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CUNY York College Physician Assistant Program
OBGYN Rotation – New York Health & Hospitals: Woodhull
History & Physical #1

Identifying Data:
Name: SM
Address: Brooklyn, NY
Age: 23 years old
Sex: Female
Nationality: Hispanic
Marital Status: Single
Date & Time: January 25, 2023, 12 pm
Location: Woodhull Hospital, Clinic
Source of Information: self, patient chart

Chief Complaint: "Routine prenatal visit"

History of Present Illness:
23 year old female G2P1001, EDD 02/01/23, currently 39 weeks and 0 days with no PMHx presents for her routine prenatal visits. Patient currently % trickling water down her leg x1 day. She states she noticed it yesterday morning after she got up from bed, where she felt something was trickling down her leg. States it now only occurs when she is walking intermittently. She was unsure if her water broke as during her last pregnancy she did not experience this. Reports + fetal movement. Denies using a pad for the leakage, alleviating factors, taking any medication, irritation, itching, odor, vaginal bleeding, headache, vision changes, RUQ/epigastric pain, nausea, vomiting, diarrhea, constipation, chest pain, palpitations, dysuria, hematuria. States she is sexually active with one male partner and does not use protection. Denies history of STIs.

Gynecologic History
LMP 04/28/2022, typical menstruation cycle is every 25-30 days
Menarche age 12
Contraception: Denies
Last Sexual Activity: 2 months ago
STIs – Denies history of STIs
Last Pap: December 2020, normal
Last mammogram: N/A
Social history: denies drugs, alcohol, and tobacco use
Family Hx – Denies breast ovarian and endometrial cancer

Obstetric History:
G2P1001, NSVD x1 LMP 04/28/2022,, currently pregnant for 39 weeks and 0 days. Denies history of termination of pregnancy, cesarean section, ectopic pregnancy.

Past Medical History:

Hospitalizations: Denies
Immunizations: Up to date for influenza, COVID-19 with booster.
Denies past injuries or blood transfusions.

Past Surgical history
Denies

Medications:

Denies use of herbal supplements.

Allergies:
Denies any known drug, environmental or food allergies.

Social History
Ms SM. is a single female, but lives with her partner and her 3 year old daughter.
Habits – Denies any alcohol use, past and present tobacco use and any history of substance abuse and illicit substance use.
Travel – Denies any recent travels.
Diet – She has a well-balanced diet with fruits and vegetables. She avoids fast food.
Exercise – States she exercises 2 to 3 times every week and sleeps 5 to 6 hours daily.
Sexual Hx – Heterosexual, monogamous, never uses protection.
Occupational Hx – She works at an office as a receptionist.

Review of Systems:
Constitutional: Denies generalized fatigue, loss of appetite, weight loss, fever or chills, or night sweats.
HEENT: Negative for headaches, visual disturbance, congestion, rhinorrhea, sinus pain and sore throat.
Breast: Denies lumps, nipple discharge or pain.
Respiratory: Negative for chest pain, cough, wheezing, hemoptysis, cyanosis, orthopnea, or PND.
Cardiovascular: Negative for palpitations, chest pain, irregular heartbeat or syncope.
Gastrointestinal: Denies lower abdominal pain, nausea, vomiting**.** Has regular bowel movements daily. Negative for constipation, diarrhea.
Genitourinary System: **Positive for leakage of water**. Denies any polyuria, nocturia, dysuria, urgency, hematuria/pyuria, or flank pain.
Musculoskeletal: **Positive for back pain,** gait problem, myalgias and neck pain.
Neurological: Negative for dizziness, weakness, light-headedness and headaches.
Hematologic System: Denies any bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.
Psychiatric: Denies any hx of abuse, depression/sadness, anxiety, OCD or ever seeing a mental health professional.

Physical:

General: Average sized female, neatly groomed, appears stated age of 23 years. Alert and oriented x 3, does not appear to be in any acute distress.

Vital Signs: BP: Seated R 127/70 mmHg
R: 18/min unlabored P: 80 bpm, regular
T: 98.9 degrees F (oral) O2 Sat: 99% Room air
Height 64 inches Weight 169 lbs. BMI: 26.47

Skin: Dry skin throughout upper and lower extremities. Good turgor throughout, varicose veins distributed b/l LE. Non-icteric, no other lesions, scars or tattoos noted
Hair: average quantity, evenly distributed. No alopecia, no nits or seborrhea noted.
Nails**:** no clubbing or cyanosis. Capillary refill < 2 seconds throughout.
HEENT: Normocephalic and atraumatic. Extraocular movements intact. PERRLA.
Breasts: Symmetric, no dimpling, no masses to palpation, nipples symmetric without discharge or lesions. No axillary nodes palpable.
Heart: RRR. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.
Chest: Symmetrical, no deformities, no trauma. Respirations unlabored. Lat to AP diameter 2:1. Non tender to palpation throughout.
Lungs: Clear to auscultation and percussion bilaterally. Chest expansion is symmetrical. Tactile fremitus symmetric throughout. No adventitious sounds.
Abdomen: Abdomen soft, non-tender, flat, and symmetric with diffuse striae noted. Bowel sounds normoactive in all four quadrants. No rebound or guarding**.** Negative Murphy's sign, McBurney's sign, Rovsing's sign. No CVA tenderness. **Fundal Height: 40 cm**
Female Genital Exam: not conducted
Peripheral Vascular Exam: Extremities are symmetric in color, size, and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No soft tissue swelling, erythema, deformities throughout. Negative Homan's sign.

Labs:
Based on previous labs, GBS, Urine culture GC/CT negative.
RH positive

UA ordered:
Negative for leukocytes, nitrates, protein

IMAGING:
Fetal heart Rate: 142 BPM

Differential Diagnosis:

1. Prelabor Rupture of Membranes
2. Urinary Incontinence
3. Urinary Tract Infection

ASSESSMENT:
23 y/o female G2P1001 with LMP 04/28/2022 and EGA 39 weeks and 0 days presents with % leakage of fluid.

Estimated due date: 02/01/2023

PLAN:

UTI

UA normal, UCX ordered.

Fluid Leakage

Patient transferred to OB triage to rule out rupture

Counseling:

If discharged from OBT, counseled patient on when to come to hospital. Labor floor number was provided to patient. Maintain adequate hydration and nutrition. Return to clinic in 1 week if discharged from OBT.

Breast feeding

Patient plans to exclusively formula feed, counseled patient on benefits of breast feeding.