Identifying Data
**Full Name**: EI
**Address:** Taken but omitted for PHI
**Date of Birth:** 12/18/76
**Date & Time:** 5/24/22@ 4pm
**Location**: Amazing Medical Services
**Religion**: N/A
**Source of Information**: Self
**Reliability**: Reliabe
**Mode of Transport**: Car

**Chief complaint**: weight loss

**HPI:** 45yo M with pmhx of GERD, HLD and 25-year hx smoking presents for F/U for anorexia 1 year. Pt states he is not hungry but denies nausea, vomiting, diarrhea or constipation. He states he does not remember when his appetite started to decrease but he has never been a big eater. Pt denies food tasting different to him or any big changes in his life in the past two years. Pt denies any dental caries, lose of teeth, difficulty chewing or swallowing however states that his throat is ticking and feels like he has to clear histhroat often with occasional hoarseness x 1 month. Pt has not actively tried to gain weight, states that he's just not hungry. He has one meal a day, dinner at night. Pt denies depression. Minimal depression found on depression screening. States his sister is asking him for money in Nigeria and he is having difficulty saying no. Pt also complaing of R lower back pain, describes it as stabbing pain associated with numbness and tingling down his R leg x 3 months. Pt states it is intermittent and is alleviated by laying down and aggravating by standing or sitting for long periods of time. Pt has not taken anything for this. Pt denies any s/s of GERD and does not take his esomeprazole unless he is planning on drinking alcohol that night. Denies SOB, chest pain, throat pain, cough, N/V/D, change in bowelmovements, urinary symptoms or fever/chills/fatigue. Pt states he also has a colonoscopy scheduled for July 1, 2022.

Pt was previously sent for CXR and abdominal US both done on 5/8/22
Resuls from Abdominal US:
- showed no abnormalities, normal abdominal sonogram.

Results from chest xray:
- no pneumothoras, no consolidation, no ffusion, and no pulmonary noldes or masses visualized.
- Bilateral perihilar thickening observed, impression was features of reactive airways.

**PMH:**
- Hyperlipidemia
- GERD

**PSHx:**
- Denies Past Surgical History

**Medications:**

- Esomeprazole magnesium 40mg BID once daily

**Supplements**:

- Centrum, mens one a day

**Allergies:** NKDA

**Social History:**

- Immigrant from Nigeria; came in 2012
- Marital status: married; sexually active; no protection used; never tested positive for STD
- Denies intimate partner violence, drug
- Admits to occasional drinking, 1-3 drinks when he drinks, monthly
- Tobacco: current smoker; 5-10 cigarettes for 25 years <30 minutes before first cigerette
- Denies history mental illness
- Depression screening: 3 minimal depression

**Family Hx:**
Father: deceased, diagnosed HTN, ischemic stroke
Mother: deceased, diagnosed HTN, ischemic stroke
Siblings: alive; 4 brother(s) , 5 sister(s) - healthy
Spouse: alive
Children: alive; daughter(s) - healthy.

**Physical exam:**

General Appearance: alert and oriented x 3, thin male in no acute
distress.
HEENT:
Head: normocephalic
Eyes: PERRLA, non-icteric sclera, no nystagmus, conjunctiva clear, Fundi: no gross abnormality noted.
Pharynx: no exudate, no lesion.
Nasal septum: midline
Ear canals: no lesions.
Neck: supple, no thyroid enlargement, no lymphadenopathy, no carotid
Bruit, no JVD, normal ROM
HEART: non-displaced PMI; normal RRR; normal S1S2 no murmurs or clicks
Skin: warm, moist, No rash, No abnormal lesions.
LUNGS: Clear to auscultation bilaterally; no rales, rhonchi
Abdomen: soft, tender, liver nonpalpable
Extremities: no edema; Pulse +2 bilaterally; no clubbing cyanosis or tremors
Neuro: alert and oriented x 3; normal sensation; normal strength bilaterally; normal gait
MENTAL STATUS EXAM: alert and oriented to person, place and time; Pleasant Mood/Affect

MUSCULOSKELETAL: Upper extremity joints, Lower extremity joints, Cervical and lumbar spine unremarkable.

**Review of Systems**

General/Constitutional: **(+) 17lb wt loss in two years (unintentional), (+) fatigue, (+) decreased appetite**, no weakness, no fever, able to do usual actvities
Head and Neck: no headache, no dizziness, no lightheadedness.
Eyes: Eyes normal vision, no redness, no blind spots, no floaters.
Ears: no earaches, no fullness, no tinnitus.
Nose and Sinuses: no stuffiness, no discharge, no itching, no nosebleeds.
Mouth and Pharynx: no bleeding gums, no sore throats, **(+) dry throat, (+) hoarseness**
Neck: no goiter, no neck stiffness or pain **(+) swollen L submandibular lymph node**
Thorax:
Heart: no chest pain or discomfort, no syncope, no
dyspnea on exertion, no orthopnea, no PND, no edema, no cyanosis, no heart murmurs, no palpitations.
Lungs: no pleuritic pain, no SOB, no wheezing, no stridor, no cough, no hemoptysis.
Gastrointestinal:, no indigestion, no abdominal pain, no heartburn/reflux, no excessivebelching or flatulence, no nausea/vomiting, no hemetemesis, no diarrhea, normal bowel movement frequency, normal stools, no rectal bleeding, no hemorrhoids, no constipation
Genitourinary: no urgency, no burning or pain on urination, normal caliber of urinary stream, no dysuria, no nocturia, no hematuria, no polyuria, normal urine color, no stones, no incontinence, increased urgency, increased frequency, burning or pain on urination, reduced caliber of urinary stream, hesitancy.
Musculoskeletal: no neck /shoulder pain, no swelling or redness in joints, no limitation in motion
**(+) R-sided lower back pain with associated with leg lifting.**
Skin: no rashes, no lumps, no itching, no pigmentation, no dryness, no changes in hair and nails, no easy bruising.
Neurologic/Psychiatric: no fainting, no seizures, no weakness, no numbness, no tingling, no tremor, good coordination, good memory and speech, no headache; no nervousness, no tension, good mood, no unusual perceptions, no current suicidal ideations.
Hematology: General no anemia, no easy bruising or bleeding.
Allergy/Immunology: General no skin rashes, no trouble breathing.
Men Only: no hernias, no discharge or sores on penis.

**Vital signs:**

Ht: 5’9” Wt: 151lb BMI: 22.3
BP: 139/82
Pulse: 58
Resp: 16
Temp: 98.1 °F (36.7 °C)
SpO2: 100%

**Assessment**:

- 45yo M with anorexia x 2 years and weight loss (17lb x 2 years). CXR and abdominal US are WNL.
    - Hoarse voice
    - Lower back pain
    - Left submandibular lymphadenopathy
    - High blood pressure reading

**Plan**:

1. Anorexia
    a. Patient encouraged to eat small frequent meals. And to stop smoking
2. Dysphonia
    a. Referral to ENT
        i. In view of ( 25 pack year hx ) other associated symptoms (weight loss and lymphadenopathy)
3. Nonspecific lymphadenitis
    a. US: soft tissue of neck; questional submandibular nodes in view of anorexia refer to sonogram
4. Radiculopathy, lumbar region
    a. Imaging: X-ray
        i. Associated symptoms of weight loss
    b. Medication: Naproxen 500mg BID
5. Elevated blood-pressure without diagnosis of hypertension
    a. Education given on low salt
6. Nicotene dependence
    a. Smoking cession counseling given