**Hematology Case Study**

CC: 59-year-old female in with chief complaint of fatigue for a month.

HPI: Gradual onset of symptoms over past month. Increase in fatigue and less tolerance to activity. Not recently sick. No new medications. No new physical activities. History of avid walking 30 minutes 5 times a week. Since increased fatigue, patient unable to go the usual distance. no changes in diet, no recent travel. Sleeps an average of 7 hours a night, does not feel rested in the morning. Does not snore and does not wake at night. No new stress in life or at work. Feels healthy overall. Last physical 7 months ago.

**PMH:** Gerd for 5 years. Overweight. Denies any history of hospitalizations or surgeries.

**Meds:** Omeprazole daily for 5 years, prn Multivitamins + calcium.

**FH:** Mother alive at 89 with dementia, father passed away at age 78 from an MI. Brother age 56 with hypertension.

**SH:** Divorced, full time financial advisor, lives in single family home. 2 children ages 33 and 36 live away from home. History of smoking from age 15 to 39. 3 glasses of wine per week. No history of illicit drug use.

**NKDA**, environmental, food or material allergies.

**ROS:**

General: no fevers, weight changes, night sweats, + fatigue

Skin: denies rashes or changes in skin lesions

HEENT: denies vision changes or eye discharge, denies nasal congestion or sneezing, denies hearing changes or ear pain, tonight sore throat

Cardio: denies chest pain but does have occasional heart palpitations

Pulmonary: denies cough but positive for occasional SOB

Abdomen: denies abdominal pain, denies nausea vomiting, constipation, or diarrhea, BM's formed and brown

MSK/neuro: denies joint pain or loss of range of motion, denies numbness tingling what changes in sensation

Psych: denies depression, anxiety, or mood disorders.

**PE:** General: alert, overweight adult female, in no acute distress

**VS:** BP 140/88 P96, RR 16, T 98.6, HT: 64 in, Wt 170# BMI 30

**Skin:** Dry, intact without any lesions.

**HEENT:** PERRLA, eyes clear, w/o discharge, TM'S intact, canals clear, mouth moist, w/o lesions, tonsils 2+ no erythema

**CV/ Lungs:** RRR, no MRG, CTAB

**Abdominal:** Soft, round, non-tender to palpation

POC testing:

Hemogram 9.6, Hematocrit 27

Other labs:

RBC: 3.2

H/H: 9.6/ 27

MCV: 70

MCH: 22

Fe Saturation: 20

Ferritin: 9

B12: <200

Folate: 5.1 nmol/L