Ruthie Schreiber

H&P #1

Family Medicine (Rotation #3)

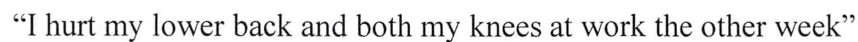
10/29/20

ID:

Mr. J.W CitiMed JFK

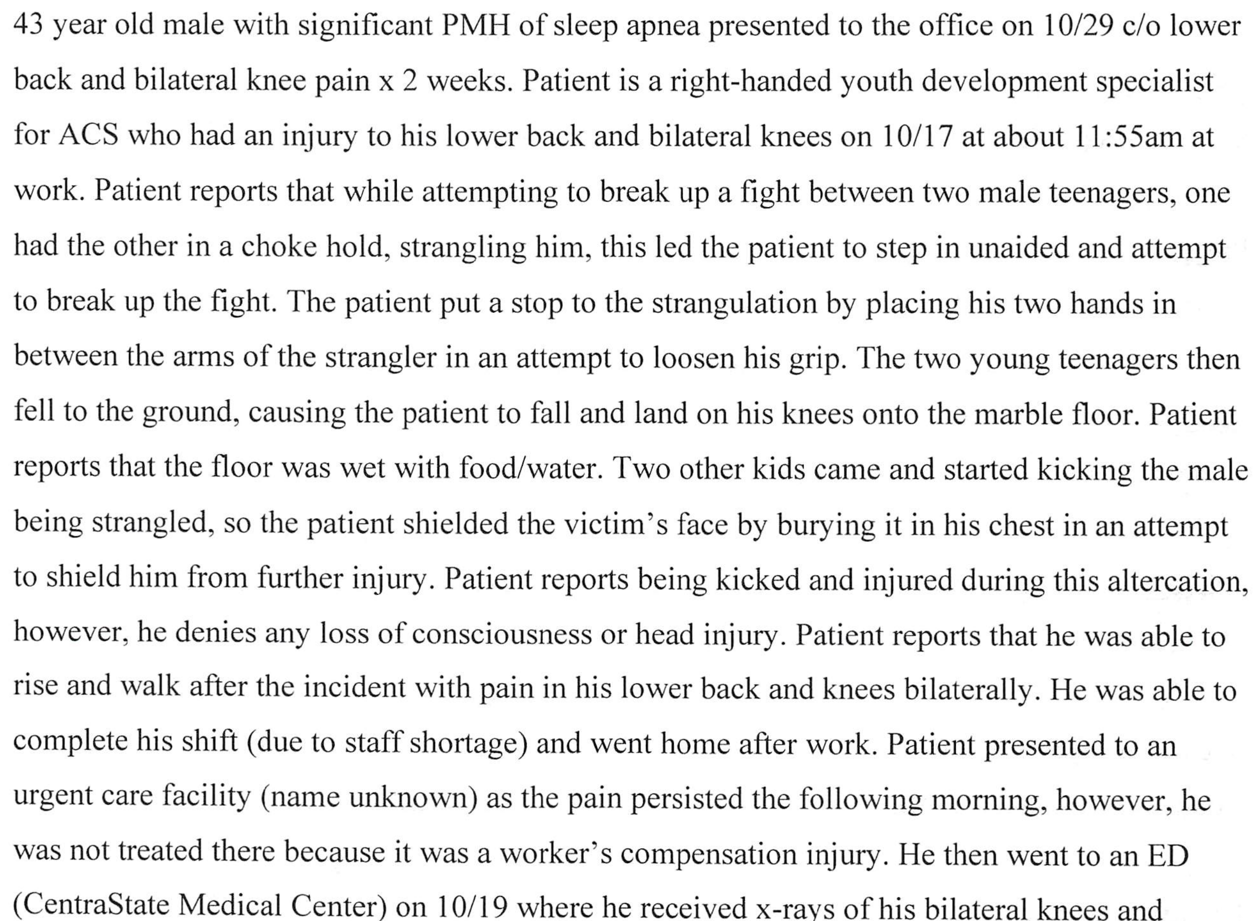
Informant: Self, Reliable

Chief Complaint:



"I hurt my lower back and both my knees at work the other week"

HPI:



43 year old male with significant PMH of sleep apnea presented to the office on 10/29 c/o lower back and bilateral knee pain x 2 weeks. Patient is a right-handed youth development specialist for ACS who had an injury to his lower back and bilateral knees on 10/17 at about 11:55am at work. Patient reports that while attempting to break up a fight between two male teenagers, one had the other in a choke hold, strangling him, this led the patient to step in unaided and attempt to break up the fight. The patient put a stop to the strangulation by placing his two hands in between the arms of the strangler in an attempt to loosen his grip. The two young teenagers then fell to the ground, causing the patient to fall and land on his knees onto the marble floor. Patient reports that the floor was wet with food/water. Two other kids came and started kicking the male being strangled, so the patient shielded the victim's face by burying it in his chest in an attempt to shield him from further injury. Patient reports being kicked and injured during this altercation, however, he denies any loss of consciousness or head injury. Patient reports that he was able to rise and walk after the incident with pain in his lower back and knees bilaterally. He was able to complete his shift (due to staff shortage) and went home after work. Patient presented to an urgent care facility (name unknown) as the pain persisted the following morning, however, he was not treated there because it was a worker's compensation injury. He then went to an ED (CentraState Medical Center) on 10/19 where he received x-rays of his bilateral knees and

lumbar spine. He drove himself to this facility today for further evaluation and treatment. Patient denies any history of pain and/or injury to his lower back and bilateral knees.

Patient's lower back pain is 8/10, constant, is shooting/throbbing in nature, and is non-radiating. The pain is aggravated by prolonged sitting, walking, and certain movements, and it is alleviated by stretching. Patient admits to numbness and tingling in his back while walking. Right knee pain is 4/10, constant, is throbbing in nature, and is non-radiating. Pain is aggravated by standing, stepping, prolonged sitting, and walking Patient denies any alleviating factors, numbness/tingling. Left knee pain is 4/10, intermittent, throbbing in nature, and non-radiating. Pain is aggravated by certain movements (i.e. descending stairs). Patient denies any alleviating factors, numbness/tingling. Patient denies headaches, shortness of breath, chest pain, abdominal pain, nausea, vomiting, fever, chills, bowel or bladder control problems.

PMH:

Sleep apnea (no CPAP)

PSH:

None

Medications:

None

Allergies:

PCN (edema)

Social History:

Non-smoker; social drinker; works at ACS as a youth development specialist

Family History:

Non-contributory

Review of Systems:

General : Denies fever, chills, night sweats, loss of appetite, weight loss.

Skin, Hair, Nails : Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution

Head : Denies headache, trauma, unconsciousness, coma, fracture, vertigo

Eyes : Denies corrective lenses, visual disturbances, fatigue, photophobia, pruritus, lacrimation

Ears : Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses : Denies discharge, epistaxis, obstruction, rhinorrhea

Mouth/Throat : Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures

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

Breast : Denies lumps, nipple discharge, pain

Respiratory : Denies SOB, DOE, wheezing, cough, hemoptysis, cyanosis, paroxysmal nocturnal dyspnea

Cardiovascular : Denies palpitations, chest pain, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal : Denies change in appetite, abdominal pain, diarrhea, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, constipation, hemorrhoids, blood in stool

Genitourinary : Denies change in frequency, urgency, hesitancy, dribbling, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain

Musculoskeletal : see HPI

Peripheral Vascular : Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

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

Endocrine : Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Neurologic : Denies loss of strength, ataxia, seizures, loss of consciousness, sensory disturbances, paresthesia, dysesthesia, hyperesthesia, memory loss, asymmetric weakness

Psychiatric : Denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

Physical Exam:

Vital Signs:

T 98.2 F

BP 128/76

P 78 bpm

RR 18 breaths/min

SpO2 100% RA

General Survey: A/O x 3, in no acute distress, well developed, well nourished

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: No conjunctival injection, pallor, or scleral icterus. PERRLA

Nose: No obvious masses, lesions, signs of trauma or discharge noted

Neck: Trachea midline. No masses, lesions, scars. Supple, nontender to palpation. Full range of motion. No palpable lymphadenopathy.

Chest: Normal expiration and no accessory muscle use. Respirations unlabored. Nontender to palpation.

Lungs: Lung fields are clear to auscultation bilaterally. No adventitious sounds noted

Cardiovascular: S1 and S2 normal. Regular rate and rhythm. No S3, S4, splitting of heart sounds, murmurs, rubs.

Abdomen: Soft and non-distended abdomen. Non-tender to palpation throughout. BS present in all four quadrants. No bruits over aortic/renal/iliac/femoral arteries. No guarding, rebound tenderness.

Musculoskeletal:

Lumbosacral spine: no edema, ecchymosis or erythema. Moderate tenderness to palpation of the lumbar paraspinal muscles. No spinal point tenderness. Lumbar range of motion: flexion 80/90 degrees, extension 25/25 degrees, left rotation 30/40 degrees, right rotation 30/40 degrees, left lateral flexion 20/25 degrees, right lateral flexion 20/25 degrees. Straight leg raise done with the patient supine is negative.

Right knee: flexion 150/150 degrees, full extension. Pain with flexion at the patellar region
Left knee: flexion 150/150 degrees, full extension. No pain noted with flexion or extension ✓
Neurologic: Alert and oriented, cranial nerves II-XII grossly intact. Slow gait, sensation intact
Extremities: No clubbing, cyanosis or edema noted. Peripheral pulses are 2+ bilaterally
Psych: Alert, oriented and cooperative with exam. No aphasia or dysarthria noted

Assessment/Plan:

X-ray lumbosacral spine (10/19 in ED): normal evaluation of the lumbosacral spine
X-ray right knee (10/19 in ED): no acute fractures, normal evaluation of right knee
X-ray left knee (10/19 in ED): no acute fractures, normal evaluation of left knee ✓

- Sprain of ligaments of lumbar spine
- Strain of muscle, fascia and tendon of lower back
- Sprain of unspecified site of left knee
- Sprain of unspecified site of right knee

-Not fit for duty; 100% temporary disability
-Apply ice hot/Bengay over affected regions
-Start Ibuprofen tablet (800mg, PO TID) with food as needed for pain
-Physical therapy referral (2-3x a week) for strengthening and to reduce pain
-F/u in 1 week or earlier if needed
-Consider MRI if symptoms worsen

* Plan should written out in more detail for each problem

1. Sprain / Strain Lumbar Spine
   - Not fit for duty
   - Apply ice / Bengay
   - Ibuprofen 800mg TID
   - Physical Therapy
   - Consider MRI
   - XR Neg for fracture

2. Sprain / Strain B/L knee
   - Not fit for duty
   - XR Neg
   - Apply ice / Bengay
   - Ibuprofen 800mg TID
   - Physical Therapy

3. HTN / HLD

- continue with home Meds

Ruthie Schreiber

H&P #2

Family Medicine (Rotation #3)

11/6/20

ID:

Mr. M.B. CitiMed JFK

Informant: Self, Reliable

Chief Complaint:

"I hurt my pinky toe on my right foot"

HPI:

55 year old right handed male with significant PMH of HTN and HLD, presents for an initial evaluation after injury to his right foot/fifth digit that occurred on 11/4/20 at 9AM while at work. The patient is a warehouse agent for WFS, and he reports that while setting down a skid it fell onto his right foot crushing his toes, primarily the 5th digit. Patient states that he had to pull his foot out from under the skid and he was wearing work boots at the time. He limped around, and then returned to work thinking that the pain would subside, however, the pain persisted so he reported the injury to his supervisor at noon (he did not complete his shift which normally ends at 4:30pm). Patient reports that while home he continued to have pain, primarily with ambulation, and since the pain continued, he was advised to present to this office for further evaluation and treatment. Patient denies any history of previous pain and/or injury to his right foot.

Patient's right foot/5th toe pain is rated at a 5/10, is constant, achy and radiates down the lateral aspect of his foot. The pain is aggravated by walking and putting on shoes, leading the patient to only be able to wear sandals. The pain is alleviated by rest. Patient admits to taking Tylenol and Ibuprofen for the pain as needed with little relief. Patient denies any numbness, tingling, headache, SOB, chest pain, abdominal pain, nausea, vomiting, fever, chills. Patient presents to the office today without any assistive devices.

PMH:

HTN

HLD

PSH:

3 Cardiac stents placed (2014)

Medications:

Plavix, ASA, Atorvastatin, Metoprolol

Allergies:

None

Social History:

Non-smoker; social drinker; works at WFS as a warehouse agent

Family History:

Non-contributory

Review of Systems:

General : Denies fever, chills, night sweats, loss of appetite, weight loss.

Skin, Hair, Nails : Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution

Head : Denies headache, trauma, unconsciousness, coma, fracture, vertigo

Eyes : Denies corrective lenses, visual disturbances, fatigue, photophobia, pruritus, lacrimation

Ears : Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses : Denies discharge, epistaxis, obstruction, rhinorrhea

Mouth/Throat : Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures

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

Breast : Denies lumps, nipple discharge, pain

Respiratory : Denies SOB, DOE, wheezing, cough, hemoptysis, cyanosis, paroxysmal nocturnal dyspnea

Cardiovascular : Denies palpitations, chest pain, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal : Denies change in appetite, abdominal pain, diarrhea, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, constipation, hemorrhoids, blood in stool

Genitourinary : Denies change in frequency, urgency, hesitancy, dribbling, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain

Musculoskeletal : see HPI

Peripheral Vascular : Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

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

Endocrine : Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism

Neurologic : Denies loss of strength, ataxia, seizures, loss of consciousness, sensory disturbances, paresthesia, dysesthesia, hyperesthesia, memory loss, asymmetric weakness

Psychiatric : Denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

Physical Exam:

Vital Signs:

T 98.4 F

BP 134/78

P 88 bpm

RR 18 breaths/min

SpO2 100% RA

General Survey: A/O x 3, in no acute distress, well developed, well nourished

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: No conjunctival injection, pallor, or scleral icterus. PERRLA

Nose: No obvious masses, lesions, signs of trauma or discharge noted

Neck: Trachea midline. No masses, lesions, scars. Supple, nontender to palpation. Full range of motion. No palpable lymphadenopathy.

Chest: Normal expiration and no accessory muscle use. Respirations unlabored. Nontender to palpation.

Lungs: Lung fields are clear to auscultation bilaterally. No adventitious sounds noted

Cardiovascular: S1 and S2 normal. Regular rate and rhythm. No S3, S4, splitting of heart sounds, murmurs, rubs.

Abdomen: Soft and non-distended abdomen. Non-tender to palpation throughout. BS present in all four quadrants. No bruits over aortic/renal/iliac/femoral arteries. No guarding, rebound tenderness.

Musculoskeletal:

Right ankle/foot: Moderate edema at talus. Dark lines on 5th toenail that do not resemble ecchymosis. No erythema noted. Tender to palpation at talus and 5th MTP joint. ROM: dorsiflexion 20/20, plantar flexion 40/40, inversion 30/30, eversion 20/20. Patient is able to wiggle all toes with slight pain.

Neurologic: Alert and oriented, cranial nerves II-XII grossly intact. Slow gait, sensation intact

Extremities: No clubbing, cyanosis or edema noted. Peripheral pulses are 2+ bilaterally

Psych: Alert, oriented and cooperative with exam. No aphasia or dysarthria noted

Assessment/Plan:

- Sprain of right foot
- Strain of unspecified muscle and tendon at ankle and foot level, right foot
- Crushing injury of right foot
- Pain in right toes

-Obtained x-ray of right foot/5th toe: preliminary views are negative for fracture, official report to follow

-Not fit for duty; 100% temporary disability

-ACE and hard sole shoe given for support

-Stat Podiatry consult (referral given)

-Tylenol prn for pain

-Apple ice, rest and elevate

-Follow up in 3 days or sooner if needed

2. HTN / HLD

- continue with Home Meds

Show you did Medication Reconcillation