Chief complaint: "Here for medication refill and also numbness in my arm."

HPI: A.B. is a 45-year-old F current smoker G4P4 with a PMHx of HTN and TIA (July 2023). She presents for a medication refill, and complaints of L upper extremity numbness and dizziness that restarted a couple months ago after previously resolving after her TIA. L upper extremity numbness occurs over the entire extremity, is intermittent, and has associated paresthesias. Patient denies pain or weakness. Dizziness is characterized as a "feeling of spinning around", is intermittent, each episode lasts ~1 hour, and episodes are accompanied by visual flashes. Patient cannot identify any triggers and states they occur "randomly through the day". She denies any headache, nausea, vomiting, tinnitus, hearing loss, or vision loss. Patient reports she previously addressed these symptoms with her neurologist after her TIA but once they resolved, care was discontinued and she has not followed up since. She denies any other acute complaints at this time.

Past Medical History:
TIA (July 2023)
HTN (time of diagnosis unknown)

Medications:
Meclizine HCl 12.5mg PO qd
Vitamin E 200 unit capsule PO qd
Amlodipine besylate 5mg PO qd

Allergies:
Penicillin
Aspirin

Surgical History: denies

Hospitalizations: denies

Vaccinations: is UTD with vaccinations

Social History:
Living: lives in a house in Queens with her husband
Occupation: patient care associate
Sexual: sexually active with her husband, monogamous, denies history of STIs, LMP: 1/29/24
Smoking: admits to current tobacco smoking (~4 cigarettes/day for many years)
EtOH: denies
Drugs: admits occasional marijuana use, denies other illicit drug use
Exercise: denies
Diet: tries to eat a well-rounded diet but often eats fast food or "fatty" home-cooked food

Family History:
Father: alive, well
Mother: alive, well
Siblings: 4 brothers, 1 sister

Children: 1 son, 3 daughters

Review of Systems:
General: denies fever, chills, headache, fatigue, lightheadedness

Skin/hair/nails: denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles, rashes, pruritus, change in hair distribution

Head: admits vertigo. Denies headache, trauma

Eyes: denies discharge, dry eye, eye pain, double vision, blurry vision

Ears: denies ear pain, tinnitus, fullness, eye discharge, hearing loss

Nose: denies sinus pain, decreased sense of smell, epistaxis, nasal discharge

Mouth/throat: denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures

Neck: denies lumps, swelling, stiffness, decreased range of motion

Respiratory: denies cough, shortness of breath, sputum production, wheezing, hemoptysis, paroxysmal nocturnal dyspnea

Cardiovascular: denies chest pain, palpitations, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal: denies abdominal pain, nausea, vomiting, constipation, diarrhea, change in bowel habits, rectal bleeding, loss of appetite, hemorrhoids

Musculoskeletal: denies deformity, redness, weakness, muscle pain, joint pain

Peripheral vascular: admits intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

Genitourinary: denies change in frequency, urgency, hesitancy, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain, dyspareunia, anorgasmia, vaginal

Hematologic: denies anemia, easy bruising/bleeding, history of DVT/PE

Endocrine: denies temperature intolerance, excessive thirst

Neurologic: admits paresthesias. Denies weakness, ataxia, seizures, sensory disturbances, change in mental status, memory loss

Psychiatric: denies feelings of helplessness, feelings of hopelessness, lack of interest in usual activities, suicidal ideation, anxiety

Physical Exam:

Vitals:

Vitals:

Temp: 98.0F
BP: 131/83
Pulse: 83
RR: 18
SpO2: 98%
Ht: 61 in
Wt: 118 lbs
BMI: 22.29

General Survey: AO3, NAD
Skin: warm and moist, good turgor, nonicteric, no lesions
Nails: capillary refill <2s throughout, no clubbing, lesions
Eyes: no conjunctival injection, pallor, or scleral icterus,
Ears: symmetrical, no lesions/masses on external ears, no discharge
Nose: symmetrical, nares patent b/l, nasal mucosa pink and well-hydrated, no masses, lesions, deformities, or discharge
Mouth: mucosa, gingivae, and palate are pink and well-hydrated, good dentition, uvula midline, no edema, no masses/lesions/leukoplakia
Neck: supple, nontender to palpation, trachea midline, full ROM, no masses, lesions, scars, palpable lymphadenopathy
Chest: LAT to AP diameter 2:1, chest is nontender to palpation without deformities, symmetrical rise and fall of chest wall
Lungs: clear to auscultation b/l, no labored breathing, accessory muscle use
Cardiovascular: regular rate and rhythm, normal S1 and S2, no S3 or S4, no murmurs, no friction rubs, no gallops
Abdomen: soft, non-distended, non-tender to palpation throughout, BS present in all four quadrants, no bruits over aortic/renal/iliac/femoral arteries, masses, guarding, rebound tenderness, CVAT
Musculoskeletal: full spine ROM, full extremities ROM, normal gait, no swelling, deformities, erythema, warmth, crepitus
Peripheral vascular: bilateral upper and lower extremities symmetric in color, size, and temperature. UE pulses are 2+ b/l. LE pulses pulses are 2+ b/l, no clubbing, cyanosis, stasis changes or ulcerations in bilateral UE or LE
Neurologic: AO3, CN II-XII intact, motor 5/5 in all extremities, reflexes 3+ and equal throughout, sensory testing normal to light touch, pinprick, and proprioception, finger-nose and heel to shin/point to point testing normal, rapid alternating movements normal, gait normal

Assessment: A.S. is a 45-year-old F with a PMHx of HTN and a TIA 7 months ago who is also a current smoker. She is experiencing a recurrence of dizziness and L UE numbness and paresthesias that first started after her TIA. Physical examination was unremarkable. A neurology referral should be provided for her dizziness and L UE numbness and paresthesias. HTN and vertigo medications should be refilled. Smoking cessation should also be addressed with A.S. When discussing health maintenance, A.S. also reports that she has not yet had a mammogram and her last pap smear was 5 years ago. Given her age,

smoking history, and time of last pap smear, a mammogram and colonoscopy referral should be provided and a f/u should be scheduled to perform a pap smear with HPV co-testing.

Plan:

- Medication refill
    - Refill meclizine
    - Refill amlodipine
    - Refill vitamin E
- Vertigo, L UE numbness and paresthesias
    - Referral to neurology
- Health maintenance
    - Pap smear with HPV co-testing at 2wk f/u
    - Mammography referral
    - Referral to GI for colonoscopy