CUNY York College Physician Assistant Program
Winter 2020
Mariyanthie Linaris
Family Medicine Rotation – SSS Family Medicine

History and Physical

Identifying Data:
Name: DL
Age: 7 years 6 months
Date of Birth: 7/21/2012
Nationality: African American
Date: 1/27/2020
Location: SSS Family Medicine – Jamaica, New York
Source of Referral: None
Source of Information: Mother - Reliable
Mode of Transport: Ambulatory

Chief Complaint:
Fever x 1 day

History of Present Illness:
DL is a 7 year old African American female with a significant past medical history of enlarged adenoids and chronic sinusitis who is brought to the office by her mother presenting with a fever (Tmax = 101.1 F) for 1 day. Her mother reports that DL woke up feeling fine and that the fever started suddenly, making her lethargic. She gave DL Children's Tylenol once last night and the fever subsided, but it spiked up again a few hours later. DL did not take any other fever-reducing medications since then. She also reports 2 episodes of vomiting, loss of appetite, sore throat, and nasal congestion. She is tolerating liquids but has shown no interest in eating solid foods. She denies body aches, diarrhea, constipation, coughing, wheezing, chest pain, palpitations, dysuria, urinary urgency or frequency, sick contacts, recent travel, and any other symptoms. She received the influenza vaccination in October, 2019.

Past Medical History:
Present illness:
1. Enlarged adenoids x 3 years
    a. Cause "breathing issue" with sleep → Sleep study conducted without abnormal results

Past illness:
Denies any past illnesses

Hospitalizations:
Denies any hospitalizations

Immunizations:
- All childhood immunizations up to date for her age group
- Influenza vaccination annually → October 2019

Past Surgical History:
Denies any past surgeries, injuries, or blood transfusions

Medications:
DL does not take any prescription medications or over-the-counter supplements on a daily basis

Allergies:
Denies any known allergies to medications, foods, or environmental factors

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Family History:

- Mother – Alive; denies history of hypertension, diabetes, hyperlipidemia, cancer, or any other medical problems
- Father - Alive; denies history of hypertension, diabetes, hyperlipidemia, cancer, or any other medical problems
- Sister – Alive, 14 years old; history of asthma
- DL's mother denies any knowledge of DL's grandparents' health status

Social History:

Travel:

Denies any recent travel

Home:

Lives at home with both parents and her sister

Diet:

Eats a balanced died and drinks mostly water; has lost appetite since symptom onset

Sleep:

Sleeps 8 hours per night

Safety:

Uses all appropriate safety measures.

Review Of Symptoms:

General:

Reports fever (Tmax = 101.1 F), chills, lethargy, weakness, and loss of appetite x 1 day. She denies night sweats and recent weight changes.

Skin, hair, nails:

She denies any changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution.

Head:

She denies any headache, vertigo, head trauma, loss of consciousness, coma, or fracture.

Eyes:

She denies the use of corrective lenses, visual disturbances, lacrimation, photophobia, or pruritus. Her last eye exam was a few months ago at school.

Ears:

She denies any hearing loss, ear pain, discharge, tinnitus, or use of hearing aids.

Nose/Sinuses:

DL has a history of enlarged adenoids and chronic sinusitis. She currently reports nasal congestion with clear discharge. She denies any epistaxis or obstruction.

Mouth and throat:

She reports a sore throat for 1 day. She denies any bleeding gums, sore tongue, mouth ulcers, voice changes, or use of dentures.

Neck:

She denies any localized swelling/lumps, stiffness, or decreased range of motion.

Pulmonary:

She denies any dyspnea, shortness of breath, coughing, wheezing, hemoptysis, cyanosis, orthopnea, or PND.

Cardiovascular:

She denies any chest pain, history of hypertension, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal:

She reports 2 episodes of vomiting 1 day ago and loss of appetite. She denies any intolerance to foods, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool, or flank pain.

Genitourinary:

She denies any dysuria, hematuria, or urinary frequency/urgency.

Physical Exam:

Vital Signs:

Blood Pressure:

103/68 (right arm, sitting)

Heart Rate:

134 beats/minute (regular)

Respiration Rate:

16 breaths/minute (non-labored)

Temperature:

101.1 F (oral)

Height:

52 in

Weight:

54 lbs

BMI:

14.04

General Appearance:

7 year old female, well nourished, appears her age; alert and oriented x 3. She appears lethargic, but in no acute distress.

Ears:

Symmetrical and normal size. No evidence of lesions/ masses/ trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TMs pearly gray and intact with light reflex in the normal position AU.

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Nose:

Symmetrical no obvious masses/ lesions/deformities/ trauma/discharge. Nares patent bilaterally. Nasal mucosa pink & well hydrated. Clear discharge noted on anterior rhinoscopy. Septum midline without lesions/ deformities/injection/perforation. No evidence of foreign bodies.

Sinuses:

Nontender to palpation and percussion over bilateral frontal and maxillary sinuses.

Mouth and Pharynx:

Lips: pink, moist, no evidence of cyanosis or lesion.
Mucosa: pink; well hydrated. No masses. Lesions noted. No evidence of leukoplakia
Palate: pink, well hydrated. Palate intact with no lesions, masses, scars.
Teeth: good dentition; no obvious dental caries noted. She has no loose teeth.
Gingiva: pink, moist, no evidence of hyperplasia, masses, lesions, erythema or discharge.
Tongue: pink, well papillated. No masses, lesions or deviation noted.
Oropharynx: Pharynx edematous and erythematous; tonsils enlarged bilaterally with exudates visualized. No lesions or foreign bodies. Uvula pink and raises symmetrically.

Neck:

Trachea midline. No masses, lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender without palpable masses or thyromegaly.

Chest:

Symmetrical, no deformities or signs of trauma. Respiration unlabored/ no parodoxic respiration or use of accessory muscles noted. Lateral : AP diameter 2:1. Non-tender to palpation.

Lungs:

Clear to auscultation bilaterally without rales, rhonchi, wheezes, or any other adventitious lung sounds.

Cardiovascular:

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 4 quadrants. Tympanic to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Work-Up:

1. Rapid Strep Test
    a. Positive
2. Rapid Influenza Test
    a. Negative

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Assessment:

7 year old female presents complaining of fever and sore throat x 1 day. Physical exam findings and rapid strep test are consistent with streptococcal pharyngitis and allergic rhinitis.

Plan:

1. Streptococcal Pharyngitis
    a. Amoxicillin 400 mg/ 5 mL oral suspension
        i. 6 mL PO BID x 10 days
    b. Ibuprofen 100 mg/ 5 mL oral suspension
        i. 10 mL PO Q 8 hours PRN x 7 days for fever
    c. Drink plenty of fluids
        i. Pedialyte recommended
    d. Return to the office or go to the ED if symptoms persist or worsen
2. Enlarged adenoids/ chronic sinusitis
    a. Referred to ENT specialist for further evaluation