**Date: 10/03/2022**

Full name: H.C

Address: Jackson Heights NY

Date of Birth: 12/28/1954

Location: Nao Medical (STATcare)

Religion: Catholic

Source of Information: Self

Reliability: Reliable

Source of Referral: None

Mode of Transport: Self

**Chief Complaint: “I have a rash on my back” x 3 days**

**History of Presenting Illness**:

67 y/o female with PMHx of T2DM, Hyperlipidemia, and Hypertension presents to the urgent care today with complaint of a rash on her left upper back x 3 days. She describes the rash as blister-like and localized to her left upper back. She states she experienced pain and skin sensitivity along her upper back a day prior to the rash erupting on her skin. She rates the pain as 6/10, intermittent and feeling like a burning sensation. She states that she has not taken any medication to help with her symptoms. She lives in Florida but came to visit her daughter in NYC 2 weeks ago. She had chicken pox when she was a teenager which was resolved. She denies any headache, fever, chills, malaise, nausea, vomiting, diarrhea, abdominal pain, visual changes, eye pain or any ocular complaints. She denies any recent illness or sick contacts. She states that she has never received the zoster vaccine but is up to date on her influenza and covid-19 boosters. She denies any other complaints at this time.

**Past Medical History**:

T2DM

Hyperlipidemia

Hypertension

**Past Surgical History**:

C-section in 1985 for her second birth. First child was born through NSVD

Cholecystectomy in 2001

**Hospitalizations**:

Was hospitalized for Cholecystectomy in 2001

**Medications:**

Evolocumab

Benicar (Olmersartran Medoxomil)

Metformin

**Allergies**:

Penicillin- develops rash

**Family History:**

Mother – Deceased

Father – Deceased

Brother – history of appendicitis

**Social history:**

- Lives in Florida in an apartment with a male partner.

- Occasional alcohol use

- Denies ever smoking or illicit drug use

- She is sexually active and has one partner which is a male.

**Review of system**

General - Denies fever, chills, fatigue, malaise

Skin, hair, and nails – Complains of painful blister like rash along her left upper back. No itching

Head – Denies headache

Eyes – denies change in vision

Ears – denies ear pain

Nose /Sinuses – denies rhinorrhea, congestion, sinus pain or fullness.

Mouth/ throat – denies sore throat

Neck – denies swelling or discomfort

Breast – denies any lumps, or nipple discharge

Pulmonary system – denies any wheezing, coughing or shortness of breath

Cardiovascular system - denies any chest pain or palpitations

Gastrointestinal system – Denies abdominal pain, diarrhea, nausea, vomiting, or constipation

Genitourinary system – denies painful urination or frequent urination

Menstrual /obstetrical – denies any abnormal bleeding

Nervous – denies dizziness or headache. Complains of generalized skin sensitivity and pain along the left upper back.

Musculoskeletal – denies any muscle or joint pain or soreness

Peripheral vascular system – denies any swelling

Hematological – denies any bleeding from gums

Endocrine system – denies polyuria

Psychiatric – denies depressed mood

**Physical exam:**

**Vital signs:**

Using machine: BP (left arm, sitting) 111/ 76 mmHg

Pulse: 98 bpm RRR

RR: 17 breaths/min unlabored

T: 97.3 F (axilla)

O2 sat: 97 % on room air

BMI: Weight: 149 lbs, Height: 5’1 = 28.15

**General appearance:** Older Black female, is alert and oriented x 3. She is no acute distress. She appears well nourished and is cooperative. She is dressed appropriately with normal affect.

**Skin, hair, and nails**: Painful grouped unilateral blister like (vesicular) rash located along the left upper back following a dermatomal pattern. No pustules.

**Head:** Atraumatic, normocephalic.

**Eyes:** PERRLA. Non-icteric sclera. 20/20 vision with corrected lenses. No corneal injection or Ulceration. No vesicular lesion near the eyes.

**Ears**: Tympanic membrane intact and normal. No external trauma or mastoiditis.

**Nose**: Patent bilaterally, no tender. No vesicular lesions along the nose.

**Mouth**: Oral Mucosa is moist.

**Neck**: Supple, non-tender.

**Throat**: Clear, uvula is midline, no erythema or exudates

**Pulmonary**: Lungs clear to auscultation bilaterally. No wheezing, rales, or rhonchi.

**Cardiovascular:** Normal S1 and S2 sounds with regular rate and rhythm.

**Abdominal exam**: soft non-tender, bowel sounds present. Non-distended, no guarding or rebound tenderness. Abdomen is soft non distended.

**Breast:** Not performed due to lack of consent.

**Genitourinary/ Pelvic exam**: Not performed due to lack of consent.

**Endocrine system**: No goiter.

**Neuro exam**: No nystagmus or focal deficits. Sensation intact in all extremities. She is alert and Oriented x 3.

**Musculoskeletal:** Active and passive ROM present in the in all extremities.

**Peripheral vascular system**: No lower extremity swelling bilaterally. No clubbing. Extremities were non-tender and warm to touch.

**Psychiatric:** Normal mood and behavior, good eye contact and speech.

**Assessment**:

67 y/o female with PMHx of T2DM, Hyperlipidemia, and Hypertension presents to the urgent care today with complaint of a blister like rash on her left upper back x 3 days. Patient noted to have erythematous painful unilateral vesicular eruptions following a dermatomal pattern along the left upper back. Patient is not up to date on the Shingrix vaccine. There are no ophthalmologic concerns currently.

**Differential:**

1. **Zoster (Shingle):** The patient presents with symptoms that correlate more with Shingles. Symptoms such as vesicular lesions along the upper back, that do not cross the dermatome indicate a likelihood for shingles. The onset of prodromal pain and skin sensitivity in the left upper back preceding the eruption of the rash also increases suspicion for shingles. The patient also admits to having varicella (chicken pox) in her childhood and denies receiving the shingles vaccine. She also is at an age of increased risk for shingles.
2. **Herpes simplex virus:** This is considerable because the appearance of the rash is similar to the eruption seen with HSV, but this is less likely considering the location of the rash, and the absence of a history of HSV or sexual risk factors supporting this diagnosis.
3. **Contact Dermatitis**: These can appear as vesicular but may be associated with intense pruritis and there is usually an inciting exposure such as exposure to poison ivy etc., and the lesion are localized to the exposed area.
4. **Stevens-Johnson syndrome / TENs**: These can develop into vesicles, or bullae’s and are more associated with epidermal sloughing of the skin. Usually, may be associated with exposure to certain medications such as sulfa drugs. Such presentation is not noted with this patient.

**Problem list**:

1. Skin Rash
2. Acute Neuritis
3. Vaccinations

**Plan:**

1. Will administer Valacyclovir, 1gm, 1 tablet, PO q8 hrs for 7 days and Gabapentin (100 mg, 1 Capsule, PO twice day for 5 days. Patient can take Tylenol or NSAIDs prn for pain/fever as an alternative as her symptoms are milder.
2. Patient counseled on Shingle’s presentation and informed that pain may persist for as many as 90 days after the onset of the rash.
3. Patient advised to avoid direct contact with others, keep the rash covered, wash hands often, and avoid contact with pregnant women, infants and immunocompromised individuals who may have not had chickenpox or the varicella vaccine especially until the rash crusts over.
4. Patient advised to return to the clinic if new or worsening sxs present.
5. Patient advised to get the Zoster vaccine (Shingrix) after her symptoms resolve.