# COMPREHENSIVE ADMISSION HISTORY AND PHYSICAL

*This is a comprehensive note meant for the purpose of teaching the student to write a comprehensive H & P. Episodic notes will be subject to large point deductions or may be returned for resubmission and late penalties will be applied.

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| Student Name: | |
| Date of Admission: | |
| Patient's Age: | 73 |
| Patient's Ethnicity and Gender: | |
| Information Source/Reliability: | |

CHIEF COMPLAINT:

SOB

HISTORY OF PRESENT ILLNESS:
Must include ALL pertinent attributes – location, quality, quantity, timing, setting, modifying factors, associated manifestations, and any PMH, family, or social history associated with CC. Include any pertinent diagnostic study findings from the ED visit if applicable.

LS is 73 years old without prior diagnosis of cardiac disease. He has history of obesity and hyperlipidemia, active smoker. 1 week ago patient complaining of shortness of breath and diaphoresis while watching TV. Denied any chest pain or loss of consciousness at that time. No fever or chills. He did not seek medical attention. His shortness of breath getting worse, 911 was called on October 1. Initially patient was found to have hypoxia 80s, 2 L/min of supplemental oxygen applied and patient was taken to Laurel Regional Hospital. troponin 2.4 (0.01-0.029), follow-up troponin 2 hours later 2.73 . EKG showed normal sinus rhythm and Q-wave inversion from V4 to V6, no acute ST-T change. (old EKG in 2015 at Kaiser did not show any T wave reversion). Diagnosis of non-ST elevation MI was made. Patient was given aspirin, received Plavix 300 mg around 1540pm, started heparin drip (4000 units IV push, then 1400 units/h). Nitro paste applied. Her proBNP is 4953, patient also received 1 dose of Lasix 20 mg.
PMH:
1. Hyperlipidemia
2. Obesity with BMI about 34
3. Osteoporosis
4. Osteoarthritis of the right knee, severe
SH: Retired aerospace engineer. Lives alone, uses a walker to ambulate, never married. Has brother and sister in this area. Smokes half pack a day for 40 years, currently smokes 3 to 4 cigarettes a day per patient
FH: Father had hypertension and stroke

PAST MEDICAL HISTORY:

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| Medications:<br>-Include all medications | aspirin 81 MG EC tablet Take by mouth.<br>atorvastatin (LIPITOR) 40 MG tablet Take by mouth nightly |

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| received in the ED if applicable<br>-Include name, route, dosage, frequency, and indication | LASIX<br>aspirin, received Plavix 300 mg<br>heparin drip (4000 units IV push<br>Nitro paste applied. |
| Allergies:<br>-Include reaction | No Known Allergies |
| Adult Illnesses:<br>-Include year of diagnosis | Smoking status: Former<br>Packs/day: 0.50<br>Years: 50.00<br>Pack years: 25.00<br>Types: Cigarettes<br>Quit date: 9/26/2022<br>Years since quitting: 0.0<br>? Smokeless tobacco: Not on file |
| Surgical History:<br>-Include year | |
| Family History: | |
| Social History:<br>Alcohol, tobacco, and illicit drug use | |

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| Admitted from/Lives at: | |
| REVIEW OF SYSTEMS:<br>Complete a comprehensive ROS. | |
| General: | Negative for chills and fever. |
| Skin/Hair/Nails: | |
| HEENT: | |
| Neck: | |
| Breasts: | |
| Respiratory: | Positive for shortness of breath |
| Cardiovascular | Negative for chest pain |
| Peripheral Vascular: | |
| Gastrointestinal: | Positive for nausea. Negative for diarrhea and vomiting |

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| Urinary (must address voiding, is Foley present?): | |
| Genital: | |
| Musculoskeletal: | |
| Neurologic: | |
| Psychiatric: | |
| Hematologic: | |
| Endocrine: | |
| PHYSICAL EXAM:<br>Complete a comprehensive physical exam. May defer breasts/genital/rectum if not pertinent to CC/HPI. | |
| Vital signs: | Vital sign :<br><br>BP 150/73 (96) HR: 83, RR: 30, Temp (C): 37 oral, Weight (Kg): 108.86<br>02 sat 95% 4 L NC, |
| Ventilator settings (if applicable): | N/A |

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| Weight, Height, & BMI: | Vital sign :<br>24hr Vitals (recent value[range]):<br>BP ( cuff:MAP \|\| artl:MAP): 150/73 [136 - 162/62 - 84] : 102 [89 - 117] \|\| ? [?/?] : ? [?]<br>HR: 53 [53 - 82], RR: 30 [23 - 30], T (C): 37 [37 - 37.1], Weight (Kg): 108.86<br>Temp (24hrs), Avg:37.1 °C (98.7 °F), Min:37 °C (98.6 °F), Max:37.1 °C (98.8 °F) |
| General survey: | Appearance: He is obese<br>Mood and Affect: Mood normal.<br>Behavior: Behavior normal. |
| HEENT: | Head: Normocephalic and atraumatic<br>Pupils: Pupils are equal, round, and reactive to light |
| Neck: | |
| Breasts: | |
| Thorax/Lungs: | Examination of the right-lower field reveals decreased breath sounds. Examination of the left-lower field reveals decreased breath sounds. Decreased breath sounds and wheezing present |
| Cardiovascular/ Peripheral Vascular: | Rate and Rhythm: Normal rate and regular rhythm.<br>Heart sounds: No murmur heard. |
| Abdomen: | General: Abdomen is flat. Bowel sounds are normal.<br>Palpations: Abdomen is soft. |
| Musculoskeletal: | Right lower leg: No edema.<br>Left lower leg: No edema<br>Cervical back: No rigidity |

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| Neurologic: | General: No focal deficit present.<br>Mental Status: He is alert and oriented to person, place, and time. |
| Genitalia/Rectum: | |
| DIAGNOSTIC STUDIES:<br>List the test ordered and results in bullet format. Highlight any abnormal findings. | |
| Laboratory studies: | |

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| Imaging: | 10/03/22 CXR<br>FINDINGS:<br>The right costophrenic angle is excluded from field-of-view. Prominence of the interstitial markings, stable from prior. Hazy appearance of the left similar to prior interval improvement in right basilar haziness.<br>No visualized large pneumothorax. Left costophrenic angle blunting, stable.<br>Cardiomegaly.<br><br>Transthoracic Echocardiography Report (TTE)<br>Summary - Left ventricular estimated EF:45 %<br>Upper normal left ventricular chamber size with mild increase in wall thickness with mild systolic dysfunction, possible anteroseptal hypokinesis EF 45%. Moderate diastolic dysfunction.<br><br>Trace tricuspid regurgitation, seemingly upper normal PASP estimate 35 mm Hg range<br><br>Cardiac Catheterization Report<br>Summary:<br>1. Triple vessel coronary artery disease<br>- Severe ostial LAD stenosis and moderate mid LAD and mid D1 stenosis<br>- Severe mid CX and proximal OM1 stenosis<br>- Occluded mid RCA with left-to-right collaterals<br>- Visualization was difficult due to patient's body habitus<br>2. LVEDP = 28 mmHg. There is no aortic stenosis<br>3. Manual removal of femoral arterial sheath |
| Other: | |

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| ASSESSMENT & PLAN: | |
| Admit to: | IMC |
| Condition: | |
| Vital Signs: | Temp: 37.1 °C (98.8 °F), Heart Rate: 82, Resp: (!) 26, BP: 162/84, SpO2: 95 %, O2 Device: Nasal cannula, O2 Flow Rate (L/min): 4 L/min |
| Activity: | |
| Diet: | CLEAR |
| Admitting Diagnosis: | NSTEMI (non-ST elevated myocardial infarction) |
| Secondary Diagnosis(es):<br>-Include chronic conditions that require management while hospitalized | HYPOXIA<br>Hypoxia secondary to below<br># most likely underlying COPD secondary to smoking and sever obesity<br>#Pulmonary congestion<br>Continue with IV lasix for diuresis , monitor I/O and renal function<br>Start Duo neb for wheezing / probably underlying COPD<br>Repeat CXR in am<br>Patient currently alert and oriented x 4, neurologically intact despite hypercapnia<br>Patient likely in COPD exacerbation vs. Worsening hypoxia from NSTEMI |

PLAN FOR ADMITTING DIAGNOSIS:
Plan should be comprehensive. List in ordering format, not narrative. Plan should be based on Evidence-Based Guidelines. Include labs, imaging, other diagnostics, consults, procedures, etc.

Assessment/Plan
Principal Problem:
NSTEMI (non-ST elevated myocardial infarction)
Acute hypoxemic respiratory failure, Acute heart failure, new diagnosis
Obesity
Hyperlipidemia
Plan:
1. Admit to IMC with inpatient status
2. Continue with heparin drip; Nitropaste every 6 hours; Lopressor 25 mg p.o. twice daily; atorvastatin
3. Cardiology consult
4. Continue with supplemental oxygen nasal cannula 2 L/min. ABG done at OSH showed mild elevation of CO2, patient has no prior diagnosis of COPD. Will repeat ABG
5. Patient has mild leukocytosis but no suspicion of infection, will follow repeat CBC.
6. Full code

Surgery represents the best option for treating this patient's multivessel disease.
Surgery Planned: CABG X 4-5

PLAN FOR SECONDARY DIAGNOSIS(ES):
List in ordering format, not narrative. The plan should be comprehensive including any labs, imaging, procedures, etc.

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| VTE Prophylaxis: | |

DISCHARGE PLANNING:
List 3 goals for discharge.

EVIDENCE-BASED PRACTICE:
Evidence-Based Practice References for the above plan. Must include a current up to date guideline as a separate document in the assignment box.

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| E/M code for Admission Note: | |