CUNY York College Physician Assistant Program
Fall 2020
Mariyanthie Linaris
Emergency Medicine Rotation – New York Presbyterian/Queens Hospital

History and Physical 1

Identifying Data:

- *Name:* CSG
- *Sex:* Male
- *Age:* 30 years
- *Date and Time:* 10/23/2020, 8:00 AM
- *Location:* New York Presbyterian/Queens Hospital, Emergency Department
- *Source of Information:* Self

Chief Complaint:

Right elbow pain x 3 weeks

History of Present Illness:

CSG is a 30-year-old Hispanic male with a significant past medical history of right renal carcinoma s/p right partial nephrectomy, IV drug use (methamphetamine), and anxiety who presented to the ED complaining of constant, throbbing right elbow pain x 3 weeks. He reports that he noticed a new wound in the area of his pain 2 days ago with significant worsening over the last day. He endorsed pain, swelling, erythema, and purulent drainage over the last 2 days. He took ibuprofen for little relief. Touching the elbow aggravates his pain and nothing alleviates it. He denies pain radiation. He admits that he began having the pain after injecting methamphetamine in his right antecubital region. He had similar symptoms in his left elbow in the past after injecting methamphetamine and was admitted to the NYPQ for IV antibiotic treatment. He denies fever, chills, body aches, shortness of breath, chest pain, cough, change in strength in his arm, and decreased range of motion in his arm. He came in today because he perceived his pain to be worse and wanted to get it checked out.

Past Medical History:

- *Present Illnesses:*
  1. IV drug use
     a. Methamphetamine – last used last night
- *Past Illnesses:*
  1. Right renal carcinoma – 2010
     - S/p right partial nephrectomy
  2. Abscess of left elbow – 2019
- *Hospitalizations*:
  1. Hospitalized at NYPQ in 2019 for IV antibiotic therapy for left elbow abscess secondary to IV drug use
  2. Hospitalized at unknown hospital for right partial nephrectomy
- *Immunizations*:
  - Childhood immunizations up to date
  - Receives annual influenza vaccination

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Past Surgical History:

- Right partial nephrectomy – 2010
    - Unable to recall where or who the surgeon was
    - Denies post-procedure complications

Medications:

- CSG denies taking any medications on a daily basis

Allergies:

CSG denies any known allergies to medications, foods, or environmental factors

Family History:

Noncontributory.

Social History:

CSG is a 30-year-old currently unemployed male who lives alone in an apartment. He reports that he has a lot of family but does not maintain contact with them because they "judge" him. He admits to daily IV methamphetamine use and reports that he last injected into his left foot last night. He also admits to vaping and social alcohol use. He is currently sexually active with men and reports occasional condom use. He has been treated for STIs in the past but was unwilling to disclose further information. He denies recent travel.

Review of Systems:

General:

Denies fever, chills, night sweats, fatigue, weakness, loss of appetite, and recent weight gain or loss

Skin, hair, nails:

Reports a new wound on his right elbow with purulent drainage. Denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, changes in hair distribution

Head:

Denies headache, vertigo, head trauma, unconsciousness, coma, fracture

Eyes:

Denies use of contacts lenses or glasses, visual disturbances, fatigue, lacrimation, photophobia, and pruritus. He reports that his last vision check was last year

Ears:

Denies deafness, pain, discharge, tinnitus, and use of hearing aids

Nose/Sinuses:

Denies discharge, epistaxis, and obstruction

Mouth and throat:

Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, and use of dentures. Reports that he has not seen a dentist in "a while"

Neck:

Denies localized swelling/lumps, stiffness, and decreased range of motion

Pulmonary:

Denies dyspnea, SOB, cough, wheezing, hemoptysis, cyanosis, orthopnea, and PND

Cardiovascular:

Denies chest pain, palpitations, irregular heartbeat, syncope, and known heart murmur

Gastrointestinal:

Denies changes in appetite, intolerance to foods, nausea and vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, change in bowel habits, hemorrhoids, constipation, rectal bleeding, and blood in stool. He has never had a colonoscopy

Genitourinary:

Denies urinary frequency, changes in color of urine, incontinence, dysuria, nocturia, urgency, and oliguria.

Musculoskeletal:

Reports right elbow swelling, pain, and erythema. Denies other muscle/joint pain, deformity, and arthritis

Peripheral Vascular:

Denies intermittent claudication, coldness, and color changes

Hematologic:

Denies anemia, easy bruising or bleeding, lymph node enlargement, and history of DVT/PE

Endocrine:

Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, and goiter.

Nervous System:

Denies seizures, loss consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, and weakness

Psychiatric:

History of anxiety. Denies feelings of depression/sadness, anhedonia, obsessions, compulsions, and visual/auditory hallucinations. He has seen a psychiatrist in the past but does not currently follow with one.

Physical Exam:

Vital Signs:

Blood Pressure: 119/71 (left arm, sitting)
Heart Rate: 65 beats/minute (regular)
Respiration Rate: 22 breaths/minute (nonlabored)
Temperature: 98.8 F (oral)
O_2 Sat: 96% (room air)
Height: 69 inches
Weight: 135 lbs
BMI: 19.9

General Appearance:

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30-year-old well-nourished male seen sitting up in bed. He is well-appearing. Alert and oriented x 3. Calm and superficially cooperative; follows commands and answers all questions. In no acute distress.

Skin:

Evidence of IV drug use bilaterally on dorsal side of forearms and antecubital regions and on the tops of his feet. 1 cm diameter, well-circumscribed circular wound on medial side of right elbow with surrounding erythema and edema. No purulent drainage noted on exam. Tenderness illicited on palpation of the affected area. No induration on palpation. Affected area warm to the touch. Healed wound on medial surface of left elbow. All other skin unremarkable; warm and moist with good turgor and no discoloration throughout.

Nails:

No clubbing or signs of infection; capillary refill <2 seconds throughout

Chest:

Symmetrical without deformities or signs of trauma. Respiration unlabored and without use of accessory muscles. Lateral : AP diameter 2:1. Non-tender to palpation.

Lungs:

Clear to auscultation bilaterally without adventitious lung sounds.

Cardiovascular:

Regular rate and rhythm. S1 and S2 present. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs, or other extra sounds. Carotid pulses are 2+ bilaterally without bruits.

Abdomen:

Flat and symmetrical without 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.

Peripheral Vascular:

Extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally.

Musculoskeletal:

Edema and erythema surrounding wound on right elbow (see Skin exam). Mild tenderness to palpation of the right elbow. All other extremities unremarkable and without deformity. FROM of upper and lower extremities bilaterally. Muscle strength 5/5 throughout. Sensation intact throughout.

Labs:

- POC ultrasound of right elbow
  - Cobble stoning without obvious drainable abscess
- X-ray of right elbow
  - Negative for fracture or gas under skin
- CBC
  - Mild leukocytosis
- CMP
  - Within normal limits

- COVID-19 swab
    - Negative

Assessment:

CSG is a 30-year-old Hispanic male with a significant past medical history of right renal carcinoma s/p right partial nephrectomy, IV drug use (methamphetamine), and anxiety who presented to the ED complaining of constant, throbbing right elbow pain x 3 weeks. Physical exam, imaging, and labs are suggestive of cellulitis of the right elbow. In no acute distress

Differentials:

1. Cellulitis
2. Abscess
3. Septic arthritis
4. Bursitis
5. Gout
6. Pseudogout

Plan:

1. Cellulitis of right elbow secondary to IV drug use
    a. Admit to inpatient medicine for IV antibiotic treatment
        i. OPAT is a poor option for this patient due to his history of IV drug use
        ii. Consult with nephrology due to history of right renal carcinoma s/p partial nephrectomy
    b. Tylenol for pain control
        i. Reassess pain needs with inpatient service
    c. Repeat labs daily to monitor improvement
    d. Infectious disease consultation
2. IV methamphetamine use
    a. Monitor for signs of methamphetamine withdrawal
    b. Patient educated in ED about risks of IV drug use
3. Full diet as tolerated
4. Monitor vitals as per floor protocol
5. Encouraged to bring up any questions and concerns with facility staff
6. Full code

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SOAP Note 1

Identifying Data

Name: MAS
Age: 33 years
Race: Latina
Date & Time: 11/1/2020, 11:00 AM
Location: New York Presbyterian/Queens Hospital, Emergency Department
Source of Referral: None
Source of Information: Self
Mode of Transport: Personal vehicle

S:

MAS is a 33-year-old G2P1001 female with a significant past medical history of HPV infections presenting to the ED complaining of suprapubic pain x 4 days and an episode of vaginal bleeding last night. She describes the pain as an 8/10 aching in the central suprapubic area that does not radiate. The pain is worse with urination, during which she also has a burning sensation. She admits that the pain resolves with Tylenol (last dose last night). She endorses now resolved vaginal bleeding last night and reports that she used 1 sanitary pad last night for the bleeding. She denies any clot passage during the bleeding episode. She estimates that she is about 10 weeks pregnant based on her LMP (8/20/2020) following a positive home pregnancy test and positive urine hCG at a local clinic. This is her second pregnancy; her first pregnancy was uncomplicated and she carried it to term and delivered via NSVD. She did not have any of her current symptoms during her first pregnancy. She has not had any OB follow-up due to her current uninsured status and has not been taking prenatal vitamins. She admits to having UTIs in the past and notes that the urinary symptoms she is having feel similar to past UTIs. She denies fever, chills, nausea, vomiting, diarrhea, chest pain, SOB, abnormal vaginal discharge, hematuria, blood in her stool, headache, back pain, sick contacts, or any other symptoms.

PMHx:
Denies
PSHx:
Denies
Allergies:
No known allergies to medications, foods, or environmental factors
Medications:
Does not take any daily medications, vitamins, or herbal supplements
FHx:
Non-contributory

O:

Vitals:

- BP – 121/77, right arm (supine)
- HR – **100 beats/minute, regular**

- RR – 18 breaths/minute, non-labored
- Temperature – 36.4 C, oral
- SpO2 – 97%, room air
- Height – 5”4’
- Weight – 165 lbs
- BMI – 28.3

Physical Exam:

General:

A&O x 3; well-appearing, sitting comfortably in stretcher. Calm and cooperative. Answers all questions appropriately. In no acute distress.

Skin:

No pallor or discolorations observed. Skin warm and moist throughout with appropriate turgor throughout. No concerning lesions noted one exam

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Abdomen nondistended without observable masses or abnormal pulsations. BS present in all 4 quadrants. Abdomen soft with mild tenderness to palpation in the central suprapubic area. Appendiceal signs negative. No CVAT elicited bilaterally.

Labs:

```
          12.9
9.83) --------- ( 174
          37.9

  139 | 104 | 11.5
-----------------------< 109
  3.6 |   23 | 0.47
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UA negative

Serum hCG – 14,000

T&S – A positive

Transvaginal ultrasound – Gestational sac visualized with yolk sac. Small subchorionic hemorrhage present

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A:

MAS is a 33-year-old G2P1001 female with a significant past medical history of HPV infections presenting to the ED complaining of suprapubic pain x 4 days and an episode of vaginal bleeding last night. Ultrasound findings are suggestive of a subchorionic hemorrhage.

Differentials:

1. Ectopic pregnancy
2. Spontaneous abortion
3. Threatened abortion
4. Subchorionic hemorrhage
5. UTI

Plan:

1. Subchorionic hemorrhage
    a. OB/GYN consulted
    b. Patient connected with Patient Navigator to set up PMD and outpatient OB follow-up
    c. Instructed to follow-up with OB/GYN in 1 week
    d. Return to the ED if the pain significantly worsens or in the setting of severe bleeding
    e. Patient provided with information on subchorionic hemorrhage
2. Dysuria
    a. UA negative, but treated for UTI with Macrobid 100 mg BID x 7 days
    b. Take Tylenol for pain
    c. Educated on UTI risk factors
3. First trimester pregnancy
    a. Instructed to follow-up with outpatient OB/GYN for prenatal care
    b. Educated on prenatal vitamin use

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SOAP Note 3

Identifying Data:

Name: MV
Age: 25 years
Race: Latino
Date & Time: 11/10/2020, 12:00 PM
Location: New York Presbyterian/Queens Hospital, Emergency Department
Source of Referral: None
Source of Information: Self
Mode of Transportation: EMS

S:

MV is a 25-year-old male with no significant past medical history who presents to the ED brought in by EMS complaining of a laceration on his right lower leg x 3 hours. He reports that he was cutting tiles at his construction job with a metal grinder when it slipped and cut his leg through his jeans. He did not clean the wound out at the time and has not taken any medication for pain. Currently, he complains of 7/10 throbbing pain in the right lower extremity that is aggravated by movement and palpation of the wound. He denies numbness or tingling of the right lower extremity, history or family history of bleeding disorders, use of anticoagulants, fever, chills, chest pain, SOB, or any other symptoms. He denies known foreign bodies in the wound. He is unable to recall when he had his last tetanus booster.

PMHx:
Denies
PSHx:
Denies
Allergies:
No known allergies to medications, foods, or environmental factors
Medications:
Does not take any daily medications, vitamins, or herbal supplements
FHx:
Non-contributory

O:

Vitals:
Temperature: 37.1 C, oral
HR: 83 beats/min, regular
BP: 112/72, right arm (sitting)
RR: 17 breaths/minute, nonlabored
SpO2: 98%, room air

Physical exam:

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General:

25-year-old well-nourished male; A&O x 3, seen sitting up in stretcher. Generally well-appearing with laceration to left lower leg. In no acute distress.

Skin:

No pallor or discoloration noted. Skin warm and moist with good turgor throughout. **8 cm long and 4 cm wide L-shaped laceration to the anteromedial aspect of the right lower leg with lateral side skin flap with exposed subcutaneous tissue; no foreign body or bone fragments visualized. Currently oozing blood at distal edge of wound. Mild skin maceration at the proximal edge of the wound. Tender to palpation surrounding the laceration.** Sensation to light touch intact throughout. Capillary refill < 2 seconds throughout in upper and lower extremities.

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Abdomen flat and nondistended. No obvious masses, lesions, or pulsations observed. BS+ in all 4 quadrants. Soft and nontender to palpation throughout.

Musculoskeletal:

See skin exam for laceration findings. No bony deformities noted throughout. No evidence of muscle or tendon involvement in the laceration. 5/5 muscle strength in upper and lower extremities with FROM throughout.

Peripheral Vascular:

No edema, cyanosis, or erythema noted throughout. Pulses 2+ throughout in upper and lower extremities. Blood oozing slowly from distal end of wound.

Imaging:

X-ray of right lower leg negative for fracture or foreign bodies in wound space

A:

MV is a 25-year-old male with no significant past medical history who presents to the ED brought in by EMS complaining of a laceration on his right lower leg x 3 hours. X-ray was negative for fracture and foreign bodies. 8 cm L-shaped laceration without muscle or tendon involvement requiring repair using sutures.

Differentials:

1. Laceration (simple)
2. Open fracture of the tibia

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P:

1. Laceration, right lower leg
    a. Wound irrigated with saline
    b. 12.5 cc of 2% lidocaine injected at wound borders for local anesthesia
    c. Laceration repair performed using 5-0 ethilon sutures
        i. 2 vertical mattress sutures and 10 simple interrupted sutures
        ii. Covered with sterile gauze dressing
    d. Instructed to return to NYPQ in 10-14 days for suture removal
    e. Augmentin 500 mg/125 mg BID x 7 days for infection prophylaxis
    f. PO Tylenol given for pain
    g. Tetanus immunization administered
        i. Patient educated on potential side effects of the immunization and when his next booster should be
2. Educated on workplace safety (safety goggles, gloves)
3. Instructed to return to the ED if he develops signs of infection (fever, worsening pain, oozing from the wound, etc.)

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SOAP Note 4

Identifying Data:

Name: JP
Age: 64 years
Race: Caucasian
Date & Time: 11/9/2020, 1:00 PM
Location: New York Presbyterian/Queens Hospital, Emergency Department
Source of Referral: None
Source of Information: Self

S:

JP is a 64-year-old Caucasian former smoker (40 pack years) male with a significant past medical history of HTN and T2DM who presents complaining of right eye blurriness and dizziness x 3 hours. He reports that he was shaving when his symptoms started and they have been constant since then with some mild improvement of the blurriness. He reports that he normally wears glasses but does not have them with him. His dizziness has since resolved, but he notes that it felt like the room was spinning around him. He denies fever, chills, eye pain, double vision, changes in speech, unsteadiness on walling, changes in sensation, headache, nausea, vomiting, diarrhea, chest pain, SOB, or any other symptoms. He reports that he takes metoprolol (last dose last night) and amlodipine (last dose this morning) for HTN, but that his baseline systolic blood pressure typically runs around 180. He has never experienced these symptoms before. Stoke code activated.

PMHx:

1. Hypertension
2. Type 2 Diabetes Mellitus

PSHx:

1. Bilateral knee replacements (2017, 2018)
2. Orchiopexy in childhood

Allergies:

No known allergies to medications, foods, or environmental factors

Medications:

1. Metoprolol 200 mg QD
2. Amlodipine/Benazepril 10 mg/40 mg QD
3. Simvastatin 40 mg QD
4. Janumet 50/1000 BID
5. Glimepiride 4 mg QD
6. Invokana 100 mg QD
7. Pioglitazone 15 mg QD

FHx:

Family history negative for stroke
Father – MI at 68

Social Hx:

- Former smoker – 1 PPD x 40 years – 40 pack years
  - Quit in 2012

O:

Vitals:

Temperature: 37.3 C, oral
HR: 86 beats/min, regular
BP: **191/106**, right arm (sitting)
RR: 17 breaths/minute, nonlabored
SpO2: 93%, room air
Height: 5"10'
Weight: 270 lbs
BMI: 28.7

Physical exam:

General:

64-year-old well-nourished male; A&O x 3, seen sitting up in stretcher. Calm and cooperative; answers all questions appropriately. In no acute distress.

Skin:

No pallor or discoloration noted. Skin warm and moist with good turgor throughout. Sensation to light touch intact throughout. Capillary refill < 2 seconds throughout in upper and lower extremities.

Eyes:

No periorbital swelling or deformity visualized bilaterally. **Sluggish pupillary reflex in the right eye**. EOMI bilaterally. Visual fields full on left side, limited in right upper outer quadrant in right eye. Nontender to palpation throughout.
Visual acuity via Snellen eye chart: 20/400 OD, 20/40 OS, 20/40 OU
Tonometry:

Right:	Left:
1. 25 mmHg	1. 20 mmHg
2. 12 mmHg	2. 12 mmHg
3. 11 mmHg	3. 19 mmHg
4. 12 mmHg	4. 20 mmHg

Fundoscopy not assessed

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Abdomen nondistended. No obvious masses, lesions, or pulsations observed. BS+ in all 4 quadrants. Soft and nontender to palpation throughout.

Peripheral Vascular:

No edema, cyanosis, or erythema noted throughout. Pulses 2+ throughout in upper and lower extremities.

Neuro:

A&O x 3. Answering all questions appropriately and following commands. No dysarthria or word-finding difficulties. See eye exam. Cranial nerves grossly intact. Able to identify objects. Negative pronator and lower extremity drift. Rapid alternating movements and finger-to-nose tests within normal limits. Sensation to light touch intact throughout (sharp sensation not assessed). Normal gait and balance. Muscle strength 5/5 throughout.

Imaging:

Non-contrast head CT – No acute bleed visualized
Bedside right eye ultrasound – Unremarkable

Labs:

CBC within normal limits
BMP within normal limits
EKG – normal sinus rhythm
Finger stick glucose – 124 mg/dL
Troponin – within normal limits

A:

JP is a 64-year-old Caucasian former smoker (40 pack years) male with a significant past medical history of HTN and T2DM who presents complaining of right eye blurriness and dizziness x 3 hours. History and physical exam are concerning for stroke vs acute angle closure glaucoma. Patient is not currently in any acute distress.

Differentials:

1. Stroke
2. Acute angle closure glaucoma
3. Central retinal vein occlusion
4. Central retinal artery occlusion
5. Retinal detachment
6. Giant cell arteritis

P:

1. Stroke vs acute angle closure glaucoma
    a. Ophthalmology consult ordered
    b. Admit patient for further work-up

        i. MRI to rule-out older stroke and get more detailed imaging of the brain
    c. Neuro onboard
        i. Neuro checks as per protocol
    d. Monitor vitals as per floor protocol
2. HTN
    a. Continue current medication regimen
    b. 1 dose of labetalol given in ED
        i. Repeat BP 164/92
    c. Monitor for headache and other warning signs
    d. Low sodium died
3. T2DM
    a. Continue current medication regimen
    b. Diabetic diet
    c. Check finger-stick glucose as per floor protocol
4. Hypoxemia
    a. Cause unknown, further investigation on inpatient service
    b. Monitor for respiratory distress
    c. 2L oxygen delivered via nasal canula
        i. SpO2 improved to 97%
5. Assess fall risk
6. Speech and swallow passed

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SOAP Note 5

Identifying Data:

Name: MT
Age: 4 months, 5 days
Race: Asian
Date & Time: 11/9/2020, 8:00 AM
Location: New York Presbyterian/Queens Hospital, Pediatric Emergency Department
Source of Referral: None
Source of Information: Mother

S:

MT is a 4 month 5 day old male born via NSVD at 39 ½ weeks with no significant past medical history, making all appropriate age milestones, brought in by EMS activated by mother complaining of a rash and swelling on the patient's face x 30 minutes. MT's mother reports that she was cooking when MT touched a spoon contaminated with butter and eggs with his left hand and then touched his face. She removed the spoon from his reach but noticed about 10 minutes later that his face appeared swollen and erythematous. She activated EMS and washed off his hand and face. She did not give him any OTC medication for his symptoms. She admits that her son looked uncomfortable but did not appear to be scratching at the rash. She denies perceived difficulty breathing, tongue swelling, lethargy, fever, coughing, sick contacts or any other symptoms. She notes that the rash and swelling have since improved. She denies any family history of dairy allergies and any known allergies in MT. He has never had a rash before. He is currently breast fed primarily with the introduction of some fruits, but no solid foods in the last 2 days. All MT's vaccinations are up to date.

PMHx:
Denies
PSHx:
Denies
Allergies:
No known allergies to medications, foods, or environmental factors
Medications:
Does not take any daily medications, vitamins, or herbal supplements
FHx:
No familial history of dairy allergies

O:

Vitals:
Temperature: 36.9 C, rectal
HR: 140 beats/min, regular
RR: 34 breaths/minute, nonlabored
SpO2: 97%, room air
Height: 27 inches

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Weight: 23 lbs

Physical Exam:

General:

Well-nourished 4-month-old male, appears large for age. Playful and alert, tracking movement and responding to stimuli. Grasping appropriately. In no acute distress

Skin:

No cyanosis or edema noted throughout. Blanching erythematous macular rash bilaterally on cheeks, chin, and nasolabial area without breaks in the skin. Appears significantly improved from picture taken by mother at onset. Mild urticaria observed on left hand. No open wounds or insect bites noted. Skin warm and moist with good turgor throughout.

Eyes:

No swelling or deformity noted bilaterally. PERRLA. EOMI bilaterally. Red reflex intact bilaterally. Fundoscopy not assessed.

Oropharynx:

Oropharynx unremarkable with no edema of the tongue or posterior pharynx. No lesions noted

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Abdomen:

Non-distended. Umbilical stump healed well. BS+ in all 4 quadrants. Abdomen soft and nontender to palpation.

A:

MT is a 4 month 5 day old male born via NSVD at 39 ½ weeks with no significant past medical history, making all appropriate age milestones, brought in by EMS activated by mother complaining of a rash and swelling on the patient's face x 30 minutes. History and physical exam findings are consistent with allergic contact dermatitis. Patient's vital signs are within normal limits and he appears playful and in no acute distress.

Differentials:

1. Allergic contact dermatitis
2. Fifth's Disease
3. Measles
4. Atopic dermatitis

P:

1. Allergic contact dermatitis:
    a. Symptoms resolving without intervention

   b. Continue monitoring for signs of respiratory distress and worsening reaction x 1 hour
   c. No intervention at this time
   d. Follow up with an allergist to determine source of allergy
2. Mother educated on appropriate Epi-Pen use
   a. Epi-Pen Junior prescribed for potential future anaphylactic reactions
   b. Educated on presenting to ED after any Epi-Pen use for monitoring
3. Continue feeding as tolerated
4. Follow up with outpatient pediatrician

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SOAP Note 6

Identifying Data:

Name: PN
Age: 73 years
Race: Caucasian
Date & Time: 11/5/2020, 5:30 PM
Location: New York Presbyterian/Queens Hospital, Emergency Department
Source of Referral: None
Source of Information: Self
Mode of Transportation: EMS

S:

PN is a 73 year old male with a significant past medical history of HTN, T2DM, HLD, and CAD s/p triple bypass in 2013 on daily aspirin 81 mg who was brought in by EMS complaining of left hip pain following a fall 1 hour ago. He reports that he was standing on his deck earlier today when he lost his footing and fell with direct impact to his left hip and leg. He did not fall with an outstretched arm. He reports that he was unable to get up or ambulate after the fall and is currently having constant 5/10 sharp pain in his left hip without pain radiation. The pain is worse with any attempted movement of the lower extremity. He did not take anything for his pain and he reports no alleviating factors. He denies head trauma, loss of consciousness, dizziness, fever, chest pain, SOB, coughing, headache, vision changes, or any other symptoms. He denies alcohol or drug use.

PMHx:

1. Hypertension
2. Type 2 Diabetes Mellitus
3. Hyperlipidemia
4. Coronary artery disease

PSHx:

1. Triple cardiac bypass – 2013
2. Appendectomy in childhood

Allergies:

Allergy to Keflex – unsure of reaction
No other known allergies to medications, foods, or environmental factors

Medications:

1. Lisinopril (last dose this morning)
2. Metformin (last dose this morning)
3. Rosuvastatin (last dose this morning)
4. Aspirin 81 mg (last dose this morning)
5. Ozempic

FHx:

Non-contributory

CUNY York College Physician Assistant Program
Fall 2020
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Emergency Medicine Rotation – New York Presbyterian/Queens Hospital

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Vitals:

Temperature: 36.7 C, oral
BP: **176/87, left arm (supine)**
HR: **100 beats/min, regular**
RR: 14 breaths/minute, nonlabored
SpO2: 97%, room air
Height: 5”9’
Weight: 180 lbs
BMI: 26.6

Physical Exam:

General:

73-year-old well-nourished male, appears his stated age. Resting comfortably on the stretcher. Calm and cooperative, answers all questions appropriately. In no acute distress.

Head:

Normocephalic and atraumatic. Nontender to palpation throughout

Skin:

No discoloration or edema noted throughout. No ecchymosis observed. Skin intact without breaks or lesions. Skin is warm and moist throughout with age-appropriate turgor.

Eyes:

Patient is wearing glasses. No visible deformity bilaterally. Sclera white, corneas clear, and conjunctiva pink bilaterally. EOMI bilaterally. Visual fields full. PERRL. Nontender to palpation bilaterally. Fundoscopy and visual acuity not assessed.

Neck:

No swelling or deformity observed. FROM without pain. Nontender to palpation of cervical spine.

Heart:

RRR; S1 and S2 present without murmurs, rubs, or gallops.

Lungs:

No increased effort of breathing or asymmetrical chest movement noted. Clear to auscultation bilaterally without adventitious lung sounds.

Musculoskeletal:

Left lower extremity shorter than right and externally rotated. No swelling, bruising, or obvious deformity observed. FROM in bilateral upper and right lower extremities FROM in left ankle and toes. Limited movement in left knee with pain. Unable to move left hip joint. Tenderness to palpation over the left hip and left upper leg. 5/5 muscle strength in bilateral upper extremities, right lower extremity, and left foot.

Peripheral Vascular:

No edema noted throughout. Pulses 2+ bilaterally in upper and lower extremities.

Labs:
- CBC WNL
- BMP WNL
- Acetaminophen level negative
- EtOH negative
- UA negative
- Coags not resulted
- Rapid COVID-19 negative

Imaging:
- X-ray of pelvis, left hip, and femur – Left displaced intertrochanteric fracture

A:

PN is a 73 year old male with a significant past medical history of HTN, T2DM, HLD, and CAD s/p triple bypass in 2013 on daily aspirin 81 mg who was brought in by EMS complaining of left hip pain following a fall 1 hour ago. Imaging and physical exam are consistent with a displaced left hip fracture.

Differentials:
1. Left hip fracture
2. Left hip dislocation
3. Spinal cord injury
4. Pelvic fracture

P:
1. Displaced left hip fracture
    a. Admit to inpatient orthopedic surgery service for surgical repair
        i. Hold aspirin before surgery
    b. Non-weight bearing
        i. Foley catheter placed
        ii. Fall risk
2. Follow-up labs
3. PO Tylenol given for pain
    a. Reassess pain level inpatient as needed
4. HTN
    a. Continue home medication regimen
    b. Low sodium diet
5. T2DM
    a. Continue current medications
    b. Diabetic diet
    c. Monitor finger-stick glucose as per floor protocols
6. CAD
    a. Continue rosuvastatin
    b. Monitor for chest pain
7. Monitor vitals as per floor protocols

8. DVT prophylaxis after surgery
9. PT consult after surgery