

## **Identifying Information**

Patient's Name: John smith

D.O.B.: 08-12-86

Unit Number: 451389

Sex: Male

Ethnic: Cuban

Birth Place: U.S.A.

Address: First street, Brooklyn, NY 11220

Telephone: 718-234-2103

Informant: Mother (English speaking) and seems reliable. No translator use.

## **Subjective**

### **Medical/Social Database**

#### **\*Reason for Visit:**

He had a fever and is not acting like his usual self

#### **\*History of Present Illness:**

Child was fine until this am when mom noted a fever of 103. The child has not been complaining of anything except the new onset of a sore throat. The child denies any vomiting, diarrhea, and has been urinating. The mother reports that the child is a well child. He was acting different this am and became agitated easily. She reports that he is usually a quiet and he has never been agitated before. The child acts scared of you and it takes frequent reassurance for you to get the vital signs done. According to the mother, this is markedly different behavior for him. The mother reports that he is a good child who has never given him any problem. She admits he was out last night at a dance at school but then did not come home until 3 pm. She reports that he had never done this before.

#### **\*Past Medical History:**

##### **- Perinatal history:**

Born to a 27 years old Hispanic mother, G2P2.

(+) prenatal care . Mother is healthy

Denies any medications or illicit drugs use before and during pregnancy.

##### **- Gestation: 39 wks**

##### **- Birth History: NSVD, Vertex . w/o any problems during labor and delivery.**

No intrapartum meds used except epidural pain meds.

##### **- Neonatal period: Birth weight: 7 lbs 9 oz. Discharged home with the mother after 2 days.**

No problems while stays in nursery.

- Early feeding history: No breast-fed. Enfamil 4 Oz Q2-3 hrs. No feeding problems.
- Common Childhood Illness, Serious Illness/Operation/Hospitalizations:  
None
- Accidents: None
- Current Medications/OTC/Alternative /home remedy: No.
- Allergies: NKDA.

Immunizations: Up to date.

- Primary care Provider: Dr. Sawyer

### **Review of System**

General: Denies any problems

Skin: Dry skin of the scalp and near the eyebrows, denies itching. Birthmark at the buttock.

Head: Denies any head injury or fallen to ground.

Eye: Denies any tearing, discharge, and redness. No vision test is done.

Ears: Denies any ear-tugging/ pulling behavior. No Q-tip use. Denies any ear discharge and history of ear infection.

Nose/Sinus: Occasional sneezing with clear mucous secretion. Denies any bleeding and history of cold.

Mouth/Throat: Denies any lesion. Go for dental care regularly.. Denies any history of throat infection.

Dentition: Reported not teething yet.

Neck: Denies wryneck, difficulty turning head.

Respiratory: Denies difficulty breathing

Cardiovascular: Denies history of heart abnormality, heart murmur and anemia.

Gastrointestinal: Denies flatus, diarrhea, constipation, or blood in stools.

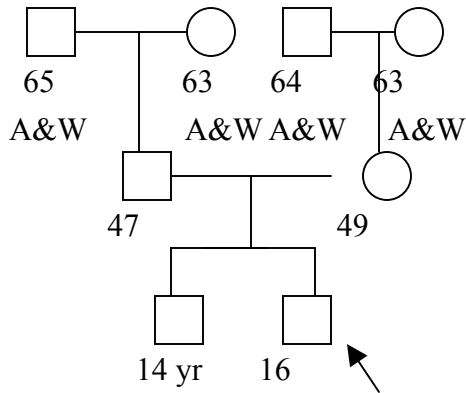
Genitourinary (Male): Not sexually active Denies blood in urine, difficulty voiding, or balloon-like at tip of penis while urinate. Denies any discharge, redness or enlargement at external genitalia.

Musculoskeletal: Denies any birth injury and congenital deformities. Denies notice any difficulty extremity movement/ stiffness.

Neurological: Denies history of syncope. Denies any seizures or tremors.

Hematological: Denies history of anemia or any hematological disease. Denies bruising easily and any past blood transfusion.

Endocrine: Denies any history of endocrine disease.

**Family Profile**

Key:  male       female

A&W: alive and well

**Family History:** Denies any family history of heart disease, hypertension, stroke, diabetes, blood disorder, sickle cell disease, thalassemia, anemia, arthritis, gout, allergies (eczema, sinusitis, seasonal, food or medication), asthma, obesity, mental illness, seizure disorder, kidney disorder, TB, hepatitis B, HIV, congenital abnormality, genetic disorder and other forms of cancer.

**Social Profile**

Both parents live together in 2<sup>nd</sup> floor rented apartment in Brooklyn. The father works 5 days a week. John, their 14-year-old is a 10th grader in gifted classes. The 16 year old is in college already. Both children are very bright.

No religion or other organizational support.

Mother is the main caretaker.

Mother states relationship with husband is fine.

Lack of family support and financial problems are their major stressors.

**Developmental Base-motor, Language, Cognitive, Social**

**Milestones:** Development was normal

**School Performance:** Is in gifted classes. Plays the violin and is considered gifted.

### **Activities of Daily Living**

**Nutrition:** Eats on the run. Occasionally has breakfast

**Sleep:** Bedtime at 11 p.m. and wakes up at 6 a.m. Sleeps well.

**Elimination:** BM: brownish and soft stool once/2 days.

**Behavior concerns:** No

**Injury Risks:** Smoke detector (+), Pet (-), Gun (-), and passive smoke (-). Family members :  
Alcohol (-),illicit drug use (-).

**Environment Risks:** Describes it is a new apartment in a nice area.

### **Objectives**

**Vital Signs:** Temp: 103° Apical Pulse: 140 bpm. R.R: 26 breaths/min.

BP 160/88

**Growth:** Wt: 144 lbs.

Ht: 5 feet 5”

**General Appearance :** Alert, well-groomed adolescent who has no apparent respiratory distress and obvious dysmorphic features. He initially was very agitated during the visit and then has non bilious emesis once and seems calmer.

**Skin:** Warm, sweaty skin with good skin turgor, mildly flushed appearance. No dry, peeling skin of the trunk and extremities. No cyanosis, jaundice, petechiae, bruising, hemangioma and café-au-lait spots.

#### **HEENT:**

Head: Normocephalic w/o deformities or prominent bony ridge.

Eyes: Symmetric eyebrows. No ptosis, erythema , tearing or masses Nystagmus noted. PERLL with (+) red reflex, central cornea light reflex. Iris: clear marking w/o brushfield’s spots. Sclera: white w/o icteric or hemorrhage. Intact extraocular movement. No crossing eyes.

Ears: Symmetrical, normal set ear w/o deformities. No periauricular skintag or dimple. T.M: intact, pearly gray with (+) LM/LR. Dry, flaky wax in the canal w/o redness, lesion or any discharge

**Nose:** patent with pink, glistening nasal mucosa. Slightly Swollen turbinates with irritation of kisselbacks triangle, deviate /perforate septum or intranasal masses /polyps. Slight crusted mucoid secretion in both nares.

**Mouth/Throat:** Symmetry of smile/cry. Lips pink and moist without cracking or scaliness. Palate intact. Buccal mucosa pink, moist w/o thrush, white patch, lesion, or ecchymosis. Slight redness at back of pharynx. Tonsil (+3) with white exudates.

**Teeth:** normal

**Neck/LNs:** Supple with good ROM. Clavicles intact No other palpable enlarged LNs. No thyroid enlargement.

**Chest/Lung:** No deformities or asymmetry in shape of the chest. No chest wall retraction. Clear breathing sound bilaterally.

**C-V:** Equal femoral and brachial pulses bilaterally.

Normal S1, S2 sounds w/o murmur. PMI at the level of 5<sup>th</sup> interspace and to the left of midclavicular line.

**Abdominal:** Soft and protuberant. No palpable organomegaly or masses. Bowel sounds (+) at 4 quadrants. No umbilical hernia.

**Genitalia:** Normal uncircumcised male genitalia with 2 descended testicles. No hydrocele. Urethra opening (+) w/o hypospadias. Tanner stages I.

**Anus:** Patent w/o displacement or anal fissure. Good external sphincter tone. Wink (+).

**Extremities:** Normal extremities with 10 fingers/toes. normal muscle strength/bulk.

**Spine:** Midline, normal curvature w/o dimple or hair tuft.

**Neurological:** Reflex brisk and +4. Can a mild tremor noted of hands Gait slightly ataxic

## Differential Diagnosis

## Lab tests