Final Site Evaluation H&P
History and Physical Rotation 6
Name: Abd-Manaaf Bakere
Rotation 6: Ambulatory
Date: 07/23/2024
Rotation Location: Center Urgent care.

Name: HI
DOB: xx/xx/2000
Age: 24 y/o
Address: Metropolitan Ave NY
Date/Time: July 18 ,2024, 10:15 AM
Location: Center of urgent Care Middle Village
Source of Information: Self
Reliability: Reliable
Preferred Language: English

Chief complaint: "I have mid abdominal pain for 3 days"

History of Present Illness
Constitutional:
A 24 y/o male with no significant past medical history presents with epigastric pain that started 3 days ago. He states the pain comes and goes every 45 min, getting worse over times and when drinking water, rates it 8/10 when pain is present. Patient denies any pain at time of exam. He took Tylenol and antacid without relief. The is no radiation and pain gets better when lying flat. He admits burping, nausea on the first day and mild cough. He admits good appetite. He denies fever, chills, Headache, dizziness, chest pain, shortness of breath, vomiting, diarrhea, constipation, changes in bowel habits, hematemesis, hematochezia or jaundice.

Past Medical History
No significant PMHx
Past Surgical History
No significant PSHx
Family History
Mother: Not available
Father: Not available
Social History
Habits – denies drinks caffeinated drinks such as coffee.
Smoking - Denies smoking cigarettes.
Illicit drugs - Denis any use of drugs.
Alcohol - Reports social alcohol use of about 1.0 standard drink of alcohol per week.
Diet - such as rice, potatoes and vegetables.
Exercise – Admits moderate regular exercise.
Sleep - Admits to getting 6-7 hours of sleep a night.

Allergies/Intolerance:

N.K.D.A
Medication:
Not on any Medication
Immunization
Up to date with all immunizations

Review of Systems (ROS):
General: denies weight changes, fevers, weakness, fatigue, night sweats, chills, body aches, sleep
• Skin: denies rash, sores, lumps, itching, color changes, hair, nails
• Head: denies trauma, headache, nausea, vomiting, dizziness
• Eyes: denies glasses/contacts, pain, redness, tearing, vision loss, discharge, double/blurred vision, glaucoma
• Ears: denies hearing loss/aid, tinnitus, vertigo, earache, discharge
• Mouth/Throat: denies bleeding gums, dentures, cavities, hoarseness, voice change, sore throat, dry mouth, difficult/painful
• Nose/Sinuses: denies stuffiness, rhinorrhea, sneezing, itching, epistaxis, allergies (perennial, seasonal)
• Neck: denies lumps/masses, goiter, pain, stiffness, swelling
• Breast: denies lumps/masses, skin changes, pain, discharge
• Respiratory: **Admits mild cough**, denies SOB, wheezing, sputum (color/quantity), hemoptysis, pleurisy, snoring
Cardiac: palpitations, pain, DOE, orthopnea, paroxysmal nocturnal dyspnea, syncope, lower extremity edema
• Gl: **Admits epigastric pain, nausea, burping** Denies dysphagia, ,, vomiting, regurgitation, indigestion, bowel movement frequency/color/size/caliber, changes in bowel habits, diarrhea, constipation, bleeding (hemorrhoids, melena, hematemesis, hematochezia), abdominal pain, jaundice
• Urinary: Denies frequency, polyuria, nocturia, hesitancy, urgency, dysuria, hematuria, incontinence, reduced caliber of stream
• Genital: interest, function, problems
• Male: bulges, penile discharge or sores, testicular pain/ masses, birth control method, history of STDs
• Vascular: claudication, edema, varicose veins, past clots
• Musculoskeletal: denies muscle or joint pain, stiffness, arthritis, gout, weakness, swelling, redness, instability
• Neurological: denies seizures, numbness, tingling, paralysis, paresthesias, fainting, blackouts, burning, tremors
• Hematological: denies anemia, easy bruising/bleeding, petechiae, purpura, ecchymosis, transfusions
• Endocrine: denies heat/cold intolerance, sweating/thirst/hunger
• Psychiatric: denies nervousness, mood, anxiety, depression or suicidal ideation.

Vital Signs
BP: 126/60 mm Hg,
HR: 62 /min,

RR: 18 /min,
Oxygen sat %: 99 %,
Temp: 98F.

General Examination
Constitutional:
GENERAL APPEARANCE: Alert, well developed, well nourished, in no acute distress
HENT:
Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.
Nose: No tenderness, discharge, No inflammation of nasal mucosa, septum or turbinates. No foreign body, No polyps
Mouth/Throat:
Mouth: Mucous membranes are moist. No erythema, exudates, uvula midline, good dentition
Pharynx: Normal mucosa.
LYMPH NODES: No lymphadenopathy.
Eyes:
General: PERRLA present. EOM intact. No scleral icterus. No discharge
Conjunctiva/sclera: Conjunctivae normal.
Cardiovascular:
Rate and Rhythm: Regular rate, rhythm, S1 and S2 appreciated. No gallops, murmurs, rubs
Pulses: Normal pulses.
Pulmonary:
Effort: No respiratory distress. Bilateral chest symmetry.
Breath sounds: clear to auscultation bilaterally , no wheezes, rales, rhonchi
Chest:
Chest wall: No tenderness.
Abdominal:
General: Intact skin. Bowel sounds presents,no distention,
Palpations: **moderate epigastric tenderness on palpation**. Abdomen is soft. No rigidity, rebound or guarding, No CVA tenderness. Negative murphy sign, McBurney point tenderness. No shifting dullness.
Musculoskeletal:
General: Normal range of motion. No weakness, atrophy
Cervical back: Normal range of motion and neck supple.
Right lower leg: No edema or swelling
Left lower leg: No edema or swelling
Neurological:
General: No focal deficit present, Sensation: Pain, temperature, position, vibration present
Mental Status: She is alert and oriented to person, place, and time. Mental status is at baseline.
Psychiatry: No acute psychosis.

Assessment
The patient is a 24-year-old male presenting with a 3-day history of intermittent epigastric pain, rated 8/10 during episodes, with associated burping, nausea (on the first day), and mild cough.

The pain is exacerbated by drinking water and alleviated when lying flat. He reports no relief from Tylenol and antacid use. The patient has a good appetite and denies any significant gastrointestinal or systemic symptoms such as vomiting, diarrhea, changes in bowel habits, fever, chills, or jaundice. Physical examination reveals moderate epigastric tenderness on palpation without signs of peritoneal irritation. Vitals are stable and within normal limits.

Differential Diagnoses

Gastroesophageal Reflux Disease (GERD):

The patient's epigastric pain, which worsens with water intake and improves when lying flat, is suggestive of acid reflux. The associated symptoms of burping and nausea further support this diagnosis.

Gastritis

Gastritis can cause epigastric pain that is exacerbated by food or drink. The patient's lack of relief from antacids and the presence of nausea on the first day are consistent with this condition.

Peptic Ulcer Disease (PUD):

Epigastric pain that is relieved by lying flat and not alleviated by antacids may indicate an ulcer. Although the patient denies melena or hematemesis, the absence of these symptoms does not rule out PUD.

Functional Dyspepsia:

This condition can cause similar symptoms of epigastric pain and discomfort without an identifiable cause on endoscopy or imaging. The patient's episodic pain and lack of systemic symptoms are consistent with functional dyspepsia.

Plan

Diagnostics:

Upper gastrointestinal endoscopy if symptoms persist or worsen to evaluate for esophagitis, gastritis, or peptic ulcers.

H. pylori testing (urea breath test, stool antigen test, or biopsy during endoscopy) to rule out infection.

Abdominal ultrasound to exclude other potential causes of epigastric pain such as gallbladder disease.

Medications:

Initiated a proton pump inhibitor **(PPI)** Omeprazole Capsule Delayed Release, 20 MG, 1 capsule 30 minutes before morning meal, Orally, Once a day, 30 days,

Alternatively, H2 blocker like ranitidine for symptomatic relief.

Lifestyle and Dietary Modifications:

Advised the patient to avoid triggers such as spicy foods, caffeine, and alcohol.

Suggest eating smaller, more frequent meals to reduce gastric acid production.

Recommend not lying down immediately after eating and elevating the head of the bed to reduce reflux symptoms.

Follow-up:

Advised to schedule a follow-up visit here or with PCP in 1-2 weeks to reassess symptoms and response to treatment. Adjust the management plan based on the patient's progress and any new findings.

Patient Education:

Educate the patient on recognizing symptoms of potential complications (e.g., gastrointestinal bleeding, severe pain) and to seek immediate medical attention if these occur.