Name: Martha Smith
Date of Birth: 5-22-47
History Number: 54970B

Date: 11-30-02

PROBLEM LIST:

Problem #	Onset (date)	Problem	Inactive/resolved (date)
1	5/02	Pain and stiffness hands bilat	
2	1992	Seasonal rhinitis	
3	1987	s/p Total abd. hysterectomy with oophorectomy	
4		Family history of diabetes	
5		Family history Alzheimer disease	
6		Family history glaucoma	

General Patient Information

Address: 841 Foxtrail Drive
St. Louis, MO 63146

Home phone: (314) 555-6423
Social security number: 111-11-1111

Employer: Memorial Hospital

Position/title: Registered Nurse

Business address: 1050 Randolph Ctr.
St. Louis, MO 63116

Business phone: (314) 747-0000

Age: 55

Marital status: Married

Sex: Female

Health insurance provider: Aetna

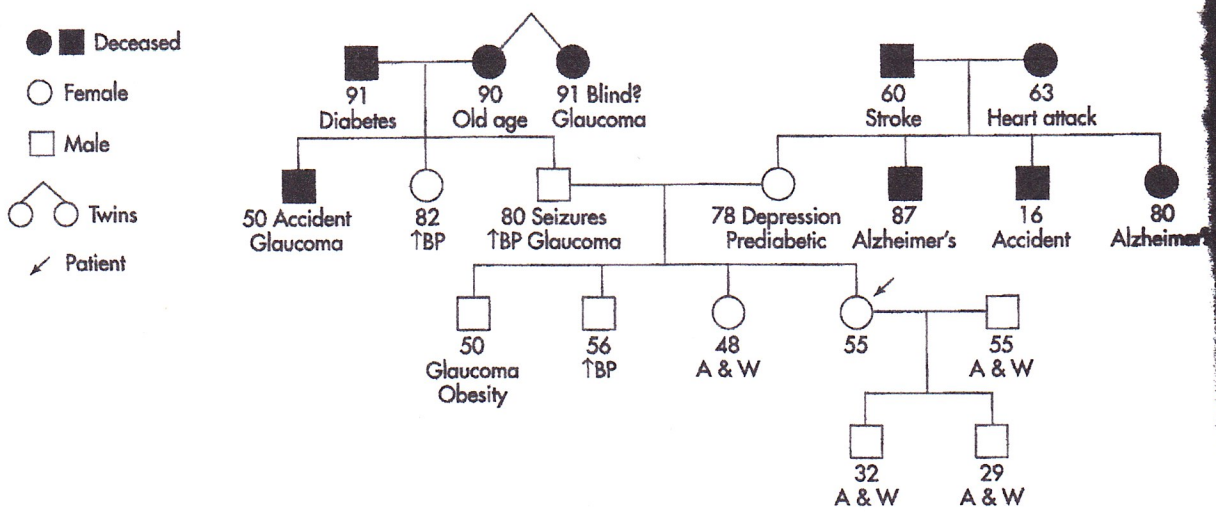
Member #: X45789

SOURCE AND RELIABILITY OF INFORMATION
Self—very reliable historian
Old record

CHIEF COMPLAINT
Time for annual examination. Has noticed pain in hands when doing needlework.

HISTORY OF PRESENT PROBLEM
Pain and stiffness in fingers and hands, began about 6 months ago but seems to be increasing in severity and with shorter time of activity. Dull, aching pain now occurs after 15 minutes of needlepoint or crocheting, right hand more than left hand. Pain ranges between 2 and 4 on a 10-point severity scale. Usually resolves with rest. Some stiffness in morning but does not currently interfere with ability to perform all job and household activities. Uses aspirin (650 mg q 4 hr) when pain does not resolve with rest; effective relief. Has not tried heat or ice. No other systemic symptoms such as fatigue, fever, or weight loss. No other joints affected.

PAST MEDICAL HISTORY
Generally healthy
Hospitalizations, Illnesses, and Injuries. Hysterectomy for fibroids in 1987, usual childhood illnesses, no major adult illnesses, car crash 1992 without major injury.
Previous Health Care. Annual physical, hepatitis B vaccine series 2 years ago, Td booster 5 years ago, oral polio vaccine series in 1976, dental care q 4 months, vision exam q year. Pap smear and mammogram 6 months ago with no problems detected, 2 pregnancies (1969 and 1973), both vaginal delivery without complications.
Allergies. Hay fever in spring, no food or drug allergies known, no reaction to blood transfusion in 1987 (blood type A+).
Family History. See genogram below. No history of cancer, tuberculosis, blood dyscrasias, or respiratory, renal, thyroid, or psychiatric disorders.



PERSONAL/SOCIAL HISTORY

Lives with husband, a psychologist in private practice, in 3-bedroom home in well-maintained neighborhood. Works as RN in hospital clinic 3 days a week. Has 2 sons, both married with 2 children each. Visits each at least once a month. Both parents still living, in retirement home in town, visits them 2 or 3 times a week. Active in church and local arts and crafts group. Needlepoint and quilting main hobbies.

Current Health Habits. Walks dog daily about 1/2 mile; 15 lb weight gain in last 2 years, tries dieting, loses a few pounds and then stops; no smoking or recreational drug use, 2 to 3 glasses of wine on weekends, 2 to 3 cups coffee and 1 glass iced tea daily.

Diet/Nutrition. Would like to lose 15 lbs; currently 150 lbs, 5'5"; diets sporadically; uses 1200 calorie diabetic exchange lists, usually has desired results when she persists, losing approximately 8 lb in 4 weeks; does own grocery shopping and cooking; rarely fries foods; binges on ice cream when traveling.

REVIEW OF SYSTEMS

General Constitutional Symptoms. No fever, chills, malaise; would like to lose 15 lbs gained over past 2 years.

Skin, Hair, and Nails. Several flat nevi, no change in appearance noted; bathes daily without special skin preparations; washes hair once a week, permanent and colored; nails short, crack and split frequently.

Head and Neck. Periodic headaches, no more than once a month, related to tension, pain up neck and back of head, relieved by aspirin. No neck tenderness or stiffness currently, has had muscle spasm in past, some pain with car crash 14 years ago, no enlarged lymph nodes noted.

Eyes. Wears glasses for reading; no pain, swelling, tearing, or halos around lights. Sees optometrist yearly.

Ears. No change in hearing noted; no dizziness, sensitivity to noise, or pain; some pressure and popping in ears when hay fever symptoms occur; resolves with Allerest.

Nose and Sinuses. Hay fever in spring, postnasal drip, no problem with sense of smell. Uses Allerest for hay fever as needed.

Mouth and Throat. No sore throats, hoarseness, change in voice, no dental appliances, no difficulty eating or chewing food, brushes and flosses daily.

Breasts. No pain, tenderness, or nipple discharge; breast self-exam done when she remembers, about every 2 months; mammogram 6 months ago revealed no masses; no history of masses.

Cardiovascular. No difficulty performing regular activities, no shortness of breath or chest pain, last BP 126/82, no pain, tenderness, discoloration, temperature change, or swelling in extremities; wears support hose for work, some varicose veins.

Chest and Lungs. No history of asthma, bronchitis, or pneumonia; no breathing difficulties, cough, or pain. PPD at work 3 months ago, negative.

Endocrine. No history of changes in thyroid, skin, hair, or temperature preference; no polydipsia or polyuria; takes no estrogen replacement therapy.

Hematologic. No bleeding, excess bruising, anemia.

Lymphatic. No known lymph node enlargement.

Gastrointestinal. No diarrhea, constipation, blood in stool, or emesis; has bowel movement every other day, brown, formed, no pain; hemorrhoids during pregnancies only; indigestion occasionally after eating fried or rich foods, resolves with Gelusil. Uses no laxatives, tries to add bulk to daily food intake.

Genitourinary. Voids 5 or 6 times a day, light yellow, no change in odor or color, no complaint of nocturia or dysuria, good control of stream, no stress incontinence; no history of sexually transmitted disease; no known genital lesions, discharge, pain, itching, dyspareunia; satisfied with sexual activity, about twice a month.

Musculoskeletal. No weakness, twitching, or pain other than in hands; no history of backache, fracture.
Neurologic. No problems with walking, balance, or sensations; no known changes in cognitive functioning; exp concern with family history of Alzheimer disease and her possibility of developing the disorder.
Mental Status and Psychiatric. Coping well with stress of older parents requiring increasing care; no history of term depression; gets depressed and anxious occasionally about growing old, but feels this does not interfere wi ability to work or lead a productive life.

PHYSICAL EXAMINATION

General. 55-year-old white female, alert, cooperative, well groomed, communicates well, makes eye contact, an expresses appropriate concern throughout history.

T 98.4° F, P 72, R 18
BP 130/76 sitting L arm, 134/80 supine L arm, 132/78 sitting R arm
Wt. 66.2 kg (150 lb), Ht. 165 cm (5 ft 5 in), about 50th percentile weight for height, medium frame, BMI = 25.0

Mental Status. Oriented to time, place, and person; reasoning and arithmetic calculations intact. Memory intact, Mini-mental score = 30; speech clear, smoothly enunciated; comprehends directions.
Skin, Hair, and Nails. Pink, soft, moist, turgor with instant recoil, no lesions, tenderness, or edema; nail beds pi without clubbing, uniform thickness; nails smooth, firmly adhered to nail bed, brisk capillary refill; hair with sill texture, thinning on crown, female distribution.
Head. Head erect and midline; scalp pink, freely movable without lesions or tenderness; well-spaced, symmetric facial features. Temporal arteries soft, nontender, no bruits.
Eyes. Brows, lids, and lashes evenly distributed; no tearing; conjunctivae pink without discharge; pupils react eq to light and accommodation; extraocular movements intact, no lid lag, no nystagmus; visual field equals examin corneal light reflex equal bilaterally, red reflex present, discs cream colored with well-defined border bilaterally; arterial-venous ratio 2:5, no crossing changes noted; cornea, lens, and vitreous clear; retina pink, no hemorrhage exudates; macula yellow; Snellen 20/20 each eye without glasses; near vision 20/40 each eye without glasses, 20 with glasses.
Ears. Auricles in proper alignment, without lesions, masses, or tenderness; canals with small amount dry cerum tympanic membranes gray, translucent; light reflex and bony landmarks present; no perforations. Rinne—air conduction > bone conduction bilaterally; Weber—no lateralization, repeats whispered words at 2 ft bilaterally.
Nose and Sinuses. No flaring of nares, septum slightly to left of midline, patent bilaterally, mucosa pink and mo no polyps or discharge; correctly identified coffee, chocolate, and orange odors bilaterally; no frontal or maxillar sinus tenderness with palpation or percussion.
Throat and Mouth. Buccal mucosa pink and moist, no lesions, salivary glands nontender; 28 teeth in good repai movement; #1, 16, 17, and 32 missing; gingivae slightly erythematous and spongy; tongue in midline without fibrillation, no lesions; uvula midline with elevation of soft palate; gag reflex intact; pharynx without erythema: hoarseness; correctly identified sweet, salty, and sour tastes bilaterally.
Neck. Trachea midline, no tracheal tug, thyroid and cartilages move with swallowing, thyroid lateral borders palpable, no enlargement or nodules noted, lymph nodes nonpalpable, full range of motion and appropriate stren
Chest and Lungs. AP diameter < lateral with 1:2 ratio; muscle and respiratory effort symmetric without use of accessory muscles; inspiration = expiration; tactile fremitus symmetric; resonant percussion throughout; 4 cm excursion bilaterally; vesicular breath sounds throughout without adventitious sounds; even, quiet breathing.

asts. Moderate size, L slightly > R, nodular, granular consistency bilaterally, no masses palpated; nipples erect hout discharge; areolas symmetric with Montgomery tubercles; no palpable axillary nodes; no dimpling, venous terns symmetric.

art. Apical impulse barely palpable at 5th intercostal space, 4 cm from midsternal line, no heaves, lifts or thrills, and S_2 heard without splitting, no murmurs, S_1 heard best at apex, S_2 heard best at base, apical impulse timed h radial pulse, no visible pulsations, no audible S_3, S_4, or murmur.

ood Vessels. Pulse regular rhythm, smooth contour, no pulse deficit; jugular venous pulsation visible at sternal gle with 30-degree elevation; no carotid, renal, or abdominal bruits; no edema, swelling, or tenderness in lower remities; Homans sign negative; lower extremities warm, pink with symmetric hair distribution; superficial icosities in lower extremities, L > R.

PULSE AMPLITUDE

	C	B	R	F	P	DP
L	2+	2+	2+	2+	2+	1+
R	2+	2+	2+	2+	2+	1+

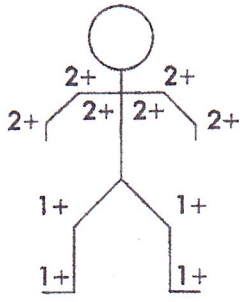
domen. Soft, rounded, faded 12-cm scar from umbilicus to symphysis pubis; aorta midline with no visible lsation, no bruit; bowel sounds heard in all quadrants; tympanic percussion tones over epigastrium, remainder dull percussion; liver span 6 cm at R midclavicular line by percussion; spleen percussed at L midaxillary line; liver, een, and kidney not palpable; no tenderness on palpation; no CVA tenderness; superficial abdominal reflexes act.

nital/Rectal. Deferred. Gyn exam 6 months ago.

mphatic. No palpable lymph nodes in neck, supraclavicular, axillary, epitrochlear, or inguinal areas.

usculoskeletal. Heberden nodes at distal interphalangeal joints on both hands; good mobility of hands but derness when making a tight fist bilaterally; no swelling, heat, or erythema noted. Remainder of muscles appear nmetric, muscle strength appropriate and equal bilaterally, full range of active and passive motion, spine and remities in good alignment, slight kyphosis.

urologic. Coordinated, smooth gait; negative Romberg sign; balance, rapid alternating movements, sensory ıctioning, and cranial nerves I-XII grossly intact; plantar flexion of toes bilaterally with plantar reflex, no clonus.



Deep tendon reflex response

ASSESSMENT PLAN

Problem #1: Pain and stiffness in both hands

Assessment: Degenerative arthritis is the most likely diagnosis. This is supported by presence of Heberden node bilaterally and lack of systemic signs and that could suggest an inflammatory process. Pain is well controlled wi aspirin. Since noninflammatory symptoms are evident, analgesia could be achieved with acetaminophen with le risk of gastrointestinal side effects.

Dx: None at present

Rx: Acetaminophen 325 mg, 2 tabs q 4 hr prn

Pt. Ed.: Discuss suspected pathophysiologic process of degenerative joint disease (DJD). Reassure that DJD pai usually be successfully controlled with mild analgesics. Recommend trials of heat and ice to augment analgesia. Return to clinic if increased signs/symptoms, any associated redness, swelling or heat.

Problem #2: Seasonal rhinitis

Assessment: Mild nasal stuffiness q spring secondary to pollen exposure. Well controlled on nonprescription antihistamine/decongestant preparation.

Dx: None at present

Rx: None at present

Pt. Ed.: Stay indoors as much as possible when pollen counts are elevated. If nonprescription agent does not cor signs/symptoms, may try nonsedating antihistamine. Warned about sedating properties of many nonprescription preparations. Discussed increased risk of sinusitis when turbinates swell. To return to clinic if fever, facial pain, purulent nasal discharge develops.

Problem #3: s/p Total abdominal hysterectomy (TAH)

Assessment: TAH with bilateral oophorectomy performed 1987 for fibroids per patient. Patient never supplemer with estrogen replacement therapy (ERT). There are no apparent contraindications to ERT. Pt not symptomatic v hot flashes, but is at increased risk for osteoporosis and coronary heart disease (CHD). Will complete baseline evaluations and develop plan with patient.

Dx: Baseline bone densometry of hips and L-spine
Fasting cholesterol and lipid profile

Rx: Ca supplement (nonprescription) as augment to diet to ensure 1500 mg Ca/day
Vit D 400 mg po qd

Pt. Ed.: Discuss increased risk of CHD and osteoporosis secondary to early surgical menopause. Explain risks a advantages of ERT. Describe alternatives to ERT. Increase weight-bearing exercise. Will discuss individual plan obtaining baseline studies.

Problem #4: Family history of diabetes

Assessment: No symptomatic evidence of hyperglycemia. Slightly obese.

Dx: Fasting serum glucose, U/A

Rx: None at present

Pt. Ed.: Benefit of weight loss, goal to reach ideal body weight to avoid insulin insensitivity. Moderate exercise 4 times/week.

Problem #5: Family history of Alzheimer disease

Assessment: No evidence of cognitive deficit at present.

Dx: None

Rx: None

Pt. Ed.: Return to clinic if memory problems or other cognitive difficulties develop.

Problem #6: Family history of glaucoma

Assessment: Sees optometrist on yearly basis. Will obtain latest tonometry screening values. No visual changes objective signs of increased eye pressures.

Dx: None

Rx: None

Pt. Ed.: Discuss important yearly glaucoma screening as glaucoma is a preventable cause of blindness. To repor visual changes, eye pain immediately.