Full Name: A.L.
Address: Bronx, New York
Date of Birth: 02/04/1992
Admitted date: 4/4/23
Location: Metropolitan Hospital: FAST Track
Religion: N/A
Source of Information: Self
Reliability of patient: Reliable
Source of Referral: Self
Mode of Transport: NYC Subway

Chief Complaint: Cough x 3 days

History of Present Illness:

31 y/o male with no significant PMH presents with a productive cough and yellow sputum that started 3 days ago. Pt notes that the cough gradually worsened and had a slow onset. While he is working, he often finds himself coughing and feels overall “more tired”. Pt took generic cough syrup yesterday with mild relief. Pt denies smoking tobacco using illicit drugs and EtOH use.

Past Medical History: None

Past Surgical History: None

Allergies: None

Medications: None

Family History:

Grandmother: Decreased at unknown age, pt does not remember their medical history
Grandfather: Decreased at unknown age, pt does not remember their medical history
Mother: 57, living and well, no significant medical history or surgery
Father: 60 living and well, no significant medical history or surgery
No siblings

Social History:
A.L. is a 31 y/o male who works for a construction company in downtown manhattan x 1 year. Pt's diet consists of sandwiches, local fast food, rice, beans and vegetables. A.L. denies exercise besides work. Denies hx of tobacco, alcohol use, or any illicit drugs.

Review of Systems:

General – Denies fever, chills, night sweats, loss of appetite, weight loss/gain, or weakness/fatigue

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

Head – Denies headaches, vertigo or head trauma.

Eyes – Denies using reading glasses, other visual disturbances, photophobia, lacrimation, or pruritus.

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

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – 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

Pulmonary system – SEE HPI

Cardiovascular system – Denies chest pain, HTN, palpitations, irregular heartbeat, syncope, edema/swelling of ankles or feet, known heart murmur

Gastrointestinal system – Has regular bowel movements daily. No intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, unusual flatulence or eructations, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate.

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

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

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

Hematological 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, excessive sweating, hirsutism, or goiter.

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

Physical

BP: 112/72

Pulse: 80

Temp: 97.9

Resp: 18

Ht: 5'10

Wt: 150 lbs

SpO2: 98%

BMI: 21.5

General: Pt appears in mild distress. Appears stated weight and age, neatly groomed.

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

Nails: no clubbing, capillary refill <2 seconds in upper and lower extremities

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

Hair: average quantity, texture and distribution, no nits, seborrhea, lice, or lesions.

Ears: Symmetrical and appropriate in size. No lesions/masses / trauma on external ears. No discharge / foreign bodies in external auditory canals AU.

Nose: Symmetrical / no 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 foreign bodies.

Sinuses: Non tender frontal, and maxillary sinus palpation.

Lips: Pink, moist; no cyanosis or lesions.

Mucosa: Pink; well hydrated. No masses; no lesions noted.

Palate: well hydrated. Palate intact with no lesions; masses; scars.

Teeth: Good dentition. No dentures, no other dental caries noted.

Gingivae: Pink; moist. No hyperplasia; masses; lesions; erythema or discharge.

Tongue: Pink; no masses, lesions or deviation.

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

Neck: Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation.

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

Chest: Symmetrical, no deformities, no trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Non-tender to palpation throughout.

Lungs: diffuse inspiratory and expiratory wheezes heard in all lung fields. No stridor/ crackles

Heart: Regular rate and rhythm (RRR). Carotid pulses are 2+ bilaterally without bruits. S1 and S2 are distinct with no murmurs, S3 or S4. No splitting of S2 or friction rubs appreciated.

Abdomen: Abdomen flat and symmetric with no scars, striae, or pulsations noted. Bowel sounds normoactive in all four quadrants with no aortic/renal/iliac or femoral bruits. Non-tender to palpation and tympanic throughout, no guarding or rebound noted. No hepatosplenomegaly to palpation, no CVA tenderness appreciated.

Neurological:

Patient is alert and oriented to person, place, and time.

Differential diagnosis:

Asthma exacerbation: Pt has diffuse B/L inspiratory and expiratory wheeze and cough. Pt has no hx of cardiac disease and no smoking history.

Allergic Reaction: Pt has diffuse wheezing and denies hx of known allergies to medications or food. Pt works in construction and may have inhaled substance. This may be their first time being exposed to an offending agent.

Asbestos: Pt has diffuse b/l wheezing, cough and has been working construction for 1 year.

Assessment - 31 y/o male with no significant PMH history % productive cough and generalized fatigue x 3 days. Exam reveals diffuse b/l inspiratory and expiratory wheeze.

Plan

Transfer patient to ED. Repeat Vitals, Administer nebulized albuterol and ipratropium. Obtain chest x-ray to rule out pneumonia. Consult pulmonology (or respiratory therapist) for PFTs. Educate patient on asthma management and why follow up with pulmonology is important. Admit patient for acute asthma exacerbation.

Following up on Pt

- ED: Chest x-ray. Give nebulized albuterol and ipratropium
- Admitted
- Dx: Asthma Exacerbation
- Problem list: Asthma (updated)
- Discharge following day with albuterol rescue inhaler and Flovent HFA (Fluticasone)