History AND Physical Examination- Example of the Write-up

ID: Mrs Sanaz Irani, 45 years – old, from shiraz, Married, student, Moslem

Source & Reliability: Mrs Irani, herself was cooperative and Reliable.

Date & Time: 31st Azar, 1389, 2:00 P.M.

CHIEF COMPLAINT

This 45-year-old married mother of two has had episodic right upper quadrant 'knife-like' pain for the past 2 days.

HISTORY OF PRESENT ILLNESS

Mrs Irani was in her usual good state of health until 2 days ago (29th Azar) when, having just finished a kebab dinner, she had severe "knifelike" pain in the right upper quadrant of her abdomen, radiating to her epigastrium. She concurrently felt "sick to her stomach" (without vomiting). "sweaty," and faint (without loss of consciousness). She immediately lay down on her bed and felt better "after a minute." The severe pain grew rapidly less, as did the nausea, but she had a "dull ache" in her right upper quadrant for several hours. She took no medication. Position did not affect the pain. She felt well enough after an hour to clean up the dinner table, and slept well that night. She has had two subsequent almost identical "attacks", the first at lunch yesterday (30th Azar) following a hamburger and french fries. The most recent episode was at breakfast today after eating "kalle pache".

She's had no fever, chills, vomiting, or diarrhea. She denies past history of similar episodes. She has no current or past history of jaundice, white stools, dark urine, or change in bowel habits. She is unaware of a history of anemia (other than a mild "low blood" associated with her first pregnancy). She has not had tarry or black stools, hematemesis, burning abdominal pain or other "indigestion", kidney stones, polyuria or hematuria, hepatitis, or foreign travel. She has had no cough, shortness of breath, or pleurisy. She has no calf pain. She regularly examines her breasts and noted no masses. There is a history of breast cancer in her mother. She has no known heart disease. She denies trauma to her chest, back, or legs. Her menses have been normal. She takes no regular medications and specifically denies the use of antacids, aspirin, clofibrate (Atromid), or alcohol.

She currently feels quite well.

PAST MEDICAL HISTORY

Childhood illness: Mumps and chickenpox as child. No measles, rheumatic fever, scarlet fever.

Adult illness: None significant. Hospitalized only for childbirth (Hafez Hospital, 1365 and 1369).

Trauma: Fractured left clavicle as child without sequelae.

Surgery: Tonsillectomy as child at 6 (Khalili Hospital). Episiotomy with each childbirth.

Allergies: Penicillin-urticarial rash without wheezing, stridor, (last dose 1376, at which time reaction occurred).

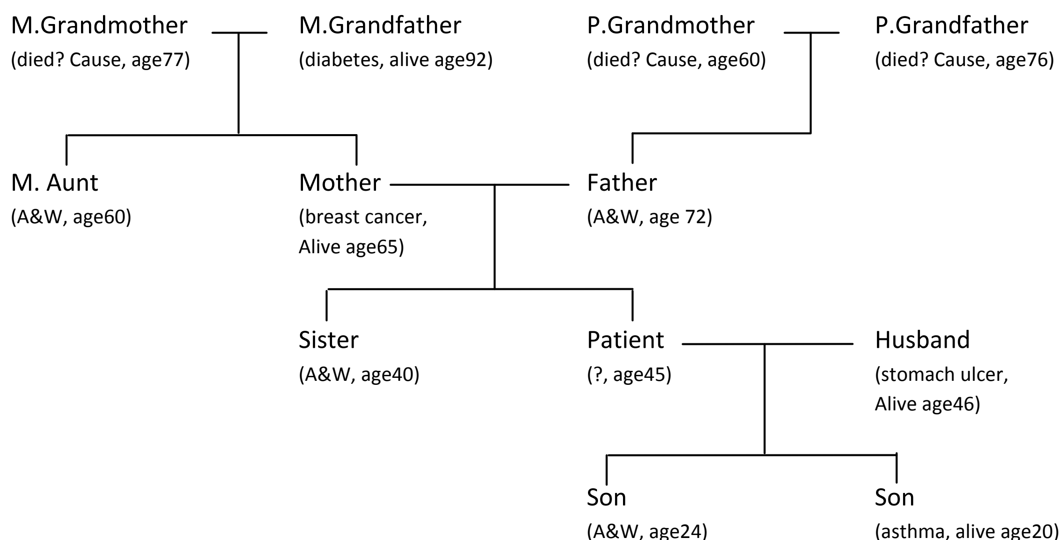
Medications: None at present. Has taken occasional Acetaminophen for headache in past.

Travel: Never outside of Iran.

Habits: Has never smoked cigarettes or water pipe tobacco. No illicit drugs. Regular diet, 3 meals a day.

Immunizations: Mrs Irani not remember childhood shots other than oral polio vaccine in early 1350. last tetanus shot 7 years ago.

FAMILY HISTORY



No family history of renal disease, liver disease, hypertension, anemia, tuberculosis.

SOCIAL HISTORY

Mrs Irani was born and raised in Shiraz, where she married her current husband after her graduation from high school in 1362. She remained at home to raise her two sons, both of whom are college students (majoring in art and mathematics, respectively), and has recently returned to night school to gain college credits herself.

She describes her life as full and her marriage as happy. Activities include housekeeping, gardening, and reading “romantic novels.” Her husband’s medical coverage extends to her, and she is not worried about money. Mrs Irani admit to some unhappiness at not having gone to college as a young woman, but “is making up for it now.” She is worried that her pain may represent an illness that will interfere with her studies, and she has “a test coming up next week” she is also fearful of cancer, as her mother has metastatic cancer of the breast, which is painful and emotionally draining on Mrs Irani, who visits her every day.

REVIEW OF SYSTEMS

General: See HPI. No weight change.
Head: Occasional “stress” headache. No dizziness. “Faintness” with her recent attacks as described in HPI.
Eyes: Last tested 1 year ago at 20/20. No blurring, double vision, pain, discharge.
Ears: No decreased hearing, tinnitus, pain. Otitis media once as a child (R ear).
Nose: No epistaxis, sinusitis.
Throat and mouth: teeth in good repair. Infrequent sore throats.
Chest: See HPI. No wheezing, hemoptysis, sputum. Chest x-ray normal on screening exam 1 year ago. Negative TB skin test 1 year age.
Heart: No pain, palpitations, orthopnea, cyanosis, edema. No history of hypertension.
GI: See HPI.
GU: See HPI. No dysuria, frequency, urgency, incontinence. No history of venereal disease or urinary tract infection.
Menstrual: Menarche age 13. Periods light flow for 3 days every 28 days and regular, with slight cramping on 1st day of flow. Last period normal, ended 19th Azar, $G_2P_2A_0$.
Neuromuscular: Faintness as in HPI, without syncope. No vertigo, dysesthesias, seizures. No history of emotional disease.

PHYSICAL EXAMINATION

31st Azar, 1389, 2:30 P.M.

General: Mrs Irani is a slightly obese, pleasant, 45-year-old white woman who is somewhat anxious but in no acute distress.

Vital Signs: BP R arm Sitting: 140/90 P85 regular R 12
L arm Sitting: 148/92
T 36.7˚C orally
L arm standing: 155/95
Height: 164 cm Weight: 73 Kg

Skin: warm and dry. No petechiae, purpura, excoriations. Anicteric. Hair and nails normal. No cutaneous lesions or rashes.

Nodes: No cervical, supraclavicular, epitrochlear lymphadenopathy: 1×1 cm, soft, nontender, mobile node R axilla. Scattered shotty inguinal nodes bilaterally.

Head: normocephalic, without trauma. No scars, tenderness, bruits.

Eyes: Conjunctivae normal. Slight scleral icterus bilaterally. Lids without lesions. Pupils equal, round, and react to light and accommodation. Vision grossly normal (reads newspaper). Visual fields full to confrontation. Extraocular motions full, without strabismus or nystagmus. Fundus shows normal discs and vasculature. No arteriovenous nicking, silver-wiring, hemorrhage, or exudates.

Ears: External ears normal. Tympanic membranes normal bilaterally. Weber midline.

Air conduction greater than bone bilaterally.

Nose: Nasal mucosa normal without inflammation, obstruction, or polyps.

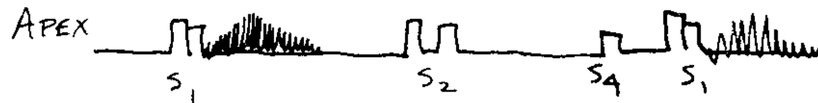
Mouth: Lips, buccal muscosa without lesions. Tongue well papillated, pink, midline.

Teeth in good repair. Uvula midline. Oropharynx without inflammation or lesions.

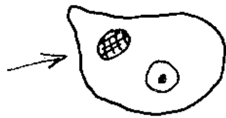
Neck: Supple. Trachea midline. Thyroid not enlarged and without nodules. Jugular veins flat. Venous pulses normal. Carotids 4+ without bruits, normal pulse contour bilaterally.

Chest and lungs: Chest wall contour normal, with symmetrical full expansion. No rib tenderness to palpation. Tactile fremitus normal. Diaphragmatic excursion 5 cm *Bilaterally:* No percussion dullness. Lungs are clear to auscultation save for an isolated musical wheeze on forced expiration at the right base posteriorly. There is no egophony over this area. No rubs heard.

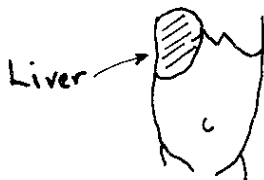
Heart: No visible lifts, PMI palpable 8 cm from the L sterna border in the 6th intercostals space, tapping in quality. No palpable thrills, lifts, heaves. Rhythm regular, rate 80. S1 normal. S2 physiologically split. There is no S3, but a soft S4 at the apex. There is a 2/6 systolic ejection murmur at the L sterna border, without radiation. No rubs, no diastolic murmurs.



Breasts: R breast slightly larger than L. No retraction, visible dimpling or skin changes. Nipples normal, everted. 2×2 cm cystic, mobile, nontender mass without skin fixation in upper outer quadrant of right breast. No nipple discharge.



Abdomen: Slightly protuberant. No scars or visible masses. Venous pattern normal. Bowel sounds normal. No hepatic or splenic rubs. No bruits. Liver is 15 cm to percussion, and is 3 cm below the right costal margin. Liver edge is smooth and tender to palpation, with positive Murphy's sign. No epigastric tenderness. Spleen and kidneys not palpable. No shifting dullness or fluid wave. No hernia.



Pelvic and rectal: External genitalia normal, including Bartholin's and Skeine's glands. Vaginal vault without lesions or discharge.

Cervix parous, without lesions or discharge. Pap smear taken.

Bimanual: Fundus normal in size & position. No tenderness. Ovaries and broad ligament felt and are without masses or tenderness.

Rectovaginal: Confirms bimanual

Rectum: No anal lesions. Sphincter tube normal. No ampulllary masses. Stool is clay colored and negative for occult blood.

Extremities: Pulses full and symmetrical, without bruits. Skin and hair normal on extremities.

Pulses:

	Carotid	Supra-clavicular	Radial	Brachial	Aorta	Femoral	DP	PT
R	4+	3+	4+	4+	0	4+	4+	4+
4+=NL								
L	4+	3+	4+	4+	0	4+	4+	4+

No clubbing, cyanosis, or edema. No swelling, redness, tenderness, limitation of movement of joints. No visible varicosities. No calf tenderness or cords. Muscle mass normal bilaterally.

Back: Slight cervical kyphosis. No spinal tenderness, CVA tenderness, or sacral edema.

Full range of motion spine.

Neurologic:

Mental status: Alert, oriented. Memory, judgment, mood normal.

Cranial nerves:

I-Not tested.

II-Pupils react to light. Reads newspaper.

III, I, VI- No strabismus, EOM normal.

V- Corneal reflex intact.

VII- Face symmetrical.

IX, X- Uvula elevates symmetrically. Gag normal bilaterally.

XI- Trapezius, sternomastoid normal.

XII- Tongue protrudes midline.

Cerebellar: Gait, finger-nose, and heel-shin normal.

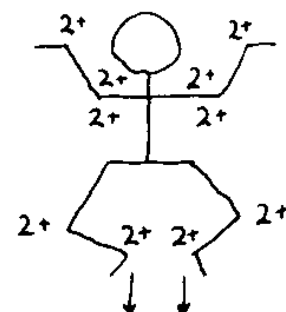
Station and gait: Romberg negative. Heel-toe walk normal.

Motor: Muscle mass normal. Good strength in arms, legs.

Deep tendon reflexes: 2+ = NI

No pathologic reflexes.

Sensory: Normal to touch, pinprick, vibration.



LABORATORY FINDING

Hemogram: Hgb 14.2, Hct 45%, WBC 8500, Polys 65, Bands 5, Monos 10, Lymphs 19, Eos 1, Baso 0.

Peripheral smear: Normocytic, normochromic RBCs. No fragments, targets, nucleated RBC. WBC morphology normal. Platelets abundant on smear.

Urine: Clear, dark yellow. SG 1015. Dipstix neg. heme, protein, glucose, ketones. 3+ for bilirubin. pH= 6.micro: 0-1 WBC, 0 RBC, no organisms per high-power field.

No crystals, casts.

Serologies:

Electrolytes: Na=140, K=4.2, Cl=100, CO_2=28, Ca=10, P=3.4, Albumin=4.0, Glob=3.5, SGOT=123, SGPT=85, Alk P'tase=210. Bili: total=4.0, direct=3.5. Amylase serum=236, Gl=123, Cr=1.0, BUN=10.

Radiologies:

Chest x-ray: Bones normal, without blastic or lytic lesions. Heart shows slight straightening L heart border. Parenchyma clear except for slight linear atelectasis at right base posteriorly (R lower lobe, basal seg.). No evident effusion.

KUB: Bones normal. Psoas shadows seen. Nephrograms show normal-size kidneys.

Bowel gas normal. No evident ascites. Speckled calcification at medial RUQ in area gallbladder is located.

ECG: Rate=80, rhythm=sinus, PR=0.15, QRS=0.10, QT=.32, axis=+30. P waves normal. QRS normal. No T wave flattening or ST segment abnormalities. No LVH by voltage. Impression-normal ECG.

IMPRESSIONS:

1. RUQ pain

    a. Probable cholecystitis with cholelithiasis. This is supported by the historical relationship of RUQ sharp pains associated with fatty foods, sclera icterus, hepatomegaly, and + murphy's sign, clay-colored stools, and laboratory findings of bilirubinuria, abnormal liver function studies with an obstructive pattern, hyperamylasemia, and calcifications on KUB that might represent gallstones. The RLL atelectasis on chest film is not inconsistent with an intra-abdominal process.

    (1) R/O carcinomatosis of the liver. With her family history of breast cancer and the breast mass and axillary node on physical examination, this diagnosis must be considered. The episodicity of her pain, the lack of nodularity of the liver, and the absence of evident disease elsewhere makes this less likely.

    (2) R/O pulmonary embolism. Though unlikely, the RLL wheeze on P.E. and atelectasis on chest film could represent the site of lodgment of pulmonary embolism from the legs (for which there is no local evidence of phlebitis) or peripelvic (she has had 2 children) areas. The liver disease in this circumstance would represent congestive hepatopathy from transient R heart failure of pulmonary embolism.

    (3) R/O myocardial infarction or ischemia. This is very improbable with her history, but should be considered in light of her recent stress in classes and the association of her pain with eating. Her hypertension, though mild, could predispose her. In this circumstance, her liver disease would be transient congestive hepatopathy.

2. R breast mass and axillary node with family history of cancer of the breast

    Although the cystic lesion of the breast probably not represent a malignancy, her FH and deep concern are troublesome.

3. Hypertension

   Although this might be due to anxiety, the presence of the S4 and the straightening of the L heart border on chest film suggests a fixed hypertension rather than a labile one.

4. Allergy to penicillin

   Her urticarial response could presage anaphylaxis

5. Systolic heart murmur

   This is probably a flow murmur.

Although other diagnoses are possible (infective pneumonia, pancreatitis, infective or toxic hepatitis), there is little to support them in the history or physical examination.

PLAN

1- RUQ Pain

   Plan: I will hospitalize her today and obtain an an abdominal sonography to determine her gallbladder and biliary tree, as the most immediately available and least invasive of studies.

   I will ask the surgeon to see her today, should another attack require emergency surgical intervention.

   Serial physical examination, urine, bilirubin testing, and serum liver function tests will allow monitoring of her progress.

2- R breast mass and axillary node with FH cancer of the breast

   Plan: Mammography and probably biopsy of the mass are in order.

   These can be done on this hospitalization.

3- Hypertension

   Plan: I will monitor her pressures in hospital. Should they remain elevated, salt restriction, weight loss, and probably diuretic therapy will be instituted.

4- Allergy to penicillin

Plan: I will instruct the nurses to flag her chart as allergic to penicillin. On discharge, Mrs Irani should obtain a Medic-Alert to the effect that she is allergic to this drug.

5- Systolic heart murmur

Plan: Observe

M. Afshari, M.D.

Experience is the mother of science. PROVERB