Chief complaint: Pt presents to the clinic stating, “I need a physical to start my new job.”

Hx of present illness: Pt denies pain, illness, and complaint today.

Past medical hx: OCD/anxiety starting in 2022.

Past surgical hx: Appendectomy (1999), Rt shoulder arthroscopy (2016).

Allergies: NKDA, no known environmental/food allergies.

Medications: Sertaline, 250 mg, PO, daily. Buspar, 20 mg, PO, BID.

Social hx: Pt is a registered nurse working in a local hospital’s labor and delivery unit. He is also working towards APRN status in an MSN program at GCSU. He reports residing with his wife of one year. She is currently pregnant with an EDD of 6/2024. The pt and his wife, a teacher, both moved from Florida approx. 2 years ago for employment purposes. Pt states his own family is not local, but his in-laws are and provide support. Pt reports a dependable friend group and active social life. Pt denies tobacco, illicit and recreational drug use. Pt reports occasional alcohol use: 1-2 standard drinks, 2-3 times/month. Pt lost 20 lbs last year due to dietary changes and frequent exercise, mainly walking. Pt states that he would “like to lose 10 more.”

Family hx:

Pt reports his father is 64 yo, was dx with Hepatitis C several years ago and receives antiretroviral therapy. His mother is 63 yo and in generally good health with an unremarkable medical hx. Pt reports he has one sibling, a brother, who is healthy 26 yo with an unremarkable medical hx as well.

Nutritional hx/24 hr diet recall:

*Breakfast*: one cup of plain Greek yogurt with honey, granola, and chocolate chips. *Lunch*: Two over easy eggs, two chicken tenders, ½ cup hash browns.

*Dinner*: one cup chicken sausage, one cup brussels sprouts.

Calculation of BMI: Height: 73 in/185.4 cm, weight: 225 lbs/102.3 kg, BMI: 29.7 (overweight)

Genogram:

Maternal

Grandfather

Paternal

Grandfather

Paternal

Grandmother

Maternal

Grandmother

81

Osteoarthritis

IBS

74

Lung

cancer

77

Breast cancer

79

HTN

Mother

Father

64

Hepatitis C

63

Brother

Matthew

26

29

Key

Deceased

Female

Female

Deceased

Male

Male

Review of systems:

*Constitutional*: Pt reports weight loss of 20 lbs in last year due to diet and exercise. Denies recent illness and unusual fatigue.

*Ears, eyes, nose, mouth, throat*: Pt reports yearly vision screening, denies hx eye infection, itching, watering. Pt denies change in hearing, ear pain, and tinnitus. Pt denies seasonal allergy symptoms and difficulty swallowing. Pt reports biannual dental exams.

*Cardiovascular*: Pt denies hypertension, chest pain, chest tightness, and irregular or elevated heartbeat. Pt denies hx of heart murmur and previous EKG.

*Respiratory*: Pt denies difficulty breathing, shortness of breath. Denies hx of pneumonia and asthma. Pt reports negative TB test in last year per workplace requirements.

*Gastrointestinal*: Pt denies abdominal pain, n/v, ulcers. Reports regular bowel movements, mostly daily, which he passes without straining. Bowels are generally soft and 3-4 on the Bristol scale.

*Genitourinary*: Pt denies pain with urination, urinary frequency. Denies STI hx. Currently in a monogamous relationship and has no complaints re: sexual performance.

*Integument*: Pt denies recent skin changes. Reports yearly mole check with dermatologist. Pt states he had an irregular mole removed approx. 1 year ago; nonmalignant per biopsy.

*Musculoskeletal*: Pt denies joint and muscle pain, weakness, injury, and trauma. Denies decreased ROM and joint stiffness.

*Neurological*: Pt denies numbness, tingling, fainting, weakness. Denies lapses in orientation and memory. Denies frequent/severe headache.

*Psychiatric*: Pt reports meeting with his therapist regularly and is compliant with prescription medication. Pt denies recent suicidal and homicide thought. States he is “in a good place.”

*Endocrine*: Pt denies unusual changes in hunger and thirst. Denies excessive sweating and temperature intolerance. Denies hx of blood glucose issues.

*Hematology/lymphatic*: Pt denies excessive bruising, bleeding. Denies tenderness and swelling in lymph nodes.

*Allergy/immunology*: Pt denies recent illness and allergies. Pt denies receiving flu shot this year.

**Objective/Physical exam**:

Constitutional/General survey/Vital signs: Pt is a 29 yo Caucasian male, dressed and groomed appropriately, well-nourished, seated comfortably on the exam table in an upright position. Free from signs of distress. No obvious physical deformities noted. Pt pleasant, well-spoken, A&Ox4. Pt good historian with no deficits in hearing or speech readily apparent. All vital signs WNL.

Integumentary: Skin warm, pink, and dry; free of lesions, excoriations, and infestations. Approx. 1cm, circular scar present on the left cheek, just below the eye. Pt stated scar is from a mole removal.

Head/neck: Head appropriately sized and proportioned to the body. Hair evenly distributed. Scalp free of lumps, lesions, and infestations. Sinuses free from tenderness. TMJ moves freely without clicks. Neck has full ROM. Preauricular, posterior auricular, occipital, parotid, tonsillar, superficial cervical, deep cervical, posterior cervical, submental, submandibular, and supraclavicular lymph nodes free of swelling and tenderness upon palpation. Trachea midline. Thyroid appropriately sized, smooth, and free of nodules upon palpation. Pt swallows without difficulty. Spinous processes palpated.

Eyes/ears: Vision acuity 20/20 per Snellen test. Eyes symmetrical and appropriately placed, free from lacrimal drainage. Ptosis absent. Sclera white, conjunctiva pink. Corneas transparent and smooth; reflex to light visualized. Irises round and evenly colored. PERRLA. Red reflex visualized. Optic disc margins smooth. External ears symmetrical, appropriately placed, and free from erythema and discharge. Auricle and tragus free from tenderness. Canal contains slight cerumen buildup. Tympanic membranes pearly grey and smooth, free from fluid and bulging. Pt hearing assessed via whisper test; WNL.

Nose, mouth, throat: Nose symmetrical and appropriately placed. Nares patent and free of drainage and lesions. Turbinates pink and moist. Septum midline, intact. Lips smooth, pink, and free of lesions. Dentition excellent, gums pink. Tongue pink and freely moving in all directions. Palate intact. Uvula mobile and gag reflex present. Tonsils +2.

Cardiovascular: Apical impulse palpated; pulse WNL. Heart auscultated in all 5 points: S1/S2 auscultated. Cardiac rhythm regular, murmurs absent. PMI palpated; appropriately sized and placed. JVD absent. BP WNL. Carotid pulses equal bilaterally, absent of bruit, 2+. Radial, femoral, dorsalis pedis, and posterior tibial pulses all symmetric and regular, 2+ bilaterally. Capillary refill <3 seconds in LUE, RUE, LLE, RLE.

Respiratory: RR WNL. Pt breathing easily without use of accessory muscles, free from retractions. Chest rise and expansion symmetrical. Lungs auscultated clear in all fields, both anteriorly and posteriorly; no adventitious sounds noted. Fields resonant upon percussion. Diaphragmatic excursion approx. 3 in.

Gastrointestinal/genitourinary/abdomen: Abdomen slightly rounded. Bowel sounds normoactive in all quadrants. Soft and free from masses, tenderness, and guarding upon palpation. Umbilicus midline, free from bulges. Abdomen tympanic upon percussion throughout. No pulsations observed. Inferior border of liver palpated. Liver span approx. 7cm. Spleen not palpable. Aortic pulsation palpated, approx. 2 cm. Abdominal aorta, renal, and iliac arteries free from bruit. Femoral pulses 2+ bilaterally. Inguinal lymph nodes free from swelling and tenderness. Colorectal and prostrate screening not indicated at this time.

Back: Pt free of CVA tenderness. Kidneys non-palpable.

Extremities: Lower extremities free from varicosities. Romberg sign absent.

Musculoskeletal: Grip strength WNL. ROM unlimited in all joints. Strength 5/5 in all major muscle groups. Normal gait visualized and pt easily capable of heel-to-toe walking.

Neurological:

CNI-XII grossly intact as follows.

CNI: Pt able to identify peppermint oil when presented.
CNII: Acuity 20/20 per Snellen test. Peripheral vision WNL.

CNIII, IV, VI: Extraocular movement/6 cardinal directions of gaze confirmed present. PERRLA.

CNV: Can clench jaw. Facial sensation present via touch.

CNVII: Can smile, raise eyebrows, frown, puff out cheeks.
CNVIII: Passed Whisper test. Balance unaffected.
CNIX/X: Can easily swallow. Uvula/palate movement observed with vocalization.

CNXI: Symmetric shoulder shrug present.

CNXII: Tongue movement unlimited in all directions.

Biceps, triceps, brachioradialis, and patellar reflexes +3 bilaterally. Achilles reflexes +2 bilaterally. Babinski reflex absent. Pt sensitive to light touch and vibration. Position sense present. Pt able to complete finger-to-nose, alternating-rapid-movements test, and slide heels down opposing shins.

Psychiatric: Pt A&Ox4. Pt affect, interaction appropriate.

**Assessment and Plan**:

Assessment: Pt is in good health and is cleared to start work with no limitations.

Differential/diagnosis: n/a

Plan: Follow up with pt re: results for routine lab work drawn today (CBC, CMP, lipid panel).

Encourage pt to maintain his diet/exercise routine as his weight, although lower, still categorizes him as overweight (bordering obese). Educate pt on benefits of increasing fiber intake as his diet per recall is low in fruit and vegetable matter.

Encourage pt to maintain his regular vision, dental, and dermatologic screenings, as well as his therapy appointments. Reinforce education on importance of sunscreen use.

Educate pt on suggested immunizations, including flu shot for this year and Tdap next spring in anticipation of the birth of his child. Discuss coordination of paternity leave benefits and availability of new parent support group.