**Sample Summary of History and PE**

**General Data:** AB is a 65-year-old female, married, from Mandaluyong

**Chief Complaint:** weakness

**History of Present Illness**

Patient was allegedly previously well until…

3 months prior to consult: Patient started to have back pain described as “parang ngalay”, occurring during periods of prolonged sitting down, VAS 4-5/10, lasting for approximately 2-3 hours and mildly relieved with intake of Alaxan and warm compress. No other symptoms at this time hence no consults done.

2 months prior to consult: Patient noted to also have knee and hip pain on top of back pain with attacks occurring almost daily with no apparent inciting factors. There was still some relief with Alaxan intake at this time. At this time patient already noted to have some pallor but was attributed to pain.

1 month prior to consult: Patient noted decreasing relief with Alaxan. Patient would note periods of severe back pain where she would be unable to get out of bed without assistance but she was still able to do other activities of daily living. She consulted her Family Physician who prescribed her with Diclofenac 50mg 1 tablet every 8 hours and advised her to have ancillary tests done. Her doctor strongly advised patient to take Diclofenac for a week only and to follow-up at the end of the week with the results of her laboratory tests. Patient however noted some relief with Diclofenac so she continued intake of Diclofenac and delayed undergoing the ancillary tests requested.

2 weeks prior to consult: Patient noted decreasing relief with Diclofenac. She then started intake of Mefenamic Acid 500mg 1 tablet 2x a day to help augment pain relief.

1 week prior to consult: Patient started to experience on and off vague abdominal discomfort with no apparent precipitating factors. No other symptoms at this time. Patient continued with Diclofenac and Mefenamic Acid. Patient also started Kremil S.

On day of consult: Patient was noted to be weak and would prefer to lie down in bed hence was brought in for evaluation.

**Review of Systems**

No headache, weakness, easy fatigability, chest pain, palpitations, dyspnea, fever

(+) anorexia

(+) unquantified weight loss

(+) dark colored stools

(+) frothy dark yellow urine, nocturia, frequency

(+) polydipsia, polyphagia

**Past Medical History**

Patient has hypertension with highest blood pressure of 160/100 and usual BP 120/80 with maintenance medication of Losartan 50mg 1 tablet once a day and Aspirin 80mg 1 tablet once a day. She claims to be compliant with these medications. She has no other known co-morbids. She has also been irregularly taking Stress tabs.

Other than her hospitalizations for her pregnancies she had 1 hospitalization 10 years prior when she had severe low back and bilateral knee pain experienced after teaching back to back lectures for a 1 week long seminar for new teachers. This was resolved after she was given unrecalled IV pain medications and physical therapy. She allegedly had unremarkable ancillary tests at this time.

**Personal/Social History**

Patient is a nonsmoker, nonalcoholic beverage drinker and she denies illicit drug use. She is a retired elementary school teacher.

**Family Medical History**

(+) diabetes mellitus – sister

(+) hypertension – father

(+) osteoarthritis – grandparents on father side

(+) rheumatoid arthritis – mother

(+) PTB – ongoing 4th month of treatment for husband

No noted history of cerebrovascular disease, myocardial infarction, or cancer.

**OB-Gyne History**

G4P4 (4-0-0-4) with all pregnancies delivered via spontaneous vaginal delivery. Menopause at age 52.

**Physical Examination on Admission**

Patient is awake, coherent, in mild distress

**Vital Signs: BP:** 80/50, **HR:** 121, **RR:** 24, **T:** 38°C

**HEENT:** pale palpebral conjunctiva, anicteric sclerae, no palpable cervical lymphadenopathy, no neck vein engorgement

**Chest and Lungs:** symmetric chest expansion, vesicular breath sounds, no adventitious breath sounds

**Heart:** adynamic precordium, tachycardic, regular rhythm, no murmurs

**Abdomen:** flat, normoactive bowel sounds, soft, (+) tenderness on direct palpation at epigastric and LUQ areas, no hepatosplenomegaly

**DRE:** good sphincteric tone, no masses, no tenderness on palpation, (+) dark colored stool per examining finger

**Extremities:** pale nail beds, (+) grade 2 bipedal edema, no jaundice, (+) pain on trying to sit up and moving of lower extremities

**Neurologic:** unremarkable findings