

H&P

(Sample 1)

January 1, 2050

Name: _____ Age: _____ Sex: _____

Chief Complaint (CC): Left foot pain

History of Present Illness (HPI):

A 77-year-old female with history of Diabetes type 2 and neuropathy presents with strong foul odor of left foot ulcer, patient states she stepped on glass two days ago, with worsening discoloration and signs of infection from foot. Walking aggravates pain. Currently denies any fevers, chills, nausea, vomiting (FCNV) or shortness of breath. No acute trauma or fall currently.

Past Medical History (PMH):

Illnesses/Diagnosis – DM2, neuropathy, HTN

Medication – Metformin, Aspirin 81mg, metoprolol

Allergies – Sulfa drugs

Hospitalization - none

Operations – previous left foot wound debridement

SH: Social history

(+) smoker for 30 pack years. Social Drinker 3-4x weekly. Denies any recreational drugs. Current retired, previously worked as a chef. She is a widow, lives alone. Has son and daughter near her home.

FH: Family history

- Mom – Deceased 2001, history of HTN and cancer
- Dad – Deceased 2005, history of DM type 2

ROS: Review of Systems

- Constitutional – denies weight loss/gain, fevers, chills, nausea, or vomiting.
- Eyes – denies visual changes, double vision or blurry vision
- ENT – denies nasal congestion, dysphagia
- Skin – denies rashes, openings, lacerations. Left foot ulcer
- Cardiovascular – denies chest pain, palpitations, dizziness
- Pulmonary – denies SOB, cough
- Endocrine – denies polyuria, polydipsia

- Gastrointestinal – denies abd pain nausea/vomiting/dementia
- Genitourinary – denies dysuria/frequency, discharge
- Musculoskeletal – denies joint aches, current fractures
- Neurologic – denies headaches/migraines. Speech normal, no motor deficit.
- Psychology – denies mood changes, anxiety, depression.
- Heme/Lymph – denies any bruising

VITALS:

1. Temperature – (36.7 C)
2. Heart Rate – (80 beats/min)
3. Respiratory Rate – (12 breaths/min)
4. Blood Pressure – (194/91)
5. Pulse Oximetry – (95% SpO2)
6. Pain Scale – (5 out of 10)

PHYSICAL EXAM:

- General – WDWN, NAD, sitting in chair. Well groomed
- HENT – ncat; mmm; oropharynx clear; no cervical lad

- Eyes – eom wnl; no pallor injection or icterus
- Cardiovascular – A-fib on telemonitor, in 100s range
- Pulmonary – CTAB
- Abdominal – soft, NDNT, incision c/d/i
- Neurological – MAE
- Extremities: no edema, erythema, openings, or lacerations
- Skin/Wound – 1 x 1 cm left lateral foot wound; mild surrounding erythema
- Neuro – CN II – VII are grossly intact; responding appropriately; moving all extremities;
- Psych – normal mood/affect
- Vascular Exam– Inspection: No rashes, swelling, color change, or cyanosis in arms. No signs of venous stasis in legs and no pigmentation around ankles. No spider veins on legs and thighs bilaterally. No clubbing in fingernails. Capillary refill is 2 sec. Palpation: Hands warm and pink. Feet are a bit cool to the touch and pale, but equal bilaterally. No edema in feet. No ulcers in lower extremities.

LABS: ESR 81, CRP 60. WBC 20.2

MICRO: Positive Growth (+) for Staph aureus

IMAGING:

- #XR L Foot 04/21/2050. Pending
- #XR Chest 04/21/2050 shows enlarged cardiac contour, consistent with cardiomegaly and/or pericardial effusion. Perihilar vascular congestion without frank pulmonary edema. No pleural effusion or pneumothorax.

ASSESSMENT & PLAN:

L 5th partial toe amputation

- L foot only heel weight-bearing
- Heparin 5000u SQ TID
- Post-op shoe dispensed to be worn on L foot
- Cefepime 2g IV Q12H, vancomycin 750mg IV Q12H
- Prevalon boots to be worn while in bed.
- Dressings: Betadine paint, Owens silk, and dry sterile dressings.

NEURO/PSYCH

Pain Management

- Tylenol, Tramadol, Oxy, Dilaudid, Baclofen for pain

Tremor – Patient with b/l DBS placement for tremor

- Propanolol 120mg PO

ANTICOAGULATION

- ASA 81 in AM
- Heparin 5000u SQ BID

ENDOCRINOLOGY

Diabetes type 2

- ISS Algorithm 2
- Insulin glargine 12 units

HTN – (BP 194/91)

- Hydralazine 50 BID, amlodipine 10 daily
- Amlodipine TAB 10mg PO
- EKG reviewed; no abnormalities noted
- 10 IV Hydral