Patient 1

Full Name: Ms. KS
Address: 110-16 Sutphin Blvd, Jamaica, NY 11435
DOB: 10/22/1999
Date & Time of Encounter: November 23,2020 @10:50am
Location: Amazing Medical Services
Source of Information: Self - Reliable

CC: "I was told I have high blood pressure."

HPI: 21-year-old female with history of morbid obesity and hypertension came in today for the first time to establish care. She was told by a previous doctor over 1 year ago that her blood pressure was somewhat high, and she did not follow-up. She also was told by GYN about a month ago that it was borderline high, but she did not follow-up. Patient has been stressed out from trying to provide for herself that she has not focused on her health. She says she has always been heavyset since she was young. She remembers when she was much younger, she was told that she has to watch out for diabetes. Pt also states that both of her parents are hypertensive. She denies any fevers, chills, chest pain, shortness of breath, headache, excessive sweating, palpitations, cold intolerance, syncope or presyncopal episodes, nausea, vomiting, urinary problems, polyuria, polydipsia or polyphagia.

PMH:

Present Illnesses: HTN

Childhood Illnesses: Denies childhood illnesses.

Immunizations: Up to date.

PSH: Denies past surgical history.

Allergies: NKDA. Denies food and environmental allergies.

Medications: Denies taking any medications.

Family History:

Mother: 50, alive, hx of hypertension

Father: 55, alive, hx of hypertension

Siblings: 2 brothers, 2 sisters, alive and healthy

Denies any family history of cardiovascular disease or cancer.

Social History: Pt lives by herself and works as a home attendant. She is an immigrant and came here when she was young and has had to support and provide for herself. She says her situation has been stressful for her and she is worried about her future. She is concerned about not being able to go to school and starting medication. She states she does not feel depressed. Denies any tobacco, alcohol, or illicit drug use. Admits to being sexually active, with males only, and does not use protection. Pt says her diet is not that healthy especially with the pandemic going on. Pt has not been able to exercise or do any physical activity because she is always tired from working and the stress she feels.

ROS:

General: Denies weakness, weight gain, weight loss, loss of appetite, fever or chills or night sweats.

Skin: Denies discoloration, texture, excessive dryness/sweating, changes in pigmentation, moles/rashes, pruritus.

Head: Denies trauma, headache, no dizziness, lightheadedness.

Eyes: Denies blurring, diplopia, halos, lacrimation, photophobia, pruritus.

Ears: Denies deafness, discharge, tinnitus and hearing aid use.

Nose: Denies discharge, epistaxis, rhinorrhea.

Mouth/throat: Denies bleeding gums, sore throat, mouth ulcers, voice changes or dentures.

Neck: Denies edema, masses, stiffness, or decreased ROM.

Cardiovascular: **Admits to HTN**. Denies murmurs, angina, palpitations, dyspnea on exertion, orthopnea, peripheral edema.

Resp: Denies cough, SOB, sputum, hemoptysis, pneumonia, wheezing, or asthma.

GI: Denies loss of appetite, nausea, vomiting, abdominal pain, and diarrhea. Denies intolerance to specific foods, dysphagia, jaundice, constipation, or blood in stool.

GU: Denies hematuria, nocturia, dysuria, frequency, oliguria, polyuria, change in color of urine, incontinence and flank pain.

Reproductive: Menarche at age 12, LMP 10/06/2020, irregular cycle, heavy flow.

MS: Denies joint stiffness, muscle fatigue, arthritis, muscle deformity/swelling and redness.

Peripheral vascular: Denies intermittent claudication, coldness, varicose veins, color changes, or history of DVT/PE.

Neuro: Denies loss of sensation, numbness, tingling, tremors, weakness/paralysis, fainting/blackouts, seizures.

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

Heme: Denies anemia, easy bruising/bleeding, petechiae, purpura, transfusions.

Psych: Denies changes in mood, memory, anxiety, or depression.

Physical Exam:

GENERAL: Patient is obese, well appearing, and well groomed.

Vitals:	BP: **166/110, repeat:160/100** Seated, RA
R: 16, unlabored	P: 87 bpm, regular
T: 97 °F Temporally	SpO2: 98 % RA
Height: 67.8 inches Weight: 292lbs	BMI: 44.66

SKIN: Warm & moist, good turgor. Nonicteric, noncyanotic, no rashes or tattoos. **Acanthosis nigricans present around the neck.**

HEENT: Head is atraumatic, normocephalic. Ears are symmetrical, no lesions, masses, discharge, trauma AU. Eyes are symmetrical OU; no exophthalmos or ptosis; sclera white; conjunctiva & cornea clear. PERRLA, EOMs full. No evidence of masses, lesions, foreign bodies in nose. Septum midline. Patent airway. No deviation noted in tongue. Mucous membranes moist. Tonsils present with no evidence of injection or exudate. Uvula pink and midline, no edema, lesions.

NECK: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM, no palpable adenopathy noted.

CHEST/LUNGS: Symmetrical with respiration, no evidence of trauma, tachypneic and labored respiration, no use of accessory muscles. No adventitious breath sounds.

CARDIAC: Regular rate & rhythm, S1 S2 normal. No murmurs, S3, S4 splitting of heart sounds, friction rubs or other extra sounds.

ABDOMEN: Symmetrical, nondistended, no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. Soft, non-tender to light/deep palpation. No evidence of guarding or rebound tenderness. No CVA tenderness.

MUSCULOSKELETAL/EXTREMITIES: No soft tissue swelling, erythema, ecchymosis, atrophy or deformities in bilateral upper and lower extremities. FROM and equal pulses of bilateral upper and lower extremities.

NEURO AND PSYCH: A/O x3. Cranial nerves II-XII grossly intact. Strength and sensation grossly intact.

Assessment

21-year-old obese female with history of HTN who presents to establish care and control her HTN.

Plan

HTN: Will have to work-up for secondary causes of hypertension in view of the fact that the patient is young and given the degree of hypertension. Patient education given in details. Low-sodium diet, exercise, weight loss, and lifestyle modifications discussed. Patient verbalizes understanding.

- Start Amlodipine Besylate tablet, 5mg, PO, QD
- Labs: CBC, CMP, TSH, Aldosterone and Urinalysis
- Imaging: Renal Artery Doppler US

Obesity: Order Lipid Profile, TSH, hemoglobin A1c, testosterone levels and encourage goal of exercise, diet modifications, and weight loss.

Will also order Beta-HCG.

Additional workups depend on initial results.

Return to clinic in 1 week to discuss lab results.