History and Physical –2

Siddharth Shah

Identifying Data

September 18th, 2023 – 1:30 PM
RV, 34, Indian
All Family Medicine Queens, NY
Informant: Patient, reliable

Chief Complaint: "lower back pain for 20 days"

History of Present Illness:

34-year-old-male with no PMHx , and PSHx on lower back 11 years ago in India due to "some nerve issues pain" presents today complaining of lower back pain that is sharp, non-radiating, 5/10 that started twenty days ago while on a long drive. Patient denies any trauma or accident. Patient went to urgent care two weeks ago for the lower back pain and was prescribed Naproxen and Cyclobenzaprine which has provided little relief. Patient notes nothing makes the pain better, but sitting for too long exacerbates the pain. Pain is also elicited when he tries to bend down and pick something from the floor Patient notes he had similar pain like this back in 2020 that lasted one week. Patient said he used a patch for his lower back, and it helped. The patient denies any fever, numbness, tingling, bowel, and urinary incontinence.

Past Medical History:

- None

Past Surgical History:

- No surgical history

Medications:

- None

Allergies:

- NKA

Family History:

- Father: deceased unknown causes
- Mother: Alive and well
- Brother: alive and well
- 4 Sisters: Alive and well

- Daughter: Alive and well
- 2 Sons: Alive, and well

Social History:

- Diet: Vegetarian
- Home: Lives at home with wife, and children
- Does not drink.
- No tobacco or illicit drugs use

Review of Systems:

General: Appears alert and orientated. Denies any recent weight loss or gain, loss of appetite, night sweats, fever, or chills

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

Head: Denies headache, and vertigo.

Eyes: Denies visual disturbances, double vision, blurriness, excess tearing or dryness, photophobia, or pruritis.

Ears: Denies hearing loss, tinnitus, discharge, earache.

Nose and sinuses: Denies discharge, obstruction, allergies, or epistaxis

Mouth and throat: Denies sore throat, bleeding gums, ulcerations.

Neck: Denies localized swelling, lumps, stiffness, or decreased range of motion.

Pulmonary: Denies shortness of breath, denies wheezing, or productive cough. Denies hemoptysis, cyanosis.

Cardiovascular: Denies chest pain, palpitations, edema, irregular rhythms.

Gastrointestinal: Denies changes in appetite, intolerance to any foods, no vomiting/dysphagia or pyrosis. No constipation or abdominal pain.

Genitourinary: Denies dysuria, pain, and frequency. Denies hematuria.

Nervous: Denies seizures, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, or weakness

Musculoskeletal: See HPI

Endocrine: Denies heat/cold intolerance, excessive sweating

Psychiatric: Negative history of depression and anxiety. Denies having SI/HI

Physical Exam:

General: Patient sitting comfortably on exam table does not appear in pain or in distress.

Vitals:

- BP(Seated): R – 125/68
- P: 78 bpm, regular
- R: 18 breaths/min,
- T: 98 F, oral
- O_2 Sat: 99% on room air
- Height: 66.8 inches
- Weight: 174 lbs

Skin: Warm and moist throughout. No erythema. No jaundice.

Hair: Average quantity and distribution.

Nails: No clubbing, capillary refill <2 seconds in all four extremities

Head: Normocephalic, atraumatic, nontender to palpation throughout.

Eyes: Sclera white, cornea clear, conjunctiva pink.

Ears: Wax b/l in both ears. No masses, lesions, or deformities on external ears. No discharge or foreign bodies in external auditory canals AU. TM's white and intact with light reflex.

Mouth:

- Lips: Pink and moist with no lesions
- Mucosa: Pink with no masses or lesions. Non-tender to palpation.
- Palate: Intact with no masses or lesions Non-tender to palpation; continuity intact.
- Teeth: Good dentition cavities notes throughout
- Gingivae: Pink. No hyperplasia; masses; lesions; erythema or discharge.
- Tongue: Pink; well papillated with no masses or lesions. Non-tender to palpation.
- Oropharynx: Well hydrated, no masses, lesions, or foreign bodies. Uvula pink, no edema

Neck: Trachea midline. 2+ Carotid pulses, no stridor, thrills, or bruits noted bilaterally.

Thyroid: Nontender to palpation, no masses, no bruits noted.

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

Lungs: Clear to auscultation bilaterally. No adventitious sounds.

Heart: Carotid pulses are 2+ bilaterally without bruits. RRR, S1 and S2 are distinct with no murmurs, S3 or S4.

Abdomen: Abdomen is symmetric without striae, no pulsations. Bowel sounds normoactive in all four quadrants. Non-tender to palpation or percussion throughout. No guarding or rebound tenderness. No CVA tenderness.

Peripheral Vascular: Extremities are normal in color and temperature. Pulses are 2+ bilaterally in upper and lower extremities. Non-tender lower extremities. No bruits, clubbing, cyanosis or edema bilaterally.

Musculoskeletal: 3inch linear scar on medial side of back above the posterior iliac crest. Negative straight leg raise test. Tender to palpation across lower back. Pain on lateral flexion, pain on rotation, pain on extension, but no pain on flexion.

Differential Diagnosis:

1. **Muscle Strain**: Most likely the cause because patient does not present with any numbness, tingling, no injury or trauma. Also, patient had a long drive which could tighten his muscles
2. **Sciatic Nerve:** Unlikely because of negative straight leg raise test, but also no tingling or pain radiating down the leg. However, the patient did have back surgery for nerve issues, so there are concerns for this.
3. **Scar tissue associated pain:** Pain can be associated with scar tissue from his previous surgery. If x-ray findings are unremarkable will get MRI.

Assessment: . 34 year-old-male with no PMHx , and PSHx of lower back 11 years ago in India due to "some nerve issues pain" presents today complaining of lower back pain that is sharp, non-radiating, 5/10 that started twenty days ago. No trauma, no injury, no numbness, no tingling, no urinary or bowel incontinence. Possible muscle inflammation. Will get x-ray and treat with pain medication. Patient to follow up in 1 week.

Plan:

- X-ray of Lumbar spine if unremarkable get MRI
- Diclofenac Sodium 10mg twice a day for 5 days
- Methocarbamol Tablet 750mg once daily for 5 days
- Prednisone 10mg twice daily for 5 days
- Lidocaine patch apply every 12 hrs for 7 days
- Labs drawn, A1C, CBC, CMP, Lipid Panel

Patient Education:

Mr. RV for your back pain we have changed your medication to something much stronger and are giving you Lidocaine patch to help with the pain. We also encourage you to stretch more but keep lifting and exercising to a minimum. The most likely cause of your back pain is muscle strain. It is imperative you get your x-ray done as soon as possible so we can review the results and take the appropriate steps.

Health Maintenance:

Annual Physical: Done today.