JAY KOLASINAC
HPPA 502 LAB
PROFESSOR MALAVET
HOSPITAL VISIT H&P – PRE-ADMISSION TESTING

IDENTIFYING DATA

- FULL NAME: MR. M
- ADDRESS: N/A
- DATE OF BIRTH: 10/30/1957 – 62 yrs OLD
- DATE AND TIME: 10/15/2019 ~ 10:10 AM.
- LOCATION: NYPQ, FLUSHING, NY
- RELIGION: ROMAN CATHOLIC
- SOURCE OF INFORMATION: SELF
- RELIABILITY: RELIABLE ✓
- SOURCE OF REFERRAL: DR. DERASSI
- MODE OF TRANSPORTATION: UBER

- CHIEF COMPLAINT: "I HAVE HAD PAIN IN MY KNEE" x 20 YR ✓
- HISTORY OF PRESENT ILLNESS:

MR. M IS A 62 YEAR OLD, WHITE MALE, CURRENT SMOKER WITH A PAST MEDICAL HISTORY OF HYPERTENSION, HYPERCHOLESTEROLEMIA, SLEEP APNEA, DIABETES, AND PERIPHERAL NEUROPATHY WHO PRESENTED TO THE PRE-ADMISSION TESTING CENTER TO BE EXAMINED ONE-WEEK PRIOR TO HIS SCHEDULED JOINT REPLACEMENT SURGERY. PATIENT HAS STATED HE ~~HAS~~ EXPERIENCED A "COMING AND GOING" TYPE OF PAIN IN THE MEDIAL PORTION OF HIS RIGHT KNEE FOR THE PAST 20 YEARS. THE PAIN IS CHARACTERIZED AS SHARP AND QUANTIFIED AS A 10/10. THE PAIN DOES NOT RADIATE TO OTHER LOCATIONS. PATIENT STATES PAIN IS ~~ENH~~ EXACERBATED J.K. UPON STRENUOUS ACTIVITY OR WALKING UP/DOWN STAIRS

DID PAIN WORSEN OVER TIME?

NOT RELEVANT TO CC

MR. M STATES PAIN IS ALLEVIATED WHEN WEARING A BRACE, WHICH HE WEARS FOR UP TO 7-10 HOURS OR UNTIL THE PAIN IS ~~A.K.A.~~ TOLERABLE. PAIN IS WORST AT NIGHT ~~AND DOES~~ J.K. ~~AND PATIENT SUFFERS FROM SLEEP APNEA~~. PATIENT TAKES NUMEROUS PAIN MEDICATIONS (ALONG WITH OTHER MEDICATIONS TO REGULATE HIS OTHER ONBOARD CONDITIONS.

PUT THIS IN FIRST LINE OF HPI

DO THEY WORK FOR THE KNEE PAIN?

- PAST MEDICAL HISTORY — TYPE??
- PRESENT MEDICAL ILLNESSES: HYPERTENSION x 1 YEAR, DIABETES x 8 YRS, HYPERCHOLESTEROLEMIA x 1 YEAR (WELL CONTROLLED), PERIPHERAL NEUROPATHY x 8 YRS, ASTHMA x "WHOLE LIFE"
  - DOES HE USE A MASK AT NIGHT? SLEEP APNEA
- CHILDHOOD ILLNESSES: CHICKEN POX, NO SEQUELAE
- IMMUNIZATIONS: RECEIVED FLU SHOT 9/19
- SCREENING TESTS AND RESULTS: DENIES ~~ANY~~ SCREENING TESTS
  - BE MORE SPECIFIC — COLONOSCOPY PSA SCREEN
- PAST SURGICAL HISTORY:
  - TRIGGER FINGER - 06/19, NO COMPLICATIONS
  - CERVICAL FUSION OF C_3-C_4, C_5-C_6 - 12/14/2017, NO COMPLICATIONS
  - BROKEN TIBIA AND FIBULA - 06/1977, NO ~~CBD~~ COMPLICATIONS
    - USUALLY "BROKEN TIBIA & FIBULA" IS NOT A SURGERY → "OPEN REDUCTION AND INTERNAL FIXATION" OF TIB/FIB IS CORRECT... DOES PT HAVE HARDWARE?
- MEDICATIONS:
  - METFORMIN, 1000mg, 2x DAY
  - LISINOPRIL, 20mg, 1x DAY
  - ATORVASTATIN, 20mg, 1x DAY
  - JANUVIA, 100mg, 1x DAY
  - MECLIZINE, 25mg, 1x DAY
  - IBUPROFEN, 600mg, 2x DAY
  - TRAMADOL, 50mg, ? UNKNOWN ~~DOSE GIVEN~~ OR UNCERTAIN FREQUENCY
  - OXCARBAZEPINE, 150mg, 4x DAY
  - LAMOTRIGINE, 25mg, 4x DAY
  - DULOXETINE, 60mg, 2x DAY
  - METHOCARBAMOL, 750mg, 2x DAY
  - AMITRIPTYLINE 25mg, 1x DAY
  - OXYCODON 7.5mg, ?

ROUTE? PO, SQ, TD...

- ALLERGIES: ~~N/A~~ J.K. NO KNOWN DRUG OR ENVIRONMENTAL ALLERGIES ✓

- FAMILY HISTORY:

WAS HE A SMOKER?

FATHER - DECEASED AT AGE ~~62~~ J.K. 61, CAUSE OF DEATH LUNG CANCER
MOTHER - 85, HISTORY OF BREAST REMOVALS AND BILATERAL HIP REPLACEMENTS. ✓
MATERNAL/PATERNAL GRANDPARENTS - UNKNOWN
CHILDREN: NO CHILDREN SIBLINGS?

SOCIAL HISTORY:

MR. M IS A SINGLE MALE WHO LIVES/TAKES CARE OF HIS MOTHER. HE IS A RETIRED ADVERTISING AGENT.

- HABITS: SMOKES A PACK ~~A~~ DAY FOR AS LONG AS HE CAN REMEMBER. STARTED SMOKING SINCE HE WAS 14 YRS OLD.
- TRAVEL: NO RECENT TRAVELS ✓
- DIET: MR. M's TYPICAL DIET EVERYDAY WOULD CONSIST OF OATMEAL FOR BREAKFAST. MOST OF THE TIME HE WOULD SKIP LUNCH. EAT RICE AND BEANS WITH CHICKEN FOR DINNER. WATCHES FOODS HE EATS TO CONTROL DIABETES.
- EXERCISE: DOES NOT EXERCISE.
- SAFETY MEASURES: ADMITS TO WEARING A SEATBELT

SEXUAL HISTORY?

- REVIEW OF SYSTEMS:

GENERAL: LOST ~20 lbs WITHIN THE LAST 8 WEEKS. INTENTIONAL VS. UNINTENTIONAL LOSS NO FEVER, CHILLS, OR NIGHT SWEATS. NO GENERALIZED FATIGUE/WEAKNESS. ✓

- SKIN, HAIR, NAILS: ~~DENIES CHANGES~~ J.K. HERNIA APPROXIMATELY 2"X2" IN LOCATED IN UMBILICAL REGION. DENIES ANY CHANGES TEXTURE, DISCOLORATIONS, MOLES, RASHES, OR CHANGE IN HAIR DISTRIBUTION. PHYSICAL FINDING/PMH

VERTIGO IS DIFFERENT THAN LIGHTHEADEDNESS AND SHOULD BE DESCRIBED BETTER

- HEAD: EXPERIENCES VERTIGO UPON STANDING TOO QUICKLY. NO HEADACHE, TRAUMA, OR FRACTURE.

DISTANCE OR READING?

- EYES: PATIENT WEARS GLASSES. LAST EYE EXAM WAS 2 YRS AGO. NO VISUAL DISTURBANCES, LACRIMATION, PHOTOPHOBIA, OR PRURITUS.

"COMPLAINS OF" NOT "CLAIMS", BUT IN ROS "ADMITS TO TINNITUS"

- EARS: ~~HE CLAIMS OF CONSTANT~~ TINNITUS IN HIS RIGHT EAR. ~~NO~~ J.K DENIES DEAFNESS, DISCHARGE, HEARING AIDS. ✓

MOUTH?

- NOSE/SINUSES: DENIES DISCHARGE, OBSTRUCTION, OR EPISTAXIS. ✓

- NECK: DENIES SWELLING/LUMPS, OR STIFFNESS. ✓

- BREAST: DENIES ~~ANY~~ LUMPS OR PAIN. NIPPLE DISCHARGE

THIS IS A VERY CONCERNING POSITIVE AND MUST BE EXAMINED ON, ESPECIALLY PRE-OP!

- PULMONARY SYSTEM: (UPON EXERTION, PATIENT EXPERIENCES EXCESSIVE SHORTNESS ~~OF~~ BREATH.) OCCASIONALLY EXPERIENCES COUGHING/WHEEZING. DENIES ANY DYSPNEA, HEMOTYPSIS, CYANOSIS, ORTHOPNEA, OR PND.

ADMITS TO

- CARDIOVASCULAR SYSTEM: HAS HISTORY OF HYPERTENSION X 1YR. ~~CLAIMS TO EXPERIENCE~~ PALPITATIONS/IRREGULAR HEARTBEAT X 2 WEEKS. DENIES ANY CHEST PAIN, EDEMA, OR SYNCOPE.

FORMED BROWN

- GASTROINTESTINAL SYSTEM: HAS ~~REGULAR~~ BOWEL MOVEMENTS DAILY. DENIES CHANGE IN APPETITE, INTOLERANCE TO FOOD, NAUSE/VOMITING, DYSPHAGIA, PYROSIS, FLATULENCE, ERUCTATION, ABDOMINAL PAIN, DIARRHEA, JAUNDICE, HEMORRHOIDS, CONSTIPATION, RECTAL BLEEDING, OR BLOOD IN STOOL.

AGAIN, WILL NEED FURTHER EVALUATION IN ASSESING AND PLAN

GENITOURINARY SYSTEM: PATIENT COMPLAINS ABOUT FREQUENCY UP TO 15X PER DAY. LAST PROSTATE EXAM IS UNKNOWN. PATIENT COMPLAINS OF DRIBBLING, AND HESITANCY. DENIES URGENCY, NOCTURIA, OLIGURIA, POLYURIA, DYSURIA, INCONTINENCE, OR FLANK PAIN.

- SEXUAL HISTORY: HETEROSEXUAL, MONOGAMOUS, NO BARRIER PROTECTION. SEXUALLY ACTIVE.

- MUSCULOSKELETAL SYSTEM: COMPLAINS OF MUSCLE/JOINT PAIN. DENIES DEFORMITIES, SWELLING, OR REDNESS.

↓ SEE HPI

- PERIPHERAL VASCULAR SYSTEM: DENIES INTERMITTENT CLAUDICATION, COLDNESS/TROPHIC CHANGES, VARICOSE VEINS, PERIPHERAL EDEMA, OR COLOR CHANGE.

- HEMATOLOGIC SYSTEM: DENIES ANEMIA, EASY BRUISING, LYMPH NODE ENLARGEMENT, OR DVT/PE.

- ENDOCRINE SYSTEM: DENIES POLYURIA, POLYDIPSIA, POLYPHAGIA, HEAT/COLD INTOLERANCE, EXCESSIVE SWEATING, HIRSUTISM, OR GOITER.

- NERVOUS SYSTEM: COMPLAINS OF SHORT TERM MEMORY LOSS. DENIES SEIZURES, LOSS OF CONSCIOUSNESS, SENSORY DISTURBANCES, ATAXIA, LOSS OF STRENGTH, OR WEAKNESS.

- PSYCHIATRIC: ~~EXH~~ d.k COMPLAINS OF ANXIETY BECAUSE ~~HE~~ IS WORRIED ABOUT HIS HEALTH. DENIES DEPRESSION/SADNESS, OCD, OR SEEN BY A MENTAL HEALTH PROFESSIONAL.

PHYSICAL

- GENERAL: OVERWEIGHT MALE, NEATLY GROOMED, LOOKS APPEAR THAT OF A 62 YR OLD. ✓

- VITAL SIGNS: BP: 150/92
  PULSE: 80
  RESPIRATION: 18/min
  TEMP: 97.9°F (ORAL) ✓
  O_2 SATURATION: 95%.
  HEIGHT: 5 FT 11½ in
  WEIGHT: 229 lbs
  BMI: 31.9.

- HEAD AND NECK / HEENT → PLEASE WRITE OUT "NORMAL" EXAM

- LUNGS

- HEART

- BREASTS

- ABDOMEN

- PERIPHERAL VASCULAR

- MUSCULOSKELETAL

- NEUROLOGICAL

- MALE UROGENITAL / RECTAL