

## Example of a Complete History and Physical Write-up

Patient Name:

Unit No:

Location:

**Informant:** patient, who is reliable, and old CUMC chart.

**Chief Complaint:** This is the 2nd CUMC admission for this 83 year old woman with a long history of hypertension who presented with the chief complaint of substernal “pressure”-like chest pain of 4 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. She was first admitted to CUMC in 2003 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 refused further cardiac stress testing at that admission. Patient was discharged after a brief stay on a regimen of lisinopril, metoprolol, and lasix for presumed congestive heart failure. Since then, she has been followed closely by her primary care physician in Washington Heights, Dr. Mejia (212-123-9000).

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 at this state of health until 6 pm on the night prior to admission when she noted the onset of “pressure in the middle of her chest” at rest, while watching television. The pain was described as “heavy” and “painful”. 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 abate after a half hour. However, over the next four hours, she noted this pain was intermittent and increased in severity when walking to the bathroom. 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 100, with ST depressions in leads I, AVL, V4-V6 and occasional ventricular paroxysmal contractions. The patient received aspirin, IV heparin, and beta-blockers in the ER and cardiology consult was called.

### Allergies

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

### Current Medications

Metoprolol 25 mg twice daily

Lisinopril 10 mg daily

Lasix 40mg once every other day

Kcl 20mg once daily

### Past Medical History

Childhood illnesses. No history of rheumatic fever.

Immunizations: Flu vaccine yearly. Pneumovax 2006

Transfusions: 4 units received in 1985 for GI hemorrhage secondary to PUD

Ob-gyn history: Menarche was at 15, menstrual cycles were regular interval and duration, menopause occurred at 54. Seven pregnancies with 5 normal births and 2 miscarriages.

Diagnoses:

1. Upper GI bleed secondary to PUD thought to be related to NSAID use in 1985, s/p 2 units PRBC transfusion. No recurrence since being off NSAIDs.
2. Hypertension: well controlled on lasix and metoprolol and lisinopril
3. 9/2003 chest pain- see history of present illness
4. Health Care Maintenance: Last mammogram 2001 Birads 1, Colonoscopy 2000 normal, last pap smear negative in 1999.

**Surgical History**

none

**Review of Systems**

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,
4. Cardiac: See HPI
5. Vascular: No history of claudication, gangrene, deep vein thrombosis, aneurysm.
6. G.I.: no abdominal pain, diarrhea, constipation, melena, or brbpr.
7. GU: Reports dysuria in the 3 days prior to hospitalization. No fever, no hematuria. No sexually transmitted diseases.
8. Neuromuscular: no seizures, stroke, syncope, or memory changes.
9. Emotional: Denies history of depression, anxiety.
10. Hematological: no bleeding or clotting problems.
11. Rheumatic: no joint pains or complaints
12. Endocrine: no wt changes, heat or cold intolerance, polydipsia or polyphagia
13. Dermatological: no new rashes or pruritis.

**Social 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 attendant who comes 3 hours a day and helps with cooking and cleaning
6. Financial: Receives Medicaid and Medicare, and is also supported by her children.
7. Psychosocial: The patient is generally an alert and active woman without any history of violence in the home or psychiatric problems.

**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 98.7 Pulse 96 regular with occasional extra beat, respiration 24, blood pressure 160/90 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 6<sup>th</sup> 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+      | 2+ | 1+ 0 |
| L       | 2+      | 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 CO<sub>2</sub>29 Glu 102 BUN 9 Creat 0.8; T bili 0.5 Dbili 0.1

Alk Phos 155 AST 55 ALT 26 LDH 274 CPK 380, MB fraction positive, Troponin 4.2

U/A Sp Gr 1.008 pH 6.5 2+ Alb many WBC many RBC 3+ bact

ABG pH 7.46 pCO<sub>2</sub>34 PO<sub>2</sub>84 O<sub>2</sub>Sat 98% (room air)

EKG NSR 96, 1.5 mm ST depressions I, AVL, V4-V6; rare unifocal VPC's ; these depressions are new compared to an EKG 1 yr ago.

CXR portable AP, probable cardiomegaly, mild PVC

(\*Note: In the Foundations of Clinical Medicine course, the labs will not generally be a part of the write-ups, as the chart is not usually available to the students. We will have exercises at the end of the year when you will be asked to include laboratory values.)

### Assessment

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. The EKG shows new ST depressions in the anteriolateral leads and the labs shows elevations of CPK and troponin.

The differential diagnosis for acute chest pain include myocardial infarction, pneumonia, pulmonary embolism and gastrointestinal disorders such as peptic ulcer disease or gastroesophageal reflux disease.

The absence of typical signs of pneumonia such as productive cough, fever, and pulmonary infiltrates lowers pneumonia on the differential. Though the patient had a distant history of GI disease, the pain did not vary with food intake, thus lowering the likelihood of PUD or GERD. Likewise the absence of risk factors for DVT or PE and absence of signs or symptoms consistent with DVT or PE such as calf swelling or pain lowers this diagnosis on the differential. Most importantly, however, given the symptoms typical for angina, the risk factors for CAD, and findings on EKG (new ST depressions) and labs (elevated troponin and CPK), an acute non-ST Elevation MI complicated by left ventricular dysfunction is the leading diagnosis.

### **Plan**

1. NonST Elevation MI: Continue aspirin, heparin, nitrates, beta-blockers, nasal oxygen. Follow serial physical exams, EKGs, and labs. Cardiology consult service is currently seeing the patient – to discuss with patient and family regarding obtaining a left heart catheterization.
2. Congestive heart failure: 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. Hypertension: Continue ACE inhibitor therapy, and monitor blood pressure.
4. Dysuria and pyuria- probable cystitis, as she is afebrile and without costovertebral tenderness. Start cefuroxime treatment (based on local susceptibilities at CUM per Division of Infections Diseases) for presumed uncomplicated urinary tract infection and follow up on urine culture result.