

Example of a Complete History and Physical Write-up

Patient Name:

Unit No:

Location:

Informant: patient, who is reliable, and old CPMC chart.

Chief Complaint: This is the 3rd CPMC admission for this 83 year old woman with a long history of hypertension who presented with the chief complaint of substernal “toothache like” chest pain of 12 hours duration.

History of Present Illness: Ms J. K. is an 83 year old retired nurse with a long history of hypertension that was previously well controlled on diuretic therapy. She was first admitted to CPMC in 1995 when she presented with a complaint of intermittent midsternal chest pain. Her electrocardiogram at that time showed first degree atrioventricular block, and a chest X-ray showed mild pulmonary congestion, with cardiomegaly. Myocardial infarction was ruled out by the lack of electrocardiographic and cardiac enzyme abnormalities. Patient was discharged after a brief stay on a regimen of enalapril, and lasix, and digoxin, for presumed congestive heart failure. Since then she has been followed closely by her cardiologist.

Aside from hypertension and her postmenopausal state, the patient denies other coronary artery disease risk factors, such as diabetes, cigarette smoking, hypercholesterolemia or family history for heart disease. Since her previous admission, she describes a stable two pillow orthopnea, dyspnea on exertion after walking two blocks, and a mild chronic ankle edema which is worse on prolonged standing. She denies syncope, paroxysmal nocturnal dyspnea, or recent chest pains.

She was well until 11pm on the night prior to admission when she noted the onset of “aching pain under her breast bone” while sitting, watching television. The pain was described as “heavy” and “toothache” like. It was not noted to radiate, nor increase with exertion. She denied nausea, vomiting, diaphoresis, palpitations, dizziness, or loss of consciousness. She took 2 tablespoon of antacid without relief, but did manage to fall sleep. In the morning she awoke free of pain, however upon walking to the bathroom, the pain returned with increased severity. At this time she called her daughter, who gave her an aspirin and brought her immediately to the emergency room. Her electrocardiogram on presentation showed sinus tachycardia at 110, with marked ST elevation in leads I, AVL, V4-V6 and occasional ventricular paroxysmal contractions. Patient immediately received thrombolytic therapy and cardiac medications, and was transferred to the intensive care unit.

Current Regimen

Digoxin 0.125mg once daily

Enalapril 20mg twice daily

Lasix 40mg once every other day

Kcl 20mg once daily

Tylenol 2 tabs twice daily as needed for arthritis

Past Health

General: Relatively good

Infectious Diseases: Usual childhood illnesses. No history of rheumatic fever.

Immunizations: Flu vaccine yearly. Pneumovax 1996

Allergic to Penicillin-developed a diffuse rash after an injection 20 years ago.

Transfusions: 4 units received in 1980 for GI hemorrhage, transfusion complicated by Hepatitis B infection.

Hospitalizations, Operations, Injuries:

1) Normal childbirth 48 years ago

2) 1980 Gastrointestinal hemorrhage, see below

3) 9/1995 chest pain- see history of present illness

4) Last mammogram 1994, Flexible Sigmoidoscopy 1997

Systems Review

1. Constitutional: energy level generally good, weight is stable at 160 lbs, height 5'8"

2. HEENT:

No headaches

Eyes: wears reading glasses but thinks vision getting is worse, no diplopia or eye pain

Ears: hearing loss for many years, wears hearing aid now

Nose: no epistaxis or obstruction

No history of tonsillitis or tonsillectomy

Wears full set of dentures for more than 20 years, works well.

3. Respiratory: No history of pleurisy, cough, wheezing, asthma, hemoptysis, pulmonary emboli, pneumonia, TB or TB exposure

4. Cardiac: See HPI

5. Vascular: No history of claudication, gangrene, deep vein thrombosis, aneurysm.

Has chronic venous stasis skin changes for many years

6. G.I.: Admitted to CPMC in 1980 after two days of melena and hematemesis.

Upper G.I. series was negative but endoscopy showed evidence of gastritis, presumed to be caused by ibuprofen intake. Her hematocrit was 24% on admission and she received four units of packed cells. Colonoscopy revealed multiple diverticuli. Since then her stool has been brown and consistently hematest negative when checked in clinic. Several months after this admission she was noted to be mildly jaundiced and had elevated liver enzymes, at this time it was realized that she contracted hepatitis B from the transfusions. Since then she has not had any evidence of chronic hepatitis.

7. GU: History of several episodes of cystitis, most recently E Coli 3/1/90, treated with Bactrim. Reports dysuria in the 3 days prior to hospitalization. No fever, no hematuria. No history of sexually transmitted disease. Menarche was at 15, menstrual cycles were regular interval and duration, menopause occurred at 54. Seven pregnancies with 5 normal births and 2 miscarriages.

8. Neuromuscular: Osteoarthritis of the both knees, shoulder, and hips for more than 20 years. Took ibuprofen until 1980, has taken acetaminophen since her GI bleed, with good relief of intermittent arthritis pain.

There is no history of seizures, stroke, syncope, memory changes.

9. Emotional: Denies history of depression, anxiety.

10. Hematological: no known blood or clotting disorders.

11. Rheumatic: no history of gout, rheumatic arthritis, or lupus.

12. Endocrine: no known diabetes or thyroid disease.

13. Dermatological: no new rashes or pruritis.

Personal History

1. Mrs. Johnson is widowed and lives with one of her daughters.

2. Occupation: she worked as a nurse to age 67, is now retired.

3. Habits: No cigarettes or alcohol. Does not follow any special diet.

4. Born in South Carolina, came to New York in 1931. she has never been outside of the United States.

5. Present environment: lives in a one bedroom apartment on the third floor of a building with and elevator. She has a home helper who comes 3 hours a day.

6. Financial: Receives social security and Medicare, and is supported by her children.

7. Psychosocial: The patient is generally an alert and active woman despite her arthritic symptoms. She understands that she is having a "heart attack" at the present time and she appears to be extremely anxious.

Family History

The patient was brought up by an aunt; her mother died at the age of 36 from kidney failure; her father died at the age of 41 in a car accident. Her husband died 9 years ago of seizures and pneumonia. She had one sister who died in childbirth.

She has 4 daughters (ages 60, 65, 56, 48) who are all healthy, and had a son who died at the age of 2 from pneumonia. She has 12 grandchildren, 6 great grandchildren and 4 great, great grandchildren. There is no known family history of hypertension, diabetes, or cancer.

Physical Exam

1. Vital Signs: temperature 100.2 Pulse 96 regular with occasional extra beat, respiration 24, blood pressure 180/100 lying down
2. Generally a well developed, slightly obese, elderly black woman sitting up in bed, breathing with slight difficulty. She complains of resolving chest pain.
3. HEENT:
 - Eyes: extraocular motions full, gross visual fields full to confrontation, conjunctiva clear. sclerae non-icteric, pupils equal round and reactive to light and accommodation, fundi not well visualized due to possible presence of cataracts.
 - Ears: Hearing very poor bilaterally. Tympanic membrane landmarks well visualized.
 - Nose: No discharge, no obstruction, septum not deviated.
 - Mouth: Complete set of upper and lower dentures. Pharynx not injected, no exudates. Uvula moves up in midline. Normal gag reflex.
4. Neck: jugular venous pressure 8cm, thyroid not palpable. No masses.
5. Nodes: No adenopathy
6. Chest: Breasts: atrophic and symmetric, nontender, no masses or discharges. Lungs: bibasilar rales. No dullness to percussion. Diaphragm moves well with respiration. No rhonchi, wheezes or rubs.
7. Heart: PMI at the 6th ICS, 1 cm lateral to MCL. No heaves or thrills. Regular rhythm with occasional extra beat. Normal S1, S2 narrowly split; positive S4 gallop. A grade II/VI systolic ejection murmur is heard at the left upper sternal border without radiation. Pulses are notable for sharp carotid upstrokes.

Pulses:	Carotid	brachial	radial	femoral	DP	PT
R	2+	2+	2+	2+	1+	0
L	2+	2+	2+	2+	1+	0
8. Spine: mild kyphosis, mobile, nontender, no costovertebral tenderness
9. Abdomen: soft, flat, bowel sounds present, no bruits. Nontender to palpation. Liver edge, spleen, kidney not felt. No masses. Liver span 10cm by percussion.
10. Extremities: skin warm and smooth except for chronic venous stasis changes in both legs. 1+ edema to the knees, non-pitting and very tender to palpation. No clubbing nor cyanosis.
11. Neurological: Awake, alert and fully oriented. Cranial nerves III-XII intact except for decreased hearing. Motor: Strength not tested, patient moves all extremities. Sensory: Grossly normal to touch and pin prick. Cerebellar: no tremor nor dysmetria. Reflexes symmetrical 1+ through out, no Babinski sign.
12. Pelvic: deferred until patient more stable.
13. Rectal: Prominent external hemorrhoids. No masses felt. Stool brown, negative for blood

Labs

WBC 12,400 Hgb 12.0 Hct 38.0 MCV 80.0 Plts 218,000 Retic 1.3 Diff Na 143
K4.1 C1 103 CO₂29 Glu 102 BUN 9 Creat 0.8; T bili 0.5 Dbili 0.1
Alk Phos 155 AST 55 ALT 26 LDH 274 CPK 480, MB fraction positive,
Troponin 25
U/A Sp Gr 1.008 pH 6.5 2+ Alb many WBC many RBC 3+ bact
ABG pH 7.46 pCO₂34 PO₂84 O₂Sat 98% (room air)
EKG NSR 96, ST elevations I, AVL, V4-V6; rare unifocal VPC's
CXR portable AP, probable cardiomegaly, mild PVC

(*Note: In the Physical Diagnosis Course the labs will not generally be a part of the write-ups, as the chart is not usually available to the students)

Formulation

This 83 year old woman with a history of congestive heart failure, and coronary artery disease risk factors of hypertension and post-menopausal state presents with substernal chest pain. On exam she was found to be in sinus tachycardia, with no JVD, but there are bibasilar rales and pedal edema, suggestive of some degree of congestive heart failure. There were EKG changes indicate an acute anterolateral myocardial infarction, and the labs shows elevation of CPK and troponin.

Impression

1. Acute anterolateral myocardial infarction, complicated by mild left ventricular dysfunction. Patient has received thrombolysis therapy.
2. Hypertension
3. Dysuria - 3+ bacteria in urine with pyuria

Plan

1. Continue aspirin, heparin, nitrates, beta blockers, nasal oxygen. Follow serial physical exams, EKGs, and labs.
2. Obtain echocardiogram to assess post MI heart function and murmurs heard on cardiac exam. If LV ejection fraction is preserved, to start early beta blocker therapy.
3. Continue ACE inhibitor therapy, and monitor blood pressure.
4. Dysuria and pyuria- probable recurrent cystitis, as she is afebrile and without costovertebral tenderness. Start Bactrim treatment for presumed uncomplicated urinary tract infection and follow up on urine culture result.