Monica Benjamin
Name - Mr. W
Address - Queens, NY
Age - 68 yo
DOB - 5/14/50
Sex - Male
Race - Asian
Nationality - Chinese - American
Religion - None
Date and Time - 4/16/19; 8:05 am
PCP - Dr. Sory
Source of Information - Self (Mandarin Interpreter)
Source of Referral - Surgery
Reliability - somewhat reliable

Chief complaint - "I have had pain" x 2 years

History of present Illness:
68 yo somewhat reliable, Asian male, with significant PMHx of HTN, hyperlipidemia, 18 pack years of smoking, and internal hemorrhoids, presents to PAT for clearance for a laparoscopic inguinal hernia repair (will be on 5/2/19) to correct his right-sided inguinal hernia without obstruction. Pt reports that the hernia cannot be reduced. Pt reports that he has had the hernia for the past 2 years and reports pain at the hernia with walking or exertion and is relieved by rest. Pt reports pain is a 5/10 and achy. Pt reports pain does not radiate. Pt reports that nothing helps with the pain and denies taking any medications to help with the pain. Pt admits to urgency, oliguria, hesitancy, and dribbling. Denies undescended testes, swollen lymph nodes, constipation, urinary incontinence, nocturia, dysuria, or polyuria. Pt admits to having a prostate exam 2 years ago and the results were normal.

good HPI ✓

Past Medical History

Present Illnesses - HTN x 20 years
- Hyperlipidemia x 22 years
- Internal hemorrhoids x 2 ~~years~~ months MAB 4/22

Past Medical Illnesses - Pt denies any past medical illnesses.
Childhood Illnesses - Pt denies any childhood illnesses.
Immunizations - Pt reports all immunizations are up to date. Pt admits to flu shot last October. Pt cannot recall last tetanus shot or ever having a pneumonia shot.
Screening tests - Pt reports having a colonoscopy performed 5 years ago and that they removed a polyp but there were no other abnormal findings. Last prostate exam was 2 years ago, normal. Pt denies any other screening tests.

Past Surgical History

Polypectomy during colonoscopy - age 63, NYPQ. Pt denies any complications.
Pt denies ever having recieved a blood transfusion.

Medications:

Amlodipine Besylate, 5 mg, 1 tab PO daily for HTN, last dose this morning.
Enalapril, 10 mg, 1 tab PO daily for HTN, last dose this morning.
Hydrochlorothiazide, 12.5 mg, 1 tab PO daily for HTN, last dose this morning.
Simvastatin, 20 mg, 1 tab PO daily, last dose last night

Allergies:

NKDA. Pt denies food or environmental allergies.

Family History:

maternal/paternal grandparents - deceased at unknown age and unknown causes.

Mother - Deceased at 65, car accident.

Father - Deceased at 72, lung cancer.

Brother - 62, DM2, HTN, hyperlipidemia.

Social History:

Mr. W is a married man, who lives with his wife in Queens, NY. He is currently retired.

Habits - Pt reports smoking half a pack a day for 35 years (about 18 pack years). He reports drinking 2 cups of black tea a day. He denies alcohol consumption and illicit drug use.

Travel - He denies any recent travel.

Diet - He eats a diet mainly of meat, vegetables, and bread.

Exercise - He takes daily walks for about 10 minutes.

Sleep - He sleeps well at about 8 hours a night.

Safety - He admits to wearing a seatbelt.

Reviews of Systems:

General - Pt reports occasional night sweats, and generalized fatigue/weakness. Denies recent weight gain/loss, loss of appetite, fever, or chills.

Skin, hair, and nails - Denies changes in texture, pruritus, excessive dryness/sweating, discolorations, pigmentations, moles/rashes, or changes in hair distribution.

Head - Denies headache, vertigo, head trauma, coma, fracture, or loss of consciousness.

Eyes - Reports using reading glasses. Denies blurring, diplopia, fatigue with use of eyes, scotoma, halos, lacrimation, photophobia, pruritus. Last eye exam was 1 year ago, normal.

Ears - Denies deafness, pain, discharge, hearing aid use, or tinnitus.

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

Mouth/throat - Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures. Last dental exam was about 5 years ago, normal.

Neck - Denies localized swelling/lumps or stiffness/decreased ROM.

Breast - Denies lumps, nipple discharge, or pain.

Pulmonary system - Reports occasional dyspnea and dyspnea on exertion. Denies wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System - Admits to HTN x 20 years and hyperlipidemia x 22 years. Reports occasional chest pain but reports it has not been bothering him lately. Denies edema/swelling of ankles/feet, syncope, palpations, irregular heartbeat, or known heart murmur.

Gastrointestinal System - Reports last bowel movement was last night, normal. Reports internal hemorrhoids for the past 2 months. Denies abdominal pain, food intolerance, flank pain, loss of appetite, nausea, vomiting, constipation, dysphagia, pyrosis, flatulence, eructations, jaundice, hemorrhoids, rectal bleeding, blood in stool, or

ever having a stool guaiac or sigmoidoscopy. Colonoscopy was 5 years ago, polyp removed but otherwise normal.

Genitourinary System: Reports urinating 5 times a day and 1 time at night. The urine is a light yellow color. Reports urgency and oliguria. Denies urinary incontinence, nocturia, dysuria, or polyuria.

Males: Last prostate exam was 2 years ago, normal. Reports hesitancy and dribbling.

Sexual Hx: Mr. P is not sexually active. Reports only having 1 sexual partner, his wife. Denies impotence and history of STIs.

Reports generalized weakness. 4/22 MB 4/22

Nervous - Denies ~~loss of memory~~, seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory.

Musculoskeletal - Denies muscle/joint pain, deformity, swelling, redness, or arthritis.

Peripheral vascular - Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change.

Hematological system - Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions, history of DVT/PE.

Endocrine system - Denies polyphagia, polyuria, polydipsia, heat or cold intolerance, excessive sweating, or goiter.

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

Physical Exam:

General - well groomed, slender male, looks stated age of 68 yo. A/O x 3 and in no apparent distress.

Vital Signs	R	L
BP: Seated	136/64	134/70
Supine	138/62	138/72

R: 18 breaths/min unlabored P: 73 bpm, regular

T: 99.2°F oral O_2 Sat: 99% room air

Height: 5'9 Weight: 150 lbs BMI: 22.2

Skin - warm and moist, good turgor. Nonicteric, no noted lesions, 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 evidence of strabismus, exophthalmos, or ptosis; sclera white; conjunctiva and cornea clear. Visual acuity - corrected - 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 evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots or neovascularization OU.

Ears - Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears. No discharge/foreign bodies in external auditory canals AU. TM's pearly white/intact with light reflex in normal position AU. Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC>BC AU.

Nose - Symmetrical / no obvious masses/lesions/deformities/trauma/discharge. Nares patent bilaterally/nasal mucosa pink and well-hydrated. No discharge noted on anterior rhinoscopy. Septum midline/without lesions/deformities/injection/perforation. No step-offs or evidence of foreign bodies.

Sinuses - Non-tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses. Normal air filled frontal and maxillary sinuses.

Mouth

Lips - pink, moist, no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa - pink, well-hydrated. Palate intact with no lesions, masses, scars. Non-tender to palpation; continuity intact.

Teeth - good dentition/no obvious dental caries noted.

Gingivae - Pink and moist. No evidence of hyperplasia, masses, lesions, erythema, and discharge. Non-tender to palpation.

Tongue - pink, well-papillated; no masses, lesions, or deviations noted. Non-tender to palpation

Oropharynx - Well-hydrated; no evidence of injection; exudate, masses, lesions; foreign bodies. Tonsils present with no evidence of injection, or exudate. Uvula no edema, lesions.

Neck - Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. Full ROM; no stridor noted. 2+ carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid - Non-tender; no palpable masses; no thyromegaly; no noted bruits.

Chest - Symmetrical, no deformities, no evidence of trauma. Respirations unlabored / no paradoxic respirations or use of accessory muscles noted. LAT to AP diameter 2:1. Non-tender to palpation.

Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious breath sounds.

Heart - JVP is 2.6 cm above sternal angle with head of bed at 30°. PMI in 5th ICS in mid-clavicular line. Carotid pulses are 2+ bilaterally without bruit. RRR. S1 and S2 normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs, or other extra sounds

Abdomen - flat / symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic / renal / iliac / femoral arteries. Tympany to percussion throughout. Non-tender to percussion or palpation throughout. No noted organomegaly or masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Breasts - Symmetric, no dimpling, no masses, nipples without discharge. No axillary nodes palpable.

Male - circumcised male. No penile discharge or lesions. No scrotal swelling or discharge. Testes descended bilaterally, smooth, and without masses. Epididymis nontender. No inguinal or femoral hernias noted.

Male Rectal - No perirectal lesions or fissures. External sphincter tone intact. Rectal vault without masses. Prostate smooth and nontender with palpable median sulcus. Stool brown.

Peripheral vascular - Skin normal in color and warm to touch in upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing, edema noted bilaterally.

Upper and Lower Musculoskeletal - No soft tissue swelling / erythema / ecchymosis / atrophy or deformities in bilateral upper and lower extremities. Non-tender to palpation / no crepitus noted throughout. FROM of all upper and lower extremities bilaterally. No evidence of spinal deformities.

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

Cranial Nerves

I - Intact, no anosmia.

II - VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No A-V nicking, hemorrhages, papilledema noted

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

V - Facial sensation intact, good strength. 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 ~~str~~ MB 4/22 and trapezius ~~intact~~ MB 4/22 strong.

Motor / Cerebellar - Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, ~~tret~~ MB 4/22 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	neg	

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

would have been nice if you could have seen the hernia on exam.

Assessment - 68 yo male with significant PMHx of ~~HTN~~ HTN, hyperlipidemia, 18 pack years of smoking, and internal hemorrhoids, presents to PAT complaining of groin pain for clearance for ~~ELA~~ a laparoscopic inguinal hernia repair. Findings consistent with right-sided inguinal hernia without obstruction. good!

Problem List

1. Right-side inguinal hernia
2. Smoking (18 pack years)
3. HTN
4. Hyperlipidemia
5. internal hemorrhoids
6. urgency / oliguria / hesitancy / dribbling
7. Lack of dental care
8. night sweats
9. Generalized fatigue/weakness
10. ~~SOB~~ Occasional dyspnea / dyspnea on exertion
11. occasional chest pain

1. Plan - Inguinal Hernia
- Confirm with physical exam
- Perform laparoscopic inguinal hernia on 5/22
- Surgery Preparation
  - NPO after midnight the night before, except for medications and small sips of water
  - Take medications for HTN and hyperlipidemia as indicated with the exception of Enalapril and Hydrochlorothiazide. Do not take Enalapril and Hydrochlorothiazide the morning of surgery.
- Advise pt to stop smoking atleast until after the surgery to reduce risk of post-op infections.
  - Do not take any other medications or herbs 7 days before procedure.

OK probably would do routine labs (CBC etc)

2. HTN

:

3. Hyperlipidemia

:

4. Smoking cessation

Differentials

1. Inguinal hernia - Due to pain w/ exertion and walking. Confirm with physical exam.
2. Hydrocele - Due to groin pain. R/o with ultrasound.
3. Inguinal lymphadenopathy - Due to groin discomfort, generalized fatigue, and night sweats. R/o groin ultrasound.
4. Undescended testis - Unlikely because no hx of cryptorchidism. R/o with ultrasound
5. Lipoma of spermatic cord - ~~Unlikely~~ MB 4/22 Unlikely because rare and pain is specific to exertion. Rule out with CT scan.

good

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