UMASS MEMORIAL MEDICAL CENTER
HISTORY AND PHYSICAL FORM
File: H&P / Progress Notes

February 2006

Source of Hx: son

Below is a write-up from a medical student. S/he does not have all the information needed to solve this case. In problem solving this case you should think about what more information you would like.

CC: confusion

HPI: 91yo female with PMH hyponatremia with mental status changes (2003), s/p hip surgery 07/05 and heart disease arrives with diarrhea of 2 days duration, reduced PO intake, and increased confusion and visual hallucinations. The son sees her weekly. Last week she seemed "fine" to him and this week as soon as he arrived he knew there was a problem. The house was messy, she seemed confused, and had trouble following commands. She could walk with her walker. She has frequent nausea, gastric pain and vomiting, particularly 1-2 hours after meals for which she takes Reglan. Last episode was Thursday of last week, where she vomited some of her lunch; no blood or coffee-ground appearance was noted. She has had no fever over the past week. She has had recent weight loss, but her son was unable to quantify. A recent clinic note indicated a 13lb loss (130lb → 117lb) over the past 10 months. The son noted no neurological abnormalities including seizure or focal motor/sensory loss, memory or speech impairment. She has not complained of palpitations or chest pain, syncope, light headedness, orthopnea, PND, and has had no cough recently. She has no fever or history of cancer.

PMH:

Hyponatremia	Admitted 2yr ago for hyponatremia and mental status changes. Resolved with fluids over the course of several days.
Multifocal Atrial Tacchycardia	Diagnosed 07/05 Lopressor for rate control.
HTN	10+ years moderately controlled HTN on lopressor.
Dyspepsia	Controlled with reglan.

ALLERGIES: None

MEDICATIONS:

Lexapro (SSRI)	Detrol (anticholinergic)	Reglan	Calcium
ASA	Lopressor (ß blocker)	Senekot	MVI

SH: Lives with her husband. Uses a walker for ambulation. Does not smoke or drink alcohol and has no history of either within the past 30 years.

FH: Noncontributory

ROS:

Skin:	Negative
PULM	No cough, rhinorrhea, sore throat, post-nasal drip

Signature_____ Beeper **xxxx**
Printed Name **Medical Student MSIII**

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PE:

T	P	R	BP	POx
36.4	76	24	170/75	100% RA

GEN	Comfortable in bed, responsive but confused
HEENT	EOMI, PERRLA, moist mucus membranes, no pharyngeal exudates or enlarged tonsils
Neck	neck supple, no LAD
PULM	CTA bilat., no wheezes or crackles
CV	RRR, normal S1S2, no murmurs
ABD	+ bowel sounds, abdominal distension with diffuse tenderness to palpation, no masses, no guarding/rebound tenderness, could not appreciate liver/spleen.
EXT	No edema, cap. refill <2sec, pedal pulses 2+, good skin turgor
SKIN	No rashes or lesions, no caput medusae
NEURO	AOx2, confused and circumferential. MMSE 20. Patellar reflexes 2+.

LABS:

BMP		HCT	35.3	Protein	Negative
Sodium	126	MCV	88.7	Glucose	Negative
Potassium	3.7	MCHC	34.9	Ketones	Negative
Chloride	97	RDW	13.8	Bilirubin	Negative
Carbon Dioxide	22	Platelet Count	308	Occult Bld	Negative
Anion Gap	9			Nitrite	Positive
Glucose	106			Urobilinogen	Normal
Blood Urea Nitrogen	6	Creatine Kinase	Nl	LE	Negative
Creatinine	0.5	CK MB	Nl	White Cells	3
Calcium	8.9	CK-MB Index	Nl	Bacteria	Rare
Magnesium	1.5				
Prealbumin	15 (17-40)	URINALYSIS		Osmolality Urine	623
CBC		Color	Yl	Creatinine Urine	54
WBC	6.7	Appearance	clear	Na URINE	176
RBC	3.98	Specific Gravity	1.020	Osmolality, Serum	266
HGB	12.3	pH	5.0	FENA	1.27%

CXR: Possibly enlarged heart. Lung fields appear clear.

Signature_____ Beeper **xxxx**
Printed Name **Medical Student MSIII**