Monica Benjamin

Identifying Data
Full Name: Mr. Z
Sex: Male
Race: White
Nationality: Greek and American
Marital status: Married
Address: Forest Hills, NY
Date and Time: 10/24/18; 8:30 am
Date of Birth: 9/27/28
Location: NewYork Presbyterian Queens, Flushing, NY
Religion: Greek Orthodox
Source of information: Self and son
Source of referral: Dr. Delentis (surgeon)

Chief complaint: "I go to the bathroom 5 times a night and can't wait a minute" x 5 years

History of Present Illness:
Mr. Z is a reliable 90 y/o married, Greek-American male, with a significant past medical history of atrial fibrillation and HTN, presents this morning to PAT, for clearance for Urolift surgery, which will be on 10/31/18. Pt complains of increased urgency and frequency of urination. Pt reports the condition started about 5 years ago and gradually worsened. Pt reports he

has a strong urgency to urinate 10 times during the day and wakes up 5 times a night to urinate. Pt also reports urinating small amounts each time. Color of urine is clear. Reports occasional hematuria. Denies incontinence, dysuria, oliguria, polyuria, hesitancy, or dribbling. Pt reports that this has mildly affected his daily activities as he must always be near a bathroom. Upon doing a DRE, it was found that he has benign prostatic hyperplasia.

at this hospital visit?

Any back pain, abdominal pain, fever, vomiting, chills? has he started any new meds in the past 5 years? has he been on any meds for this in the past 5 yrs?

Past Medical History

Present Illnesses: Hypertension X 20 years; atrial fibrillation X unknown; constipation x 10 years; erectile dysfunction x 20 years

Past Medical Illnesses - Hospitalized for right inguinal hernia ~~X~~ 1.5 years ~~to~~ MB 10/28 ago (see surgeries).

Childhood Illnesses - Denies any childhood illnesses.

Immunizations - Up to date; flu vaccine 1 month ago.

Pt cannot recall last tetanus shot.

Screening test and results - Pt recall having an ECG done in the past ~~10 yrs~~ MB 10/28 2 years and cannot recall the result. DRE performed last week and unknown years ago, benign prostatic hyperplasia found.

was colonoscopy ever done?

Past Surgical History MB 10/28
Hernia surgery - ~~1.5~~ 88 years old, NYPQ, Flushing, NY.
No complications.
Denies past injuries or transfusions.

Medications
Metropolol tartrate, 50 mg, 2 tab PO daily for HTN, last dose this morning.
Tamulosin HCL, .4 mg, 1 tab PO daily for ~~benign~~ MB 10/28 benign prostatic hyperplasia, last dose this morning
Finasteride, 5mg, 1 tab PO daily for benign prostatic hyperplasia, last dose this morning.
Simvastatin, 40 mg, 1 tab PO daily for hypertension, last dose last night
Warfarin Sodium, 4 mg, 1 tab PO daily for atrial fibrillation, last dose this morning

Allergies
Denies drug, environmental, or food allergies.

Family History
Maternal/paternal grandparents - Deceased at unknown age and unknown reasons.
Father - deceased at 75, lung cancer. History of heavy smoking.
Mother - deceased at 99, heart failure.
Brother - deceased at 54, natural causes.
Brother - deceased at 85, natural causes. History of heavy smoking

Sister - deceased at 40, cancer (pt cannot recall type)
Daughter - 62, alive and well.
Daughter - 58 alive and well. Mild heart attack 1 year ago.
Son - 54, alive and well.
Wife - 40, alive and well.

Social History
Mr. Z is a married male, living with his wife and dog. He is currently retired and previously worked as a textile technician.
Habits - He drinks 2 glasses of wine 3-4 times per week with dinner. He denies drinking hard liquor, beer, or illicit drug use. Pt used to smoke 5 cigarettes a day for 10 years (0.5 pack years) and quit 40 years ago. He drinks a small cup of coffee twice a day with breakfast and dinner.
Travel - He denies any recent travel.
Diet - He eats what his wife cooks. His diet primarily consists of lamb, beef, chicken, pasta, fish, and vegetables.
Exercise - He walks the dog twice a week on the weekends for a mile each time. He takes the stairs.
Safety measures - He reports wearing a seatbelt.
Sexual History - He denies currently being sexually active and has not been sexually active for the past 10 years. He denies a history of sexually transmitted diseases. He has only had one sexual partner throughout his life, his

wife. Pt struggled with erectile dysfunction when he was sexually active.

Review of Systems

General - Reports weight is always between 180 and 184 lbs. Denies recent weight gain or loss, loss of appetite, generalized weakness/fatigue, fever, chills, or night sweats.

Skin, hair, nails-Fingernails and toenails are slightly brittle. Nevus of 3 mm length on left cheek. Denies changes in texture, clubbing, excessive dryness or sweating, discolorations, pigmentations, pruritus, or changes in hair distribution.

Head - Reports occasional headaches and dizziness. Denies vertigo, unconsciousness, vertigo, coma, or fracture.

Eyes - Reports slight eye fatigue and occasional pruritus. Denies visual disturbances, lacrimation, or photophobia. Reports wearing reading glasses but is unsure of visual acuity. Last eye exam was 10 months ago, normal.

Ears - Reports difficulty hearing in both ears. Denies deafness, pain discharge, tinnitus or use of hearing aids.

Nose/sinuses - Reports epistaxis. Denies discharge or obstruction.

Mouth/throat - Reports gum bleeding upon brushing teeth. Uses dentures on superior portion of mouth. Denies sore throat, sore tongue, mouth ulcers, or voice changes. Last dental exam was a month ago to get new dentures, normal.

Neck - Denies localized swelling/lumps or stiffness/decreased range of motion.

Breast - Denies lumps, nipple discharge, or pain.

Pulmonary system - Reports light wheezing. Reports contracting a cough a few times a year, which typically resolves itself in 7-10 days. Denies dyspnea, dyspnea on exertion, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system - Has a history of HTN x 20 years. Pt also has atrial fibrillation and is medicated for it (Warfarin Sodium, 4 mg), however was unaware of the diagnosis. Atrial fibrillation confirmed by PA Sarcat. Denies chest pain, palpitations, edema/swelling of ankles/feet, syncope, or known heart murmur.

Gastrointestinal System - Reports constipation for 10 years. Has bowel movements every 2-3 days with the help of laxatives. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations,

abdominal pain, diarrhea, jaundice, hemorrhoids, rectal bleeding, or blood in stool. Last colonoscopy was 4 years ago, normal. Denies having a sigmoidoscopy or stool guiac performed.

Genitourinary system - Pt has history of benign prostatic hyperplasia. Reports urinary frequency of about 15 times per day with urgency and small amounts of urine released for each urination. Reports nocturia of 5 times per night. Color of urine is clear. Reports occasional hematuria. Denies incontinence, dysuria, oliguria, polyuria, hesitancy, or dribbling. Last DRE was performed last week with finding of benign prostatic hyperplasia.

Nervous - Reports occasional headaches. Denies seizures, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, or weakness.

Musculoskeletal system - Pt has started to have stiffness in fingers but denies dx prior diagnosis of arthritis. Pt has some redness on lower ~~ref MB 4/28~~ right leg. Denies muscle pain, deformity, or swelling.

Peripheral vascular system - Reports feeling cold often. Denies intermittent claudication, varicose veins, trophic changes, peripheral edema, or color changes.

Hematological system - Denies anemia, easy bruising or bleeding, lymph node

enlargement, blood transfusions, or history of DVT/PE.

Endocrine System- Reports polyuria and slight intolerance to cold. Denies polydipsia, polyphagia, heat intolerance, excessive sweating, ~~hiro~~ MB 10/28 or goiter.

Psychiatric- Denies depression/sadness, anxiety, OCD, or ever seeing a mental health professional.

Physical Exam

General- well-groomed older male, looks much younger than stated age of 40. AO x 3. In no apparent distress with good posture.

Vital Signs-

BP:	R	L
seated	114/74	112/72
supine	114/70	110/70

R: 18 breaths per minute, unlabored
P: 82 beats per minute, regular rhythm
T: 97.8° F (oral)
O_2 Saturation: 95% room air
Height: 5'8
Weight: 180 lbs
BMI: 27.4

Skin: Skin warm and moist. Mole on left buccal area of 3 mm, Erythema on lower right leg of 3 inches diameter. Several cherry angiomas on neck. 4 inch scar on lower abdomen from hernia surgery. Skin atrophied, unremarkable color, good turgor, thinner and more opaque skin. No noted marks or tattoos.

Nails: Capillary refill under 2 seconds throughout. Unremarkable shape and color. No noted clubbing, lesions, or signs of infection.

Hair: Male pattern baldness with sparse white hairs on temporal and occipital regions of head. No noted seborrhea or lice.

Head: ~~Normal~~ MB 10/28 Normocephalic, atraumatic, no signs of specific facies, no noted lesions, masses, scars, tenderness, swelling, or signs of trauma.

Eyes: symmetrical OU; no noted strabismus, ~~exophthalmos~~ MB 10/28 exophthalmos, or ptosis; sclera white, palpebral conjuctiva pink and moist. Bulbar conjunctiva and cornea clear. ~~No noted p~~ MB 10/28

Visual Acuity - (uncorrected - 20/40 OS, 20/40 OD, 20/40 OU)
Visual fields full OU. PERRLA, EOMs full with no nystagmus.
Fundoscopy - Red reflex intact OU. Symmetrical OU; no noted strabismus, exophthalmos or ptosis. No AV nicking, papilledema, hemorrhage, exudates, or cotton wool spots.

Ears - Symmetrical and normal size. No evidence of lesions, masses, trauma on external ears. No discharge/foreign bodies in external auditory canals AU. Tympanic membranes are pearly gray, intact, and cones of light are in normal position AU.

Auditory Acuity not intact to both ears, left ear affected. Weber lateralizes to left ear / Rinne reveals AC>BC AU. Possible conductive hearing loss.

Nose - Symmetrical, no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa pink and moist. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No noted foreign bodies.

Sinuses - No noted tenderness in bilateral frontal, ethmoid, and maxillary sinuses.

Mouth -

Lips - Pink and slight dryness. No noted cyanosis, masses, lesions, or tenderness.

Mucosa - Pink and moist. No noted masses or lesions. No evidence ~~of~~ of ~~tenderness of leukoplakia~~. MB 10/28

Palate - Denture covering palate. Upon removal, palate is pink and moist and intact with no lesions, masses, or scars.

Teeth - Good dentition. No obvious dental caries noted.

Gingivae - Pink and moist. No noted hyperplasia, masses, lesions, erythema, or discharge.

Tongue - Pink and well-papillated. No noted, masses, lesions, or deviation noted.

Oropharynx - Pink and moist. No evidence of injection, exudate, masses, lesions, or foreign bodies.
Grade 1 tonsils present with no noted injection or exudate.
Uvula pink, no edema or lesions. xmb 10/28

Neck - Trachea midline. No noted masses, lesions, tenderness, scars, or pulsations. No swelling or tenderness noted in the lymph nodes.

Thyroid: No noted tenderness, palpable masses, no thyromegaly or bruits noted.

you were able to do all physical exam?

95.3 F