CHIEF COMPLAINT:, Lump in the chest wall.,HISTORY OF PRESENT ILLNESS: , This is a 56-year-old white male who has been complaining of having had a lump in the chest for the past year or so and it has been getting larger and tender according to the patient. It is tender on palpation and also he feels like, when he takes a deep breath also, it hurts.,CHRONIC/INACTIVE CONDITIONS,1. Hypertension.,2. Hyperlipidemia.,3. Glucose intolerance.,4. Chronic obstructive pulmonary disease?,5. Tobacco abuse.,6. History of anal fistula.,ILLNESSES:, See above.,PREVIOUS OPERATIONS: , Anal fistulectomy, incision and drainage of perirectal abscess, hand surgery, colonoscopy, arm nerve surgery, and back surgery.,PREVIOUS INJURIES: , He had a broken ankle in the past. They questioned the patient who is a truck driver whether he has had an auto accident in the past, he said that he has not had anything major. He said he bumped his head once, but not his chest, although he told the nurse that a car fell on his chest that is six years ago. He told me that he hit a moose once, but he does not remember hitting his chest.,ALLERGIES: , TO BACTRIM, SIMVASTATIN, AND CIPRO.,CURRENT MEDICATIONS,1. Lisinopril.,2. Metoprolol.,3. Vitamin B12.,4. Baby aspirin.,5. Gemfibrozil.,6. Felodipine.,7. Levitra.,8. Pravastatin.,FAMILY HISTORY: , Positive for hypertension, diabetes, and cancer. Negative for heart disease, obesity or stroke.,SOCIAL HISTORY: ,The patient is married. He works as a truck driver and he drives in town. He smokes two packs a day and he has two beers a day he says, but not consuming illegal

drugs.,REVIEW OF SYSTEMS,CONSTITUTIONAL: Denies weight loss/gain, fever or chills.,ENMT: Denies headaches, nosebleeds, voice changes, blurry vision or changes in/loss of vision.,CV: See history of present illness. Denies chest pain, SOB supine, palpitations, edema, varicose veins or leg pains.,RESPIRATORY: He has a chronic cough. Denies shortness of breath, wheezing, sputum production or bloody sputum.,GI: Denies heartburn, blood in stools, loss of appetite, abdominal pain or constipation.,GU: Denies painful/burning urination, cloudy/dark urine, flank pain or groin pain.,MS: Denies joint pain/stiffness, backaches, tendon/ligaments/muscle pains/strains, bone aches/pains or muscle weakness.,NEURO: Denies blackouts, seizures, loss of memory, hallucinations, weakness, numbness, tremors or paralysis.,PSYCH: Denies anxiety, irritability, apathy, depression, sleep disturbances, appetite disturbances or suicidal thoughts.,INTEGUMENTARY: Denies unusual hair loss/breakage, skin lesions/discoloration or unusual nail breakage/discoloration.,PHYSICAL EXAMINATION,CONSTITUTIONAL: Blood pressure 140/84, pulse rate 100, respiratory rate 20, temperature 97.2, height 5 feet 10 inches, and weight 218 pounds. The patient is well developed, well nourished, and with fair attention to grooming. The patient is moderately overweight.,NECK: The neck is symmetric, the trachea is in the midline, and there are no masses. No crepitus is palpated. The thyroid is palpable, not enlarged, smooth, moves with swallowing, and has no palpable masses.,RESPIRATION: Normal respiratory effort.

There is no intercostal retraction or action by the accessory muscles. Normal breath sounds bilaterally with no rhonchi, wheezing or rubs. There is a localized 2-cm diameter hard mass in relationship to the costosternal cartilages in the lower most position in the left side, just adjacent to the sternum.,CARDIOVASCULAR: The PMI is palpable at the 5ICS in the MCL. No thrills on palpation. S1 and S2 are easily audible. No audible S3, S4, murmur, click, or rub. Carotid pulses 2+ without bruits. Abdominal aorta is not palpable. No audible abdominal bruits. Femoral pulses are 2+ bilaterally, without audible bruits. Extremities show no edema or varicosities.