

# GU Week 2 NR667 ihuman

## Subjective findings

### Reason for Encounter:

MH presents with right-sided flank pain, nausea, vomiting, fever, and painful urination.

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### History of Present Illness (HPI):

MH states that her flank pain began two days ago and is located around the lower ribs on the right side of her back. She describes the pain as constant and reports experiencing nausea three or four times, along with one episode of vomiting, and notes that her appetite has been poor. She indicates that her temperature rose to 100.2°F yesterday, and she also experienced chills. Although she has taken over-the-counter acetaminophen, she explains that it only temporarily reduces her fever and does not significantly alleviate her pain.

MH describes a history of recurrent urinary tract infections, stating that she has had three bladder infections over the past two years. She recalls that her most recent infection occurred two months ago and was treated with nitrofurantoin. According to MH, she began experiencing dysuria two days ago, which she characterizes as severe and persistent throughout urination. She also notes increased urinary frequency and urgency, but denies noticing any blood in her urine.

In terms of sexual history, MH reports that she is sexually active only with her husband. She recalls having had a chlamydia infection in college, which was treated successfully, and denies any current concerns about sexually transmitted infections. She explains that she tried acetaminophen for her flank pain and fever, but it provided minimal relief for her pain. She also notes that her nausea tends to worsen after she eats or drinks orange juice.

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### Review of Systems (Subjective Findings):

MH reports feeling feverish and occasionally experiencing chills, but she denies fatigue, night sweats, unintended weight changes, or generalized weakness. She denies headaches, vision changes, hearing loss, tinnitus, nasal congestion, sore throat, or neck pain or masses. She denies chest pain, palpitations, and any history of hypertension, and she denies coughing, shortness of breath, or difficulty breathing.

She reports nausea, with one episode of vomiting, and states that her appetite has decreased. She denies diarrhea, constipation, or the presence of blood in her stool. She reports severe dysuria, along with increased frequency and urgency of urination, and denies hematuria, urinary incontinence, or passing kidney stones. She explains that she has right flank pain but denies other muscle aches, joint pain, or stiffness. She denies dizziness, confusion, numbness, tingling, or any focal weakness.

She denies any rashes or skin lesions, denies breast lumps or changes, and does not report any emotional or mood disturbances. She denies feeling depressed or hopeless over the past two weeks. She denies having heat or cold intolerance, excessive thirst, or other endocrine-related concerns. She denies experiencing unusual bruising, bleeding, or swollen lymph nodes.

Regarding allergies and immunologic concerns, she denies having any known drug or environmental allergies and states that her immunizations are up to date according to her knowledge.

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#### Past Medical History:

MH reports three previous urinary tract infections over the past two years, and she explains that she was treated with nitrofurantoin two months ago. She recalls having a chlamydia infection in college that was successfully treated and has no other significant chronic illnesses.

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#### Hospitalizations/Surgeries:

MH explains that she was hospitalized for childbirth with her three children but denies any other hospital admissions. She denies having undergone any surgical procedures.

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#### Preventive Health:

MH states that she believes her immunizations are current. She reports routine dental care every six months and has not encountered any significant dental issues. She has undergone regular Pap smears, all of which have produced normal results.

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#### Medications:

MH is currently taking acetaminophen over the counter for pain and fever. She notes that she took nitrofurantoin for a urinary tract infection two months ago.

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#### Allergies:

MH denies any known drug, food, or environmental allergies.

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#### Social History:

MH reports that she is married, has a husband, and takes care of three children. She works in business management, which she finds rewarding despite long hours. She denies any history of smoking or using chewing tobacco. She admits to drinking alcohol occasionally, typically one beer or one glass of wine per week. She denies using any recreational drugs.

She states that she drinks one or two caffeinated beverages per day and enjoys chocolate. She explains that she exercises approximately five days per week by jogging or walking for about thirty minutes each session. She generally sleeps six to eight hours per night and practices regular hand washing. She denies any recent travel.

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#### Family History:

MH reports that her father was diagnosed with diabetes at age fifty-six. She states that her mother and sister are healthy and mentions no significant health concerns among her grandparents.

### Objective findings

#### General:

MH appears well-developed and well-nourished, and she does not appear to be in acute distress. She has a flat affect appropriate to the situation, and she maintains an upright posture without any visible abnormalities. Her skin is warm and dry on general inspection.

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#### HEENT/Neck:

MH's head is normocephalic and atraumatic. She demonstrates symmetrical facial features, and her temporal arteries are non-tender upon palpation. Her maxillary and frontal sinuses are non-tender bilaterally. She exhibits normal facial sensation to both sharp and dull stimuli across her forehead, cheeks, jaw, and nose. No nystagmus is noted during the Dix-Hallpike maneuver.

Her visual acuity is 20/20 in both the right (OD) and left (OS) eyes, and her visual fields are full to confrontation. Inspection of her eyelids reveals no ptosis, erythema, or swelling; her sclerae