Anannya Dey

Chief Complaint: "I was feeling dizzy" x 1 month.

History of Present Illness:

85 year old female with PMHx of COPD, Arrhythmias, DM, atrioventricular block, DVTs, HTN, Hypothyroidism, Spinal Stenosis, Thyroid Goiters, Skin Cancer, with a pacemaker and on oxygen supplemental O2 at home, presents with dizziness for the last one month. Pt reported that she came into the hospital 5 days ago because that morning she could not walk from her bedroom to the bathroom. The dizziness worsened that morning to a 9/10. Pt stated that if she did not have her walker, she would have lost her balance. Also added that the distance from her bedroom to bathroom is only about 10 ft. Describes the dizziness as her head feeling heavy, "head spinning sensation" and feeling faint and weak. Pt states that she also experiences numbness and tingling in her upper extremities when she feels dizzy as well. Reported that the pain has been progressively getting worse as the month went by. Pt stated she has never felt this in the past before it started one month ago. The dizziness resolves after she sits down for about 30 mins but was unable to quantify how long each episode lasts in general. It happens mostly if she gets up from bed throughout the night and in the morning after waking up. Walking while she feels dizzy makes the dizziness worse and sitting down makes it better. Pt has not tried any medications for pain relief.

Denies room spinning sensation, visual changes, any hearing changes, headache, fatigue, chest pain, shortness of breath, fever and n/v.

Past Medical History:

Present illnesses – COPD (On oxygen at home), Arrhythmias, Diabetes mellitus, Atrioventricular block, DVT, Hypertension, Hypothyroidism, Spinal stenosis, Thyroid Goiter, Skin cancer (unable to recall type), Glaucoma and Cardiac Pacemaker since 2016 and pt uses a walker

Hospitalized for Spinal Stenosis and fracture of spine "several times" unable to recall dates

Past medical illnesses – 2 Cataracts (removed)

Childhood illnesses – unable to recall

Immunizations **–** Up to date

Screening tests- Mammogram 3 times, negative. Biopsy of neck lump. Unable to recall the date of both.

Past Surgical History:

Gallbladder removal in 2017, no complications

Pacemaker in 2017

Denies past injuries or transfusions.

Medications: Gave me medicine bag and confirmed reason
Losartan- HCTZ 50-12.5 Mg tablets for HTN, once a day
Eliquis- 5mg tablets twice a day for blood clots
Lumigan- 0.01% solution at bedtime for Glaucoma
Clopidogrel- 75 mg tablets once a day for blood clots
Metoprolol- 50 mg 1 tablet a day for arrhythmias
Novolog Flexpen- 100 units/ml for diabetes mellitus dose- 8-20 ml before meals (states it depends on the day)
Tresiba- once at night 30 or 36 units insulin for diabetes mellitus

Allergies:
Denies any drug, environmental or food allergies.

Family History:
Mother – Deceased at age 82, due to a hip injury
Father – Deceased at age 79, due to a "stomach problem"
Son- Two living
Siblings- 3 living, Sister has history of stroke and diabetes
History of skin cancer in mother and sister (unable to recall type of skin cancer)

Social History:
Ms. J is a divorced female, living alone with occasional visits from one nurse aid. She does not work and does not exercise much. She stated that since she can not walk without her walker, she is unable to do any exercise. She spends most of her time sitting down and watching tv or cooking. Her diet consists of salad (cucumber, lettuce), meat and fish. She does not smoke, do any drugs or alcohol. She occasionally drinks coffee, about twice a week. Ms. J stated she sleeps well at night with the exception of her bladder incontinence issue. She has to wake up every 3 hours to use the bathroom. She is not sexually active and has no partners.

Review of Systems:
General – Denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

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

Head – (+) dizziness Denies headaches, vertigo or head trauma.

Eyes – History of glaucoma. Denies other visual disturbances, or photophobia. She wears glasses. Last eye exam Dec 2022.

Ears – Denies deafness, pain, discharge, tinnitus or use of hearing aids.

Nose/sinuses – (+) nasal cannula in. Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures. Last dental exam Sept 2022.

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

Breast – Denies lumps, nipple discharge, or pain.

Pulmonary system – (+) Chronic cough due to the COPD. Denies dyspnea, dyspnea on exertion, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Has a history of hypertension. Denies chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal system – Has regular bowel movements daily. Denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – (+) urine incontinence. Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, awakening at night to urinate or flank pain.

Menstrual/Obstetrical – G2P2002, no complications. No longer menstruating, last LMP was when she was 52. Currently in menopause – denies hot flashes or associated menopausal symptoms. Denies breakthrough bleeding/spotting or vaginal discharge.

Nervous – (+) numbness and tingling on upper extremities. Denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

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

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

Hematological system – (+) Has history of DVT. Denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions.

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

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

Physical-

General: Ms. J is an elderly bariatric female who looks chronically ill. She is lying supine with the nasal cannula with oxygen. She is alert and with good eye contact. Did not appear to be in respiratory distress.

Vital Signs:
BP:
Seated: Right (124/78) Left (124/82)- performed on sibling
Supine: Right (128/70) Left (130/70)- pt was supine throughout the encounter.

R: 14/min unlabored
P: 60, regular

T: 98.6 degrees F (oral)
O2 Sat: 92% Room air (pt on nasal cannula, COPD)

Height: 5'2 inches **Weight:** 232 lbs. **BMI:** 42.4

Skin, Hair and nails:
Skin: (+) Several 5-6 cm brown macule asymmetric patches of discolorations throughout both arms. One nevus of about 2 cm on the right dorsal aspect of lower RT arm about 8 cm above the radiocarpal joint. Skin mildly dry and warm, good turgor. Nonicteric, no scars, tattoos.
Hair: (+) Some crown balding in 2 spots with thin average hair distribution
Nails**:** No clubbing, capillary refill <2 seconds in upper and lower extremities
Head: Normocephalic, atraumatic, non tender to palpation throughout

EOM and visual acuity done on pt, rest performed on sibling at home

Eyes - Symmetrical OU. No strabismus, exophthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.
Visual acuity uncorrected - 20/30 OS, 20/30 OD, 20/20 OU
Visual fields full OU. PERRLA, EOMs intact with no nystagmus
Fundoscopy - Red reflex intact OU. Cup to disk ratio< 0.5 OU. No AV nicking, hemorrhages, exudates or neovascularization OU.

Ears: performed on pt
Ears are symmetric and appropriate in size. No lesions, masses, or evidence of trauma on external ears. No discharge or foreign bodies in external auditory canals AU. TM's are pearly white and intact with light reflex in a good position AU. Auditory acuity intact to whispered voice AU. Weber midline, Rinne reveals AC>BC AU.

Nose, Sinus: performed on pt
(+) Nasal mucosa appears dry. Nasal cannula in place. Symmetrical with no masses, lesions, deformities, trauma, bleeding or discharge. Nares patent bilaterally. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, or perforation. No foreign bodies.
Sinuses - Non tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Mouth, Pharynx: Performed on sibling
Lips – Pink, moist, no cyanosis or lesions. Non-tender to palpation.

Oral Mucosa – Pink, well hydrated. No masses or lesions noted. No leukoplakia.

Palate – Pink, well hydrated, and intact with no lesions or masses. Non-tender to palpation.

Teeth – Good dentition with no obvious dental caries noted.

Gingivae – Pink, moist. No hyperplasia or masses.

Tongue – Pink, well papillated. No masses, lesions or deviation. Non-tender to palpation.

Oropharynx – Well hydrated, with no erythema, exudates, masses, or lesions. Tonsils are present with no erythema or exudates. Uvula midline, with no lesions.

Neck, Trachea and Thyroid:
Neck – Trachea midline. No masses, lesions, scars, or visible pulsations noted. Supple and nontender to palpation. Full range of motion. No palpable cervical adenopathy.
Thyroid – Non-tender, no thyromegaly. No palpable nodules noted

Differential diagnosis:
Vertigo
A new arrhythmia
Side effect of medication
Dehydration
Anemia