**H&P 1 for AC**

**Identifying Data:**

Full Name: C.D.

Date of Birth: xx/xx/2004

Age: 14 y/o

Sex: Male

Date & Time: 11/14/2019, 11:50 am

Location: Centers Urgent Care, Flushing, NY 11379

Religion: None

Source of Information: Self and Father

Reliability: Reliable

Source of Referral: None

**Chief Complaint:** “fatigue, fever, chill, sore throat, cough, sputum” x 1 day.

**History of Present Illness:**

Mr. D, a 14 y/o male c/o 1 day ago, he had fatigue, fever, chill, nasal congestion, sore throat, cough, and sputum. The sputum is yellow and little amount. He took Motrin (200 mg) and no relief. Denies recent traveling or sick family members. Denies weight loss, night sweats, headache, rashes, chest pain, coughing blood, nausea, vomiting, diarrhea, or bone or joint pain.

**Past Medical History:** Denies

**Past Surgery History:** Denies

**Past Hospitalization History:** Denies

**Immunizations** – Up to date

**Medications:** Denies

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

**Family History:** Non-contributory

**Social History:** Single, living with family. 8th grade in school. Routine exercises include running and soccer. Denies drinking alcohol/caffeine, smoking, or illicit drug use. Denies recent traveling. Regular diet. Denies sleeping problem. Sexually inactive.

**Review of Systems:**

General –Admits fever, chill and fatigue. Denies recent weight loss or gain, loss of appetite, 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 headaches, vertigo or head trauma.

Eyes – Denies pain, redness, swelling, visual disturbances, or photophobia. No glasses. Last eye exam 2018, normal.

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

Nose/sinuses – Admits nasal congestion. Denies discharge, or epistaxis.

Mouth/throat – Admits sore throat. Denies bleeding gums, sore tongue, mouth ulcers, voice changes or use dentures. Last dental exam 2018, normal.

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

Pulmonary system – See Hpi. Denies dyspnea, dyspnea on exertion, 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 –Denies change in appetite, intolerance to specific foods, dysphagia, nausea, vomiting, constipation, diarrhea, or jaundice.

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, fatigued. Alert and cooperative. Appears stated age.

Vital signs: BP: R L

 Seated 114/72 117/75

 Supine 114/72 116/75

 R: 17 breaths/min, unlabored

 P: 108 beats/min, regular

 T: 39.1 degrees C (oral)

 O2 Sat: 97% Room air

 Height 65 inches Weight 123 lbs. BMI: 20.5

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 mild congestion. 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: Erythema. No exudate; masses; lesions or 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 evidence of organomegaly. No masses noted. No tenderness or 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:** 14 y/o male with fatigue, fever, chill, nasal congestion, sore throat, cough, sputum for 1 day along with PE findings, compatible with diagnosis with viral upper respiratory tract infection.

**Plan:**

- Rest

- IVF (NS bolus 1000 ml)

- fever reliever (Tylenol 650 mg q6hrs prn PO)

Differential diagnosis based on the chief complaint: viral upper respiratory tract infection, acute tonsillitis, pneumonia, allergic rhinitis, infectious mononucleosis, otitis media, pediatric retropharyngeal abscess, tuberculosis (TB).

Differential diagnosis after H&P: viral upper respiratory tract infection.

Work up: After treatment, the symptoms were relieved and the patient was discharged. Diagnosis and treatment are proper and timely.

Follow up: after discharge, no follow up.

Patient education: Upper respiratory tract infections (URTI) are illnesses caused by an acute infection which involves the upper respiratory tract including the nose, sinuses, pharynx or larynx. Most infections are viral in nature and in other instances the cause is bacterial. Upper respiratory tract infections can also be fungal or helminth in origin, but these are far less common. Children have 2-9 viral respiratory illnesses per year. Symptoms of URTIs commonly include cough, sore throat, runny nose, nasal congestion, headache, fever, facial pressure and sneezing. Symptoms of rhinovirus in children usually begin 1–3 days after exposure. The illness usually lasts 7–10 more days. Color or consistency changes in mucous discharge to yellow, thick, or green are the natural course of viral upper respiratory tract infection and not an indication for antibiotics. In terms of pathophysiology, rhino virus infection resembles the immune response. The viruses do not cause damage to the cells of the upper respiratory tract but rather cause changes in the tight junctions of epithelial cells. This allows the virus to gain access to tissues under the epithelial cells and initiate the innate and adaptive immune responses. Up to 15% of acute pharyngitis cases may be caused by bacteria, most commonly Streptococcus pyogenes, a group A streptococcus in streptococcal pharyngitis ("strep throat"). Other bacterial causes are Streptococcus pneumoniae, Haemophilus influenzae, Corynebacterium diphtheriae, Bordetella pertussis, and Bacillus anthracis. Sexually transmitted infections have emerged as causes of oral and pharyngeal infections. Diagnosis is made according to symptoms . Vaccination against influenza viruses, adenoviruses, measles, rubella, Streptococcus pneumoniae, Haemophilus influenzae, diphtheria, Bacillus anthracis, and Bordetella pertussis may prevent them from infecting the URT or reduce the severity of the infection. Treatment for viral URTI is anti-symptomatic and for bacteria, antibiotics.