DO CASE STUDY 3 THROUGHOUT

**ADVANCED HEALTH ASSESSMENT**

# **Module 1 Discussion**

No unread replies.No replies.

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 **Religious, Cultural, Spiritual Beliefs, History Taking, Physical Exam, & Documentation Strategies**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |
| --- | --- | --- |
| **Case 1** | **Case 2** | **Case 3** |
| * 76-year-old Black/African-American male with disabilities living in an urban setting. * Adolescent Hispanic/Latino boy living in a middle-class suburb | * 55-year-old Asian female living in a high-density poverty housing complex. * Pre-school aged white female living in a rural community. | * 16-year-old white pregnant teenager living in an inner-city neighborhood. * 35-year-old transgender white male living in a homeless shelter. |

Answer the following questions. Please be specific and relate your questions to your specific case (s). Assignments per case study are below.

1. **What are the barriers to interpersonal communication?**
2. **What are the procedures and examination techniques that you will use during the physical exam of your patient?**
3. **Describe the Subjective, Objective, Assessment, Planning (S.O.A.P.) approach for documenting patient data and explain what they are.**

**Submission Instructions:**

* You have been assigned **your case number** (See Announcement), and you will post about the case number you have been assigned.
* You will reply to your peers who have posted on the **other two case studies (One of each)**.
* Your initial post **should be at least 500 words**, formatted and cited in the current **APA style** with support from at least **2 academic sources other than your textbook**. Your initial post is worth 8 points.
* You should respond to **at least two of your peers**by extending, refuting/correcting, or adding additional nuance to their posts. Use at least **1 academic source for each response to your peers other than your textbook**. Your reply posts are worth 2 points (1 point per response).
* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
* Please post your initial response by 11:59 PM ET Thursday, and comment on the posts of two classmates by 11:59 PM ET Sunday.
* You can expect feedback from the instructor within 48 to 72 hours from the Sunday due date.

# **Module 2 Discussion**

No unread replies.No replies.

null

 **Cultural, Spiritual, Nutritional, & Mental Health Disorders**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Subjective Data** | | | |
| **Chief Complaint  (CC)** | “I came for my annual physical exam, but do not want to be a burden to my daughter.” | “I am here for my annual physical exam and have been having vaginal discharge.” | “Annual physical exam” |
| **History of Present Illness (HPI)** | At-risk 86-year-old Asian male – who is physically and financially dependent on his daughter, a single mother who has little time or money for her father’s health needs. | 32-year-old pregnant lesbian – her pregnancy has been without complication thus far. She has been receiving prenatal care from an obstetrician. She received sperm from a local sperm bank. | 23-year-old Native American male comes in to see you because he has been having anxiety and wants something to help him. He has been smoking “pot” and says he drinks to help him too. He tells you he is afraid that he will not get into Heaven if he continues in this lifestyle. |
| **PMH** | Hypertension (HTN), gastroesophageal reflux disease (GERD), b12 deficiency and chronic prostatitis |  |  |
| **PSH** | S/P cholecystectomy |  |  |
| **Drug Hx** | Current Meds: Lisinopril 10mg daily, Prilosec 20mg daily, B12 injections monthly, and Cipro 100mg daily. | Current Meds: prenatal vitamins and takes Tylenol over the counter for aches and pains on occasion | Current Meds: denied |
| **Allergies** |  |  | No allergies to food or medications. |
| **Family Hx** |  | She has a strong family history of diabetes. Gravida 1; Para 0; Abortions 0. | He has a family history of diabetes, hypertension, and alcoholism. |
| **Review of Systems (ROS)** | | | |
| **General** | + weight loss of 25 lbs over the past year; no recent fatigue, fever, or chills. | No fatigue, fever, or chills. | No recent weight gains of losses, fatigue, fever, or chills. |
| **Head, Eyes, Ears, Nose & Throat (HEENT)** | No changes in vision or hearing, no difficulty chewing or swallowing. |  |  |
| **Neck** | No pain or injury | No pain or injury |  |
| **Respiratory** |  |  |  |
| **CV** |  |  | no chest discomfort or palpitations |
| **GI** |  |  |  |
| **GU** | no urinary hesitancy or change in urine stream |  |  |
| **Integument** | multiple bruises on his upper arms and back. | multiple piercings, and tattoos. Old scars related to “cutting” | history of eczema – not active |
| **MS/Neuro** | + falls x 2 within the last 6 months; no syncopal episodes or dizziness | no syncopal episodes or dizziness, no change in memory or thinking patterns; no twitches or abnormal movements. | no syncopal episodes or dizziness, no change in memory or thinking patterns; no twitches or abnormal movements |
| **Objective Data** | | | |
| **PE** | B/P 188/96; Pulse 89; RR 16; Temp 99.0; Ht 5,6; wt 110; BMI 17.8 | B/P 128/76; Pulse 83; RR 16; Temp 99.0; Ht 5,6; wt 128; BMI 20.98 | B/P 158/90; Pulse 88; RR 18; Temp 99.2; Ht 5,7; wt 208; BMI 32.6 |
| **General** |  |  | 23-year-old male appears well developed and well-nourished. He is anxious – pacing in the room and fidgeting, but in no acute distress. |
| **HEENT** | Atraumatic, normocephalic, PERRLA, EOMI, arcus senilus bilaterally, conjunctiva and sclera clear, nares patent, nasopharynx clear, edentulous. | Atraumatic, normocephalic, PERRLA, EOMI, conjunctiva and sclera clear; nares patent, nasopharynx clear, good dentition. Piercing in her right nostril and lower lip. | Atraumatic, normocephalic, PERRLA, EOMI, sclera with mild icterus, nares patent, nasopharynx clear, poor dentition – multiple carries. |
| **Lungs** | CTA AP&L | CTA AP&L | CTA AP&L |
| **Card** | S1S2 without rub or gallop | S1S2 without rub or gallop | S1S2, +II/VI holosystolic murmur; without rub or gallop |
| **Abd** | benign, normoactive bowel sounds x 4 | benign, normoactive bowel sounds x 4 | benign, normoactive bowel sounds x 4; Hepatomegaly 2cm below the costal margin. |
| **GU** |  | external genitalia intact, no lesions or masses. White copious discharge with an amine odor; no cervical motion tenderness; adnexa intact. |  |
| **Ext** | no cyanosis, clubbing or edema | no cyanosis, clubbing or edema | no cyanosis, clubbing or edema |
| **Integument** | multiple bruises in different stages of healing – on his upper arms and back. | intact without lesions masses or rashes. | intact without lesions masses or rashes. |
| **MS** |  |  |  |
| **Neuro** | No obvious deformities, CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII |

Answer the following questions about your specific case number assigned:

1. **Discuss the specific socioeconomic, spiritual, lifestyle, and other cultural factors related to the health of the patient you selected.**
2. **Utilizing the five assessment domains, which ones would you utilize on your patient in conducting a comprehensive nutritional assessment?**
3. **Discuss the functional anatomy and physiology of a psychiatric mental health patient. Which key concepts must a nurse know in order to assess specific functions?**

**Submission Instructions:**

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* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
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* You can expect feedback from the instructor within 48 to 72 hours from the Sunday due date.
* **Module 2 Assignment**

For this assignment, list the parts of a comprehensive mental status examination (MSE) for mental health patients. Give examples of each and describe the significance to the advanced practice nurse.

**Submission Instructions**

* The paper is to be clear and concise and students will lose points for improper grammar, punctuation, and misspellings.
* The paper should be formatted per the current 7th edition APA and 3-4 pages in length, excluding the title, abstract, and references page. **This paper requires an abstract.**
* Incorporate a minimum of 5 current (published within the last five years) scholarly journal articles or primary legal sources (statutes, court opinions) within your work.
* Complete and submit the assignment by 11:59 PM ET Sunday.
* Late work policies, expectations regarding proper citations, acceptable means of responding to peer feedback, and other expectations are at the discretion of the instructor.

# **Module 3 Discussion**

No unread replies.No replies.

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 **Skin, Eye, & Ear Disorders**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Chief Complaint  (CC)** | A 57-year-old man presents to the office with a complaint of left ear drainage since this morning. | A 45-year-old female presents with a complaint of an itchy red rash on her arms and legs for about two weeks. | A 11-year-old female patient complains of red left eye and edematous eyelids. Her mother states the child complains of “sand in my left eye.” |
| **Subjective** | Patient stated he was having pulsating pain on left ear for about 3 days. After the ear drainage the pain has gotten a little better. | She has been going on a daily basis to the local YMCA with children for Summer camp. | Patient noticed redness three days ago. Denies having any allergies. Symptoms have gotten worse since she noticed having the problem. |
| **Objective Data** | | | |
| **VS** | (T) 99.8°F; (RR) 14; (HR) 72; (BP) 138/90 | (T) 98.3°F; (RR) 18; (HR) 70, regular; (BP) 118/74 | (T) 98.2°F; (RR) 18; (HR) 78; BP 128/82; SpO2 96% room air; weight 110 lb. |
| **General** | well-developed, healthy male | healthy-appearing female in no acute distress | well-developed, healthy, 11 years old |
| **HEENT** | EAR: (R) external ear normal, canal without erythema or exudate, little bit of cerumen noted, TM- pearly grey, intact with light reflex and bony landmarks present; (L) external ear normal, canal with white exudate and crusting, no visualization of tympanic membrane or bony landmarks, no light reflex EYE: bilateral anicteric conjunctiva, (PERRLA), EOM intact. NOSE: nares are patent with no tissue edema. THROAT: no lesions noted, oropharynx moderately erythematous with no postnasal drip. | EYES: no injection, no increase in lacrimation or purulent drainage;  EARS: normal  TM: Normal | EYES: very red sclera with dried, crusty exudates; unable to open eyes in the morning with the left being worse than the right |
| **Skin** | No rashes | CTA AP&L | CTA AP&L |
| **Neck/Throat** | no neck swelling or tenderness with palpation; neck is supple; no JVD; thyroid is not enlarged;  trachea midline | mild edema with inflammation located on forearms, upper arms, and chest wall, thighs and knees; primary lesions are a macular papular rash with secondary linear excoriations on forearms and legs |  |

Answer the following questions for your specific case study assigned:

1. **What other subjective data would you obtain specific to your case?**
2. **What other objective findings would you look for?**
3. **What diagnostic exams do you want to order?**
4. **Name 3 differential diagnoses based on this patient's presenting symptoms.**
5. **Give rationales for each differential diagnosis.**

**Submission Instructions:**

* You have been assigned **your case number** (See Announcement), and you will post about the case number you have been assigned.
* You will reply to your peers who have posted on the **other two case studies (One of each)**.
* Your initial post **should be at least 500 words**, formatted and cited in the current **APA style** with support from at least **2 academic sources other than your textbook**. Your initial post is worth 8 points.
* You should respond to **at least two of your peers**by extending, refuting/correcting, or adding additional nuance to their posts. Use at least **1 academic source for each response to your peers other than your textbook**. Your reply posts are worth 2 points (1 point per response).
* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
* Please post your initial response by 11:59 PM ET Thursday, and comment on the posts of two classmates by 11:59 PM ET Sunday.
* You can expect feedback from the instructor within 48 to 72 hours from the Sunday due date.
* **Module 3 Assignment**
* Due: Sun, 5 Nov 2023 23:5905/11/2023
* Ungraded

***Telehealth Medicine***

For this assignment, answer the following questions by using them as your headings for your paper.

* What are the Pros and Cons of telehealth?
* How will you approach and perform a telehealth assessment?
* What are the limits to telehealth?
* What is the difference between the provider's need for a successful telehealth visit versus the Patient's perspective?

**Submission Instructions**

* The paper is to be clear and concise and students will lose points for improper grammar, punctuation, and misspellings.
* The paper should be formatted per the current APA and 4-5 pages in length, excluding the title, abstract, and references page.
* **An abstract is required.**
* Incorporate a minimum of 5 current (published within the last five years) scholarly journal articles or primary legal sources (statutes, court opinions) within your work.
* Complete and submit the assignment by 11:59 PM ET Sunday.
* Late work policies, expectations regarding proper citations, acceptable means of responding to peer feedback, and other expectations are at the discretion of the instructor.

# **Module 4 Discussion**

No unread replies.No replies.

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 **Throat, Respiratory & Cardiovascular Disorders**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Chief Complaint  (CC)** | A 65-year-old male with chronic obstructive pulmonary disease (COPD) presents to the clinic with a cough he has had for the past 2 weeks. | A 25-year-old Hispanic female, computer programmer presents to your clinic complaining of a 12-day history of a runny nose | A 75-year-old female reports experiencing pain in her chest while walking up steps today. |
| **Subjective** | denies chest pain, denies night sweats, admits to having a fever but does not know the temp. | States that her symptoms began about 12 days ago. She suffers from allergies; she gets a runny nose during the spring-time, pollen season. However, in the winter, her allergies are not a problem. | Could not sleep previous night. Feels like an ache or a burning sensation at the center of sternum. Denies any arm pain, pain was at a scale of 8 in the AM now it is at a 2. Suffers from History of hypertension, denies heart disease, denies leg swelling up, denies pain feeling worse when taking deep breath. |
| **Objective Data** | | | |
| **VS** | (BP) 115/75, (P) 89, (RR) 16, (T) 100.4°F (38°C), O2 sat 98% on room air. | (BP) 115/75, (P) 89, (RR) 16, (T) 100.4°F (38°C), O2 sat 98% on room air | BP 129/70, (HR) 72 and regular, (RR) 16 unlabored, temperature 98.8°F, oral pulse oximetry is 99% |
| **General** | patient appears tired; skin color pale, patient is diaphoretic and sweaty, height 5′3″; weight 175 lbs | No signs of acute distress. Patient appears mildly fatigued. She is breathing through her mouth. Breathing easily. Voice has a nasal quality to it. | obese female, alert, in no acute distress. |
| **HEENT** | EYES: no injection, no increase in lacrimation or purulent drainage;  EARS: normal  TM: Normal  NOSE: Bilateral erythema and edema of turbinates with significant yellow drainage on the right. Obstructed air passages | Ear canals: normal;  EYES: normal;  NOSE: Bilateral erythema and edema of turbinates with significant yellow drainage on the right. Nares: Obstructed air passages | Atraumatic, normocephalic, PERRLA, EOMI, sclera with mild icterus, nares patent, nasopharynx clear, poor dentition – multiple carries. |
| **Respiratory** | lung crackles in LLL, no wheezes or rhonchi noted; does not clear with coughing; dullness to percussion over the LLL; shallow respirations and is 30, accessory muscles use not present | CTA AP&L | CTA AP&L |
| **Neck/Throat** | no neck swelling or tenderness with palpation; neck is supple; no JVD; thyroid is not enlarged;  trachea midline | Posterior pharynx: mildly injected, scant postnasal drainage (PND), no exudate, tonsils 1+, no  cobblestoning | carotids are 2+ without bruits; thyroid is not palpable; no lymphadenopathy |
| **Heart** | Regular rate and rhythm, no murmur, S3, or S4 | Regular rate and rhythm, no murmur, S3, or S4 | S1 and S2 normal without murmur, gallop, or rub |

Answer the below questions. Note that all your responses should apply to your specific patient from your assigned case study.

1. **What other subjective data would you obtain?**
2. **What other objective findings would you look for?**
3. **What diagnostic exams do you want to order?**
4. **Name 3 differential diagnoses based on this patient's presenting symptoms.**
5. **Give rationales for each differential diagnosis.**

**Submission Instructions:**

* You have been assigned **your case number** (See Announcement), and you will post about the case number you have been assigned.
* You will reply to your peers who have posted on the **other two case studies (One of each)**.
* Your initial post **should be at least 500 words**, formatted and cited in the current **APA style** with support from at least **2 academic sources other than your textbook**. Your initial post is worth 8 points.
* You should respond to **at least two of your peers**by extending, refuting/correcting, or adding additional nuance to their posts. Use at least **1 academic source for each response to your peers other than your textbook**. Your reply posts are worth 2 points (1 point per response).
* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
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Module 4 Assignmen

**Presentation: Realistic Clinical Case Study**

For this assignment, you will develop a presentation on a realistic clinical case on a topic that is of interest to you. You will prepare a **PowerPoint Presentation** with **voice-over** or you can use **Canvas Studio's Screen Capture** feature to record (**voice-over**) your presentation.

[How do I record a Canvas Studio video with a webcam in a course?](https://community.canvaslms.com/docs/DOC-14265-50736850213)

#### **Submission Instructions:**

* The presentation should be original work and logically organized, formatted, and cited in the current APA style, including citation of references.
* The presentation should consist of 10-15 slides and be less than or about 5 minutes in length.
* **Voice-Over**is required.
* Incorporate a minimum of 4 current (published within the last five years) scholarly journal articles or primary legal sources (statutes, court opinions) within your work. Journal articles and books should be referenced according to APA style (the library has a copy of the APA Manual).
* Complete and submit the assignment by 11:59 PM ET Sunday.

**Content Requirements:**

You will create a PowerPoint presentation with a realistic case study and include appropriate and pertinent clinical information that will cover the below aspects. Also, review the distribution of your points based on the assignment rubrics below.

1. **Subjective data:**Chief Complaint; History of the Present Illness (HPI)/ Demographics; History of the Present Illness (HPI) that includes the presenting problem and the 8 dimensions of the problem; Review of Systems (ROS)
2. **Objective data:**Medications; Allergies; Past medical history; Family history; Past surgical history; Social history; Labs; Vital signs; Physical exam.
3. **Assessment:**Primary Diagnosis; Differential diagnosis
4. **Plan:**Diagnostic testing/Labs to order; Pharmacological treatment plan; Non-pharmacologic treatment plan; Patient education, Anticipatory guidance (primary/secondary prevention strategies); Follow-up plan.
5. **Other:**Incorporation of current clinical guidelines; Integration of research articles; Role of the Nurse practitioner

**Below is the distribution of your points based on assignment rubrics:**

-Chief Complaint (Reason for seeking health care) 4/4

-Demographics 2/2

-History of the Present Illness (HPI) 4/4

-Allergies 2/2

-Review of Systems (ROS) 9/9

-Vital Signs 2/2

-Labs 3/3

-Medications 4/4

-Screenings 3/3

-Past Medical History 3/3

-Past Surgical History 3/3

-Social History 3/3

-Family History 3/3

-Physical Examination 9/9

-Diagnosis 5/5

-Differential Diagnosis 5/5

-Pharmacologic treatment plan 4/4

-Diagnostic/Lab Testing 5/5

-Education 5/5

-Anticipatory Guidance 4/4

-Follow up plan 4/4

-References 3/3

-Grammar 3/3

-Incorporation of Current Practice Guidelines 4/4

-Role of the Nurse Practitioner 4/4

Total Points-100/100

# **Module 5 Discussion**

No unread replies.No replies.

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 **Gastrointestinal & Endocrine**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Chief Complaint  (CC)** | “I am here today due to frequent and watery bowel movements” | “I have pain in my belly” | “neck swelling” |
| **History of Present Illness (HPI)** | A 37-year-old European American female presents to your practice with “loose stools” for about three days. One event about every three hours | A 25-year-old female presents to the emergency room (ER) with complaints of severe abdominal pain for 2 weeks . The pain is sharp and crampy It hurts if I run, sit down hard, or if I have sex | A 42-year-old African American female who refers that she has been noticing slow and progressive swelling on her neck for about a year. Also she stated she has lost weight without any food restriction |
| **PMH** | No contributory | Patient denies | Patient denies |
| **PSH** | Appendectomy at the age of 14 |  | Surgical removal of benign left breast nodule 2 years ago |
| **Drug Hx** | No meds | Birth control | No medication at the time |
| **Allergies** | Penicillin | NKA | NKA |
| **Subjective** | Fever and chills, Lost appetite Flatulence No mucus or blood on stools | Nausea and vomiting, Last menstrual period 5 days ago, New sexual partner about 2 months ago, No condoms, he hates them No pain, blood or difficulty with urination | Mild difficult to shallow, Neck feels tight, Pt states she feels Palpitations |
| **Objective Data** | | | |
| **PE** | B/P 188/96; Pulse 89; RR 16; Temp 99.0; Ht 5,6; wt 110; BMI 17.8 | B/P 138/90; temperature 99°F;  (RR) 20; (HR) 110, regular; oxygen saturation (PO2) 96%; pain 5/10 | B/P 158/90; Pulse 102; RR 20; Temp 99.2; Ht 5,4; wt 114; BMI 19.6 |
| **General** | well-developed female in no acute distress, appears slightly fatigued | acute distress and severe pain | 42-year-old female appears thin. She is anxious – pacing in the room and fidgeting, but in no acute distress. |
| **HEENT** | Atraumatic, normocephalic, PERRLA, EOMI, arcus senilus bilaterally, conjunctiva and sclera clear, nares patent, nasopharynx clear, edentulous. | Atraumatic, normocephalic, PERRLA, EOMI, conjunctiva and sclera clear; nares patent, nasopharynx clear, good dentition. Piercing in her right nostril and lower lip. | Bulging eyes |
| **Neck** | Supple |  | Diffuse enlargement of the thyroid gland |
| **Lungs** | CTA AP&L | CTA AP&L | CTA AP&L |
| **Card** | S1S2 without rub or gallop | S1S2 without rub or gallop | S1S2 without rub, Tachycardia |
| **Abd** | positive bowel sounds (BS) in all four quadrants; no masses; no organomegaly noted; diffuse, mild, bilateral lower quadrant pain noted Mild diffuse tenderness. | • INSPECTION: no masses or thrills noted; no discoloration and skin is warm to; no tattoos or piercings; abdomen is nondistended and round  • AUSCULTATION: bowel sounds (BS) are normal in all four quadrants, no bruits noted  • PALPATION: on palpation, abdomen is tender to touch in four quadrants; tenderness noted on light palpation, deep palpation reveals no masses, spleen and liver unremarkable  • PERCUSSION: tympany heard in all quadrants, no dullness noted in abdominal area | benign, normoactive bowel sounds x 4 |
| **GU** | Non contributory | • EXTERNAL: mature hair distribution; no external lesions on labia  • INTROITUS: slight green-gray discharge, no lesions  • VAGINAL: normal rugae; moderate amount of green discharge on vaginal walls  • CERVIX: nulliparous os with small amount of purulent discharge from os with positive cervical motion tenderness (CMT)  • UTERUS: ante-flexed, normal size, shape, and position  • ADNEXA: bilateral tenderness with fullness; both ovaries without masses  • RECTAL: deferred  • VAGINAL DISCHARGE: green in color | Non contributory |
| **Ext** | no cyanosis, clubbing or edema | no cyanosis, clubbing or edema | no cyanosis, clubbing or edema |
| **Integument** | good skin turgor noted, moist mucous membranes | intact without lesions masses or rashes | Thin skin, Increase moisture |
| **Neuro** | No obvious deformities, CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII |

**Answer the below questions. Note that all your responses should apply to your specific patient from your assigned case study.**

1. **What other subjective data would you obtain?**
2. **What other objective findings would you look for?**
3. **What diagnostic exams do you want to order?**
4. **Name 3 differential diagnoses based on this patient presenting symptoms.**
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# **Module 6 Discussion**

No unread replies.No replies.

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 **Neurological & Male Genitourinary Disorders**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Chief Complaint  (CC)** | “It burns when I urinate” | “I had a severe headache yesterday with difficulty to speak” | “I have been having frequents headaches lately” |
| **History of Present Illness (HPI)** | A 68-year-old Caucasian male who reports to have increase on the frequency of urination with urgency for the last 5 days. He also present dysuria and nocturia. | A 64-year-old African American female who reports having a severe pulsatile diffuse headache yesterday with sudden difficulty to talk with last for about two hours. She did not seek medical attention. This morning she woke up with no problems but is here today due her husband advise. | A 25-year-old Hispanic female presents to your clinic with a headache located on right temporal area, pulsatile. |
| **PMH** | Benning prostatic hyperplasia diagnosed 3 years ago, UTI 6 months ago, Lithotripsy left kidney 10 years ago. No issues after treatment | Atrial Fibrillation, Hypertension. Is allergic to Non-steroidal Anti-inflammatory drugs Aspirin | Frequent headaches since I was 15, with menses. |
| **Drug Hx** | Rosuvastatin 20 mg  Olmesartan 20 mg | Losartan 50 mg  Xarelto 15 mg BID | Ibuprofen for Headaches |
| **Subjective** | Fever and chills, no changes in vision or hearing, no difficulty chewing or swallowing. No sexually active, nocturia, dysuria.  Yellowish urethral secretion. | Feels Palpitations, joint pain with yesterday’s episode | Light makes headache worst Nausea associated with headaches. No vomiting, Headaches improve usually with rest, ibuprofen, and sleep, but it is annoying to have to sleep all-day |
| **Objective Data** | | | |
| **VS** | B/P 150/96; Pulse 89; RR 16; Temp 99.4; Ht 6,1; wt 180; | B/P 131/80; temperature 98.2°F;  (RR) 18;  (HR) 84, irregular; oxygen saturation (PO2) 96%; | B/P 108/64; Pulse 86; RR 16; Temp 98.6; |
| **General** | well-developed male, no acute distress | well-developed female, no acute distress | 25-year-old female appears well developed and well-nourished, healthy appearing, wearing dark glasses in a dim room |
| **HEENT** | Atraumatic, normocephalic, PERRLA, EOMI, arcus senilus bilaterally, conjunctiva and sclera clear, nares patent, nasopharynx clear, edentulous. | Atraumatic, normocephalic, PERRLA, EOMI, conjunctiva and sclera clear; nares patent, nasopharynx clear, good dentition. | no injection, anicteric, PERRLA, EOMs intact, without pain to movement; normal vision |
| **Lungs** | CTA AP&L | CTA AP&L | CTA AP&L |
| **Card** | S1S2 without rub or gallop S4 present | Irregular heart beat with normal rate | S1S2 without rub or gallop |
| **Abd** | No tenderness normoactive bowel sounds x 4; | No tenderness normoactive bowel sounds x 4; | benign, normoactive bowel sounds x 4; |
| **Rectal exam** | Warm, swollen and painful prostate gland | Non contributory | Non contributory |
| **Integument** | good skin turgor noted, moist mucous membranes | intact without lesions masses or rashes. | intact without lesions masses or rashes. |
| **Neuro** | No obvious deformities, CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII | Cranial nerves II to XII intact; sensation intact, DTRs 2+ throughout.  Functional neurological exam is WNL |

Answer the below questions. Note that all your responses should apply to your specific patient from your assigned case study.

1. **What other subjective data would you obtain?**
2. **What other objective findings would you look for?**
3. **What diagnostic exams do you want to order?**
4. **Name 3 differential diagnoses based on this patient presenting symptoms.**
5. **Give rationales for each differential diagnosis.**
6. **What teachings will you provide?**

**Submission Instructions:**

* You have been assigned **your case number** (See Announcement), and you will post about the case number you have been assigned.
* You will reply to your peers that have posted on the **other two case studies (One of each)**.
* Your initial post **should be at least 500 words**, formatted and cited in the current **APA style** with support from at least **2 academic sources other than your textbook**. Your initial post is worth 8 points.
* You should respond to **at least two of your peers**by extending, refuting/correcting, or adding additional nuance to their posts. Use at least **1 academic source for each response to your peers other than your textbook**. Your reply posts are worth 2 points (1 point per response).
* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
* Please post your initial response by 11:59 PM ET Thursday, and comment on the posts of two classmates by 11:59 PM ET Sunday.
* You can expect feedback from the instructor within 48 to 72 hours from the Sunday due date.

# **Module 7 Discussion**

No unread replies.No replies.

null

 **Female Genitourinary, & Musculoskeletal**

For this Discussion, you will take on the role of a clinician who is building a health history for one of the following cases. Your instructor will assign you your case number.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Case 1** | **Case 2** | **Case 3** |
| **Chief Complaint  (CC)** | “I have a tumor on my left breast” | “I have pain during intercourse and urination” | “My back hurts so bad I can barely walk” |
| **History of Present Illness (HPI)** | A 55-year-old African American social worker presents to your clinic with a finding of a lump in her left breast while in the shower this past week. | A 19-year-old female reports to you that she has “sores” on and in her vagina for the last three months. | A 35-year-old male painter presents to your clinic with the complaint of low back pain. He recalls lifting a 5-gallon paint can and felt an immediate pull in the lower right side of his back. This happened 2 days ago and he had the weekend to rest, but after taking Motrin and using heat, he has not seen any improvement. His pain is sharp, stabbing, and he scored it as a 9 on a scale of 0 to 10. |
| **Drug Hx** | I took birth control pills for 10 years, starting when I was 20 I am not on hormone replacement | She tries to practice safe sex but has a steady boyfriend and figures she doesn’t need to be so careful since she is on the birth control pill | Motrin for pain. |
| **Family Hx** | My grandmother had breast cancer when she was 76 years old |  | Father hypertension  Mother DM |
| **Subjective** | Denies any fever or chills. No changes in vision or hearing, no difficulty chewing or swallowing. Supple neck, states that she does self-breast-exams on occasion. Menopause at 52  No skin changes or nipple discharge from the left breast | states “I have sores and bumps on the inner creases of my thighs and pelvic area”. “There is yellowish discharge from the sores that comes and goes” | He is having some right leg pain but no bowel or bladder changes. No numbness or tingling |
| **Objective Data** | | | |
| **VS** | temperature 98.6°F; respiratory rate (RR) 16; heart rate (HR) 80, regular; blood pressure (BP) 130/84; height: 5′8″; weight 160 lbs; body mass index (BMI) 24 | temperature: 100.2°F; pulse 92; respirations 18; BP 122/78; weight 156 lbs, 25 lbs overweight; height 5′3″ | temperature: 98.2°F, respiratory rate 16, heart rate 90, blood pressure 120/60  O2 saturation 98% |
| **General** | well developed, nourished, healthy-appearing female | patient appears to have good hygiene; minimal makeup, pierced ears, no tattoos; well nourished (slightly overweight); no obvious distress noted | well-developed healthy 35-year-old male; no gross deformities |
| **HEENT** | Atraumatic, normocephalic, PERRLA, EOMI, conjunctiva and sclera clear, nares patent, nasopharynx clear, edentulous. | Atraumatic, normocephalic, PERRLA, EOMI, conjunctiva and sclera clear; nares patent, nasopharynx clear, good dentition. Piercing in her right nostril and lower lip. | Atraumatic, normocephalic, PERRLA, EOMI, sclera with mild icterus, nares patent, nasopharynx clear, poor dentition – multiple carries. |
| **Lungs** | clear to auscultation | within normal limits, appropriate lung sounds auscultated, clear and equal bilaterally | CTA AP&L |
| **Card** | regular rate and rhythm (RRR) | S1S2 without rub or gallop | S1S2 without rub or gallop |
| **Breast** | Examined in sitting and supine positions. In sitting position, no evidence of skin changes, right breast is slightly larger than the left, symmetrical movement with the arms above the head and at the side and with flexion of the pectoral muscles; 5-mm nonmobile, non-tender, firm mass felt at 10 o’clock position, 5 cm from the areola. Right breast without dominant masses or tenderness. Nipples without inversion or evidence of nipple discharge. Breast mass is palpated in the supine position in the same manner as in the sitting position | • INSPECTION: no dimpling or abnormalities noted upon inspection  • PALPATION: Left breast no abnormalities noted. Right breast: denies tenderness, pain, no abnormalities noted. | • INSPECTION: no dimpling or abnormalities noted upon inspection  • PALPATION: Left breast - no abnormalities noted. Right breast - denies tenderness, pain, no abnormalities noted. |
| **Lymph** | negative axillary, infraclavicular, and supraclavicular lymphadenopathy | Inguinal Lymph nodes: tenderness bilaterally, numerous, 1 cm in size | no bruising, fever, or swelling noted, no acute bleeding or trauma to skin. |
| **Abd** | normoactive bowel sounds x 4; | tender during palpation; the left lower quadrant was very tender during palpation; patient denies nausea or vomiting | benign, normoactive bowel sounds x 4; Hepatomegaly 2cm below the costal margin. |
| **GU** | Bladder is non-distended. | labia major and minor: numerous ulcerations, too many to count; some ulcerations enter the vaginal introitus; no ulcerations in the vagina mucosa; cervix is clear, some greenish discharge; bimanual exam reveals tenderness in left lower quadrant; able to palpate the left ovary; unable to palpate the right ovary; no tenderness; uterus is normal in size, slight tenderness with cervical mobility | Bladder is non-distended. |
| **Integument** | good skin turgor noted, moist mucous membranes |  | intact without lesions masses or rashes. |
| **MS** | Muscles are smooth, firm, symmetrical. Full ROM. No pain or tenderness on palpation. | Muscles are smooth, firm, symmetrical. Full ROM. No pain or tenderness on palpation. | No obvious deformities, masses, or discoloration. Palpable pain noted at the right lower lumbar region. No palpable spasms. ROM limited to forward bending 10 inches from floor; able to bend side to side but had difficulty twisting and going into extension. |
| **Neuro** | No obvious deformities, CN grossly intact II-XII | No obvious deficits and CN grossly intact II-XII | DTRs 2+ lower sensory neurology intact to light touch and patient able to toe and heel walk. Gait was stable and no limping noted. |

Answer the below questions. Note that all your responses should apply to your specific patient from your assigned case study.

1. **What other subjective data would you obtain?**
2. **What other objective findings would you look for?**
3. **What diagnostic exams do you want to order?**
4. **Name 3 differential diagnoses based on this patient's presenting symptoms.**
5. **Give rationales for each differential diagnosis.**
6. **What teachings will you provide?**

**Submission Instructions:**

* You have been assigned **your case number** (See Announcement), and you will post the case number you have been assigned.
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* You should respond to **at least two of your peers**by extending, refuting/correcting, or adding additional nuance to their posts. Use at least **1 academic source for each response to your peers other than your textbook**. Your reply posts are worth 2 points (1 point per response).
* All replies must be constructive and literature must be used accordingly. Your replies **must be at least 150 words each**.
* Please post your initial response by 11:59 PM ET Thursday, and comment on the posts of two classmates by 11:59 PM ET Friday.
* You can expect feedback from the instructor within 48 to 72 hours from the Friday due date.
* **Module 7 Assignment i**
* Due: Sun, 3 Dec 2023 23:5903/12/2023

***Physical Exam Video***

**Comprehensive Physical Examination Competency**

Use a **Canvas Studio** link or the **Record Media** option to record a video of yourself doing a complete physical examination that will be performed on a person who is 18 years old or older. The physical examination should be no longer than 30 minutes.  
[How to Submit a Studio Video on Canvas](https://stu.instructure.com/courses/34469/files/2129723?wrap=1)[Download How to Submit a Studio Video on Canvas](https://stu.instructure.com/courses/34469/files/2129723/download?download_frd=1)   
[How do I record a Canvas Studio video with a webcam in a course?](https://community.canvaslms.com/docs/DOC-14265-50736850213)

**Submission Instructions:**

* **Submit a URL** of a Canvas Studio recording or use the Media option. **Do not embed a video**.
* Complete and submit the assignment by 11:59 PM ET **Sunday, December 3rd.**
* Late work policies and expectations are at the discretion of the instructor.

Module 7 assignment ii

***SOAP Note***

**Module 7 Assignment i Cont'd.**

**SOAP** is an acronym that stands for **S**ubjective, **O**bjective, **A**ssessment, and **P**lan. The episodic SOAP note is to be written using the attached template below.  
[SOAP Note Template](https://stu.instructure.com/courses/36480/files/2357599/download?wrap=1)[Download SOAP Note Template](https://stu.instructure.com/courses/36480/files/2357599/download?download_frd=1)

For all the SOAP note assignments, you will write a SOAP note about one of your patients and use the following acronym and all rubric details below:

|  |  |
| --- | --- |
| **S** = | Subjective data: Patient’s Chief Complaint (CC). |
| **O**= | Objective data: Including client behavior, physical assessment, vital signs, and meds. |
| **A** = | Assessment: Diagnosis of the patient's condition. Include differential diagnosis. |
| **P** = | Plan: Treatment, diagnostic testing, and follow-up |

**Submission Instructions:**

* Your SOAP note should be clear and concise and students will lose points for improper grammar, punctuation, and misspellings.
* Complete and submit the assignment using the appropriate template in MS Word by 11:59 PM ET Sunday.

**Follow these Rubrics for maximum points:**

* **Chief Complaint 4 Points**-Includes a direct quote from the patient about the presenting problem.
* **Demographics 2 Points**-Begins with patient initials, age, race, ethnicity, and gender (5 demographics).
* **History of the Present Illness 5 Points**-Includes the presenting problem and the 8 dimensions of the problem (OLD CARTS – Onset, Location, Duration, Character, Aggravating factors, Relieving factors, Timing and Severity).
* **Allergies 2 Points**-Includes NKA (including = Drug, Environmental, Food, Herbal, and/or Latex or if allergies are present (reports for each severity of allergy AND description of allergy).
* **Review of Systems 12 Points**-Includes a minimum of 3 assessments for each body system and assesses at least 9 body systems directed to chief complaint AND uses the words “admits” and “denies”.
* **Vital Signs 2 Points**-Includes all 8 vital signs, (BP (with patient position), HR, RR, temperature (with Fahrenheit or Celsius and route of temperature collection), weight, height, BMI (or percentiles for pediatric population), and pain).
* **Labs 3 Points**-Includes a list of the labs reviewed at the visit, values of lab results, and highlights abnormal values OR acknowledges no labs/diagnostic tests were reviewed.
* **Medications 4 Points**-Includes a list of all of the patient-reported medications and the medical diagnosis for the medication (including name, dose, route, and frequency).
* **Screenings 3 Points**-Includes an assessment of at least 5 screening tests
* **Past Medical History 3 Points**-Includes (Major/Chronic, Trauma, Hospitalizations), for each medical diagnosis, year of diagnosis, and whether the diagnosis is active or current.
* **Past Surgical History 3 Points**-Includes, for each surgical procedure, the year of the procedure, and the indication for the procedure.
* **Family History 3 Points**-Includes an assessment of at least 4 family members regarding, at a minimum, genetic disorders, diabetes, heart disease, and cancer.
* **Social History 3 Points**-Includes all 11 of the following: tobacco use, drug use, alcohol use, marital status, employment status, current and previous occupation, sexual orientation, sexually active, contraceptive use, and living situation.
* **Physical Examination 12 Points**-Includes a minimum of 4 assessments for each body system and assesses at least 5 body systems directed to the chief complaint.
* **Diagnosis 5 Points**-Includes a clear outline of the accurate principal diagnosis AND lists the remaining diagnoses addressed at the visit (in descending priority).
* **Differential Diagnosis 5 Points**-Includes at least 3 differential diagnoses for the principal diagnosis
* **Pharmacologic Treatment Plan 5 Points**-Includes a detailed pharmacologic treatment plan for each of the diagnoses listed under “assessment”. The plan includes ALL of the following: drug name, dose, route, frequency, duration, and cost as well as education related to pharmacologic agents. If the diagnosis is a chronic problem, the student includes instructions on currently prescribed medications as above.
* **Diagnostic/Lab Testing 5 Points**-Includes appropriate diagnostic/lab testing 100% of the time OR acknowledges “no diagnostic testing clinically required at this time”
* **Education 5 Points**-Includes at least 3 strategies to promote and develop skills for managing their illness and at least 3 self-management methods on how to incorporate healthy behaviors into their lives.
* **Anticipatory Guidance 4 Points**-Includes at least 3 primary prevention strategies (related to age/condition (i.e., immunizations, pediatric and pre-natal milestone anticipatory guidance), and at least 2 secondary prevention strategies (related to age/condition (i.e., screening).
* **Follow-up plan 4 Points**-Includes recommendation for follow-up, including time frame (i.e., x # of days/weeks/months).
* **References 3 Points**-High level of APA precision.
* **Grammar 3 Points**-Free of grammar and spelling errors.