**Identifying Data:**

**Name:** JJ

**DOB:** 10/1X/19XX

**Date:** 6/14/2019 9:31 am

**Referral:** NYPQ

**Source of Information:** Self, reliable

**Religion:** Christian

**Ethnicity:** Black

**Language:** English

**Marital Status:** married

**Location:** AMZ, Jamaica, NY

**Mode of Transport:** Ambulance Service

**PCP:** Dr. Dairo, AMZ

**CC:** “low back pain” x 1 month

**HPI:**  JJ is a 48 year old obese male PMHx controlled HTN, DM, HLD c/o low back pain x 1 month. Back pain does not radiate. It lasts a few hours at a time starting 2 hours after waking up. Pain is dull and aching. Movement from a chair to standing position worsens the pain. Tylenol Extra Strength improves pain. Pain currently 2/10. Pain does not change throughout the day. Patient currently ambulates and is independent in ADLs. Able to walk 1 mile and at baseline ambulation. Patient has never had PT. Denies unstable gait, claudication, arthritis, swollen/erythematous joints, edema, murmurs, palpitations, fever, chills, nausea, vomiting, SOB, DOE, PND, orthnopnea, syncope, fainting, seizures, hx of osteoporosis, family hx of cancer.

**Medications**

Amlodipine 10 mg 1 tablet PO qd for HTN

Metformin 500 mg 1 tablet PO qd for DM

Atorvastatin 20 mg 1 tablet PO qd for HLD

Tylenol Extra Strength unknown dose for low back pain

True Metrix Strips 3 strips via fingerstick three times daily before meals for DM

Denies supplements

**Past Medical History:**

Present

HTN x 12 years

Controlled DM x 6 years

HLD x 6 years

Obesity due to excess calories- 6 years

Past-Mono

Denies hospitalizations

Childhood illness- chickenpox at 4

Immunizations- UTD

Screening tests/results- A1C- 5.9, Eye exam: 3/2019, Podiatry 12/18

Allergies:

NKDA, no other food/environmental allergy

Family hx:

Father- unknown

Mother- 78, alive and well

Daughter- 23 alive and well

Son- 26 alive and well

Denies hx HTN, CVA, CA, DM, asthma

Social:

Married male living with wife working as an accountant

Habits- Never smoker, denies drinking alcohol or other drug use. Drinks 1 cup of coffee in am

Travel- denies recent travel

Diet- avoids fried foods and sugar

Exercise- Denies

Sleep- 7 hr/night without PND, OSA, orthopnea

Safety- uses seatbelt

Sexual hx- sexually active with wife denies contraception or hx of STIs

ROS

General - denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats.

Skin, hair and nails - denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes,

pruritus, or changes in hair distribution.

Eyes – wears glasses, last eye exam 3/2019. denies visual disturbance, lacrimation, photophobia, or pruritus.

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

Nose/Sinuses – denies discharge, epistaxis or obstruction.

Mouth and throat – does not remember date of last dental exam; denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, or use of dentures.

Neck - denies localized swelling/lumps, or stiffness/decreased range of motion.

Breast - denies lumps or pain.

Pulmonary System –Denies dry or productive cough, DOE, hemoptysis, cyanosis, orthopnea or PND.

Cardiovascular System – POSITIVE HTN, denies chest pain, palpitations, irregular heartbeat,

edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal System –POSITIVE: occasional constipationdenies, no change in appetite,

intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, change in bowel habit, hemorrhoids, or melena.

Genitourinary System – does not remember date of last prostate exam; denies urinary frequency, urinary urgency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence, hesitancy or dribbling.

Nervous System - denies seizures, headache, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, or weakness.

Musculoskeletal System –POSITIVE low back pain with decreased ROM, no deformity/swelling, redness, or arthritis.

Peripheral Vascular System - denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change.

Hematologic System - denies anemia, easy bruising or bleeding, lymph node enlargement, blood transfusions or history of DVT/PE.

Endocrine System - denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism.

Psychiatric - denies depression/sadness, anxiety, obsessive/compulsive disorder, seeing a mental health professional, or taking psychiatric medications.

Physical

General: 48 y/o obese male, AO x3. Patient is well developed, and well groomed. He looks his stated age and doesn’t appear to be distressed.

Vital Signs:

BP: Seated 156/90 LT 158/94 RT

Supine 158/92 160/94

RR: 16 breaths/min, unlabored

HR: 88 beats/min, regular

Temp: 98.6 T (oral)

O 2 Sat: 97%, room air

Height: 5” 10 in

Weight: 272 lbs

BMI: 38.9

Skin: warm &amp; moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos.

Hair: average quantity and distribution.

Nails: no clubbing, capillary refill &lt;2 seconds throughout.

Head: normocephalic, atraumatic, non-tender to palpation throughout.

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva &amp; cornea clear. Visual acuity (uncorrected - 20/50 OS, 20/40 OD, 20/40 OU).

Visual fields full OU. PERRL, EOMs full with no nystagmus.

Fundoscopy - red reflex intact OU. Cup:Disk &lt; 0.5 OU, no evidence of A-V nicking, papilledema, hemorrhage, exudate,

cotton wool spots, or neovascularization OU.

Ears: Symmetrical and normal size. No evidence of lesions/masses/trauma on external ears.

No discharge/foreign bodies in external auditory canals AU. TM pearly white/intact with light reflex in normal position AU.

Auditory acuity intact to whispered voice AU. Weber midline/Rinne reveals AC>BC AU.

Nose: Symmetrical, no obvious masses/lesions/deformities/trauma/discharge. Nares patent bilaterally/nasal mucosa pink & well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions/deformities/injection/perforation.

No evidence of foreign bodies.

Sinuses: Non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses.

Lips: Pink, moist; no evidence of cyanosis or lesions. Non-tender to palpation.

Mucosa: Pink; well hydrated. No masses; lesions noted. Non-tender to palpation. No evidence of leukoplakia.

Palate: Pink; well hydrated. Palate intact with no lesions; masses; scars. Non-tender to palpation.

Teeth: Good dentition, no obvious dental caries noted.

Gingivae: Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Non-tender to palpation.

Tongue: Pink; well papillated; no masses, lesions or deviation noted. Non-tender to palpation.

Oropharynx: well hydrated; no evidence of exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions.

Neck: Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid: Non-tender, no palpable masses, no thyromegaly, no bruits noted.

Chest - Symmetrical, no deformities, no evidence trauma. Respirations unlabored/no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation.

Lungs - Clear to auscultation and percussion bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus intact throughout. No adventitious sounds.

Heart: Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are normal. There are no murmurs or extra heart sounds.

Abdomen: Obese, symmetrical, no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries.

Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Rectal: Deferred

GU: Deferred

Ext: no clubbing, cyanosis, edema, pulses 2+ b/l, all FROM.

MSK: Lumbar spinal tenderness to palpation, FROM, no deformity noted

Neurological: No focalizing signs. DTRs 2+ and symmetric throughout. Muscle strength is 5/5 in all other muscle groups. Cranial nerves grossly intact.

PSYCH: A/o x 3. Proper mood and affect. Intact memory and cognition. No dysarthria,

Labs/Imaging

A1C- see above

CBC, CMP, UA, BG, Lipids, wnl 5/30/19

Assessment: 48 y/o obese male PMHx controlled HTN, DM, HLD c/o low back pain x 1 month. Pain is most likely MSK d/t focal tenderness to palpation without limited ROM. Denies hx of trauma.

.