NURC 304 Subjective/Objective Notes
Heart and Peripheral Vascular System

Student Name: Brittany Hackler	Preceptor Name: Renita Armstrong
Patient Initials: B. P.	Date of Exam: 3/12/21
Patient Gender: F	Patient Age: 58
System: Heart and Peripheral Vascular System	

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Subjective

Chief Complaint (patient's own words): "I am here with Brittany as her patient for a skills check-off."

History of Present Illness: (*include pertinent negatives and positives)*
Patient denies any angina, diaphoresis, cold sweats, palpitations, dyspnea, nausea, or tachycardia. Resident states, "I have been feeling more tired lately, but it could be due to my age. My job is also stressful due to COVID-19." Denies orthopnea and reports only using two pillows to sleep with at night. Denies hemoptysis, increased sputum production, mucoid production, or purulent discharge. Denies cyanosis or pallor to skin. Denies edema and nocturia. Denies hypertension, heart murmur, congenital heart disease, unexplained pain in childhood or youth, rheumatic fever, or anemia. Denies history of CAD, CVD, ulcers, chronic emphysema, or bronchitis. Patient reports having elevated cholesterol and triglycerides. Patient states, "I had my labs drawn 6 months ago to check my levels. Reports having issues with tonsils r/t strep throat. Denies any history of smoking, drug or alcohol use, no hormonal replacement therapies, or decline in activity level. Patient states, "I take vitamin D primarily because of where we live. I tend to stay out of the sun and use sunscreen when I do go out. I try to eat a low sodium diet and tend to snack throughout the day. I am sedentary at work, so I tend to get up and walk around periodically. I also do mild exercises such as walking or yoga." Patient denies leg pain or cramps, skin changes, swelling, or lymph node enlargement.

Past Medical History:
Patient reports dentures and deviated septum at age 16 r/t abuse. Tonsillectomy at age 30 r/t strep throat. No other reported surgeries or hospitalizations. No family history of disease in the ears, nose, mouth, or throat, heart or vascular. No personal or family history of diabetes, hypertension, glaucoma, obesity, CAD, or history of sudden death at a young age. Family history of abuse. Up-to date on all immunizations including flu shot and COVID-19 vaccine. Last labs drawn 6 months ago: CBC with fasting lipids and CMP.

Medications:
Ibuprofen 400mg PO PRN for headaches
Mucinex 600mg PO 1 to 2 tabs every 12 hours for colds
Lipitor 20mg PO daily

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Clinical Exam:
Patient is AOx3, no respiratory difficulty, no c/o pain now, skin turgor good, skin color good, skin is warm and dry, no problems voiding, and bowel movement was in the early am.

Heart Neck carotids upstrokes are brisk and equal bilaterally and no bruit noted. Precordium inspection, no visible pulsations, heaves, or lifts. Palpation of apical pulse in 5th internal costal space at left midclavicular line, no thrill. Auscultation of Aortic, Pulmonic, Erb's point, Tricuspid, and Mitral areas. S1-S2 present, not diminished, or accentuated, no S3, no S4, no other extra heart sounds, no murmurs.

Objective	**Peripheral Vascular System:** Upper extremities warm, pink, symmetrical in size, no lesions, no edema. Capillary refill < 2 sec bilaterally. Pulse regular rhythm, equal 2+ radial rate 78. Lower extremities warm, pink, symmetrical in size, even hair distribution, no lesion, no edema, no varicosities, faint superficial vessels, toenails clear and pink. Pulses 2+, regular, equal.