**Identifying Data:**

Full Name: N.S.

Sex: Female

DOB: XX/XX/1954

Race/Nationality: Caucasian/Bulgarian

Primary Language: Bulgarian – Fluent in English

Address: New York, NY

Date & Time: 10:00AM 01/14/22

Location: Metropolitan Geriatric Clinic

Source of Information: Self & Medical records

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** New Patient – “I would like to establish care”

**HPI:**

NS is a 67 y/o female with a PMHx of osteoporosis w/o fracture, myalgia of the bilateral lower extremities, tachycardia, Herpes Zoster, and flexural eczema that presents to the clinical to establish care due to her prior PCP recently closing their practice. She is a retired engineer from Bulgaria and currently works part time as a nanny. Able to perform all ADLs/IADLs & exercises daily. Drives a car and denies traffic violations/citations. Living in an apartment building with her husband who has moderate dementia with their adult children close by. Medical records from prior PCP indicate Penicillin allergy but pt denies ever having an allergic reaction/adverse event to medication. She reports a positive patch test to Gentamicin ~30 years prior but denies ever taking the antibiotic. Pt reports one episode of tachycardia while working last year, described as palpitations for >30 minutes and feeling of near syncope that prompted her to go to the ER. Reports initial ER workup was unremarkable. Subsequently had detailed investigation with TTE & 72 hr. Holter monitor that was unremarkable except for mild regurgitation of mitral, tricuspid, aortic, & pulmonic valves. Routine labs all WNL 3 months prior. 2007 DEXA scan positive for early osteoporosis of lower lumbar and left femoral neck but repeat DEXA in 2019 only positive for osteopenia without therapy in between. Since 2019 pt has increased her Vitamin D & Calcium intake & exercises daily (Yoga, speed-walking). One episode of Herpes Zoster 6 months prior on her buttocks and upper trunk treated with acyclovir. Denies recent leg/muscle cramps, Hx of PVD, chest pain, SOB, palpitations, N/V/D, constipation, or abdominal pain.

**Geriatric Assessment:**

* ADLs: Independent
* IADLs: Independent
* Cognition: No impairment. 5/5 Mini-Cog
* Home health aide: No.
* Social support: Husband, daughter, grandchildren, friends in area
* Visual impairment: No.
* Hearing impairment: No.
* Dental: Dentition in-tact. Last dental exam 1 year prior
* Falls: Denies prior falls.
* Assistive devices: None
* Gait impairment. No
* Nutritional concerns: None. Eating 3 meals/day – Cooks primarily Bulgarian Cuisine
* Urinary incontinence: No
* Fecal incontinence: No
* Osteoporosis: 2007 DEXA positive for osteoporosis of lumbar spine & L femoral neck, 2019 next only positive for osteopenia w/o therapy in between
* Depression: Pt denies feeling sad/depressed. PHQ9 score 0
* Home Safety issues: None reported
* Health care proxy: Daughter. MOLST form completed
* Advanced directives: Full code

**Past Medical History:**

*Present Illnesses:*

* Osteopenia – 2019 DEXA. No Hx of fractures
* Myalgia (legs) – Pt reports only feels them 3-4x/yr with mild-mod intensity
* Tachycardia – 1 prior incident (2020). Unknown if NSR or arrythmia
* Herpes Zoster – 1 prior incident (2020) on buttocks and trunk, Tx w/ acyclovir
* Flexural eczema – “Entire life”

*Past illnesses:*

* No prior hospitalizations
* Childhood illnesses: Chickenpox

*Immunizations*

* Td given today 1/10/21
* Shingrix to be given at f/u in 6 months
* All other immunizations up to date
	+ COVID-19 + booster (Pfizer x3)
	+ Prevnar 13
	+ Pneumovax 23
	+ Influenza (Annual)
	+ All childhood immunizations

**Past Surgical History:**

* None reported

**Current Medications:**

* Quinine Sulfate 200mg PO 1x/daily – Prescribed “several years” prior by former PCP for muscle cramps in legs
* Vitamin D 1000 units PO 1x/daily OTC – 2019
* Multivitamin “Centrum Silver” PO 1x/daily OTC – 2019

**Allergies:**

* NKDA
* No known food or environmental allergies

**Family History:**

* Mother – Living, 87, denies medical conditions
* Father – Deceased, 78, CVA
* Maternal Grandmother – unknown
* Maternal Grandfather – unknown
* Paternal Grandmother – unknown
* Paternal Grandfather – unknown
* Siblings – none
* Children – Daughter, healthy

**Social History:**

* PR is a 67 y/o female that lives in an elevator apartment building with her husband
* Habits – Denies ever using alcohol, tobacco, or illicit drugs.
* Travel – Denies recent travel
* Occupation – Retired engineer, current part-time nanny
* Marital History – Husband. No pets
* Diet – Cooks for herself, primary Bulgarian cuisine. 3 meals/day with protein, fruits, vegetables, whole grains. Drinks water.
* No difficulty falling or staying asleep. Feels rested. Sleeps 7-9 hours per night.
* Exercise – Daily yoga in the morning, speed-walking in the evenings, & walking to park when nannying
* Sexual History – Sexually active with husband. Monogamous. No Hx of STIs

**Review of Systems:**

* General
	+ Denies generalized weakness/fatigue. Denies weight loss, loss of appetite, fever/chills/night sweats
* Skin, hair, nails
	+ **Admits to mild pruritis and dry skin in elbow creases bilaterally**. Denies excessive sweating, pigmentations, rash, moles, change in hair distribution.
* Head
	+ Denies headache, vertigo, or new head trauma
* Eyes
	+ Denies visual disturbances, abnormal lacrimation, photophobia, or pruritis
	+ Last eye exam 1 year prior. Visual acuity 20/20 OU. Denies wearing glasses.
* Ears
	+ Denies, pain, discharge, tinnitus, hearing loss, hearing aids, or feeling of fullness
* Nose/Sinuses
	+ Denies epistaxis, congestion, or discharge
* Mouth and Throat
	+ Denies bleeding gums, sore tongue/throat, mouth ulcers, voice changes, or dentures. Last dental exam 1 year prior.
* Neck
	+ Denies swelling/lumps, stiffness, or decreased ROM
* Breast
	+ Denies lumps, nipple discharge, or pain. **Lumpectomy in left breast 20 years prior – benign. All other routine mammograms normal. Last mammogram 2 years prior.**
* Pulmonary System
	+ Denies SOB, DOE, cough, wheezing, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
	+ Denies recent chest pain, known murmur, HTN, palpitations, irregular heartbeat, edema/swelling of ankles/feet, or syncope. **Hx of palpitations and feelings of near syncope**
* Gastrointestinal System
	+ Denies changes in appetite, intolerance to specific foods, N/V/D, constipation, dysphagia, pyrosis, flatulence, abdominal pain, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool. **No prior colonoscopy. Last FOBT 1 year prior negative for occult blood.**
* Genitourinary System
	+ Denies changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, dysuria, or incontinence. **Up to date on Pap Smears – all unremarkable per pt.**
	+ Sexual History – refer to Social Hx
* Nervous System
	+ Denies seizures, headache, loss of consciousness, ataxia, loss of strength, or weakness
	+ Denies changes in cognition, mental status, or memory
* Musculoskeletal System
	+ **Admits to muscle infrequent muscle cramps of calf muscles bilaterally. Hx of osteoporosis on DEXA scan 2007 but DEXA scan in 2019 only showed osteopenia.**
	+ Denies deformity, swelling, redness, or joint pain
* Peripheral Vascular System
	+ Denies intermittent claudication, coldness/trophic changes, varicose veins, peripheral edema, or color change
* Hematologic System
	+ Denies anemia, easy bruising/bleeding, lymph node enlargement, or history of DVT/PE
* Endocrine System
	+ Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, goiter, excessive sweating, or hirsutism
* Psychiatric
	+ Denies depression/sadness, anxiety, or obsessive/compulsive disorder. Never seen a mental health professional. Never taken psychiatric medications

**PHYSICAL EXAM**

Vital Signs:

BP: 113/73mmHg – sitting & supine, R arm

RR: 18 breaths/min, unlabored

Pulse: 91 bpm, regular

T: 97.3F (oral)

O2 SAT: 98% on room air

 Height: 63 inches Weight: 50.6 kg BMI: 19.77 kg/m2

General Appearance: alert & oriented x3, no acute distress. appropriate development and body habitus, well nourished, appropriate posture, appears stated age, well groomed

Head: normocephalic, atraumatic

Eyes: Symmetrical OU. No strabismus/exophthalmos/ptosis. Sclera white, cornea clear, conjunctiva pink. No erythema of lacrimal sack. PERRLA. EOM intact with no nystagmus.

Ear: Appropriate in size. Ear and tragus nontender AU. No lesions/masses/trauma visualized on external ear. No discharge/foreign bodies in external auditory canals AU. TM pearly white/intact with cone of light in appropriate position AU. Non-obstructing cerumen bilaterally.

Nose: Symmetrical, no masses/lesions/deformities/trauma/discharge.

Mouth & Throat:

Lips: Pink & moist. No cyanosis, lesions, or ulcerations

Oral Mucosa: Pink, well hydrated. No masses/lesions noted. No leukoplakia.

Palate: Pink, well hydrated. No visible lesions/masses/scars.

Teeth: All teeth retained. No visible dental caries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

Tongue: pink, well papillated. Frenulum intact. No masses/lesions/deviation.

Oropharynx: Well hydrated, no exudate/masses/lesions/erythema/postnasal drip/foreign bodies noted. Grade 1 tonsils. Uvula pink, midline with no lesions or edema.

Neck: Trachea midline. No masses/lesions/pulsations noted. Neck supple, non-tender to palpation. Free range of motion. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation. Thyroid is non-palpable, unremarkable. No goiter

Lymph nodes: non-palpable, unremarkable preauricular, postauricular, submandibular, posterior cervical chain, anterior cervical chain, supraclavicular, and infraclavicular lymph nodes

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. RRR. S1/S2 distinct with no murmurs or S3/S4 heard. No splitting of S2 or friction rubs appreciated.

Chest: Symmetrical with no deformities or trauma. No tenderness on palpation. Respirations unlabored, no paradoxical respirations or use of accessory muscles. Lat/AP diameter 2:1.

Lungs: Clear to auscultation and percussion bilaterally. Chest expansion/diaphragmatic excursion symmetrical. No adventitious sounds.

Abdomen: Abdomen symmetric and flat. No scars, striae, or pulsations noted. Bowel sounds are normoactive in all 4 quadrants. No aortic/renal/iliac/femoral bruits heard. Non-tender to palpation. No guarding or rebound tenderness. No hepatosplenomegaly to palpation. No CVA tenderness appreciated.

Skin: **Mild xerosis and erythema with pruritis on the flexural creases of cubital fossa bilaterally.** All other skin areas warm and moist. Non-icteric. No tattoos noted. No moles.

Hair: Average quantity and distribution. No seborrhea/lice/dandruff noted

Nails: Capillary refill <2 seconds in bilateral upper and left lower extremities. Appropriate color, shape, and thickness.

Musculoskeletal: No soft tissue swelling / erythema / ecchymosis / atrophy / or deformities in bilateral upper and lower extremities. Non-tender to palpation.

Peripheral Vascular: 2+ pulses throughout. No ulcerations. Upper and lower extremities have normal skin color and warm to touch bilaterally. No calf tenderness bilaterally, equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: Peripheral sensations intact on feet bilaterally. A&O x person/place/time. Able to follow commands.

Psychiatric: Appropriate appearance, speech/language, mood, thought process/content. PHQ9 Score = 0.

Foot: Skin over the bilateral foot intact without cracking, ulcerations, lesions, masses, scars, or deformities. Appropriate arch. Sensations intact. Nails have appropriate color, thickness, and shape. Dorsalis pedis & posterior tibialis 2+. Capillary refill < 2 seconds. Non-tender to palpation w/o crepitation. Full ROM.

**Labs:**

New Patient – Labs to be completed one week prior to f/u visit in 6 months: CBC, Lipid Panel, CMP, TSH, A1c, & Vitamin D

CBC, Lipid Panel, and CMP WNL 3 months prior from prior medical records that pt brought to visit.

**Differential Diagnosis:**

Hx of Palpitations/near Syncope:

1. Arrythmia induced by Quinine Sulfate
	1. Pt’s Hx palpitations and near-syncope developed while taking Quinine Sulfate for leg cramps, which has black box warning for life-threatening cardiac arrythmias and syncope.
2. Tachycardia due to physiologic state
	1. Pt’s Hx palpitations and near-syncope did occur while at work as a nanny and pt reports “working too hard” which may have increased her physiologic demand for greater cardiac output. Denies illness during episodes or Sx being induced by standing upright. TSH was WNL upon workup.
3. Anxiety
	1. Feelings of palpitations may be due to anxiety brought on by increased stress at work during that period. However, pt denies feeling anxious or episodes precipitated by an attributable event. Medical records from prior PCP report episodes due to anxiety but pt denies Hx.
4. Atrial Fibrillation/Flutter
	1. Palpitations possibly from unknown atrial fibrillation/flutter that terminated before ER visit/workup. 72 hr. Holter monitor did not show findings of AFib/Flutter.
5. Myocardial infarction
	1. Atypical presentation of MI was r/o based on hospital records from event. EKG & troponin were normal. Denied chest pain or SOB during event.

**Assessment:**

NS is a 67 y/o female with a PMHx of osteoporosis w/o fracture, myalgia of the bilateral lower extremities, tachycardia, Herpes Zoster, and flexural eczema that presents to the clinical to establish care due to her prior PCP recently closing their practice. She is overall good health status with no limitations in ADLs or IADLs. She experienced several episodes of palpitations and near-syncope last year that brought her to the ER and prompted a cardiac workup that was unremarkable except for mild regurgitation in all heart values. The only medication she takes aside from Vit D & multivitamin is Quinine Sulfate 200mg PO 1x/daily that was started for muscle cramps in her legs “several years prior”. Prior to starting this medication, the cramps were mild-moderate intensity and only occurred 3-4x per year and she reports she is not concerned about them.

**Plan:**

* Arrythmia Induced by Quinine Sulfate
	+ D/C Quinine Sulfate 200mg PO due to unexplained Hx of palpitations/near-syncope after starting Quinine which has black box warning for cardiac arrythmias
* Myalgia of lower extremities bilaterally
	+ D/C Quinine Sulfate 200mg because it is not recommended for the prevention/treatment of leg cramps due to the potential for severe and/or life-threatening side effects such as cardiac arrythmias, thrombocytopenia, and HUS/TTP, severe hypersensitivity reactions.
	+ Pt denies need for medical intervention at this time reporting the cramps are infrequent and “not bad”.
	+ Re-evaluation of Sx at f/u visit in 6 months
* Osteoporosis/Osteopenia
	+ Continue Vitamin D 1000 units and Centrum Silver multivitamin OTC 1x/daily
* Hx of Herpes Zoster
	+ Shingrix to be given at f/u visit in 6 months
	+ Follow-up sooner if rash reoccurs
* Flexural Eczema
	+ Apply Ammonium Lactate 12% in affected areas 1x/daily
* Allergy Status to Penicillin / Gentamicin
	+ Referral to allergist/immunologist at f/u in 6 months for determination of true allergy status by allergy skin test
* Healthcare Maintenance
	+ Administered 1st dose of Td today 1/10/2022
	+ Shingrix for Herpes Zoster to be administered at f/u visit in 6 months.
	+ Up to date with all other vaccines & boosters
	+ Screening mammogram and colonoscopy referrals will be provided at f/u visit in 6 months