All the gear you need under $50 or over $1,495.87

Stethoscopes $6 to $200
Your stethoscope not only transmits sound but it assures the patient you are the doctor. They all work the same. There is a chest piece, tube(s), earpieces. The chest piece may be single or double headed. With a single head you apply variable pressure to differentiate the high from low pitched sounds. The double head has a smooth flat side (diaphragm) and a hollow side (bell). If you have two smooth sides, the smaller is intended for children and can be converted to a bell by removing the diaphragm. The diaphragm vibrates and transmits higher frequency sounds from the patient’s body up the tubing to your ears. The bell transmits lower frequency sounds from the skin directly up to your ears through the tubes. The major stethoscopes are Littmann Cardiology/Classic, Allen Gemini (the only stereo tube), ADC Cardiology/Professional, Welch Allyn Tyco Elite, Sprague Rappaport type several manufacturers (twin tubes), AllHeart Cardiology/Nurses (no bell). Pick your color and test them if possible before you buy. Place the chest piece on a table and TAP the table softly with your finger about 12 inches from the chest piece. The ear pieces come in several sizes both soft and hard. Go for comfort first then go for best sound, your ears will learn best when happy.

Once you get the scope start with the diaphragm on the speaker of your computer at:
http://www.med.ucla.edu/wilkes/intro.html

Sphygmomanometer - Blood pressure cuff $10 to $200
A cheap cuff is fine it will have twin tubes and do the job. Hospitals and clinics have either wall mounted or electronic ones but you do need one for training. The more expensive Lifetime warranty single ones are in the $150 to $200 range. I just sent mine in for free calibration and it is from 1975 BVC (Before Velcro® Cuffs) The best deal on the net is a kit (Lumiscope or ADC); where you get a cuff and decent beginner double head scope for under $25

Then find a body with arms and move on to taking blood pressures. Practice on picking out the FIVE Korotkoff sounds while taking a blood pressure. If you learn to identify these sounds, heart sounds and breath sounds will be a snap, crackle and pop later. Always start with palpating the radial pulse and inflating the cuff until you lose the pulse. Then, pump 10 mmHg higher and listen to the brachial artery.

The First Korotkoff sound is the first of two CLEAR snapping sounds for the systolic pressure.
The Second K. sounds are the murmurs heard for most of the pressure between the systolic and diastolic pressures.
The Third K. sound is described as a loud, crisp tapping sound. (may or may not be present).
The Fourth K. thumping sound is often 10 mmHg above the diastolic blood pressure.
The Fifth Korotkoff sound is silence as the cuff pressure drops below the diastolic blood pressure. The disappearance of sound is considered diastolic blood pressure – 2 mmHg below the last sound heard.

Reflex hammer $2 to $15
Taylor has the triangle tomahawk shaped head
The Queen Square or Babinski have a long handle and round disc head.
The Buck hammer has a bullet double head with or w/o a brush that screws into the handle. Thr Tromner neurologic hammer has two different size bullet ends - adult peds. (Older versions (before HIV and Hep B) had a screw in nail.

Tuning fork: $5 to $12 each
You only one in real world but for training buy at least a 128 Hz and a 256 Hz.

Lights: $15 to $530
A good halogen pen light will be your best friend. You may want to wait before you buy the $50 one in favor of a $1.50 disposable light. AVOID the LED lights that distort true color illumination. You can buy a home otoscope kit at any pharmacy for around $10 or you can spend $340 for the head alone. A recharging base and 2 handles otoscope and ophthalmoscope runs about $650. A nice pocket set should be around $150- $200 but may run as high as $850 with multiple illuminators. All you need for now is some way to safely light up ears and throats.

For another $20 this optional gear is nice to have: tape measure ($1.50), small ruler ($1), washable scented marker ($1.20), Goniometer ($8), EKG caliper ($3), monofilament ($2.75), 12 gauge white coated finishing nails (.018); 512 Hz tuning fork. Many of these things are sold in packs of 6-25 so buy in bulk and split the cost and experience collaboration.

Don’t buy tongue depressors, ear specula, cotton swabs, gloves, thermometers, alcohol preps (to clean your gear between patients); these are available at the clinical sites. ASK or scrounge for them and carry extras.
Effective Patient Visits

INITIAL

Hello...

How have you been?
Have you been the ER or seen any other doctors since I last saw you?
The last time we spoke you were complaining of...how’s that now? Better? Worse? The same?
Any problems with your medications?
Are you still taking....? Reconcile meds. If patient recently stopped a med ask why.

what brings you here today?

Visit

Reason for the visit  -- CC  --  Reason for the visit
Location, quality, severity, duration, timing, modifying factors  HPI  Same as INITIAL
Complete: constitutional head/neck, CV/resp, GI/GU, neuromusculoskel  ROS  Pertinent
Allergy: Past medical surgical/ Family / Social: work-education, lifestyle  PFSHx  Changes
Complete: head/neck, CV/resp, GI/GU, skin/lymph, neuromuscu  EXAM  Appropriate

Medical Decisions
Clinical-Social

Here’s what I’m thinking.

Explain your findings and plan.
Offer choices and direct them to what you want but do what they want first.
Ask the patient if there are any questions or concerns about your impression. DO NOT go through an extensive DDX they will only remember either the fatal or insignificant possibilities.
Order labs and explain what and why you ordered.
Explain what the meds are and why they need them. Give one common side effect they will look up the rest.
Be sure they can afford and are in agreement with your treatment plan. Have an alternative plan ready.
Have a plan for the next step(s) if the plan/treatment is ineffective and for communicating this to the patient.

Follow up

Negotiate the next visit. If they choose the date and time they are more likely to show up. Give them a range and explain why you need to see them again. Give them a 24 access number and instructions to call if there are nay problems with fulfilling your treatment. Encourage pre-visit labs that are critical to your plan. If they can’t schedule a test in time before the next visit give them the option to reschedule the visit after the testing is complete .

Physician/Patient
Satisfaction

The patient should be able to voice their opinion anonymously or to you about; ease of making an appointment, wait times, interaction with staff, interaction with you, and if were happy with the visit.
You should be happy with what you did and how the interaction went. If not, evaluate why. Medical, social, logistics?
Current Procedural Terminology

All providers use CPT codes to quantify their medical visit. These codes are also known as Evaluation and Management (E/M) codes. The fee/reimbursement corresponds with the chosen code: the higher the complexity, the higher the fee. Fees may vary for the same level of care according to location were the services are performed (hospital/office) and/or if the patient is NEW or ESTABLISHED. Each of the following SEVEN components are considered when choosing the correct code for a visit.

**TIME:** Face to face time spent with the patient may range between 5 to 60 minutes.

**HISTORY:** All coded visits must have a documented chief complaint (CC:) and a History of Present Illness (HPI:) Review of Systems and Past Medical, Family, and Social history (ROS  PFSH) are not necessary in a Minimal or Focused visit.

**PHYSICAL EXAMINATION:**
- **Minimal** exam doesn’t require the doctor to be present (nurse simply checks blood pressure).
- **Focused** exam includes a brief history and exam for single problem.
- **Expanded** exam is limited to the affected body area or organ system.
- **Detailed** exam is extended to the affected body area and other symptomatic or related organ systems.
- **Comprehensive** - exam is a general multi-system exam or complete examination of a single organ system.

Elements of the physical examination include:

**CONSTITUTIONAL** (general appearance) & VITALS: BP supine • sitting • standing, Temp, Weight, Height, Pulse (regular irregular), Respiration (regular irregular), BMI, Waist circumference, O2 %sat

**BODY AREAS:** Head-Neck, including the face, Chest, including breasts and axillae, Abdomen, Genitalia, groin, buttocks

**ORGAN SYSTEMS:** Cardiovascular, Musculoskeletal, Ophthalmologic, Otolaryngologic, Respiratory, Neurologic Hematologic/Lymphatic, Endocrine, Gastrointestinal, Each extremity Back including spine, Allergic/Immunologic Genitourinary, Integumentary, Psychiatric

**SEVERITY:** How serious and what are the consequences of the presenting medical problem?

**COMPLEXITY:** Medical decisions are made by considering and DOCUMENTING the following issues:
- What is the most probable diagnosis?
- What are the possible diagnoses, treatment, and management options?
- What tests if any, should be ordered, reviewed, and interpreted?
- What is the risk or complication of the decision: low, moderate, or high?

*Low Complexity* Medical Decision Making, the problem will (1) be of low severity, urgency with a low risk of complications, (2) have a limited differential diagnosis and data, (3) have a straightforward diagnostic and treatment plan.

*Moderate Complexity* Medical Decision Making, the problem addressed will (1) be of moderate severity with a moderate risk of complications, (2) require review of a moderate amount of additional information with an extended differential diagnosis, (3) require complicated diagnostic and/or therapeutic intervention.

*Highly Complex* Medical Decision Making, the problem addressed will (1) be of high severity with a high risk of complications and clinical deterioration, (2) require review of an extensive amount of additional information with an extensive differential diagnosis, (3) require highly complex multiple diagnostic and/or therapeutic interventions, with a highly complex treatment plan.

For the purpose of documentation 2 of these 3 elements must either meet or exceed the requirement for medical decision making.

**COUNSELING:** Discussing lifestyle changes, personal or medical dilemmas, or adherence to treatment.

**COORDINATION OF CARE:** Discussion and planning with other health care professionals.
**The SOAP Note**

**Subjective** – The “history” section

CC/HPI: include symptom dimensions, chronological narrative of patient’s complains, information obtained from other sources. Pertinent past medical history. Pertinent review of systems. Current medications.

**CC:** Rash for 2 days

**HPI:** TC is a 78 y/o man who resents with abdominal pain. He noticed a rash two days ago Tuesday night that began on his right mid abdomen and has since extended to his right flank. He does not recall scratching, being bitten or contact to the area with any new soaps, lotions, or other substances. By Wednesday he began to feel a burning and shooting sharp pain without itching, sweats, chills or fevers. The pain progressed in severity to 7/10 deterring his routine daily activities and sleep. The pain has not improved despite using calamine lotion, and 2 ibuprofen every 6 hours. Because he could not sleep he borrowed a friend’s Vicodin last night to help him sleep but came in this morning for treatment of the pain. He has a 12 year history of hypertension for which he takes ramipril 5 mg daily.

**Objective** – The physical exam and laboratory data section. Vital signs including oxygen saturation when indicated. Focuses physical exam. All pertinent labs, x-rays, etc. completed at the visit.

**General:** TC is a youthful gentleman who appears in moderate distress when he moves.

**VS:** BP-137/64 RR-18 HR-90 regular T-37˚

**Abdomen:** not distended, erythematous clustered 2-4 mm vesicles many with a clear fluid and others open in appearance. The rash extends from the midline to the RIGHT posterior axillary line n a T12 dermatome distribution. Bowel sounds are normoactive, palpation of the unaffected abdomen was soft without tenderness or groin adenopathy.

**Assessment** – A summary description of the patient and major problem. The likely supported diagnosis as well as a narrative or numerical problem list. You may wish to include your differential at this time.

**Plan** – to include testing, treatment, and follow-up. Include pharmacologic doses, consults you might consider should the condition worsen.

**A/P:** Gradual onset of a painful rash in a dermatomal distribution. The most likely diagnosis is Shingles due to reactivation of varicella-zoster as herpes zoster because of the location, quality of pain, and character of the lesions. Less likely is drug reaction from the ACE inhibitor, contact dermatitis or cellulitis; because of the focal distribution for the former and no history of injury and absence of fever in the latter.

- # Vesicular painful abdominal rash H. Zooster
  - Local treatment of lesions with Burrows solution
  - Systemic treatment of zoster with valacyclovir 1 g q 8h x 7 days (symptoms began <72 hrs ago)
  - Systemic treatment of pain with flurbiprophn 100 bid # 30
  - Advised that he is contagious to others until all vesicle have crusted over
  - Return to clinic if pain does not resolve or rash worsens

- # Insomnia secondary to the pain
  - Tylenol® #3 1 tab HS pm pain # 10 disp

- # Hypertension controlled increased HR due to pain
  - Continue with ramipril 5 mg

*Here is where you can make some points by footnoting your treatment plan with evidence based citations. Look up the diagnosis or symptoms and go back to the patient and asked what you might have missed.*


Discharge Summary

**ID** • Your name, Patient name, MRN, Admit date, Discharge date, Clinical Admitting and Final Discharge diagnosis

**Reason For Admission** • Mode of admission (direct-ER, transfer), Age/gender/ethnicity CC/HPI with pertinent ROS positives, Allergy, Pertinent Past Med Hx, Working diagnosis if different from above, Active problem list.

**Hospital Course** • Problem list based description with treatment rendered, procedures, labs tests/imaging confirming the Dx, Consults ordered and opinions rendered, Adverse events, complications or explanation of delays.

Discharge Data: BP weight, labs (K+, BS, H/H, BUN/Cr)

Discharge Instructions • Where (home, SNF/Rehab, hospice, other) Who (self, family, guardian). Diet. Physical restrictions with estimated return to previous activity. Specific instructions/information given and to whom. Educational material given (DM, HTN, CAD, Wound care, anticoagulant precautions, smoking cessation, ETOH)

**Medications** • List of Rx given and reconciled with pre-admit medications. Core measures employed when applicable (ACE/ARB, Statin, ASA, Flu, Pneumo, Tdap)

**Followup Care** • Therapy (PT, OT) prescribed and why, Home health ordered and why (why they are home bound), Consultant(s) they need to see. Post discharge testing ordered. PCP appointment date ≤ 2 weeks. Your contact information for any post discharge questions.
### Depression Screen PHQ4

**Score**

- > 3 for questions 1 & 2 = Anxiety
- > 3 for 3 & 4 = Depression

**During the last 2 weeks how many days...**

1. Have you felt nervous or anxious?  
2. Not been able to stop or control your worry? None 1-2 days > 7 days daily  
3. Have you felt a loss of interest or pleasure?  
4. Were you feeling down, hopeless or depressed?
**Social Hx:**

Tobacco: never _______c/day _______Yr quit _______ pk/yrs 2nd hand

Alcohol: never past rare social weekends binge daily __________

Drugs: never past present __________

Diet: General Cardiac Low Na Diabetic Renal Healthy Tube

Exercise: never past rare 2-3/wk 4-7/wk

Who do you live with?

**PAP/PSA**

Mammo  Flu  A1C

DRE  Coln/FOB  Pneumo  LDL

Alert ☐  Cooperative ☐  No distress ☐  Pain 0 1-2 3-4 5-6 7-8 9-10

**Exam:**

<table>
<thead>
<tr>
<th>Eyes</th>
<th>Oropharynx</th>
<th>GU</th>
<th>GI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivae</td>
<td>tongue</td>
<td>M Genitals</td>
<td>Scars</td>
</tr>
<tr>
<td>Lids</td>
<td>mucosa</td>
<td>Prostate</td>
<td>Bowel sounds</td>
</tr>
<tr>
<td>Sclera</td>
<td>pharynx</td>
<td>F Genitals</td>
<td>Consistency</td>
</tr>
<tr>
<td>Vision ≥20/40 OU</td>
<td>Resp</td>
<td>Urethra</td>
<td>Pain • Tender</td>
</tr>
<tr>
<td>PERRL</td>
<td>Effort</td>
<td>Bladder</td>
<td>Mass</td>
</tr>
<tr>
<td>Fundi lens • disc</td>
<td>Breath sounds</td>
<td>Skin</td>
<td>Liver • spleen</td>
</tr>
<tr>
<td>ENT- Mouth</td>
<td>Percussion</td>
<td>Inspection</td>
<td>Hernia</td>
</tr>
<tr>
<td>Ears external</td>
<td>Fremitus</td>
<td>Palpation</td>
<td>Ano-rectal</td>
</tr>
<tr>
<td>TM EAC right</td>
<td>CV</td>
<td>Lymph</td>
<td>Psych</td>
</tr>
</tbody>
</table>

Tests Ordered Today

- CMP
- BMP
- CBC
- INR
- Lipids
- HgbA1C
- PSA
- CXR
- TSH
- T3
- T4
- FTI
- Iron studies
- Stool C/S
- UA
- Urine C/S
- 2D Echo
- Ultrasound

**DO NOT PUT PATIENT’S NAME ON THIS WORKSHEET**

√ or / = done or asked  No Circle = normal  Circle abnormal or if present and elaborate

Time in  Time Out
Let's start with some basics before you go through a corrected H&P.

Introduce yourself and what you plan to do, use a confident, gentle approach to minimize the patient's anxiety. Anxiety may present as anger, hostility, affection, extreme dependence, crying, etc. YOU control the interview. Depth of questioning should be adjusted to the circumstances. Watch for non-verbal cues so you know when to bail incase the interview begins to deteriorate. Try to talk in complete sentences so it is more like a conversation than an interrogation. Eye contact - look at the person when you are talking to them.

Questions can be: Neutral - tell me about your pain? Loaded - how bad is your gallbladder pain? Direct - is this pain you have; burning, achy, stabbing or campy? Leading - do you have right upper quadrant pain that comes on after a fatty meal? Environment - be sure room temperature, privacy, lighting, and other factors are appropriate-turn off TV.

Somewhere in the record document the patients AGE, GENDER, RACE, ETHNICITY, LEVEL OF EDUCATION, PREFERRED LANGUAGE. You may know about PHI Protected Health Information or HIPAA regulations. What you need to remember, in the most simple terms DO NOT DISCUSS, COPY, POST, TRANSMIT in any form, any of the information about the patient you obtain. Keep the information confidential with specific attention to keeping the patient's identity private when you do your write-ups. SHRED your notes or papers in the big box shredders if you have any identifying information about your patient. Only use patient initials on your work sheets. Do not discuss patients in elevators or public areas in or out of the hospital.

CHIEF COMPLAINT: C.C. Briefly describe primary symptom and duration, preferably in patient's own words.

HISTORY OF PRESENT ILLNESS: H.P.I. ONSET: When was patient last well? Was the condition in the CC acute or insidious in onset? NATURE and COURSE: Begin with neutral questions about each problem and follow with direct questions. If the patient leads you to another problem ask the appropriate questions to elaborate but in your write-up maintain a chronological order. Repeat the order of events to the patient to confirm the order. Practice journalistic integrity: Don't embellish, slant, or add to what you've been told. Sort out the: Who? What? When? Where? And why, will be answered later. Pertinent negatives should be listed. Review of systems will pick up what you don't know or forget to ask. Include associated symptoms and review of pertinent organ systems in the HPI.

Symptoms - Pain, SOB, Nausea,
O opinion (is it now better, worse or the same from when it began)
P precipitated/provocative/palliative (how did it start how does it change)
Q quality (dull, colicky, sharp, burning, aching, cramping)
R region/radiation (location at onset and now/where does it go)
S severity ("How does it interfere with... Rate it 0-10 people pass out at 10.")
T timing chronology-sequence/frequency/duration (constant, intermittent, diurnal)
U undercurrent associated symptoms


MEDICATIONS: List medication, dose x duration. Lasix 40mg qam X 3 months. OTC. Herbal. Borrowed

PAST MEDICAL FAMILY SOCIAL HISTORY:
Medical History: Have you had any medical problems in the past? Have you ever been treated for any kind of medical condition? Did any of your illnesses come back more than once? Have you ever had surgery or an operation or been in a hospital as a patient? (When for what) Common conditions/surgeries: I DM II HTN MI Angina CAD CHF CA Stroke A Fib PVD Anemia Jaundice Lipidemia Thyroid CKD ESRD Seizure Wound/Ulcer GERD Arthritis Glaucoma Hepatitis S Apnea PE DVT Asthma Pneumonia TB COPD HIV Psych OB/G/P:A - Tonsils Appy Hernia R L GB Colon Prostate Implants Stomach Bladder Total Hysterectomy Partial Pacer/ICD Stents CABG Vascular Kidney R L o Lung R L Breast R L o Cataracts R L o Hip R L o Knee R L o Foot R L Psychiatric (have you ever been in counseling, had a nervous condition or been treated by a psychiatrist?). Childhood illness and immunization history. DPT/MMR/HepB/shingles/flu shot/pneumovax etc.

Family History: List blood relatives with age at onset or cause of death. Specifically ask about: diabetes, cancer, stroke, heart problems or surgeries, thyroid disease, kidney problems, T.B., hypertension, seizures, arthritis, blood problems (SICKLE, THALASSEMIA, DVT, LEUKEMIAS)
Social History: Habits: Have you ever used tobacco? Type? How much? How long? (calculate pack/years) Ever Stop? Ever thought of quitting? Do you drink alcohol? Daily, social, weekends, parties? How often? How much? What? Do you regularly use any over the counter medications, supplements, or vitamins? Any use of someone else's prescription medication or street drugs? Do you regularly drink coffee or colas? Cups per day? EDUCATION: How far did you go in school. What kind of work have you done? ETHNICITY: What is your first language your preferred language? Where were born where does your family come from? RISK: Toxic exposure Transfusions, Trauma, Travel history, military, work and hobby history (ever been exposed you to chemicals, fumes or hazardous materials?) Sex: Are you sexually active? At what age did you become sexually active? Have you changed sexual partners in last month? Ever had any sexually transmitted infections or rashes? Ever been tested for HIV or STI? How did you meet your last partner? Do you always use a condom? When did you put the condom on? Do you recall any experiences of sexual or physical abuse? Are you straight, gay or bi? Some info from here can go under G/U ROS.


REVIEW OF SYSTEMS
GENERAL General health and well-being, weakness, sweats, chills, fevers.
SKIN Color changes, rashes, lumps or bumps, moles that have changed, nails, hair loss-growth, itching, bruising, photosensitivity, ulcers or non-healing lesions or sores, Jaundice.
HEENT/NECK Trauma, pain, dizzy. Glasses/contacts, tearing, dry eyes, vision changes, spots, floaters, flashes of light, night blindness, blindness or blind spots, photophobia. Hearing, pain, discharge, bleeding, tinnitus, punctured eardrum. Sinus, epistaxis, discharge, smell, postnasal drip, perforated or devised septum. Dentures, teeth, gums, jaw pain, clicking, tongue pain with chewing, sores, taste, strep throats, hoarseness, speech changes, halitosis, dry mouth. Thyroid, swollen glands, stiffness, pain, goiter.
CARDIO-RESPIRATORY Cough; dry, productive, brassy, loud, high pitched, paroxysmal. Loud snoring, hiccups, wheezing. Sputum; color, quantity, hemoptysis. Chest pain (O,P,Q,R,S,T,U) pleural, chest wall, angina. S.O.B.= short of breath, D.O.E.=dyspnea on exertion, How far can you walk on level ground? stairs?, at rest, supine, P.N.D.= paroxysmal nocturnal dyspnea ie. awakes S.O.B. vs. can't sleep supine = orthopnea, sleeps on >1 pillow. Palpitation skipping heartbeats or pounding in the throat. Edema at the end of the day or all day long, both feet or just one foot, face, hands. Nocturia. Syncope or fainting, lightheaded with standing(orthostasis), can't tolerate tight collars.
GASTROINTESTINAL Pain Esophageal; retrosternal with radiation to the back. Gastric; epigastric radiates to left subscapula. Duodenal; epigastric radiates to back & R subscapula. Gallbladder; right upper quadrant and epigastric radiates to tip of R shoulder. Anorexia. Heartburn, nausea, vomiting (color, amount, content, odor), regurgitation, flatulence, aerophagia, reflux, dysphagia (solids, liquids), odynophagia (pain), food intolerance. BM color, shape, size, amount, consistency, frequency, tenesmus.(blood, pus, mucus, black tarry stool-melena, maroon stool-hematochezia), hemorrhoids.
HEME:IMMUNO Pallor, pica(eat dirt=geophagia, eat ice=pagophagia), bleeding, bruising, lymph nodes, recurrent infections, oral yeast infections, Raynaud's phenomenon.
ENDOCRINE Weight change, polyuria, polyphagia, polydypsia, goiter, lethargy, slow speech, nervousness, galactorrhea, amenorrhea, flushing, sweats, heat/cold intolerances.
CENTRAL NERVOUS SYSTEM Right or Left handed, sleep patterns, napping, headache, memory, lightheadedness, vertigo, blackouts, sensory and motor changes, vision, hearing, taste, seizures, dizzy, numbness, tingling, burning, balance, walking, tremors, tics, incontinence.
PSYCH Nerves, stress at home and work, relates to family friends, depression, crying, sleep, anger, suicidal ideation, anxiety, panic, attention, memory, affect, obsessive compulsive disorder, seasonal affective disorder.

End with: Is there anything else I haven't cov Next visit in: 

days     weeks     months
Before and After correction for a History and Physical

B-CC: Swollen testicles and fluid collecting in the body
A-CC: “Swollen testicles and fluid collecting in my body for the third time”
Add quotes if it is verbatim Or paraphrase properly: Body retaining fluid with swollen testicles

B-HPI:
61yo African-American male with DM and two previous instances of fluid collecting in the body and SOB presented again with fluid collecting in all areas of the body but especially concentrated in the testicles. The swollen testicles have made it very difficult to walk. Patient reports urinating 1-2x or less per day and takes a “water pill” that is ineffective, both which he says contributed to the fluid collection. After being admitted this past Monday, patient was diagnosed with CHF. Patient denies chest pain. Patient states that the medications administered after being admitted are helping his urination.

A-HPI:
61 year-old African-American man with a history of Type II diabetes, and two episodes of edema extending to his abdominal wall was admitted on 10/2. The first episode occurred about 6 months ago and the second 1 month ago. When he awoke this past Monday, the patient noticed the swelling that had been present in his legs for a week, now also involved his abdomen and testicles. This change prompted his arrival to the ED. The swollen testicles are tender and three times normal size and making it very difficult to walk. The week prior to admission the patient also recalls increasing shortness of breath with walking ≥ 10 feet, and unable to sleep flat in bed. He was unable to sleep even with on 3 pillows and moved to sleeping in a chair the last 2 nights prior to admission. He is awakening at night 4 or more times to urinate, but urinating 1-2 times less per day even with taking his “water pill.” Since his admission the urination has been more frequent and he feels better. The current episode is identical to the previous episodes without symptoms of chest pain/pressure, arm or jaw pain, palpitations, cough, nausea, sweats, chills, or fevers.

B-Past Medical Hx:
Diabetes

A-Past Medical Hx:
DM Type II diagnosed 1960
Congestive Heart Failure first diagnosed 3/2012

B- Past Surgical Hx:
Left leg and toe

A- Past Surgical Hx:
Left tibia/fibula reconstruction of compound fracture after a fall (1987)
Left toe amputation because of bone infection (July 2008)

B-Allergies: None
A-Allergies: No Known Allergy to medication, foods or airborne allergens

B-Medications: Lasix Insulin Potassium

A-Medications:
Lasix 40 mg twice daily
KCl 20 meq daily
Novalin 70/30 29 units in the morning and 10 units at night
B-Family Hx:
Mother - stomach ulcers
1 of 4 brothers - DM
MGF - bilateral leg amputation from complication of DM
Family Hx of tobacco and alcohol use

A-Family Hx:
DM Type I brother 32
Maternal grandfather died in his 70's bilateral amputee from DM.
Peptic Ulcer Disease Mother died 78
Two uncles with alcohol problems
Parents smoked in the home with moderate second hand smoke exposure
No Heart disease, cancer, strokes, TB
3 younger brothers in good health

B-Social Hx:
Greyhound bus driver since 1974
15 year history of smoking (1-2 packs/week), quit in 1994
Lives with 17 y-o godson since June 2008
Desires to lose weight

A-Social Hx:
Over the road bus driver since 1974
4 pack-year smoking quit in 1994
Lives with 17 y-o godson since June 2008
Does not use alcohol or illicit drugs.
Does not follow a diabetic diet most of the time
Uses a seatbelt, does not exercise, and has no unlocked weapons in the home
Sees a podiatrist and ophthalmologist yearly

B-ROS:
General: Denies energy loss, sleep disturbances, fevers, chills, and headaches. Did gain weight
Skin: Denies skin problems
Head: Denies trauma, headaches, or dizziness
Eyes: Uses glasses for reading; denies blurriness, double vision
Ears: No problem
Nose: Denies nose problems
Mouth: Uses dentures
Neck: Denies pain, lumps, stiffness, swelling.
Respiratory: SOB per HPI
Cardiovascular: Denies chest pains
GI: Denies GI problems
GU: Denies changes in stream. Genital swelling per HPI
Musculoskeletal: Left leg swelling as a complication of reconstruction surgery, alleviated by elevation
Psych/CNS: Denies depression, anxiety, paralysis, paresthesias.
A-ROS:
General: No loss of energy, heat or cold intolerance. Sleep problems as per HPI. No night sweats. Has had an increase in appetite with a weight gain of 18 lbs in the past 6 months.
Skin: No lesions, itching, bruising, new moles, or color changes.
Head: Denies past or recent trauma, headaches, or dizziness. No hair changes.
Eyes: No change in vision, discharge, pain, jaundice, or redness; wears glasses only for reading.
Ears: No loss of hearing, pain, discharge or tinnitus
Nose: Good sense of smell, no discharge, nosebleeds, or sinus problems.
Mouth: Has both upper and lower dentures, good sense of taste, no sores, difficulty chewing or swallowing, pain or dry mouth.
Neck: Denies neck or jaw pain, no swollen glands, thyroid, masses, or neck stiffness.
Respiratory: Denies snoring, wheezing, sputum, hemoptysis.
Cardiovascular: As per HPI. Denies paroxysmal nocturnal dyspnea.
GI: No food intolerances, dysphagia, heartburn, reflux, pain, vomiting, changes in bowels. Has a hard BM every 2 days without mucus, or blood. Does have hemorrhoids and has seen bright red blood on the paper once or twice a month.
GU: No dysuria, polyuria, hematuria, urgency, incontinence. No high risk sex, discharge, change in stream. Nocturia as per HPI.
Musculoskeletal: End of the day left leg swelling off and on since surgery improved with elevation and never present in the AM before current problem. No other joint pain, swelling, redness or stiffness.
CNS: No weakness, numbness, or tingling. Denies changes in memory or thought process.
Psych: No persistent feelings of nervousness, anxiety, unusual mood changes, loss of interest, sadness, or inappropriate fear.

B-EXAM:
Vitals: BP - 124/77  Pulse - 84  RR - 20  Wt: 128kg  Ht: 174 cm  T: 37.2°

General: Patient is awake and alert and oriented.
Cardiac: Heart RRR no murmur. No JVD normal carotids.
Respiratory: Lungs clear to auscultation and percussion.
Vascular: Pulses regular bilateral extremity edema.
Musculoskeletal: Scar on left leg and left great toe absent. Gait OK.
GU: Testes swollen.
Skin: Skin warm and dry to touch.
Neuro: DTR's 2+. Sensory intact.

A-EXAM:
Vitals: BP - 124/77 sitting L arm  Pulse - 84 regular  RR - 20 unlabored  Wt: 128kg  Ht: 174 cm  T: 37.2° C

General: Patient is awake and alert, appears comfortable  Pain is now: 0 / 10
Head and Neck: Sclera are clear, there is no facial weakness, speech clear. PERRLA:EOM (Pupils Equal Round Reactive to Light: Extra Occular Movements) full. Oral mucosa moist tongue midline no pharyngeal lesions. Gums pink good dentition. No cervical, or clavicular lymphadenopathy. Neck supple without tenderness. No Thyromegally. Ears without discharge R/L EAC (External Auditory Canal) clear both Tympanic Membrane's well visualized with light reflex.
Cardiac: Heart sounds S1 and S2 regular with an S3 gallop. Apical rate equals pulse, no Lift and PMI not displaced. No murmur appreciated. No JVD at 30’ and symmetrical carotids with good uptake and no bruits.
Respiratory: Good respiratory effort with clear breath sounds bilaterally. Fremitus R>L and no chest wall tenderness. There was no dullness on percussion over lung fields.
Abdomen: Soft with good bowel sounds and pitting edema to the umbilicus. Liver span 20 cm and tender 2/10. Spleen not felt. Inguinal hernia right. Large external hemorrhoid at 2:00.
Musculoskeletal: Right & left Upper Extremities ROM (Range Of Motion) strength-tone- symmetrical 5/5 without deformity or lesions. Left Lower Extremity with 6 cm scar over tibia and left great toe absent. ROM strength-tone of lower extremities symmetrical. Gait stable wide based and slow.
GU: Increased urine output clear yellow urine in urinal. Testes descended scrotal sac 9 cm across. No genital lesions.
Skin: Skin warm and dry to touch. No ecchymosis, decubitus, rashes.
Neuro: Patellar, biceps DTR (Deep Tendon R Reflexes) are 2+ symmetrical. Trigeminal sensory light touch symmetrical, intact.
**DATA:**
Testing Results Review:
CXR Markedly enlarged heart with right pleural effusion with increased vascularity
2 D Echo 25% EF no valvular abnormalities
Na 144 K 3.2 Cl 101 CO2 30 BNP 2300

![Chemical Diagram]

**B-Differential Diagnosis:**
1. CHF - associated with poor renal perfusion and low filtration/excretion of fluids
2. Nephropathy - associated with poor filtration/secretion/excretion/ of fluids
3. Liver cirrhosis - associated with low venous return and pooling of fluid in lower extremities
4. DVT - that embolized to IVC, leading to a blockage of venous return and pooling of fluid in lower extremities

**A-Differential Diagnosis:**
1. Anasarca is likely due to Diastolic Heart Failure brought on by cardiomyopathy from his longstanding diabetes or valvular heart disease. Diabetics may also have asymptomatic coronary artery disease which may cause Systolic dysfunction and heart failure. Examining the patient should separate these two since an S3 gallop is more likely in Systolic dysfunction and an S4 gallop or significant murmur is more likely found in Diastolic dysfunction.
2. Nephropathy - Renal failure associated with diabetic renovascular disease could also explain the anasarca and obtaining a serum Blood Urea Nitrogen and creatinine would confirm the presence of renal failure. The patient is less likely to be short of breath.
3. Constrictive Pericarditis - is associated with scrotal swelling in the elderly and because he is a bus driver he may have been exposed to TB. He does not have weight loss, or night sweats but observing no engorgement of his neck veins when he takes a deep breath should help eliminate the diagnosis.
4. Liver cirrhosis - associated with low venous return and pooling of fluid in lower extremities but causes jaundice and ascites which he does not have, there is also no breathlessness with cirrhosis.
5. Lymphatic or venous obstruction - this might be more likely with a unilateral or distinct distribution of the edema due to a blockage of the venous system by a clot or the lymphatic system by a tumor or parasite. Ultrasound and radiographic tests could eliminate these causes.
6. Other causes of edema - associated with medications for blood pressure, arthritis, and steroid use. Evaluation for thyroid and adrenal function may also be necessary.

**B-Problem List:**
1. Body-wide edema
2. Swollen testicles
3. SOB lasting the past month
4. IDDM
5. Left tibia/fibula compound fracture reconstruction, left leg swelling
6. Left toe amputation
7. CHF
8. Weight gain

**A-Problem List:**
1. Anasarca due to Congestive heart failure
2. Type I Diabetes
3. Diabetic cardiomyopathy due to Type I Diabetes
4. Congestive heart failure due to cardiomyopathy
5. Dyspnea on exertion due to Congestive heart failure
6. Orthopnea due to Congestive heart failure
7. Nocturia due to Congestive heart failure
8. Swollen tender testicles due to Anasarca
9. Weight gain due to Diabetes and Congestive heart failure
10. Driving long distance
11. Constipation due to driving long distance
12. Hemorrhoids due to Constipation
NO
PAIN
Alert and smiling.

MILD
PAIN
Pain can be ignored

MODERATE
PAIN
Furrowed brow. Pain interferes with tasks

MODERATE
PAIN
Rapid breathing. Raised upper lip. Pain interferes with concentration

SEVERE
PAIN
Slow blink, mouth open. Pain interferes with basic needs

WORST
PAIN
Possible
Crying. Eyes closed. Confined to bed

<table>
<thead>
<tr>
<th>St. Louis University Mental Status Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>What day of the week is it</td>
</tr>
<tr>
<td>What is the year</td>
</tr>
<tr>
<td>What state are we in</td>
</tr>
</tbody>
</table>

Remember these 5 objects: apple pie tie house car

You have $100 and you go to store to buy a dozen apples for $3 and a tricycle for $20. How much did you spend? 1

How much do you have left? 2

Name as many animals as you can in one minute

0-4 0 5-9 1 10-14 2 15+ 3

What were the 5 objects I asked you? 5

Please repeat these #’s backward. If I say 24 you say 42

87 0 649 1 8537 1

Which one is a triangle

Which figure is the largest

This is a clock face
Draw the hour markers on this clock and the time ten minutes to three

I am going to read you a story. Listen carefully because afterwards I am going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had 3 children. They lived in Chicago.

She then stopped work and stayed at home to bring up her children.

When they were teenagers, she went back to work. She and Jack lived happily ever after.

What was the female’s name? 2

What work did she do? 2

When did she go back to work? 2

What state did she live in? 2

High School Education

Less Than High School Education

27-30 Normal

21-26 Mild Neurocognitive Disorder

1-20 Dementia

25-30

1-19
Impression  • Plan  • Data

4.0% risk of event per year if no warfarin.

Discussed warfarin CHADS = 2 Intermediate risk of thromboembolic event. 4.0% risk of event per year if no warfarin.

Daily weights RTO in 24-48 hours + furosemide 20 IVP stat then 40 po qam.

Resume metoprolol 50 and start valsartan 40 mg causes less ED

Order ECG, TSH, Echo, CBC, PT, INR, CMP.

Refuses hospitalization. Restrict fluid limit salt stay home for next week.

History of HTN non adherent. PUD last year.

New onset A fib with CHF NYH Class 2.

Over the last week heart seems to race off and on with some DOE of 1/2 flight of stairs PND x last 2 days. Wakes up with bilateral midtibial edema x 7 D. 4 weeks prior only PM swelling of ankles. Stopped BP Rx 3 months ago because of change in sex drive he blamed on the lisinopril/HCTZ.

General : comfortable in no distress

cc: Palpitations for 1 week

H P I: Over the last week heart seems to race off and on with some DOE of 1/2 flight of stairs PND x last 2 days. Wakes up with bilateral midtibial edema x 7 D. 4 weeks prior only PM swelling of ankles. Stopped BP Rx 3 months ago because of change in sex drive he blamed on the lisinopril/HCTZ.

Increased resp effort bilateral rales R>L no dullness Variable S1 no murmur

JVD 2 cm at 90°

UE pulses irregular, unequal and symmetrical.

Bilateral 2+ pedal edema to lower 1/3 tibia no redness with trophic changes both legs

138 100 18 96 11 220

Level 1 Focused 1-3 0 1-2 3-8 30 elements severe
Level 2 Expanded 1-3 0 1-2 12 elements systemic
Level 3 Detailed 4 3-8 30 elements severe
Level 4 Compreh

This is a level 4 or comprehensive visit. The HPI and ROS have about 20 elements. The exam has at least 2 elements for 9 regions. (Three vitals count for 2 element) His PFSH was reviewed. The diagnosis is complex in terms of systemic involvement and has the possibility of severe consequences. Testing is extensive, and the return visit reflects urgency.
**Medical Work Sheet**

**Attending:**

<table>
<thead>
<tr>
<th>SWEATS</th>
<th>CHILLS</th>
<th>FEVERS</th>
<th>Δ APPETITE</th>
<th>Δ WEIGHT</th>
</tr>
</thead>
</table>

**Depression** memory loss, sleep, fatigue dizzy

**Headache** vision, ears, throat, sinus, Δ voice, epistaxis

**Chest pain pressure** palpitations, DOE, PND, edema

**Orthopnea** SOB, wheezing, cough, spu tum, hemoptysis

**Food intolerance** pain, dysphagia, dyspepsia, bloating

**Nausea** vomiting, reflux, hemorrhoids Δ BM blood

**Nocturia dysuria** urgency, frequency Δ libido, incontinence

**Joint muscle** pain, stiffness, weakness, cramps

**LMP** G: P: A: monogamous, high risk

**Skin lesions** rashes, ulcer, bruising Δ nails, Δ hair

**Alert** ☐ Cooperative ☐ Pain 0 1-3 4-6 7-9 10

---

**FHx:**

- **DM**
- **CAD**
- **HTN**
- **TB**
- **CVA**
- **CA**

---

**SHx:**

- **Tonsils**
- **Appy**
- **Hernia**
- **R**
- **L**
- **GB**
- **Colon**
- **Prostate**
- **Stomach**
- **Bladder**
- **Lung**
- **Heart**
- **Vasc**

---

**CC:**

- **HPI:** location, quality, severity, duration, timing, context, modifying factors, associated symptoms

---

**PAP/DRE**

- **Mammo**
- **Colon**
- **Lipids**
- **Dexa**

---

**Wt**

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse reg irreg</th>
<th>Temp</th>
<th>BMI</th>
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</thead>
</table>

**Eyes**

- Opharynx
- GU
- GI

**Vision** ≥20/40 OU
- OU

**Conjunctivae**

- mucosa
- Prostate
- Bowel sounds

**Lids**

- pharynx
- F Genitals
- Consistency

**Sclera**

- Resp
- Urethra
- Pain + Tender

**ENT - Mouth**

- Effort
- Bladder
- Mass

**Lens • disc**

- Breath sounds
- Skin
- Liver + spleen

---

**Percussion**

- Inspection
- Hernia

**Ears external**

- Fremitus
- Palperation
- Ano-rectal

**TM EAC right**

- CV
- Lymph
- Psych

**TM EAC left**

- Palpate PMI
- Neck
- Year Season Place

**Hearing R = L**

- Heart sounds
- Axillary
- Affect + Insight

**Speech clear**

- No murmur
- Groin
- 3 step command

**Nose**

- Carotids
- Neuro
- Mus/Skel

**mucosa**

- Femorals
- CN II-XII
- Back + Spine

**septum**

- Pedal pulses
- DTR UE
- Digits nails

**Dentures**

- Varicose veins
- DTR LE

**upper**

- Edema
- Gait > 50 ft

**lower**

- Neck
- Cerebellar

**Teeth**

- Supple
- Breasts

**lips**

- No tenderness
- Inspection

**gums**

- Thyroid
- Palpation

---

**Trop**

- CBC
- CMP
- TSH
- T3
- T4
- INR
- A1C
- UA
- Lipids
- EKG
- 2DE
- CXR

**PHQ 4 =**

- VTE ☐
- 3 65 spin ☐
- IVF ☐
- ABx ☐
- Medication reconciled on back ☐

**Diet**

- General
- Tube
- Cardiac
- DM
- Renal
- NPO

**Orders done** ☐

**H&P Signed** ☐

**Stable**

**Guarded**

**Unstable**
<table>
<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>HR</th>
<th>Temp</th>
<th>RR</th>
<th>I/O</th>
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Notes/Labs:

To do:

Medications: