Ian Wert
June 29th, 2024

H&P 1- Long Term Care

Chief Complaint:
"I am here for a routine follow up"

History Of Present Illness:
82 year old male with pmh of HTN, HLD, BPH, gynecomastia, and obesity presents to the clinic today for a routine follow up. Patient has complaints of right sided trunk pain that he has been experiencing for the past 2 weeks. Patient reports his pain a constant 8/10, describes it as a burning throbbing sensation. Patient denies any radiating pain. Patient states that nothing alleviates or worsens his pain. Patient denies any fever, headache, nausea, diarrhea, chest pain, palpitations, unintentional weight loss, changes in appetite, recent outdoor activities, recent travel, or recent sick contacts.

Past Medical History:
Past medical illnesses: Chronic – HTN, HLD, gynecomastia, obesity
Hospitalizations: denies
Childhood illnesses: denies
Immunizations: Up to date
Screening Tests: Up to date

Surgical History:
- Left inguinal hernia repair 2018

Medications:
- Atorvastatin 10 mg once daily
- Doxazosin 2mg once nightly
- Finasteride 5mg once daily
- Amlodipine 2.5 mg once daily

Allergies:
N.K.D.A

Family History:
Mother – deceased , HTN
Father- unaware

Geriatric Assessment:
ADL: Independent in all
IADL's: Needs assistance in meal preparation, household chores, transportation, paying bills, shopping, and taking medications

Visual Impairment: None
Hearing Impairment: slight, doesn't want hearing aids
Falls in the Past year: None
Assistant devices: Has cane but does not use it
Gait Impairment: None
Urinary Incontinence : None
Fecal Incontinence: None
Osteoporosis: None – up to date Dexa
Cognitive Impairment: None – Mini-Cog 5/5
Depression: None PHQ-9 score 8, no suicidal ideations or homicidal ideations
Home Safety Issues: None
Health Care Proxy: Yes – daughter
Advance Directives: Does not have; undecided at this time.

Social History:
M.M is a 82 y.o married male who is currently retired.
Habits- Patient denies smoking and denies illicit drug use, denies alcohol use, denies caffeine consumption.
Diet: He states that he likes to eat Puerto Rican food (rice, beans, meat, plantains).. tries to avoid fried and salty foods.
Exercise: He denies any exercise
Sleep: BPH symptoms sometimes prevent him from normal sleep but has improved.
Recent Travel: Denies
Sexual History: He is currently not sexually active and has no prior history of STD's.

Review Of Systems:
General- Denies fever, chills, night sweats, fatigue, weakness. Denies loss of appetite, denies recent weight loss or gain.

Skin, hair, and nails – Denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritis, or changes in hair distribution.

Head: Denies head trauma, headache, vertigo, syncope, fracture, or coma.

Eyes – Denies visual disturbances, fatigue, lacrimation, photophobia, pruritis, use of glasses or contacts. Last eye exam 5 months ago.

Ears – **Reports slight hearing loss** , denies pain, drainage, tinnitus, and the use of hearing aids.

Nose/sinuses – Denies epistaxis, discharge, and obstruction.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures. Last dental exam was roughly 6months ago.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – Denies dyspnea, cough, wheezing, SOB, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular system – Denies chest pain, palpitations, irregular heartbeat, edema or swelling of ankles, syncope, or known heart murmur.

Gastrointestinal System- Denies abdominal pain. Denies constipation, dyspepsia, pyrosis, regurgitation, loss of appetite, nausea, vomiting, flatulence, eructation's, jaundice, hemorrhoids, and renal bleeding.

Genitourinary System- Denies urinary retention, urinary urgency, dysuria, **reports polyuria**, **reports nocturia**, hematuria, pyuria, and incontinence.

Nervous system- Denies seizures, loss of consciousness, ataxia, change in cognition, change in mental status, change in memory, weakness, sensory disturbances, paresis, and hyperesthesia's.

Musculoskeletal System –**Reports pain along the right side of the trunk to under his right breast.** Denies deformities, arthritis, and swelling.

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

Hematological system – Denies anemia, easy bruising or bleeding, enlargement of lymph nodes, blood transfusions, or history of DVT or PE.

Endocrine system – **Reports polyuria**, polydipsia, polyphagia, heat or cold intolerance, goiter, or hirsutism.

Psychiatric – Denies feelings of helplessness or hopelessness, lack of interest in usual activities, depression, sadness, anxiety, OCD, or ever seeing a mental health professional.

Physical:
General: Well-groomed male with appropriate posture appears his stated age of 78. Presents awake, alert, and oriented to person, place, time, and situation.

Vitals:
BP: Seated- (R) 136/82

T: 97.9. F (Tympanic)

R: 14 breaths/min, unlabored

P: 82 beats/min, regular rate, and rhythm

O2 Sat: 99% room air

Height: 5' 4 inches Weight: 175 lbs BMI: 30

Skin, Hair, Nails:
Skin: **Presence of a unilateral, erythematous, group vesicular rash following a dermatomal pattern (T5), primarily on the right thoracic area. Pain is worse upon palpation of rash.**
Hair: Appropriate quantity, texture, and distribution. No lice or dandruff.
Nails: No clubbing, cyanosis, paronychia, or splinter hemorrhages present. Capillary refill <3 seconds in upper and lower extremities.
Head: Normocephalic, atraumatic, non-tender to palpation throughout.

Eyes:
Eyes: Symmetrical OU. No strabismus, exophthalmos, or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual fields full OU. PERRLA, EOM's intact with no nystagmus.

Ears:
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 canal intact to finger rub test AU.

Nose/Sinus:
Nose**:** Symmetrical. No masses, lesions, deformities, trauma, or discharge. Nares patent bilaterally. Nasal mucosa is pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No foreign bodies present.
Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses.

Mouth, Pharynx:
Lips - Pink and moist. No cyanosis, lesions, or edema.
Mucosa - Pink and well hydrated. No masses, lesions, ulcerations, or leukoplakia.
Palate - Pink and well hydrated. Palate intact with no lesions, masses, scars, or ulcerations.
Teeth - Good dentition. No dental caries. No plaque buildup.
Gingivae - Pink and moist. No hyperplasia, masses, lesions, erythema, or discharge.
Tongue - Pink and well papillated. No masses, lesions, or deviation.
Oropharynx - Well hydrated. No injection, exudate, masses, lesions, or foreign bodies. Tonsils present with no injection or exudate. Grade 2 tonsils. Uvula midline, pink with no edema or lesions.

Neck, Trachea, Thyroid:
Neck - Trachea midline. No masses, lesions, scars, pulsations. Supple and nontender to palpation. FROM, no stridor noted. 2+ carotid pulses, no thrills or bruits noted bilaterally. No cervical adenopathy.
Thyroid - Nontender to palpation. No masses, thyromegaly or bruits noted.

Thorax and Lungs:
Chest - Symmetrical, no deformities, no trauma. Respirations unlabored/ no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation throughout.
Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus symmetric throughout. No adventitious sound

Abdominal:
Abdomen: Denies CVA tenderness. Abdomen flat and symmetric, no striae or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Denies tenderness to palpation, no guarding or rebound noted. No hepatosplenomegaly to palpation.

Cardiac:
Heart: Regular rate & rhythm. S1/S2 with no splitting, murmurs, friction rubs or S3/S4. Carotid pulses are 2+ bilaterally, no bruits noted.

Extremities/Peripheral Vascular:
Bilateral upper and lower extremities symmetrical in size, color, temperature. Pulses 2+ bilaterally in upper and lower extremities. No clubbing, cyanosis, stasis, ulcerations noted in bilateral upper and lower extremities.

Neurology:
Alert and Oriented X3. CN's II-XII grossly intact.
Mental Status: Alert and oriented to person, place, and time. Recent and remote memory, attention, and abstract thinking
Motor: Good muscle bulk and tone with 5/5 strength on bilateral upper and lower extremities.

Differential Diagnosis:
- Herpes zoster (Shingles)
- Contact dermatitis
- Folliculitis
- Cellulitis
- Heat Rash

Assessment:
A 84 year old male with past medical history of HTN, HLD, BPH, obesity, and gynecomastia presents to the outpatient geriatric clinic for a routine follow up. Patients present complaint is right thoracic/trunk pain that he has been experiencing for 2 weeks. The patients chief complaint and physical exam findings indicates Herpes Zoster virus. The plan is to prescribe him calamine lotion, and give him an referral to dermatology as he is unaware when the lesions he has developed.

Plan*:*
- Herpes Zoster- Prescribed calamine lotion, referral to dermatologist
- BPH- Continue Finasteride 5gm once daily, Doxazosin 2mg once nightly
- HTN- Amlodipine 2.5 mg once daily, Doxazosin 2mg once nightly
- HLD- Atorvastatin 10 mg once daily