99214: Established Patient Visit, Level 4

MEDICAL DECISION MAKING

New problem, with prescription drug management; or Undiagnosed new problem with uncertain outcome; or Major elective surgery in a patient without identified risk factors; or Acute illness with systemic symptoms; or Physiological tests under stress; or Diagnostic endoscopies; CV imaging studies with contrast in patient with no identified risk factor.

Established patient visits require 2 of 3 key components.
All visits require a chief complaint/reason for visit/presenting problem.

Chief Complaint: Headache The patient presents today for follow up of her hypothyroidism. She also notes that over the last several months she has had unilateral throbbing headaches, focused over her right eye. She states she is very light sensitive to them and is somewhat sick to her stomach. She denies a relationship with her menstrual cycle, which she states is regular. She denies other associated neurological complaints. She also notes her allergies have been worsening in the last several days. She has been using Claritin and Sudafed but she still has a lot of runny, sinus discharge. She denies fever or chills. Her family history is negative for migraines. He does not smoke or use alcohol. Medicines: Synthroid 0.125 daily, Claritin, 10 mg q.d. I started her on Flonase nasal spray today and also Imitrex 25 mg prn.	**HPI** *4 elements (or status of 3 chronic diseases)* location duration quality associated sign/symptom **ROS** *2-9 elements* • GU • Neuro • Allergies • Constitutional **PFSH** *1 required* All documented
She appears well. Weight 148 pounds, BP 110/70, Pulse 76 and regular. HEENT: Normocephalic/ atraumatic, non tender. TM's are normal bilaterally. PERRLA. Funduscopic examination shows sharp discs. Oropharynx is negative. Neck: No adenopathy or thyromegaly. Lungs: Clear to A/P Heart: RRR, Normal S1, S2 Neurological: Alert and oriented. Normal gait. 2+ DTR's throughout. Normal coordination.	**Exam** *12 bullets (1997)* • General appearance • Vital signs • TM's • Pupils • Optic Discs • Oropharnyx • Neck • Neck – Lymph • Lungs - auscultation • Lungs - percussion • Heart – auscultation • Psych – oriented • Psych - mood • MS – gait • DTR's
Assessment and Plan: 1. Hypothyroidism: she appears euthryoid. Continue Synthroid 0.125 mg a day. 2. Allergic rhinitis. I will add Flonase nasal spray to her regimen. 3. Migraine headaches. I will try Imitrex 25 mg at the onset of headache and she will repeat in two hours if needed. 4. Return prn.	**MDM** "New" problem with prescription drug management

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SUBJECTIVE: Patient presents today for a four-month follow-up of diabetes, hypertension, COPD. She has been doing pretty well recently. As far as type 2 diabetes, it is pretty well controlled. Hemoglobin A1C is 6.3 today. She denies any polyuria, polydipsia, or polyphagia. Actually had some hypoglycemic symptoms at night she decreased her glipizide to just one pill at night instead of two. As far as COPD, it has been pretty well controlled. She is on Advair now. She seems to be breathing a little bit better. She went through pulmonary rehab as well and sees pulmonology on a regular basis. GERD is well controlled with cimetidine. Her pain seems well controlled at the Pain Clinic. She sees them on a regular basis. She had no other complaints or concerns today. MEDICATIONS: 1. Verapamil 240 mg daily 2. Glyburide 5 mg two in the morning and one in the evening 3. Lasix 40 mg daily 4. Actos 30 mg daily 5. Percocet as needed 6. Albuterol MDI as needed 7. Cimetidine 800 mg at nighttime 8. DuoNeb as needed 9. Advair 250/50 twice daily SOCIAL HISTORY: Ex-smoker, no alcohol use. She is divorced and has a significant other now. Disabled. REVIEW OF SYSTEMS: Denies any fever or chills, no chest pain, shortness of breath or leg edema.	**HPI** *4 elements (or status of 3 chronic diseases)* Status of 3 chronic problems **ROS** *2-9 elements* • Constitutional • CV • Respiratory • GI • Endo **PFSH** *1 required* • Past medical • Social history *(CONTINUED)*

OBJECTIVE: Blood pressure 132/62. Pulse 72. Resp .20. In general, alert and oriented, morbidly obese, middle-aged, white female in no acute distress, in a wheelchair. She had nasal oxygen and appeared comfortable. Oral mucosa moist and pink, no lesions. Neck supple, no JVD. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi. Cardiovascular: distant heart sounds. Abdomen: morbidly obese. Extremities have no edema, normal sensation to monofilament exam, no diabetic ulcers.	**Exam** *12 bullets (1997)* • Const: 3 vital signs • Psych: mood & affect • ENT: lips, teeth & gums • Resp – AUSC • GI – masses • Neuro - sensation • General appearance • Respiratory effort • Neck • CV – AUSC • CV – Edema • Skin – inspection
ASSESSMENT AND PLAN: 1. Type 2 diabetes, well controlled. Continue Actos mg daily and continue with glipizide 5 mg two in the morning and one at night. Will check hemoglobin A1C in another few months. 2. COPD, stable. Continue Advair, oxygen, and inhalers as needed. Follow up with pulmonology as scheduled. 3. CHF, stable. Continue Lasix 40 mg daily. 4. Hypertension, well controlled. Continue Verapamil 240 mg daily. 5. GERD, stable. Continue cimetidine 800 mg at nighttime. 6. Chronic pain. Follow up with Pain Clinic. 7. Healthcare maintenance. I will see her for a physical exam, as she is overdue for that. At next visit we will get lab tests prior to that exam.	**MDM** Moderate 3 or more chronic problems with prescription drug management

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Dear David:

I had the opportunity to follow up with patient. I had last seen her six months ago for atrial fibrillation and valvular lesions.

Since her last visit, she has been feeling reasonably well. She does describe increased lower extremity swelling. She informs me her hydrochlorothiazide was switched to Lasix with good results. She has been using compression stockings and has been trying to watch her diet for the sodium content by avoiding certain foods at the manor.

She is not extremely active citing the nursing staff limiting her activities secondary to fear of her falling. She however denies any symptoms of chest pain. Denies any recent shortness of breath exacerbations. Denies any symptoms of orthopnea or paroxysmal nocturnal dyspnea. She is asymptomatic towards her atrial fibrillation and denies any symptoms of palpitations, syncope, or new syncope.

EKG shows atrial fibrillation with mild irregularity and a controlled ventricular rate. Mild nonspecific ST abnormalities. There is significant baseline artifact. No change compared to EKG from March 2007.

Current Medications:

1. Atenolol 100 mg q.d.
2. Aspirin 81 mg q.d.
3. Coumadin adjusted to INR.
4. Lisinopril 2.5 mg q.d.
5. Digoxin 0.125 mg q.d.
6. Lasix 80 mg q.d.
7. Levothyroxine.
8. Folic acid.

HPI
4 elements (or status of 3 chronic diseases)

- location
- modifying factor
- severity
- associated signs & symptoms

ROS
2-9 elements

- CV
- Resp

PFSH
1 required

- Past medical

(CONTINUED)

Physical Examination: Height 5 feet, weight 106 pounds, body mass index 20.7 (21.5 on last visit), pulse 80, blood pressure 111/79. Head and Neck: No evidence of elevated jugular venous pressure. Normal carotid upstrokes. No bruits. Chest: Lungs clear to auscultation bilaterally. Occasional end-expiratory wheezing appreciated on deep breath. Heart: S1 and S2 irregular. Abdomen: Soft and nontender. Extremities: Trace pitting edema and 1+ pedal pulses.	**Exam** *Expanded problem focused – not detailed* *6-12 bullets (1997)* • 3 vital signs • CV – carotids • CV – AUSC • GI - abd • Neck • Resp – AUSC • CV - Edema
ASSESSMENT AND PLAN: 8. Atrial fibrillation. Appears to have adequate rate control. We can continue with atenolol and digoxin at the current dosage. She is maintained on anticoagulation. As you recall, she had symptoms of a transient ischemic attack back in January before I had seen her. She appears to be tolerating anticoagulation and that can be continued for now. 9. Valvular regurgitation. She does have moderate mitral and moderate-to-severe tricuspid regurgitation. She has been maintained on a low dose of lisinopril for after-load reduction. Her blood pressures are fairly low and I do not think she will necessarily benefit from further up titration of that medication. We can continue the current dosage. 10. Pulmonary hypertension, likely multi-factorial with a significant lung component. Control of her chronic obstructive pulmonary disease and asthma will assist in stabilizing her pulmonary pressures. 11. Hypertension, blood pressure is well controlled. We can continue the current regimen. 12. Lipids. Her last lipid profile in March showed excellent numbers with a total cholesterol of 199, high density lipoprotein of 60, low density lipoprotein of 53, and triglycerides of 53. She is not maintained on any antilipedimic agents and she does not require them. I will plan to see her back in follow-up in a year's time. I plan on repeating an echocardiogram prior to her next visit. To follow up baseline, I have ordered pro-BNP level to be done now as well as prior to her next visit.	**MDM** Moderate 5 problems addressed, some better, some worsening – none severe – with prescription drug management

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CHIEF COMPLAINT: Bumps around her anus.
HPI: This is an established patient. Patient reports about a year to a year a half she has had several small bumps near her anus. They are slightly itchy and irritating. Sometimes when she wipes she'll get a little bit of blood, or some drainage from them, otherwise she really has no other problem with them. She denies ever having a perirectal abscess before or perianal abscess. Denies ever having a pilonidal cyst in the past. She has never had a problem with hemorrhoids in the past. She has no problem with constipation or diarrhea and no other complaints associated with these. She does not think she has any drainage. She usually wears a throng and has not noticed any soilage on her pants. She has had some warts removed from her vulva in the past and doesn't seem to think this is the same.
PAST HISTORY: Significant for some depression.
SURGICAL HISTORY: C-section in 1989. A NovaSure procedure in 2006. Tonsils and adenoids as a child.
MEDICATIONS: Current medications include Cymbalta 60mg.
ALLERGIES: No known drug allergies.
SOCIAL HISTORY: She is married and has two children. She smokes approximately a pack of cigarettes per day. She does not drink any alcohol. She works as a rehab aide locally.
FAMILY HISTORY: Significant for heart disease and her father had adrenal cancer. Also significant for depression.
ROS:
PSYCHE: Significant for the above mentioned depression.
RESPIRATORY: No chronic cough or sputum production.
CARDIOVASCULAR: No chest pain or heart palpitations.
GI: As per HPI
MSK: Normal

HPI
4 required
location
quality
associated signs and symptoms
duration

ROS
2-9 required
- GI
- resp
- CV
- MS
- psyche

PFSH
1 required
All three documented

(CONTINUED)

PHYSICAL EXAM: Exam reveals an awake and alert female who appears her stated age and appears in good shape- normal mood and affect. Height 5'3" Weight 145lbs. BP 140/72 **LUNG:** Clear. **HEART:** Regular rate and rhythm. **ABDOMEN:** Soft and nontender. No HSM, no hernia. **RECTAL:** Her anal region shows at the midline in the cleft region going posterior as she as on her side, we'll call that 12 o'clock, there is a small dimple right there. It could easily be a chronic fistula tract from a previous perirectal abscess if she had had one. There does not appear to be any drainage at this time. Just off the side there are two other small cyst-like areas. They are 2-3 mm in size. They almost appear like infected inclusion cysts. They have small amount of drainage if I put pressure on them. Of note, there is absolutely no hair present in this area and on further questioning of the patient, she does keep the area completely shaved on a regular basis. Rectal examination revealed normal tone and no significant abnormalities or masses felt. No signs of an abscess or scarring were felt. Upon applying pressure behind the area, there appeared to be a fistula over these two cyst areas. There was no increased drainage. There are also several small wart-like lesions present on the perineum between the posterior wall of the vagina and the rectum. Otherwise, the rest of the exam is unremarkable. There are no signs of pruritus, inflammation, or irritation and no erythema. Rectal mucosa appeared to be quite normal. Occult negative. Skin: warm. Negative lymph nodes in groin.	**EXAM** *12 bullets from 1997* *multi-system exam* • Vital signs • General appearance • Resp auscultation • CV auscultation • GI masses • GI no organs • GI hernia • GI occult test • GI anus and perineum • Lymph groin • Skin palpitation • Psych mood and affect
ASSESSMENT: Chronic fistula versus several small chronic draining cysts versus ingrown hair plus several small warts. **PLAN:** I recommend we go to the OR and do an exam under anesthesia. That way I can easily use a standard probe to find out if the posterior 12 o'clock lesion is in fact a chronic fistula tract. The other two lesions can also be probed and if they are truly just draining cysts, they can be ID'd and formally debrided extensively which would be quite helpful in the healing process. She is quite happy with this and we'll be performing this soon. The risks, benefits, and complications have been discussed in great detail. Consent has been signed.	**MDM** New problem to examiner. Risk: undiagnosed new presenting problem