Nicholas Burney Family HPI #4

Identifying Data:
Name: B.B
Address: Staten Island, NY
DOB: 1994
Date and Time: 11/26/19, 11pm
Location: Staten Island, NY
Source of information: self
Reliability: Good
Source of referral: self
Mode of transport: self (car)

Chief Complaint: "I've been vomiting and having diarrhea for 2 days"

HPI: 25 y/o caucasian male with PMH of GERD x 2 years presents with fever, chills, frequent diarrhea and vomiting x 2-3 days. Patient reports taking an airplane from California 3 days ago and was served a pastrami sandwich that "didn't smell or taste right". Pt ate the sandwich around 6pm and then at 12 am, woke up to vomit. Pt reports 5/10 abdominal pain, and getting up every hour to vomit and experiences a bowel movement simultaneously. Initially vomit contained undigested food but after 3-4 episodes became green liquid. Similarly diarrhea began as unformed brown bowel movement and then became purely mostly-clear liquid after several episodes. Episodes began to subside after 24 hours but still has intermittent bouts of diarrhea 48 hours later. Reports loss of appetite and inability to drink fluids without vomiting. Reports fever, chills, night sweats and fatigue concurrent with period of illness. Denies dysphagia, pyrosis, intolerance to certain foods, unusual

flatulence and eructations, jaundice, hemorrhoids, constipation rectal bleeding and hematochezia. Reports unintentional loss in weight concurrent with illness.

PMH:
- GERD x 2 years - controlled with 306 mg ranitidine
- Migraines x 5 years - experiences rarely

Immunizations - up to date
- received flu vaccine Oct 2019

Past Surgical History
- Nevi removal - midline at level of suprasternal notch - 2015

Medications:
- Ranitidine - 306mg PO tablet once a day
- Vitamin D3 - 5000 IUs 1 pill PO per day
- Vitamin K2 - 100 mcg - PO 1 pill per day

Allergies:
- Pollen - sneezing, nasal pruritis and congestion - mild
- nuts - pruritis in throat, mild

Family History:
- Mother A+W - 56 y/o
- Father - A+W - 62 y/o, has hemochromatosis and HTN, 50 pack year smoking history
- Brother a+w, - 27 y/o
- Maternal grandfather - deceased 48 y/o - 1982 COPD, MI
  maternal grandmother - deceased 87 y/o 2018 - alzheimers
  Paternal grandmother - deceased 95 y/o - 2017 - natural causes
  Paternal grandfather - a+w 92 y/o
  Confirms maternal grandmother with breast cancer
  maternal aunt with DM II and HTN, denies knowledge of CVD

Social History:
Unmarried, lives with parents and girlfriend. Has 4-5 beers with friends every 2 weeks or so. Works as EMS dispatcher for NYFD. Does crossfit workouts 3-4 times per week. Eats mainly homecooked italian food but gets sushi once or twice a week. Denies all other substance use past and present and denies history of STI's. Only partner is girlfriend of 2 years.

ROS!

General - See HPI

Skin/hair/nails - denies changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritis or change in hair distribution

Head - denies vertigo or head trauma. Confirms rare migraine headache with aura

Eyes - Denies changes in vision, pruritis, photophobia, lacrimation glasses. Last eye exam August 2019

Ears - Denies deafness, pain, discharge, tinnitis or use of hearing aids.

nose/sinus - denies discharge, obstruction, epistaxis

mouth/throat - denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures Last dental exam 2 weeks ago.

Neck - denies localized swelling, stiffness, and decreased range of motion

Breast - denies lumps, discharge or pain

Pulmonary - denies hemoptysis, cyanosis, orthopnea, PND, dyspnea on exertion, cough, wheezing

Cardiovascular - Denies palpitations, HTN, chest pain, irregular heartbeat, syncope, known heart murmurs, and peripheral edema.

Gastrointestinal - See HPI

Genitourinary - Denies urinary frequency, urgency, nocturia, polyuria, oliguria, dysuria, incontinence, does not awaken at night to urinate, Denies difficulty starting or stopping urination and denies flank pain.

Nervous - Denies seizures, headaches, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition mental status, memory or weakness.

Musculoskeletal - Denies muscle/joint pain, deformity, swelling, redness or arthritis.

Peripheral vasular - denies intermittent claudication, coldness or trophic changes, color changes, varicose vens and edema.

Hematological - Denies anemia, lymph node enlargement blood transfusions, DVT, and easy bruising.

Endocrine - Denies polyuria, polydipsia, polyphagia, heat and cold intolerance, excessive sweating, hirsutism and goiter.

Psychiatric - denies depression, sadness, anxiety, OCD, or ever having seen a mental health professional.

Physical Exam:

General: - Slim build, good posture and grooming, looks stated age, no acute distress

Vitals: BP R L
Seated 130/90 132/86

R - 16 unlabored P: 78 regular

T - 98.6°F - oral O2 sat - 98% RA

Height - 5'10 weight 138 lbs BMI - 19.8

Skin - skin clammy, hands and feet ~~warm~~ cold NB 2019, no lesions or scars. No jaundice, cyanosis, ecchymoses. Large tattoos covering chest and upper arms - professional grade.

Hair - good color, texture and distribution

Nails - good shape, texture, capillary refill <2 seconds, good color.

Head: Non-tender to palpation, no deformities, lice or seborrhea, normocephalic + atraumatic.

Eyes: Symmetrical OU, no strabismus, ptosis. Sclera white and conjunctiva pink and clear. Visual acuity assessed with Rosenbaum chart. 20/25 OD, 20/25/OS, 20/20 OU - uncorrected. Good eyebrow and eyelash distobution. Slight nystagmus noted and crescent sign absent. EOM intact with full visual fields. PERRLA and convergence intact. Fundoscopy - red reflex intact OU, retina good color OU. No retinopathies, exudates AV nicking, copper wiring, exudates noted. Cup:disk < 0.5. OU

Ears: Symmetrical, no deformities, signs of trauma, masses, lesions or scars AU. Non-tender to palpation. Otoscopy - no foreign bodies, discharge or erythema in auditory canal. Almost no cerumen present. Tympanic membrane pearly gray and cone of light in good position AU. Weber is midline and Rinne AC > BC AU.

Nose: Symmetrical, normal size, no discharge, non-tender to palpation, no masses, lesions or scars. Both nostrils patent Nasal mucosa injected and reddish, no foreign bodies or signs of trauma. Septum midline, no deformities or punctures Inferior turbinates appreciated.

Sinuses - Frontal and maxillary sinuses non-tender to palpation

Mouth - Lips dry, pink, no lesions. Symmetrical. Oral mucosa is pink, dry. No masses, lesions, or scarring. Hard and soft palate continuous, no masses or lesions.
Teeth - good dentition, no signs of caries, filling in right lower second molar.
Gingiva - pink, no swelling, masses, lesions, or candidiasis.
Tongue - pink, well papillated, no masses or lesions.
Oropharynx - reddish pink, uvula reddish pink and rises

midline upon phonation. Tonsils visualized at level I with no swelling, tonsoliths or exudates.

Neck: lymph nodes and thyroid non-papable, trachea deviates laterally upon pressure. Full range of motion

Lungs + Thorax - Symmetrical, no deformities or accessory muscle use. Breaths unlabored. Good chest sounds upon percussion, non-tender to palpation.
Lungs - clear to auscultation bilaterally. No ronchi, rales or wheezing heard.

Abdomen: Stomach flat, no scars or striae, or caput medusae. ~~BS~~ NB Bowel sounds present in all 4 quadrants No aortic, renal, iliac bruits heard. No guarding, rebound noted. Rovsings and psoas sign negative. Non-tender to palpation. Liver and spleen non-palpable

Cardiac: Regular rate and rhythm, S1 and S2 distinct with no murmurs, gallops or rubs. JVP is 3cm above sternal angle with head of bed at 30°. Carotid pulses are 1+ bilaterally without bruits. PMI is in 5th ICS at mid-clavicular line.