**CC.** 55 yo m c/o headache

**HPI: SIQUORAAA or**

Starts \*d ago, last for

.0\*h, increases during the day (worse better)

Worse with \*\*\*, better with (or nothing makes better or worse)

**CC ile birlikte gelebilecek ve DD ile uyumlu herseyi sorulmali +/- yazilmali**

**PMHx:** no similar cc, no no associated symptoms (headache abd pain, chest pain bowel movement change), no HT, DM, high Chol NKDA, NKA, No meds, no OTC***, (PMHx: none)***

No hosp, surg, trauma ***(PSHx: none)***

**FHx:** No similar cc, mother, asthma, father cancer, no Ht, DM, high chol. **(or no significant medical issues in the family) or *noncontributory***

**SHx**: active with one women, 3 partners last year, HIV test negative, No STD, works as a server, smoke 1 pack/day for 10y, EtOH every day 2 bears .

**PE**

no acute distress, speech is clear

**VS:** T 37.2C other WNL

**HEENT**: NC/AT (normocephalic, Head atraumatic) eyes: **PERRLA** (**P**upils,**E**qual**R**ound**R**eactive to**L**ight and**A**ccommodation), **EOMI**(Extraocular movements are intact), normal fundus, no nasal congestion, no tonsilar erythema, exudate, enlarement, oropharynx clear, no JVD, thyroid WNL, no LAD

**Lung**: No wheezing, rales, rhonchi or rubs (or clear breath sounds bilaterally), TVF WNL, no cyanosis, clubbing, trachea WNL

**CV:** PMI not displaced, RRR, S1,S2 WNL, no murmurs Rubs and Gallops, pulses brachial, DP/PT 2+

**Abdomen** is soft, nontender; no notable splenic or hepatic enlargement or tenderness, BS+ for all 4Q

**NS:** Alert oriented, good concentration, CN: II-XII grossly intact, motor 5/5 in all muscle groups, DTRs: 2+ intact and symmetric, Babinski -, Sensation intact to sharp, light and dull, - Romberg, intact finger to nose.

**MMT**: orientated to person, date and place, good judgment, good concentration, good short memory, 3/3 registration, 3/3 recall, good eye contact,

CC: 48 yo f co abdominal pain

HPI: burning, epigastric 7/10 pain with no radiation, started 2 wks ago, occurs 2-3h before meals, getting worse with heavy, fatty food, getting better with milk, antacids. Had nausea vomiting 2day ago, vomits yellow color, no blood, half drinking-glass. No diarrhea constipation, no weight appetite changes. no changes in color of the stool, no blood in the stool.

ROS: WNL except above

PMHx: no similar CC, NKDA, NKA, Maalox, Ibuprofen for pain, Arthritis in the knees tx wt ibuprofen, UTI last year treated wt amoxicillin.

PSH: 2 C-section

SH no smoking, ETOH, illicit drugs. Sexually active with husband, no STD, HIV test negative.

FH: no similar CC, Father Died of pancreatic cancer was 55yo

PE

Pt is in no acute distress, speech is clear

VS: WNL

Chest no tenderness, clear breath sounds bilaterally

CV RRR, normal S1/S2, no murmurs, gallops or rubs

Abdomen is soft, non-distended, 2 C section scar, epigastric tenderness without rebound, + murphy sign, +BS, no HSM

DD

Peptic ulcer, cholecystitis, gastritis, gastric cancer

Rectal exam, U/S of abdomen, CBC, AST, ALT bilirubin, ALP, lipase, upper endoscopy

**Time: 13 min**

**CC**: 21yo f co abdominal pain

HPI: Strong, stubbing, 7/10, RLQ abd pain started this morning, no radiation,

Worse with movement, nothing gets better

Nausea and yellowish vomiting this morning, without blood.

Diarrhea this morning, no blood, no problems with urination,

LMP 5wk ago, menarche at 13yr, usually last for 7 days, every 4wks, today first day of menses, brownish vaginal spotting, P1G1, normal delivery

**PMH**: STD 1 year ago, treated with antibiotics, no surgeries, hospit for delivery, no traumas

All: NKDA, NKA,

Meds: OCP, Ibuprofen

FHX, no similar CC, no HBP, DM, high chol

SHx: 1ppd for 10 years, no ETOH, no illicit drugs, sexually active with 1 partner, 3 partners last year, STD last year, no HIV test

PE

Patient is in pain

Chest: normal breath sound bilaterally, no clubbing, cyanosis

CV, RRR, S1/S2 WNL, no M,R,G

Abdomen soft, no HSM, direct and rebound RLQ tenderness, RLQ guarding, psoas sign, Rovsing sign, Obturator sign, no CVA tenderness

DD: PID, Appendicitis, Ectopic pregnancy, Endometriosis

Workup: Rectal exam, pelvic exam, Urine HCG, U/S abdomen, CT abdomen

**Time: 14 min**

42 yo m co pain in the right arm

HPI: Pain stared 3 days ago after fall, while playing with grandchildren in the garden, pain mostly in middle and upper part of the arm, no radiation, 5/10 intensity. NO loss of sensation no weakness, no loss of consciousness. Used sling and Tylenol. Not moving makes feel better, moving makes pain worse. Come to doctor 3 days after accident, probably bed situation at home.

ROS: negative accept as above

PMHx: no similar cc, no HTN, DM, no high chol, allergic to aspirin, has asthma. prostatectomy 2 years ago, no complications, no traumas.

FHx: widower, wife died 3 years ago, then lives with his son family

SHx: not sexually active, no Tabaco, no ETOH, walks every day for 20 min, retired school teacher

PE

Patient is in pain

VS: WNL

Chest: clear breath sounds bilaterally

Heart: RRR, S1/S2 WNL, no m,g,r

Extremity: Tenderness over the middle R arm and shoulder, restricted range of motion on flexion, extension, abduction, external rotation. Pulses normal and symmetric in radial and brachial arteries. unable to assess muscle strength due to pain. DTR 2+ intact and symmetric. Sensation intact to sharp light and dull

DD

Humeral fracture, Shoulder dislocation, osteoporosis, elder abuse,

Workup

x-ray of R shoulder and arm, MRI, DEXA

**Time: 15:25**

21yo m co sore throat

Sore throat started 2 weeks ago, nothing makes better or worse, feels fatigue for last 2 weeks, no runny nose, mild fever, no coach, no night sweets, no jaundice, no eye redness, has swollen painful glands in the neck, no chest pain, 4/7 LUQ abdominal pain, no radiation, no nausea/vomiting, no changes in the bowel movement, no urinary changes, no headache. His girlfriend has a same cc 2 month ago.

PMHx: has a gonorrhea 2 moth ago treated with antibiotics,

Meds: Tylenol for pain and fever,

NKDA, NKA

No surg, no traumas, no hospit.

FH: mother and father are in good health

SH: sexually active, 2 partners for last, year, interested in men and women, STD last year, no HIV test. Smokes 1ppd for 6 yr. ETOH on weekends. No illicit drugs.

PE

Patient is not in distress, oriented

VS: WNL

HEENT: nose, oropharynx, mouth WNL, no tonsilar erythema, no tenderness over the neck, no LAD, no JVD.

Chest, clear breath sounds bilaterally, TVL WNL, no cyanosis.

Heart RRR, S1/S2 WNL, no m,r,g.

Abdomen soft, tenderness in LUQ, no HSM

Skin: no rash, no LAP

DD

Infectious mononucleosis, pharyngitis, acute HIV infection,

Workup:

CBC, monospot test, HIV antibody and viral load, peripheral smear, throat culture

**Time: 13:39**

55 yo m co blood in the stool

HPI: birght red blood in stool each time patient moves his bowels, strats 1 mo ago, has constipation for a long time, 2 BM a week, use laxatives, now has a watery brown, mixed with blood diarrhea, 3 times a day, for a past 2 days. No fever/chills, no abdominal pain, no chest pain, no nausea/vominting, no appetite changes, lost 10 pounds over the last month, no sick contacts.

ROS: WNL except as above

Meds: phenolphthalein, bisacodyl.

All: NKDA, AKA

PSH: none

FH: noncontributory

SH: No tobacco, no ETOH, no illicit drugs, sexually active with wife, works as a lawyer.

PE

Patient not in an acute distress

VS: WNL

Chest: clear breath sounds bilaterally

Heart: RRR, S1/S2 WNL, no m,r,g

Abd: soft, nonteder, + BS, no HSM

DD: Colorectal cancer, hemorrhoids, diverticulosis

Workup: Rectal exam, stool for occult blood, cbc, Colonoscopy.

**Time: 10:15 min**

CC: 46yo m co chest pain

HPI: 7/10, pressure type, chest pain starting this morning at 5:00 am, last 40 min, locates in the middle of the chest, radiates to jaw and left arm, nothing makes better or worse. Has sweeting, nausea, but no vomiting, no coach abdominal pain, dyspnea, bm changes, appetite, or weight change, had same cc during last 3 mo, less severity, 2-3 times/week, decreased with antacids.

PMH: HTN treated with diuretic, high cholesterol managed with diet. GERD 10yrs

NKDA, NDA, uses Maalox, and diuretics. No hosp, surg, traumas.

FH: father lung cancer at age 72, mother alive has a peptic ulcer. No HTT, DM, high chol, cancer, heart attacks.

SH: uses cocaine once a week, last time took yesterday, smoking 25 p/y quite 3 mo ago, ETOH: once a while. Doesn’t have a sex with wife because of chest pain during intercourse.

PE

Patient is in severe pain.

BP: 165/85 RR22/min

Neck: no JVD

Chest no tenderness, clear breath sounds bilaterally

Heart, RRR, S1/S2 WNL, no M,R,G

Abd: soft, nontender, +BS, no HSM

Extremities: no edema, peripheral pulses 2+ and symmetric.

DD

Myocardial ischemia or infarction, cocaine induced myocardial ischemia, GERD, ASortic dissection

Workup

ECG, troponin, CPK CK-MB,CXR, Upper endoscopy, transthoracic echocardiogram

**Time: 14:42 min**

CC: 7m/o m child with fever

HPI. History obtained from mother. 7m/o m childe has a 1 day fever. Rectal body temperature 101F. Child has a runny nose difficulty breathing, decrease in appetite refuse breast and baby food, difficulty swallowing, baby looks tired since yesterday. His older brother had a URI 1 wk ago. Child attends daycare center. No cough, ear pulling, discharge, rash, no eye redness.

All: NKDA, NDA

Meds: Tylenol

PMH: jaundice in the first week of life

BHx: 40-week vaginal delivery wt no complication

Diet: Breast feeding and supplemental vitamins

Immunization: UTD

Developmental hx: last checkup was 2 weeks ago, and showed normal weight, height, hearing/vision and developmental milestones.

PE

None

DD: Viral URI, Pneumonia, Meningitides, UTI

Workup: Otoscopy, CBC, Urine culture, LP, CXR

**Time: 9:25**

18m/o f child with fever

HPI: history was obtained from mother. Child has a fever for the past 2 days, rectal body temp 101F, ear pulling last two days, problem with swallowing, 2 days ago red small dots, slightly elevated over the skin rash started from head now it is on the chest, back and neck. Child has decreased appetite, looks tired, no runny nose, dyspnea, cough, red eyes, nausea/vomiting, no BM changes, no seizures and ill contacts.

PMHx: no hospit, had era infection treated with amoxicillin, no traumas.

All: NKDA, NDA

Meds: Tylenol

Immunization: UTD

Last checkup: everything showed normal weight, height, hearing, vision and developmental milestones.

Birth Hx: Normal vaginal birth on 40th week with no complication

Dietary Hx: formula milk and solid food, no breast feed

PE

None

DD: Otitis media, meningitides (meningococcal), Scarlet fever, 5th disease

Workup: LP, Pneumatic, otoscopy, throat culture, URI, CBC,

**Time: 11:00**

CC 26yo m c/o cough

HPI: Cough started 1 week ago followed 2 weeks of fever, sore throat. Pt does has a fever but didn’t take a temperature. Also has a R chest pain increased wt coach, deep breath, and decreased wt sleeping on the R side. No nausea/vomiting, weight changes, appetite is normal, no TB exposure, no PPD, no ill contacts, night sweetings, recent travels

ROS: negateve except as above

All: NKDA, NDA

Meds: Tylenol

PMH: gonorrhea 1yr ago treated wt antibiotics. No hos., surg., traumas.

SH: Smokes since age 15, ETOH: drinks heavily on weekends CAGE 0/4, Sexually active wit multiple partners.

FHx: noncontributory

PE:

Pt is in no acute distress

VS: WNL

HEENT: no JVD, No cervical LAD, nose, nasopharynx, mouth WNL

Chest increased TVF and decreased breath sounds on R side, no ronchi, rales, wheezing

Heart: RRR, S1/S2 WNL, No m,r,g

Extremities: no Cyanosis, no edema

DD: Pharyngitis, bronchitis, GERD, HIV acute phase, Pneumonia,

W: CXR, CBC, sputum gram stain culture, HIV antibody.

**Time: 10:16**

CC: 54 y/o f c/o cough

HPI: Patient has a cough for years, which worsening last month, has a nocturnal cough, nothing makes better or worse. Has a sputum, 2 teaspoon, yellow, thick and viscous, with blood streaks in it. Mild fever, night sweets, lost 6lb last mo, dyspnea while walking up the stairs, TB exposure, PPD last year, Low appetite, fells fatigue. No chest pain, abd pain, N/V, BM changes

All: NKDA, NDA

Meds: OTC: syrup, multivitamins, Albuterol

PMH: Chronic bronchitis. Tonsillectomy/Adenoidectomy at age 11.

FH: Mother Alzheimer, Father died at old age.

SH: Sexually active wt husband, cigarettes: 35p/y quite 2 yrs. ago, No ETOH

PE

Patient is in no acute distress

VSWNL

HEENT: Nose, nouth, oropharynx WNL. No cervical LAD, no JVD

Chest: Clear breath sounds bilaterally, VTF WNL, no ronchi, rales, wheezing.

Heart: RRR, S1/S2 WNL, no m,r,g

Abdomen soft nontender, BS+, NO HSM

Extremities, no cyanosis, no edema, clubbing

DD: COPD exacerbation, Pulmonary TB, Lang cancer

Workup: PPD, CBC Blood cultures, Sputum gram stain AFB smear, CXR, CT chest.

**Time: 10:00 min.**

CC: 52 yo f c/o yellow skin

HPI: yollew skin starts 3 wk ago, with light stool, and dark urine discoloration, pruritus starts 2 mo ago, takes Benadryl for this. 3/10, dull, RUQ abdominal pain once a day, with no radiation, takes 4 Tylenol makes better. Nausea comes with abd pain, fatigue, decrease in appetite, patient went to Mexico 2 mo ago , did have an immunization before trip. No vomiting, no night sweetings, no BM changes.

PMH: No similar cc, C-S at age 25 and 30, tubal ligation at age 35, hypothyroidism, no traumas.

All: NKDA, NDA

Meds: Tylenol, Synthroid

FH: No similar cc. Father died of pancreatic cancer at age 55. Mother healthy.

SH: no sigaretes, no Illicit drugs, 1-2 glass of wine each day, CAGE0/4. Sexually active with husband

PE:

Patient is no in acute distress.

VS: WNL

Head: nasopharynx, nose, mouth WNL, sclerae icteric. No LAD. Thyroid WNL.

Chest: clear breath sounds bilaterally,

Heart: RRR, S1/S2 WNL, no m,g,r

Abdomen: Soft, C-section scar. Mild RUQ tenderness without rebound or guarding, - Murphy, BS+, no HSM or masses.

Extremities: no asterixis, no edema

Skin: Jaundice, Excoriations due to scratching, no spiders, telangiectasias, palmar erythema.

DD Pancreatic cancer, Choledocholitiasis Viral hepatitis, acetaminophen liver toxicity

Workup CBC, ALT, AST, PT/PTT viral hepatitis serology, U/S abdomen.

**Time: 14 min**

CC65yo F co forgetfulness and confusion

HPI: starts 1 year ago, patient cannot perform daily activities by herself. Can’t do shopping, cooking, lost way to home. No headache, no urinary problems, no gait problems, but had a frequent falls and possible head trauma, had a head a bruise on the R side of the head. Weakness on th L arm. Dizziness when stand up. Decreased appetite and weight loss.

PMH: Stroke heart attack a while ago, HTN.

PSH. Partial bowel resection due to bowel obstruction.

All: NKDA, NKA

Social, no smoking, no Etoh, no illicit drugs, widow, retired, lives with her daughter, has a good support.

PE:

Patient is in no acute distress

VS: WNL

HEENT: normocephalic atraumatic, PERRLA, EOMI normal fundus. Normal thyroid.

Neuro: Mental status: alert and oriented, good concentration, good judgment, spells backward, but can’t remember 3 objects. CN 2-12 intact, Motor: 5/5 strength in all muscle groups except left arm. DTR: asymmetric 3+in left and lower extremities, 1+ in the right, - Babinski bilaterally. Romberg-, Normal gait, sensation intact to sharp light and dull.

DD: Alzheimer disease, vascular dementia, hypothyroidism, subdural hematoma.

Workup: CBC, electrolytes, Glucose, Serum B12, TSH,

Ct head, MRI brain

**Time 13:00**

HPI: 56 yo M wt DM follow-up

25yr history of DM, treated wt insulin. Complaint with medication, no adverse effects. Monitors blood sugar 2 times a week 120-145mg/dl. Last HBA1c 6 mo ago was 7%. Palpitation after missing meals, resolve wt orange juice

Tingling and numbness in feet all the time especially at night, worse past 2 mo

Loss of erection X 2yrs, no morning stiffness, no changes in libido.

No weight loss, no appetite changes, no special diet

ROS: negative except as above. ALL: NKDA,NDA

Meds: Lovastatin, NPH insulin, aspirin, atenolol.

PMH: high chol for 2 yrs, MI 1 yr ago.

PSH: none

FH: Father died of stroke at age 60

SH, no smoking, no illicit drugs, drinks whiskey on weekends, CAGE 0/4

PE

Patient is no in distress

VS: WNL

HEENT: PERLA, eye fundus normal.

Neck: no JVD, NO carotid bruits.

Heart:S1/S2 WNL, RRR, no m,g,r

Extremities, no edema, no cyanosis, 2+ pulses

Neuro: 5/5 strength, DTR symmetric 2+ knee jerks, absent ankle jerks – Babinski. Sens: decreased sensation pinprick, soft touch , vibration, and position in bilateral lower legs.

Dd: Insulin dependent neuropathy, peripheral neuropathy due to DM, alcohol, Multiple myeloma

Workup: Genital exam, serum glucose, HBA1c, UA, Urine microalbumine, BUN/Cr,CBC

**Time: 11:00**

**53 yo M co dizziness**

HPI: Dizzines feels srats 2 days ago, and getting worse, last for 23-30 min. and happens anytime, gets worse when getup from the bed or lie down to the sleep. Nothing makes better. Hearing problem on the left, no fullness, discharge ear pain. Some times feels like going to fall, has nausea and vomiting, had a diarrhea 3 day ago with no blood, normal color, now normal stool. No abd pain, headache, chestpain.

PMH. No similar cc, has HTN diagnosed 7 years ago.

PSH: appendectomy, last year.

All: NKDA, NDA.

Meds: Furosemide, captopril

SH: no smoking, no Illicit drugs, use alcohol occasionally. Sexually active with wife

FH: noncontributory.

PE

Patient is in no distress

VS:WNL

HEENT:PERLA. EOMI without nystagmus, TM is normal, oropharynx clear.

Heart: RRR, S1/S2 WNL, no m,g,r

Neuro : CN: 2-12 grossly intact, Rinne and Weber test WNL or localization on the right on the Weber test. Strength 5/5 throughout, DTR 2+ intacts, symmetric,- Babinski, - Romberg, finger to nose normal. Gait normal

DD: Meniere Disease, BPPV, Labrinthitis, ortostatic hypotension due to dehydration

VDRL/rpr, audiometri, MRI brain, EEG

**Time:11:08**

HPI: 46 y/o M c/o fatigue started 3 mo ago after car accident where patient loss his friend. Fatigue is same throughout the day, decreased performans at work, sleep problems with nightmares about accident and friend death, snoring during sleep. loss of appetite, gained 6 lb/3mo, feels depressed and sad, problem to concentrate on daily life and work. Cold intolerance, hair loss, no BM changes, no abd pain, chest pain, dyspnea, palpitation. Loss of sexual interest.

ROS. Neg except as above

All: NKDA, NDA

Meds: none

PMH: STD treated antibiotic 5 mo ago, no traumas,

PSH none

FH: no similar cc, noncontributory:

SH: smoking 25pk/yr, no illicit drugs, 2-3beers/ month, no exercise. Unprotected sex with multiple female partners. Accountant

PE

Patient is sad, and depressed

HEENT: Conjuctivas WNL, No JVD, Thyroid, WNL, no LAD

Heart: S1/S2WNL. RRR, no M,g,r

Chest: clear breath sounds bilaterally

Abd: nontender, soft, BS+, no HSM

Extremities: no edema, DTR WNL

DD

Depression, Hypothyroidism, Obstructive sleep apnea, HIV infection

Workup: CBC, TSH, ambulatory pulse oxymetry, MRI brainm Polyspmnpography, Hiv antibody

**Time: 11:10**

32yo F c/o fatigue

HPI: fatigues starts 5 mo ago, increasing during the day, decrease energy level, no sleep problems, loss of concentration, normal appetite and no weight changes, no suicidal thoughts. Has some bruises, caused possibly by domestic abuse of alcoholic husband, which also hurt his child. Regular, heavy menstrual periods, last 7 days, and last was 2 weeks ago. Nocturia, polyuria, polydipsia.

NKDA, NDA, no meds

ROS: negative except as above

PMH: no similar CC, no HTN, DM, high chol.

PSH: arm fracture.

FH: Father DM, died of MI, Mother alive has a Alzheimer.

SH: no smoking, no ETOH, no illicit drugs. Vegetarian

PE

Patient is no in acute distress

VS: WNL

HEENT: Nasopharynx, nose WNL, Thyroid normal, no LAD. Pale conjunctivas.

Chest: clear breath sounds bilaterally.

Heart: RRR, S1/S2 normal, no murmurs, gallops, rubs

Abdomen: Soft nontender, +BS no HSM

Extremities: Muscle strength 5/5 throughout, DTR 2+, symmetric painful bruises on both arms

DD Domestic violence,

Depression, anemia, DM

Workup

CBC, blud glucose, HBA1c, TSH Iron level TIBC, Ferritin, serum B12, UA

**Time: 11:40**

CC 61 y/o M c/o fatigue

HPI: Ftaigue starts 6 mo ago, same throughout the day, affects daily activities, decreased appetite, lost 8lb/6mo. BM 2-3/wk. 4/10 epigastric abd pain with radiation to the back, nothing makes worse, leaning forward makes better, nausea sometimes. Feels sad with no reason, no suicide thoughts (or patient denies suicidal ideation or plans), no feelings of blame, sleep problems: wakes up early in the morning past 2 mo, has a loss of concentration, and decreased interest in usual hobbies. No skin, hair problems.

ROS: negative except as above

All: NKDA, NDA

Meds: Tylenol

PSH: appendectomy, at age 16.

FH: father DM, died in car accident, mother breast cancer.

SH, quit smoking 6 mo ago, smoked 35 p/yrs. No ETOH, no illicit drugs, exercise 30 min walking every day.

PE

Patient is no in acute distress.

VS: WNL

HEENT: no conjunctiva pallor, , mouth and nasopharynx normal.

Cheast: clear breath sounds bilaterally.

Heart: RRR, S1/S2 WNL, no murmurs, gallops, rubs.

Abd: soft, nontender, mild epigastric tenderness, no rebound tenderness, - Murphy, +BS, no HSM

Depression, colon canser, anemia, pancreatic canser, chronic pancreatitis.  
CBC, Glucose, amylase, lipase, AST/ALT,TSH, AXR

**Time: 11:00**

CC: 35y/o F C/o headache

HPI: headache X 2 weeks, once a day, 9/10, on R side of the head, no radiation, last for 1-2h, shar and pounding, getting wors from the beginning. May come any time. Worse with light, stress, noise, better with quite, dark room, sleep, aspirin. Had a N/V couple days ago. Non visual changes, no runny nose, eye redness, speech difficulties, weakness, numbness, dizziness, no weight and appetite changes.

ROS. Negative except as above

PMH: similar cc in college, headache + nausea. Joint pain treated wt ibuprofen.

All: NKDA, NDA

Meds: Ibufrofen for joint pain

SH: tubal ligation 8 yrs ago.

FH. Father brain tumor died at age65, mother has a migraine

SH: no smoking, no ETOH, no illicit drugs, sexually active with husband

PE

Patient is in severe pain

HEENT: NC/AT, PERRLA, EOMI, no papilledema, no nasal conjestion. Dentition good. No LAD.

Chest: clkear breath sounds bilaterally

Heart: RRR, S1/S normal, no murmurs, gallops, rubs.

Neuro, Alert and oriented, good concentration Cranial nerves: 2-12 intactMotor strength 5/5 throughout. DTR: 2+ intact, symmetric.

Migraine, Tension headache, Depression,

CBC, CT – head, MRI - brain, LP,

**Time 11:30**

CC: 57y/o M c/o hematuria

Bright red blood and clots in urine yesterday occurred once, now normal. Nocturia, dribbling, weak stream. No dysuria, no frequency, no abd flank pain, no N/V, no fever, no BM changes. No weight loss, appetite changes, night sweet.

PMH no similar cc . gout treated with allopurinol. No traumas,

PSH, appendectomy at age 23.

All: NKDA, NDA,

Meds: allopurinol

FH, father died of kidney disease.

SH: 2-3 beers/week, 30 pack/years, sexually active wt one partner, use contraception randomly, STD: herpes, last attack several month ago, resolve with no Tx.

PE

Patient is in no distress

VS’’; WNL

HEENT: AT/NC, no LAD,

Chest: clear breath sound bilaterally

Heart: RRR, S1/S2 normal, no murburs, gullops, rubs

Abdomen, soft nontender, BS+, mild R CVA tenderness, no HSM

Extremities: no edema, cyanosis, clubbing

DD

Bladder cancer, urolitiasis, BPH Prostate cancer,

Work Genital exam rectal exam UA

Urine culture, BUN/Cr PSA U/S –renal.

**Time: 9:26**

54 yo M HTN follow-up, and ED

HPI: HTN was diagnosed 1 yr ago. Last BP check-up 6 mo ago. Comliant with medication, but ED started, 4 mo ago with decreased libido, no morning erections, no depression, weight changes, appetite normal. No abd pain, head ache, chest pain, dyspnea, palpitations, BM changes, urinary problems.

ROS. Negative except as above

PMH: no similar cc, has a hypercholesterolemia diagnosed 1 yr ago,

All: NKDA, NDA

Meds: Propranolol, HCTZ, lovastatin

PSH: none

FH: father died of heart attack at age 50, mother has an Alzheimer disease.

SH: no smoking, no illicit drugs, sexually active with wife, but decreased performans because of ED and decreased libido. 2-3 beers/week

PE

Patient is in no acute distress

VS: WNL

HEENT: NC/AC, no carotid bruits, no JVD

Chest: clear breath sounds bilaterally

Heart: RRR, S1/S2 no murmurs, no rubs, no gullops

Extremities, no edema, no skin changes or loss of hair. No cyanosis. Radial brachial, dorsalis pedis, and posterior tibialis pulses 2+ and symmetric

Dd

Drug induced ED, hypogonadism ED caused by vascular disease, Depression

Work

Genital exam, rectal exam, serum glucose testosterone LH/FSH prolactine, TSH

**Time: 10:43**

CC:33 yo F c/o R knee pain

HPI: knee pain starts 2 days ago, unable to move R knee, redness, swelling. Pain increased with motion, and decreased with Tylenol, no history of trauma to the knee. Wrisat and fingers always painfull, 6 mo ago had a podagra. Mornining stiffnes lasting for 1 h. no rush, no photosensitivity, had on oral ulcers last month but resolved now, feels hot, sensitive to cold tempreture, fingers become pale and blue.

O/G G2,

ROS: negative except as above,

All: NKDA, NDA

Meds: Tylenol

PMH: toe arthritis 5 yr ago, gonorrhea 1 yr ago

PSH: 2 C-S

FHMother has a RA

SH: smoking 1ppd fpr 20 yr, 2-4 beers/week CAGE 0/4, Sexually active wt multiple partners, inconsistent condom use

PE

Patient is in no acute distress

VS: WNL

HEENT: no oral lesion, AT/NC, no LAD

Chest, clear breath sounds bilaterally

Heart: RRR, S1/S2 normal, no murburs, gallops, rubs

Abdomen: soft nontedner, +BS, no HSM

Extremities: erythema, tenderness, restricted range of motion on flexion and extension of L knee compared to the R. Other body joints WNL

DD: Gout, RA, SLE,

Work: Pelvic exam, knee joint fluid aspiration and synovial fluid analisys. cervical cultures, XR L knee and both hands.

**Time: 11:11**

CC49 y/o M c/o loss of consciousness

HPI: passed out this morning, for several minutes,, patient lost consciousness then fall down, had seizures for about 30 seconds involving upper and lower extremities. Had a palpitation and felt lightheaded before fall. No aura, tong biting, speech difficulties, gait abnormalities, headache, chest pain, dyspnea, abd pain, N/V, weight and appetite changes.

ROS: negative except as above

All: NKDA< NDA

Meds: HCTZ, Captopril, aspirin, atenolol

PMH: no similar CC, HTN for past 15years. MI last year.

PSH: Appendectomy

SH, quit smoking 1 yr ago, smoked for 25years 1ppd, 2-3beers/week, no illicit drugs, sexually active with wife

PE:

Patient is in no acute distress

VS: WNL

HEENT: conjunctivas non pallor, Thyroid Normal, no carotid bruits,

Chest: clear breath sounds bilaterally

Heart: RRR, S1/S2 normal, no murmurs, no gubs, no gallops

NE: Motor: strength 5/5 throughout, CN: 2-12 grosly intact, sensation: intact to pinprick, soft touch. DTRs: Symmetric 2+ in upper and lover extremities. – Babinski bilaterally.

Extremities, pulses symmetric 2+ bilaterally.

Dd

Hypoglycemia, electrolytes disbalance, vasovagal syncope, drug indused hyupotension,

CBC, ECG and Holter monitor, CXR, CT-head, MRI - brain

**Time: 12:49**

CC: 30 y/o F c/o weight gain

HPI: gained 20 pounds over last 3 month, has dry skin, cold intolerance, hair loss, dry skin. Olygomenorrhea, hypomenorrhea, use less tampons than usual. No BM changes, no appetite changes, no abd pain, no depression, fatigue, sleep problems, hirsutism.

ROS: negative except as above

G/O: menarche at age 13. LMP 1 wk ago. Changes in cycles starts 6 mo ago. G1/P1 normla delivery.

PMH: no similar CC, no HTN, DM, bipolar disorder,

Meds: Lithium

All: NKDA, NDA

FH: mother and sister have obesity

SH, quit smoking, 3 mo ago, had smoked for 2pp for 10 years. No ETOH, no illicit drug use. Sexually active with husband.

OE

Patient is in no acute distress

Heent: AT/NC, PERRLA, no myxedema on the face, Thyroid normal, no LAD

Heart: RRR, S1/S2 normal, no murmurs, gallops, rubs

Chest: clear chest sounds bilaterally

Abdomen nontender, soft, no HSM, + BS.

Extremities, no edema, no cyanosis, normal DTR

DD: Smoking cessation, hypothyroidism, Lithium realted obecity, Familial obecity, pregnancy

Work-up: TSH, Urine HCG, glucose, cholesterol, trigliserides Lithium level

**Time: 9:53**

CC 36 y/o F c/o Amenorrhea,

HMI: amenorrhea (LMP 3 mo ago), olyromenorrhea, menorrhagia over the past 1 year. Gained 15lb over the past 1 year, no changes in appetite or diet, vegiterian for 10 years. Facial hirsutism, galactorrhea, No voice, no skin or hair, no BM, no headache, no visioun problem, depression, fatigue, sleep, urinary problems or abdominal pain.

G/O: Menarche at age 13. G1/P1 no complication during pregnancy healthy child. Last pap smear 10 month ago. see HPI.

ROS: negative except as above.

PMH: none

PSH: none

All: NKDA, NDA

Meds: OCP

FH: mother menopause at age 55

SH: no ETOH, no smoking, no illicit drugs. Runs 2 ml/wk. works as a nurse

PE

Patient is in no acute distress

VS: WNL

Heent: AT?NC, EOMI, PERRLA Thyroid WNL, no LAD

Chest: clear chest sounds bilaterally

Heart: RRR, normal S1/S2 no murmurs, no gullops, no rubs.

Abdomen: Soft, nontender +BS

DD: Pregnancy, Hyperprolactinemia, PICOS, Hypothyroidism

WORKUP: pelvic exam, breast exam, CBC, bHCG, UA, LH/FSH, Prolactine, TSH, MRI brain wt IV contrast

**Time: 10:13**

CC: 28 y/o F c/o Dyspareunia

Dyspareunia X 3mo, aching and burning, happens during each sexual intercourse, in vaginal area, with small white~~, amount~~, discharge with fishy odor ~~fish smelling~~ which started recently, itching.no depression, no abdominal pain, no headache, dyspnea, sleeping problems, urinary problems, fatigue, skin or hair changes, flashes, vaginal dryness and libido is normal. She feels safe at home.

O/G: LMP 2 weeks ago, dysmenorrhea started over the past year, regular menses each 4 week, last dor 3 days. G0/P0.

ROS: negative except as above

All: NKDA, NDA

Meds: uses patch as a contraception.

PMH: gonorrhea 10 yr ago after had been raped. no traumas, no hospitalization, no illnesses.

SH: no smoking, 2-3 beer on weekends, marijuana in collage, doesn’t use now. Exercise regulary. Sexually active with one boy friend, had been raped in collage.

FH: noncontributory.

PE

Patient is in no acute distress

VS: WNL

HEENT: AC/NC, no cervical LAP, normal Thyroid

Abdomen : soft nontender, +BS, no HSM

Extremities, no edema

DD: Vulvovajinitis, vajinitis, Endometriosis, vaginismus

Work: Pelvic exam, wet mount, KOH, Cervical cultures, u/s pelvis

**Time: 10:01**

CC: 51 y/o M c/o back pain

HPI: Sharp back pain starts 1 week ago after lifting heavy boxes. Pain stays same, 8/10, with radiation to L tight and foot. Decrease with lying and increase with walking, sitting, cough. No weakness or numbness. Strain during urination and incomplete emptying present, no incontinence. No fever, weight or appetite changes, normal BM, no night sweets.

ROS: negative except as above

PMH: Had a similar CC for years. No traumas.

PSH: none

All: Penicillin cause rashes

Meds: Ibuprofen

FH: father died of MI at age 65

SH 2 beer with in weekends, smoking: 1ppd/18yr. Sexually active with wife

PE

Patient is in pain

VS: WNL

Back examine: mild paraspinal muscle tenderness, no warmth or erythema, normal range of motion.

Extremities, peripheral pulses bilateral 2+ symmetric.

Neuro: Motor strength 5/5, DTR: 2= symmetric.- Babinski. Gait, normal slightly bend over while walking

DD: Disk herniation, osteoporosis, metastatic prostate cancer, Multiple myeloma

Work: Rectal exam, XR –spine, MRI - L-Spine, PSA, calcium, BUN/Cr

**Time: 10:05**

CC: 75 y/o M c/o hearing loss

HPI: CC bilateral hearing loss for all sounds starts 1 yr ago and getting worse, both ears a affected, can locate sounds, understands speech, went to doctor 1 mo ago, wax was removed. Has headaches occasionally. No ear pain, discharge, fullness. No dizziness, vomiting, abd pain, chest pain, ear pain. Exposed to the loud noise.

ROS: negative except as above

All: Penicillin rash

Meds: HCTZ, Aspirin

PMH, no similar CC, HTN X 25yr,

PSH: none

FH: none

SH, no smoking, no ETOH, no illicit drugs, sexually active with wife only.

PE

Patient is in no acute distress

VS: WNL

HEENT: PERRLA, EOMI, no nystagmus no papilledema, ears clean, TM WNL, light reflex, no stigmata or infection, no redness no tenderness of auricle or periauricle, no LAD, clear oropharynx. Rihnne test +, Weber test without lateralization.

Neuro: CN 2-12 grossly intact,exept for CN8: decreased hearing. Motor strength: 5/5 throughout. DTR 2+ throughout. Gait normal.

DD: Presbyacusis, cohlear nerve damage due to loude noise otosclerosis, Mniere disesase

Audiometry, Tympanogrraphy, CT head

**Time: 10: 32**

CC: 25 yo M c/o chest pain, dyspnea

HPI: following MVA patient starts experiencing 8/10 chest pain and dyspnea, chest pain increasing with inspiration, nothing make better, has also cough yellow sputum. Small scratches on the hands after MVA. Has LUQ abdominal pain. Patient did not use ETOH or any illicit drugs during accident. No head trauma, no LOC, no headache, no seizure, no appetite change, no weakness or numbness, palpitations or N/V. No CV or neurological symptoms.

PMH: has a infectious mononucleosis 2 weeks ago.

All: NKDA, NDA

Meds: none

PSH: none

SH: occasionally on weekends, no smoking, no illicit drugs.

FH: Noncontributory

PE

Patient is in acute distress, dyspneic.

VS: Temp 102F. RR22 /min

HEENT, AT/NC, PERRLA, EOMI. No exudates, bruises.

Chest, 2 large bruise on the L chest, left rib tenderness, decreased breath sounds over the all L lungs, R lung field clear,

Heart: S1/s2 NORMAL, RRR, no murmurs, no gallops, no rubs

Abdomen, soft LUQ tenderness, BS+, no organomegaly

Skin: bruises and lacerations

Neuro: CN2-12 intact, DTR 2+ symmetric

DD: Pneumothorax, spleen rupture, pneumonia, hemothorax

Work CXR, AXR, Urine toxicology, Blood alcohol level

**Time: 10:24**

CC: 25y/o F c/o being assaulted

HPI: patient has being sexually and physically assaulted by 2 men 3 h ago. After the bar she usually goes, on her way to the car. Sexually assault, no condoms, patient not sure about ejaculation, only vaginal intercourse, no foreign object used. R 8/10 chest pain, increasing with inspiration, decreased when sit still, no radiation, no cough. Mild abdominal pain throughout, palpitation. No BM, changes, no N/V, no headache, changes in vision no dizziness,weaknes or numbness.

ROS, see per HPI

All: NKDA, NDA,

Meds: none

PMH: none,

PSH none

FH: noncontributory

SH: no smoking, ETOH occasionally, no illicit drugs. Sexually active with boyfriend.

PE:

Patient is in distress, and looks depressed

VS: WNL

HEENT: AT/NC, PERRLA, EOMI, no LAP, nasopharynx looks normal

Chest: tenderness over the R chest, clear breath sounds bilaterally

Heart: RRR, S1.S2 normal, no murmurs, no gallops, no rubs.

Abdomen nontender, soft, +BS, no HSM.

Extremities: no bruits, no tenderness on muscles.

DD: Rib bone fracture, Pneumothorax, hemathorax, STD Pregnancy

Work: Pelvic exam, CXR, AXR, UA, BUN/Cr, CBC bCHG

HIV antibody

**Time: 10: 40**

CC 28 yo F coming with positive pregnancy test

HPI: G0/P0, LMP 6 weeks ago, usually each 4 weeks, last for 3-4 days (regular periods, 4-5/30), 4-5 pads a day. Menarche at age 14, sexually active with husband, no STD, NO HIV test done, use withdrawal (coitus interruptus.) Pregnancy is unplanned. Decreased appetite because of mild nausea. Last pap smear was 8 mo ago and was normal. No vomiting, dizziness, abd pain, chest pain, headache, vaginal discharge, dysmenorrhea, dyspareunia and dysuria. Patient starts go more frequently to the toilet (?), feels fatigue, decreased energy level and cuts usual exercises.

ROS: as per HPI

O/G: as per HPI

All: NKDA, NDA

Meds: multivitamins

PSH: appendectomy at age 14

SH, no smoking 2-3 beer/week, no illicit drugs.

SxH: as per HPI

FH Father DM, mother thyroid problems and obesity.

PE

Patient is in no acute distress

VS: WNL

HEENT: NC/AT, PERRLA, EOMI, no icterus, no conjunctival pallor, mouth oropharynx normal. Thyroid normal, no LAP

Chest: clear breath sounds bilaterally

Heart: RRR, S1/S2 normal, no murmurs, gallops, rubs

Abdomen: soft nontender, BS+, no HSM

DD: Normal pregnancy, Ectopic pregnancy, Molar pregnancy

Work: Breast exam, Pelvic exam, U/S pelvis, urine hCG, TSH, rubella, HIV Ab, HBsAg, Blood type RH screen, Pap smear.

**Time is money**

**CC 20** yo F co sleep problems

HPI: CC starst 1 mo ago, sleeps 4 h at nights, wake up then difficult to get back to sleep, wach Tv before sleep, multiple wakeups during the night, day time sleepiness, no time for naps, snoring at night, stresfull time in college, no depression, 5-6 cups of coffe/day, has a palpitations, wet palms, irritability, 2-3 BM/day (was 1 BM before CC starts), lost 6 lbs/mo with no appetite changes. No dyspnea palpitation, abd pain, chest pain, vision problems, skin changes, hair loss, head ache, feels save at home.

ROS: as per HPI

G/O: LMP, 3wkago, regular, 2-3 pads.

PMH: none

ALL: NKDA, NDA

Meds: Multivitamins, OCP

PSh: Tonsillectomy at age 12

SH: sexually active with boyfriend, no Hx of STD, no HIV test, no smoking, no illicit drugs, ETOH occasionally.

FH: noncontributory

PE

Patient is in no acute distress, looks anxious

VS: DR 102/min

HEENT: AT/NC, PERRLA, EOMI, Thyroid WNL, no LAD

Heart: RRR, S1/S2 WNL, no murmurs, gallops, rubs

Lungs: clear breath sounds bilaterally

Extremities, no edema

DD:

Coffein realted insomnia, Anxiety Hypertiroidism, Insomnia related ton depression

Work: TSH free T4, CBC, ECG, Urine toxicology

Time: 11:00