**History**

Identifying Data:  
Full Name: Ms. R   
Address: Queens, NY  
Date of Birth: March 25th, 1953  
Date & Time: May 18, 2021 (9:15 am)  
Location: NYP, Queens, NY  
Religion: Atheist  
Source of Information: Self  
Reliability: Reliable  
Source of Referral: None  
Mode of Transport: Self  
Chief Complaint: “I need medical clearance for my right knee replacement”

History of Present Illness:

68 year old female with a past medical history of HTN, HLD, Obstructive sleep apnea, CHF, Atrial Fibrillation, Osteoarthritis, HIV + (last CD4 cell count was 3 months ago) and a prior surgical history of hysterectomy, presents to the PAT for medical clearance of a knee arthroplasty. Patient complains of right knee pain x10 years. She states the pain is sharp, does not radiate and worsens at night. Rates the pain as 9/10 and describes it as muscle tightness that lasts for 10 to 15 minutes. It is associated with redness and swelling. Denies any aggravating factors and states she was given injections which did not alleviate the pain. Denies urinary urgency, frequency, dysuria, blood in urine, difficulty walking, numbness, tingling, weakness, recent travel, nausea, chest pain, SOB, dyspnea, vomiting and fever.

**Past Medical History:**

Hypertension x 15 years, well controlled on medications  
Hyperlipidemia x10 years, well controlled on medications   
CHF x 5 years   
Atrial Fibrillation  
Osteoarthritis   
HIV + with a low cell count; last tested 2 months ago   
GERD  
Obstructive Sleep apnea

Denies other illnesses

Immunizations – Up to date

**Screening tests and results –**

Colonoscopy x5 years ago and Mammogram x3 months ago

**Past Surgical History:**

Hysterectomy 2018   
Denies blood transfusions

**Medications:**

Metoprolol Succinate 50 mg twice a day   
Xaeralto 20 mg three times a day   
Metformin HCL 500mg   
Fluticasone Propionate 50mg  
Albuterol Sulfate HFA 90 mcg   
Symbicort 80/4.5 mg  
Pravastatin Sodium 20 mg   
Montelukast Sodium 10mg   
Furosemide 40mg   
Multivitamin N/A   
Folic Acid 1mg   
Omeprazole  
Bikatry 40mg

Denies use of Herbal supplements

**Allergies:**

Bactrim - Rash   
Latex - Rash  
Shrimp - Rash   
Tomatoes - Rash   
Cats and Dogs - Rash

**Family History:**

Mother – Dementia, deceased   
Father – Kidney problems, deceased   
Maternal and paternal grandparents – unknown  
Sibling- Brother - kidney problems, alive

**Social History:**

Ms. R is a recent divorcee, single female who lives alone. She has three children who she visits weekly.

Habits -Denies history of substance abuse and history of illicit substance use. Denies past and present tobacco and alcohol use.

Travel - Denies recent travels.

Diet - Home cooked food mostly and tries to avoid fast food and dine out. She tends to eat toast, tea and tuna.

Exercise - Denies any kind of physical activity as she is unable to due to her weight.

Safety measures - Admits to wearing a seatbelt and using a cane.

Sexual Hx – Denies sexual partner. Reports HIV +, which she has been tested

**Review of Systems:**

General – Reports recent weight loss of 20 pounds. Denies loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

Skin, hair, nails – Denies other changes in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus or changes in hair distribution.

Head – Denies headaches, vertigo, unconsciousness or head trauma.

Eyes – Reports use of glasses; Last Exam: 3 months ago; no change. Denies use of contacts, visual disturbances, or photophobia.

Ears –Reports decreased hearing in the right ear. Denies pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Reports full upper and lower dentures. Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes. Last dental exam – 1 month ago.

Neck – Denies localized swelling/lumps or stiffness/decreased range of motion.

Breast – Denies lumps, nipple discharge, or pain. Last mammogram: March 2020.

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies chest pain, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies polyuria, nocturia, oliguria, dysuria, incontinence, awakening at night to urinate or flank pain.

Sexual history – States not sexual active, Reports HIV+. Denies any other history of sexually transmitted infections.

Menstrual/Obstetrical – LMP: 2000. Denies vaginal discharge, dyspareunia. G3T3P0A0L3

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

Musculoskeletal system – States knee pain and swelling but denies other muscle/joint pain, inflammation or redness.

Peripheral vascular system – Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system – Reports anemia. Denies bruising, DVT, blood transfusion, bleeding and lymph node enlargement.

Endocrine system – Denies polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter.

Psychiatric – Reports depression/sadness and sees a mental health professional. Denies anxiety, OCD or suicidal ideations.

Physical

General: Obese, Neatly groomed, well nourished, well oriented, not in respiratory distress, appears older than stated age.

Vital Signs:

BP: R L

Seated 101/71 1

Supine

R: 14/min unlabored P: 70, regular

T: 97.6 degrees F (oral) O2 Sat: 98% Room air

Height 57 inches Weight 221 lbs. BMI: 47.9

Skin: Warm & moist, good turgor, no pigmentation, no lesions, no tattoos, no rash, no papules and no moles noted.

Nails: No clubbing, no Koilonychia, no Splinter hemorrhages, no paronychia, no lesions and capillary refill <2 seconds throughout.

Hair: Soft and silky with average quantity and distribution. No seborrhea, no lice.

Head: Normocephalic, atraumatic, non tender to palpation throughout.

Ears: Symmetrical and appropriate in size. No lesions, masses or trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white, intact with light reflex in good position AU. Auditory acuity intact to whispered voice AU. Weber lateralizes to the left / Rinne reveals AC>BC AU.

Nose: Symmetrical, no masses, lesions, deformities, trauma or discharge. Nares patent bilaterally with nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, perforation. No evidence of foreign bodies.

Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Eyes: Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink; Visual acuity uncorrected - 20/100 OS, 20/70 OD, 20/70 OU; Visual fields full OU. PERRLA , EOMs intact with no nystagmus

Fundoscopy: Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Lips: Pink, moist; no cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink, well hydrated. No masses and lesions noted. Non-tender to palpation. No leukoplakia.

Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation; continuity intact.

Teeth: Full upper and lower dentures. / no obvious dental caries noted.

Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.

Tongue: Pink; well papillated; no masses, lesions or deviation. Non-tender to palpation.

Oropharynx: Well hydrated; no injection; exudate; masses; lesions; foreign bodies.

Tonsils present with no swelling, peritonsillar abscess or exudate. Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses; lesions; scars; pulsations noted.

Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no cervical adenopathy noted.

Thyroid: Non-tender; no palpable masses; no bruits noted.

Thorax & Lungs:

Chest - Symmetrical, no deformities, no trauma. Respirations unlabored/no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation throughout.

Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.

Heart: JVP is 2.5 cm above the sternal angle with the head of the bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruits. Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdominal: Abdomen flat and symmetric with no scars, striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. Tympanic throughout, no hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Extremities: No deformity, edema, erythema. Distal pulses are intact. Right knee is tender to palpation.