Ling Yi Mei

Rotation 2: Ambulatory Medicine

Note: physical exams highlighted in grey are NOT performed

**Identification:**

Patient’s name: MK

Age: 24

Gender: Female

Race: African American

Location: Brookdale Urgent Care Center, Brooklyn, NY

Date and Time: Feb 20, 2019, 11:00AM

**Informant**: self, reliable

**CC:** “I have a very high fever since last night.”

**HPI:**

24 y/o female w/o significant PMHx presents with a temperature of 104F at home. States that she has been taking OTC Tylenol to bring down the fever. Admits to vomiting once in the morning. Does not recall any sick contact or recent travel. Denies HA, stiff neck, cough, chest pain, SOB, abdominal pain, diarrhea, rash, and any urinary symptoms.

**PMH:**

None

**Past Surgical History:**

None

**Medications:**

None

**Allergies:**

None

**Family History:**

Maternal grandmother: alive, diabetes, hypertension

Maternal grandfather: alive, hypertension

Paternal grandmother: alive, hypertension

Paternal grandfather: alive, hypertension

Father- alive, healthy

Mother- alive, healthy

Sister- alive, healthy

**Social History:**

Pt reports never smoked and never used smokeless tobacco. Drinks alcohol occasionally. Denies the use of illicit drugs. Pt is currently employed as a RN elsewhere.

**ROS:**

General: Patient denies recent weight loss or weight gain, loss of appetite, night sweats. **Positive: generalized weakness, fatigue, fever, chills.**

Skin, Hair, Nails: Patient denies any changes of texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, or changes in hair condition

Head: Patient denies headache, vertigo, head trauma, or fracture

Eyes: Patient denies visual disturbance, lacrimation, photophobia, pruritus, or last eye exam

Ears: Patient denies deafness, pain, discharge, tinnitus

Nose/Sinuses: Patient denies discharge, epistaxis, or obstruction

Mouth and throat: Patient denies bleeding gums, sore tongue, sore throat, mouth ulcers or last dental exam

Neck: Patient denies localized swelling or lumps, stiffness or decreased range of motion

Breast: Patient denies lumps, nipple discharge, pain, or last mammogram

Pulmonary System: Patient denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, paroxysmal nocturnal dyspnea

Cardiovascular System: Patient denies chest pain, palpitations, edema, syncope, or known heart murmur

Gastrointestinal System: Patient denies changes in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructation, abdominal pain, diarrhea, jaundice, change in bowel habits, hemorrhoids, constipation, rectal bleeding, blood in stool or stool guaiac test or colonoscopy

Genitourinary System: Patient denies changes in frequency, nocturia, urgency, oliguria, polyuria, dysuria, change in color of urine, incontinence, awakening at night to urinate, or pain

Sexual history: Patient is sexually active with men only and use contraception, patient denies STD.

Menstrual and Obstetrical: LMP: 02/03/2019. Her menstrual cycle is 28 days with medium flow without clots. Patient denies postcoital bleeding, dyspareunia.

Nervous System: Patient denies seizures, headache, loss of consciousness, sensory disturbances, numbness, paresthesia, dysesthesias, ataxia, loss of strength, change in cognition, mental status, memory, or weakness

Musculoskeletal System: Patient denies muscle or joint pain, deformity or swelling, redness, arthritis

Peripheral System: patient denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color changes

Hematological System: Patient denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: Patient denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: Patient denies depression, sadness, feeling of helplessness, hopelessness, lack of interest in usual activities, anxiety, obsessive or compulsive disorder, seen a mental health professional, or use medications

**Physical Examination:**

General: 24 years old female is alert and cooperative. She is well dressed. Slender female, neatly groomed, looks like her stated age of 24 years. Well developed and well nourish.

Vital Signs:

BP (seated): 104/68

HR: 144bmp

RR: 18 breaths per min

Temp: 103.2F oral

O2 sat: 100% room air

Height: 5 ft 5 in weight: 134 lbs BMI: 22.3kg/m2

Skin: Warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: Average quantity and distribution

Nails: No clubbing, capillary refill <2 seconds throughout.

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

Eyes: Symmetrical OU; no strabismus, exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. Visual acuity with glasses 20/20 OS, 20/20 OD, 20/20 OU. Visual fields full OU. PERRLA, EOMs full with no nystagmus. Fundoscopy - Red reflex intact OU. Cup:Disk < 0.5 OU, no AV nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU

Ears: Symmetrical and normal size. No lesions, masses, trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's pearly white, cone of light at 4 o’clock in right ear, 7 o’clock in the left ear. Auditory acuity intact to whispered voice AU. Weber midline, and Rinne reveals AC>BC AU

Nose: Symmetrical with no masses, lesions, deformities, or trauma. Nasal mucosa pink, no discharge or foreign bodies. No deviation, lesions, deformities, injection perforation

Sinuses: Nontender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Lips: Pink, dry, no cyanosis or lesions

Mucosa: Light pink, dry, no masses, lesions, or leukoplakia

Palate: Pink, hydrated. Palate intact with no lesions, masses, scars

Gingivae: Pink, no hyperplasia, masses, lesions, erythema, or discharge

Tongue: Pink, no masses, lesions, or deviations noted

Oropharynx: Hydrated, no injection, exudate, masses, lesions, or foreign body. Tonsil present with no injection or extrudate, uvula light pink, no edema or lesions

Neck: No masses, lesions or scars. Trachea midline, pulsation noted. Supple nontender to palpation. 2+ carotid pulses, no thrills, bruits bilaterally. No palatable adenopathy

Thyroid: Nontender, no palpable masses, no thyromegaly, no bruits

Chest: Symmetrical, lat to AP diameter 2:1, no deformities, no trauma. Respirations unlabored. Nontender to palpation

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. No wheezing, crackles, rales.

Heart: S1, S2 without murmur, no gallops, S3 or S4. RRR. No JVD. Carotid pulse are 2+ bilaterally without bruits

Abdomen: Flat, symmetrical, no scars, striae, caput medusae or abnormal pulsations. Bowel sounds in all 4 quadrants. No bruits. Tympany to percussion throughout. Nontender to percussion or to light and deep palpation. No organomegaly, guarding, or rebound tenderness. **Positive CVAT bilaterally**

Rectal: No external hemorrhoids, skin tags, ulcers, sinus tracts, anal fissures, inflammation or excoriations. Good anal sphincter tone. No masses or tenderness. Trace brown stool present in vault. FOB negative

Peripheral vascular: The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits, clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted

Neurological:

Mental status: Alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted

Cranial nerve:

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD

III-IV-VI- PERRLA, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar: Full active and passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (5/5 throughout). No Pronator Drift. Gait normal with no ataxia. Tandem walking and hopping show balance intact. Coordination by RAM and point to point intact bilaterally. Romberg negative

Sensory: Intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally

Reflexes R L R L

Brachioradialis 2+ 2+ Patellar 2+ 2+

Triceps 2+ 2+ Achilles 2+ 2+

Biceps 2+ 2+ Babinski neg neg

Abdominal 2+/2+ 2+/2+ Clonus negative

Meningeal signs: No nuchal rigidity noted. Brudzinski's and Kernig's signs negative

Musculoskeletal System:

Upper extremities and lower extremities: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. Nontender to palpation, no crepitus noted throughout. Full range of motion of all upper and lower extremities bilaterally. No spinal deformities

**Imaging/lab report:**

CXR: negative

Urine Pregnancy Test: negative

Rapid flu test: negative

Rapid strep test: negative

U/A dipstick: small bilirubin, moderate blood, 300mg protein, small leukocytes, positive nitrate.

**Assessment:**

24 y/o female present with fever of 103.2F. U/A and CVA tenderness b/l most consistent with acute pyelonephritis.

**Differential Diagnosis:**

Flu

Strep throat

Gastroenteritis

Pneumonia

UTI

**Plan:**

Acute pyelonephritis:

* 250mg Ceftriaxone, IM gluteal injection, single dose
* 500mg tablet Cipro, twice daily x 7 days

Fever:

* Tylenol and fluid by mouth

Vital rechecked:

* temp 100.2, HR 111

Discharge:

* advise to increase fluid by mouth
* return to ER if symptoms worsen or in any acute distress
* Otherwise F/U with PCP.