**Identifying Data:**

Full Name: M.M.

Sex: Male

DOB: XX/XX/1963

Race/Nationality: African American

Primary Language: English

Address: Queens, NY

Date & Time: 02:00PM 09/08/22

Location: CitiMed JFK

Source of Information: Self

Reliability: reliable

Source of Referral: N/A

**Chief Complaint:** Employment Physical Exam

**HPI:**

M.M., 59 y/o male, PMHx Diabetes Mellitus Type 2 well-controlled with Metformin, presents for a physical examination for his employment. He is a CDL driver. His last physical examination was September 2020 with no reported abnormal physical exam findings at that time. His last dental exam was June 2022, and his last eye exam was April 2022. He does wear corrective lenses for reading but states he does not need them for distance or while driving. He has no complaints or concerns today.

**Past Medical History:**

* Diabetes Mellitus Type 2 – Diagnosed 2019

*Immunizations*

* Up to date on vaccinations
* SARS-CoV-2 (3 doses Pfizer)

**Past Surgical History:**

* ACL repair right knee 2016 – Denies current complications

**Past Hospitalizations**

* Denies

**Current Medications:**

* Metformin 500mg once daily

**Family History:**

* Mother – Deceased at 82 “natural causes”
* Father – Deceased at 76 myocardial infarction
* Brother – living, 46, healthy
* MGM – unknown
* MGF – unknown
* PGM – unknown
* PGF - unknown

**Social History:**

* Habits – Social alcohol use 2-3 beers 2x/month. Never smoker. No reported illicit drug use
* Travel – Denies recent travel outside of U.S. Travels along eastern coast for work.
* Occupation – CDL driver
* Marital History – Divorced
* Diet – Follows a diabetic diet low in sugar
* Sleep – Denies snoring. Sleeps 7-8 hours per night. Feels well rested
* Exercise – Walks half a mile per day for exercise. Goes to the gym when not traveling for work.
* Sexual History – Not currently sexually active, prior sexual partners were female

**Review of Systems:**

* General
  + Denies weakness, fatigue, weight loss, loss of appetite**,** fever/chills/night sweats
* Skin, hair, nails
  + Denies rash, pruritis, excessive sweating, pigmentations, moles, change in hair distribution.
* Head
  + Denies headache, vertigo, or new head trauma
* Eyes
  + Denies visual disturbances or photophobia.
* 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 unknown
* Neck
  + Denies swelling/lumps, stiffness, ppain or decreased ROM
* Pulmonary System
  + Denies dyspnea, cough, wheezing, hemoptysis, cyanosis, orthopnea, or PND
* Cardiovascular System
  + Denies chest pain, known murmur, palpitations, irregular heartbeat, or syncope
* Gastrointestinal System
  + Denies decreased appetite, intolerance to specific foods, N/V/Constipation, abdominal pain,diarrhea, dysphagia, pyrosis, flatulence, jaundice, changes in bowel habits, hemorrhoids, rectal bleeding/blood in stool.
* Genitourinary System
  + Denies incontinence, changes in frequency, nocturia, oliguria, polyuria, abnormal color of urine, flank plain, or dysuria
* Nervous System
  + Denies weakness, loss of strength, changes in cognition/mental status, changes in memory, seizures, headache, loss of consciousness, & ataxia
* Musculoskeletal System
  + Denies deformity, redness, swelling, painw
* Peripheral Vascular System
  + Denies intermittent claudication, coldness/trophic changes, varicose, or color change
* Hematologic System
  + No Hx of DVT/PE, anemia, or lymph node enlargement
* Endocrine System
  + Denies polyuria/polydipsia/polyphagia, heat/cold intolerance, excessive sweating, or hirsutism
* Psychiatric
  + Denies Hx of depression/anxiety, or other psychiatric illnesses

**PHYSICAL EXAM**

Vital Signs:

BP: 136/78mmHg – sitting, L arm RR: 14 breaths/min Pulse: 74 bpm

T: 98.8F(oral) O2 SAT: 100% on room air

Height: 5’11 inches Weight: 219 lbs BMI: 30.5 kg/m2

General Appearance: Alert and oriented to person, place, and time. No acute distress. Not diaphoretic. Appears reported age and well groomed. Obese body habitus.

Head: normocephalic, atraumatic.

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

Ear: Appropriate in size. No lesions/masses/trauma visualized on external ear.

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

Mouth & Throat:

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

Oral Mucosa: Pink &Moist. No masses/lesions noted. No leukoplakia.

Palate: Pink. No visible lesions/masses/scars.

Teeth: Teeth mostly intact with multiple visible dental carries. All teeth have appropriate shape.

Gingivae: No hypertrophy or recession. Unremarkable

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

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

Neck: No goiter. Trachea midline. No lesions/pulsations noted. No stridor noted. No cervical adenopathy. No carotid pulses/thrills/bruits heard on auscultation.

Cardiovascular: PMI located at the 5th ICS in midclavicular line. Carotid pulses are 2+ bilaterally without bruits. regular rate/rhythm. No murmurs. Normal S1 & S2. No splitting of S2 or friction rubs appreciated.

Pulmonary: Chest symmetrical with no deformities or trauma. Lat/AP diameter 2:1. Normal chest expansion and diaphragmatic excursion. Clear to auscultation bilaterally. No adventitious sounds appreciated.

Abdomen: Abdomen symmetric and protuberant**.** No scars or pulsations noted. Bowel sounds are normoactive in all 4 quadrants. No aortic/renal/iliac/femoral bruits heard.

Skin: Non-icteric. No tattoos noted. No visible moles. No visible wounds, ecchymosis, or erythema to other body parts.

Hair: Average quantity, quality, 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 atrophy or deformities in bilateral upper and lower extremities. Full ROM throughout. 5/5 strength in UE/LE.

Peripheral Vascular: Warm to touch bilaterally. 2+ pulses throughout. No LE edema or ulcerations. Calves equal in circumference. No palpable cords bilaterally. No palpable epitrochlear adenopathy.

Neurological: Peripheral sensations intact on feet bilaterally. A&O x 3. Able to follow commands. DTR 2+ throughout.

**Assessment:**

59 y/o male encounter for general medical examination without abnormal findings

**Plan:**

* Laboratory Diagnostic Testing:
  + CBC, CMP, Lipid Panel TSH, UA, A1C
* Vaccination
  + Tdap booster
* Education
  + Discuss importance of heart, healthy diet and continued diabetic diet. Drink 8-10 glasses of water per day for adequate hydration
  + Physical activity: Aerobic exercise 3x/week for a total of 150 minutes per day and strength exercises
* Follow up in 1-2 years for next CDL examination based on laboratory results