**H&P 1 for FM**

**Identifying Data:**

Full Name: V.L.

Date of Birth: xx/xx/1966

Age: 52 y/o

Sex: Male

Date & Time: 10/17/2019, 10:50 am

Location: Dr. Michael Richter’s clinic, 92-15 63rd Drive, Rego Park, NY 11374

Religion: None

Source of Information: Self

Reliability: Reliable

Source of Referral: None

**Chief Complaint:** “fever, chill, epigastric pain, nausea and diarrhea” x 10 hours.

**History of Present Illness:**

Mr. F, a 52 y/o male c/o 10 hours ago, he felt fever, chill, epigastric pain, nausea and diarrhea. Pain is consistent, dull, 5/10, no radiation, no significant aggravating or relieving factors. Diarrhea for 6 times. The stool was very soft, but not watery, no blood. He took no medication. He got the symptoms 5 hours after dining out with family. No other family members got sick. Denies recent traveling history or any previous similar episode. Denies cough, sputum, chest pain, vomiting, constipation, blooding in stool or STDs.

**Past Medical History:** DMII, HTN and HLD for 8 years, controlled by medications (see medications).

**Past Surgery History:** None.

**Past Hospitalization History:** None.

**Immunizations** – Up to date except no flu shot.

**Medications:** metformin 500 mg bid PO for DM, atacand 16 mg qdaily PO for HTN, and lipitor 10 mg qdaily PO for HLD.

**Allergies:** Denies any drug, environmental or food allergies.

**Family History:** Non-contributory

**Social History:** married, living with wife. Denies drinking alcohol/caffeine, smoking, or illicit drug use. Denies recent traveling history. Regular diet. Routine running. Denies sleeping problem. Sexually active, only with his wife.

**Review of Systems:**

General – Admits fever and chill. Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, or night sweats.

Skin, hair, nails – Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headache, vertigo or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses. Last eye exam 2017, normal.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies sore throat, bleeding gums, sore tongue, mouth ulcers, voice changes or use dentures. Last dental exam 2016, normal.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies chest pain, palpitation, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – See Hpi. Denies intolerance to specific foods, dysphagia, vomiting, constipation, blood in stone or jaundice. Colonoscopy 2018, normal.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysura, incontinence, awakening at night to urinate or flank pain.

Nervous – Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system – Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.

Endocrine system – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric – Denies depression/sadness, anxiety, OCD or ever seeing a mental health professional.

**Physical Exam:**

General: Well developed, well nourished male, in no acute distress. Alert and cooperative. Appears stated age.

Vital signs: BP: R L

 Seated 142/84 142/82

 Supine 142/80 144/84

 R: 17 breaths/min, unlabored

 P: 92 beats/min, regular

 T: 37.2 degrees C (oral)

 O2 Sat: 97% Room air

 Height 69 inches Weight 190 lbs. BMI: 28.1

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: average quantity and distribution.

Nails: no clubbing, capillary refill <2 seconds throughout.

Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity (uncorrected - 20/20 OS, 20/20 OD, 20/20 OU). Visual fields full OU. PERRLA. EOMs full with no nystagmus. Fundoscopy – not performed.

Nose: Symmetrical / no obvious masses / lesions / deformities / trauma / discharge. 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.

Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.

Oral 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 dental caries noted.

Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.

Tongue: Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.

Oropharynx: Well-hydrated. No injections; exudate; masses; lesions; foreign bodies. 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 and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Flat/ symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all quadrants. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Soft. No tender over abdomen. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: deferred.

Peripheral Vascular: Skin normal in color and warm to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing / edema noted bilaterally.

Neurological:

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 anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopy not performed.

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without 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. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative.

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

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+ 2+/2+ Clonus negative

Meningeal Signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM (Full Range of Motion) of all upper and lower extremities bilaterally. No evidence of spinal deformities.

**Assessment:** 52 y/o male with H/O of HTN, DMII, and HLD c/o fever, chill, epigastric pain, nausea and diarrhea for 10 hours, compatible with diagnosis with gastroenteritis, HTN, DMII and HLD.

**Plan:**

gastroenteritis

- Oral hydration

- Zofran for nausea (4 mg, prn PO)

- Flu shot

HTN

- low salt diet and exercises

- monitor BP

- atacand 16 mg qdaily PO

DMII

- low sugar diet and exercises

- monitor blood sugar

- metformin 500 mg bid PO

HLD

- low fat diet and exercises

- monitor lipid

- lipitor 10 mg qdaily PO

Differential diagnosis based on the chief complaint: Viral Gastroenteritis Amebiasis, Bacterial Gastroenteritis, Campylobacter Infections, Clostridium Difficile Colitis, Escherichia coli (E coli) Infections, Food Poisoning, Giardiasis, Peritonitis and Abdominal Sepsis, Salmonella Infection (Salmonellosis), Shigellosis, Traveller's diarrhea, Urinary tract infection, Constipation with overflow, Gastritis, and Inflammatory bowel disease.

Differential diagnosis after H&P: Viral Gastroenteritis, Bacterial Gastroenteritis

Work up: After treatment, the symptoms were resolved. The diagnosis was proper and the treatment was optimal and prompt.

Follow up: return to clinic if any related symptoms worsen.

Patient education: Gastroenteritis, also known as infectious diarrhea, is inflammation of the gastrointestinal tract—the stomach and small intestine. In 2015, there were two billion cases of gastroenteritis, resulting in 1.3 million deaths globally. Children and those in the developing world are affected the most. It is less common in adults, partly due to the development of immunity. Symptoms may include diarrhea, vomiting and abdominal pain. Fever, lack of energy and dehydration may also occur. This typically lasts less than two weeks. Gastroenteritis is usually caused by viruses. However, bacteria, parasites and fungus can also cause gastroenteritis. In children, rotavirus is the most common cause of severe disease. In adults, norovirus and Campylobacter are common causes. Eating improperly prepared food, drinking contaminated water or close contact with a person who is infected can spread the disease. Treatment is generally the same with or without a definitive diagnosis, so testing to confirm is usually not needed. Prevention includes hand washing with soap, drinking clean water, proper disposal of human waste and breastfeeding babies instead of using formula. The rotavirus vaccine is recommended as a prevention for children. Treatment involves getting enough fluids. For mild or moderate cases, this can typically be achieved by drinking oral rehydration solution (a combination of water, salts and sugar). In those who are breastfed, continued breastfeeding is recommended. For more severe cases, intravenous fluids may be needed. Fluids may also be given by a nasogastric tube. Zinc supplementation is recommended in children. Antibiotics are generally not needed. However, antibiotics are recommended for young children with a fever and bloody diarrhea.