last dental exam 5 months ago.
→ Neck: Denies localized swelling/lumps, stiffness/ decreased range of motion
→ Breast: Denies lumps, nipple discharge, pain
→ Pulmonary: Denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, PND
→ Cardiovascular: Denies chest pain, HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur
→ Genitourinary: Denies frequency, nocturia, urgency, oliguria, polyuria, dysuria, irregular color of urine, incontinence, awakening at night to urinate, pain (flank), hesitancy, dribbling. Admits to last prostate exam within past 10 years.
→ Gastrointestinal: Denies loss in appetite, intolerance to specific foods, nausea + vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, change in bowel habits hemorrhoids, constipation, rectal bleeding, blood in stool, colonoscopy.
→ Nervous: Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, weakness
→ Musculoskeletal: Denies muscle/joint pain, deformity, swelling, redness, arthritis

→ Peripheral Vascular: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change
→ Hematologic: Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, history of DVT/PE
→ Endocrine: Denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, hirsutism
→ Psychiatric: Denies anxiety, OCD, use of mental health professional + medications. Admits to depression/sadness (featuring feelings of helplessness + hopelessness, lack of interest in usual activities, suicidal ideations)

• General Survey: 59 y/o male, A/O x 3, no evid. of distress, appears younger than stated age

• Vital Signs:

	R	L
BP: Supine only	118/78	120/82

R: 18 breaths/min, unlabored
P: 75 beats/min, regular
T: 98.7 °F (Oral)
O_2 Sat: 97%, Room Air

Height: 70 inch
Weight: 155 lbs
BMI: 21

• Skin: warm + moist, good turgor. Nonicteric, no lesions noted, no scars or tattoos
• Hair: average quantity + distribution
• Nails: fingernails with possible clubbing, no cyanosis, capillary refill < 2 seconds throughout
• Head: normocephalic, atraumatic, non-tender to palpation throughout

Ruthie Schreiber H+P#a cont'

- Eyes: symmetrical AU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva + cornea clear. Visual acuity (uncorrected - 20/20 OD). Visual fields full OD. PERRLA, EOMs full with no nystagmus. Fundoscopy - Red reflex intact OD. Cup: Disc ≤ 0.5 OD/no evidence of AV-nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OD. CRAO present OS
- Ears: symmetrical + normal size. No evidence of lesions/masses/trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TM pearly white/intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC>BC AU
- Nose: symmetrical/no obvious lesions/deformities/trauma/discharge. Mass noted on the inferior portion of left nostril. Nares patent bilaterally. Nasal mucosa pink + well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, perforation. No evidence of foreign bodies.
- Sinuses: Non-tender to palpation + percussion over bilateral frontal, ethmoid, + maxillary sinuses
- Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation
- Mucosa: Pink, well hydrated. No masses/lesions noted. Non-tender to palpation. No evidence of leukoplakia
- Palate: Pink, well hydrated. Palate intact with no lesions, masses, scars. Non-tender to palpation. Continuity intact
- Teeth: Good dentition, no obvious caries or missing teeth

- Gingivae: Pink, moist. No evidence of hyperplasia, masses, lesions, erethyma or discharge. Non-tender to palpation
- Tongue: Pink, well-papillated; no masses, lesions or deviation noted. Non-tender to palpation
- Oropharynx: Well-hydrated, no evidence of injection exudate, masses, lesions, foreign bodies, etc. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions
- Neck: Trachea midline. No masses, lesions, scars pulsations noted. Supple, non-tender to palpation FROM, no stridor noted. 2+ carotid pulses, no thrills, bruits noted bilaterally, no palpable adenopathy noted
- Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted
- Chest: symmetrical, no deformities, no evidence 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 + percussion bilaterally. Chest expansion + diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds