PROGRESS NOTE #1

Steven Perry
2/15/2011

Mr. Perry is here today for extended visit exam, lab results, pt complains today of URI symptoms and colored sputum.

HPI: The patient returns reassessment, feeling quite well. He enjoyed his vacation. He relates no HA, syncope, no exertional chest pain. He has a negative nuclear stress test last summer with Dr Freed. Recent office visit there was normal, niacin prescribed. He is been intolerant of simvastin, Vytorin in the past, although he did fairly well on a small, half dosage. He is willing to try again. His cholesterol is 100 points high, unfavorable ratio.

NKDA

Current meds:

Aspirin 81 mg oral 1 tablet dail
Viagra 100 mg oral 05 as directed
Lovaza 1 gm oral capsule – I capsule twice daily
Co Q-10 100 mg oral take 1 capsule daily
Dexamethasone Sodium Phosphate 4 mg injection solution 1.5 ml per treatment for 10 treatments Medication list verified DS, MA

Active problems:

BPH (600.00)
Blood Pressure Isolated elevated (796.2)
Coronary artery disease (414.00) 2009 coronary Ca score 280 primarily in LAD
Hyperlipidemia (272.4)
Male erectile Dysfunction (302.72)
Need for vaccine – pneumococcal (V04.81)
Osteoarthritis (715.90) left thumb, has had Kleinert
Tendonitis (726.90)

PMH

Coronary Artery Disease (414.00)
Need for vaccine – pneumococcal (V04.81)
Tendonitis (726.90)

Family History

Positive for Coronary Artery Disease

Personal History

Denied alcohol
Denied Tobacco use

Review of Systems:

Systemic: Not Feeling tired (fatigue) and not feeling poorly (malaise). No fever and no chills
Head: no Headache
Otolaryngeal: No ear symptoms. Nasal symptoms nasal passage blockage and throat symptoms feeling of tightness in the throat
Cardiovascular: No chest pain of discomfort and no palpitations, no chest pain starting with exertion
Pulmonary: No shortness of breath and not during exertion. No paroxysmal nocturnal dyspnea, not sleeping upright or with extra pillows, no cough, not coughing up sputum and no wheezing
Gastrointestinal: Heartburn and nausea. No vomiting, no abdominal pain, no diarrhea and no constipation |
Genitourinary: No hematuria and no polyuria. No urinary loss of control and no dysuria
Hematologic: No tendency for easy bruising
Musculoskeletal: Myalgias. No arthralgias and no regional soft tissue swelling in both lower extremities. Pain localized to one or more joints
Neurological: No dizziness, no vertigo, no fainting, no confusion or disorientation, and no memory lapses or loss
Psychological: No anxiety, no depression and no insomnia
Skin: No dry skin, no pruritis, no erythema and a skin wound is not slow to heal.

The remainder of the review of systems was negative.

Physical exam:
Constitutional: Oriented to time, place, and person – well developed – well nourished
Thyroid – not diffusely enlarged.
Eyes: general /bilateral - extraocular Movement's normal – Pupils: PERRLA
Ears: general /bilateral Tympanic membrane: normal
Cardiovascular: JVD not increased, HRR normal, heart sounds normal, No murmur or thrills No bruits in the carotid, arterial pulses equal bilaterally and normal edema not present
Abdomen: Auscultation palpation revealed no abnormalities – Abdomen is soft, no abdominal tenderness. Liver: not enlarged
Genitalia: Penis normal showed no lesion
Rectal exam normal – rectum a stool sample was taken for occult blood – negative
Prostate: prostatic enlargement was observed 2-3+ smooth
Musculoskeletal system: general/bilateral Normal movement of all extremities
Neurological: cranial nerve normal, no sensory exam abnormalities noted, no motor dysfunction, coordination is normal, gait and stance normal, reflexes normal.
Skin: color and pigmentation is normal.

Results: EKG from summer 2010 negative
COMP metabolic panel, CBC, PSA, UA

Orders:
Crestar 5 mg oral take 1 daily
Refer to Dermatology
Azithromycin 250 mg oral take 2 tablets on day 1, then 1 tablet for 4 days.

Assessment:
- Isolated blood pressure was elevated (796.2
- Coronary Artery Disease (414.00)
- BPH (600.00)
- Hyperlipidemia (272.4)
- Actinic keratosis (702.0
- Tendonitis (726.90)

Plan:
Medications reviewed
Labs reviewed
Return to office 4 months
1. BP, cardiac symptoms are stable
2. Concerned about hypercholesterolemia, he is willing to try a different Rx, will start with ½ Crestor
3. Prostate enzyme exam normal
4. Refer to Dermatology
5. Left elbow tendonitis is improved, will continue PT
6. Azithromycin for bronchitis

Electronically signed …….

PROGRESS NOTE #2

Date: 09-13-2011 **Name:** Elsie Smith **Date of Birth:** 04-20-1944
Sex: Female **Occupation:** Married

CC/HPI: Write in your own words what the chief complaint is:

Recently relocated to South Philly and need to establish physician

For continuation of care—refilled Rx , fasting labs**.**

PMH: Highlighted have positive response.

Asthma	Emphysema	Kidney Stones	Other_____
Angina	Epilepsy	Pancreatitis	_____
Anemia	Gall Stones	Poor Blood Clotting	_____
Arthritis	Glaucoma	Positive TB Test	_____
Blood Transfusions	Fractures	Rheumatic Fever	_____
Cancer	Heart Failure	Seizures	_____
Chronic Bronchitis	Heart Murmur	Stroke	_____
Cirrhosis	Heart Attack	Thrombophlebitis	_____
Colitis	**Hypertension**	Tuberculosis	_____
Diabetes	Hepatitis	Thyroid Disease	_____
Diverticulosis	Kidney Infection	Ulcers	_____

Operations:
List any surgical operations you have had: Date:
1. Tubal Pregnancy 09-1982

Allergies:
List any drugs you are allergic to:
None

Medicines:
List all medicines you are taking:
1. Spironolactone HTZ 25-25
2. Pravastatin Sodium 40mg
3. Aspirin 81mg
4. Vitamin B-6, 100mg
5. Citrucel tablets
6. Vioctiv Chewables

Immunizations/Vaccinations
Circle and indicate when you had any of the following:
Tetanus 09/2008
Diptheria 09/2008
Influenza
Pneumococcal 2009
Zostarax 2009

Do you take birth control pills? Yes **No**

Family Medical History: If any blood relative has ever had any of the following, circle and indicate which relative(s).

Arthritis_____ Kidney Disease _____
Bleeding Tendency_____ Liver Disease_____
Cancer_____ Obesity **Brother, Sister**
Diabetes_____ Migraines Headaches_____
Heart Attack Father Stroke_____
High Blood Pressure Father Tuberculosis_____

Have you ever smoked cigarettes? **Yes** No (30 years ago)
Are you currently smoking? Yes **No** If yes, how many per day? _____ Quit?_____ When?_____
Do you regularly drink alcoholic beverages? Yes **No** If yes, how many per day? _____ For how long? _____

Please turn over and complete backside of form – (positive responses are highlighted)

Date: 09-13-2011 **Name:** Elsie Smith **Date of Birth:** 04-20-1944

REVIEW OF SYSTEMS

Circle if you have any of the following symptoms:

General	**GI**	**Endocrine**
Fever	Problems Swallowing	Excessive Thirst
Swollen Glands	Frequent Heartburn	Always Too Cold
Weight Loss	Diarrhea	Always Too Hot
Poor Appetite	Constipation	**GU (Men)**
HEENT	Change in Bowel Habits	Lump in Testicles
Recurrent Nose Bleeds	Bloody Stools	Sore on Penis
Ear Pain	**Kidney/Bladder**	Discharge from Penis
Sores in Mouth	Blood in Urine	**GU (Women)**
Persistent Hoarseness	Decreased in Force of Urination	Lump in Breast
Skin	Painful Urination	Nipple Discharge
Rash	Frequent Urination	Vaginal Discharge
Change in Mole(s)	**Neuro**	Abnormal Vaginal Bleeding
Cardiopulmonary	Fainting Spells	**Hot Flashes**
Irregular Heartbeat	Dizziness	Change in Periods
Shortness of Breath with Exertion	**Muscle Skeletal**	Possibly Pregnant
Shortness of Breath Lying Down	***Painful Joints***	Date of Last Menstrual Period: 1984-?
Chest Pain	***Swollen Joints***	Date of Last Pap Smear: 9-23-2010
Chronic Pain	Painful Muscles	Date of Last Mammogram
Wheezing	Muscle Weakness	**Heme/Lymphatic**
Swollen Ankles	**Psychiatric**	Easy Bruising
Leg Cramps	***Sadness***	Unusual Bleeding
	Depressed	Enlarged Lymph Nodes

Are you in a high risk group for AIDS? (i.e., Homosexual, IV user, hemophiliac, or prostitute) Yes No

Wt. 152 **Ht.** 66 ½ **BP** 118/66 **P** 60 **R** _____ **T** _____ **Labs** _____AM, RMA

PHYSICAL EXAM:
ASSESSMENT:
PLAN:
Return Appointment: _____

Name: Elsie Smith **Age:** **79** **Chief Complaint:** _____ **Date:** **9/13/2011**

History of Present Illness: L3 (1-3), L4 (4+), L5 (4+)
Doing well, depressed secondary to stress from retirement and move from home in May.

REVIEW OF SYSTEMS: (N) Normal (A) Abnormal

	N	**A**	**L3 (1), L4 (2-9), L5 (10+)**	**L3 (N/A), L4 (1), L5 (1 from 2 of 3)**
Constitutional				PMH Reviewed (see Problem List)
HEENT				
Cardiovascular				
Respiratory				
GI				MEDS Reviewed (see medication list)
GU				
Musculo/Skeletal				
Neuro				Allergy Reviewed
Psych				FHx NC
Skin				

Hemo/Lymph				
Allergy/Immuno				SHx NC
Misc.				

EXAM (N) Normal (A) Abnormal L3 (6), L4 (12), L5 (19)

BP _____ P _____ RR _____ TEMP_____ HT _____ WT _____

GENERAL APPEARANCE		N/A	_____
SKIN	Inspection	N/A	_____
EYES	Inspection	N/A	_____
	Pupils/Iris	N/A	_____
	Ophthalmic	N/A	
_____			
ENT	Inspection	N/A	_____
	EC's/TM's	N/A	_____
	Nose	N/A	_____
	Teeth/Gums	N/A	_____
NECK	Neck	N/A	_____
	Thyroid	N/A	_____
RESP	Inspection	N/A	_____
	Auscultation	N/A	_____
	Percussion	N/A	_____
	Palpitation	N/A	_____
CV	Auscultation	N/A	_____
	Palpitation	N/A	_____
	Carotids	N/A	_____
	Abd. Aorta	N/A	_____
	Peripheral A.	N/A	_____
	Veins	N/A	_____
BREAST	Inspection	N/A	_____
	Palpitation	N/A	_____
ABD	Inspection	N/A	_____
	Bowel/Sounds	N/A	_____
	Liver/Spleen	N/A	_____
	Mass/Tenderness	N/A	_____
M. SKELETAL	Extremities	N/A	_____
	Spine	N/A	_____
NEURO	A & O X3	N/A	_____
	CNS		_____
	DTR's	N/A	_____
	Strength	N/A	_____
	Galt	N/A	_____
GU	Scrotum	N/A	_____
	Penis	N/A	_____
	Externa	N/A	_____
	Vagina	N/A	_____
	Cervix	N/A	_____
	BM	N/A	_____
RECTUM	Occult Blood	N/A	_____
	Prostate	N/A	_____
LYMPH NODES		N/A	_____
OTHER		N/A	_____

ASSESSMENT: L3 (Low), L4 (Mod), L5 (High)

1) HLP: due for labs, refilled Pravastatin
2) HTN: 2º to stress, Advised to take off ½ days for 2 weeks
3) Hot Flashes: Tmal of black Kohash, Vit E, □ PO Fluids
4) Situational stress, Counseled, Defers meds

PLAN:
X-RAY:
LABS:
COUNSELING:

F/U appointment: Days Weeks Months PRN Additional notes dictated: Y / N
NOTES:

LD,MD

PROGRESS NOTE #3

Jerry Miller
03/22/2011
DOB: 02/26/1932
Marital Status: Single/ Language: English / Race: White / Ethnicity: Undefined
Gender: Male

History of Present Illness: (DK 03/28/2011)
The patient is a 79 year old male who presents with hypertension. The last clinic visit was 7 month(s) ago. No changes in management were made at the last visit. Symptoms do not include headache, confusion, visual disturbance, dizziness or shortness of breath. Symptoms are exacerbated by stress. Associated symptoms include edema, while associated symptoms do not include chest pain, near syncope or weakness. By report, there is a good compliance with treatment. Pertinent medical history includes diabetes, dyslipidemia and left ventricular hypertrophy. Risk factors include obesity and physical inactivity.

Additional Complaints:
Skin Lesion: described as the following:
The skin lesion appeared gradually and has been occurring for 6 months. It has been increasing in size. The skin lesion is characterized as raised about the skin. The skin lesion is located on the back.

Anxiety is described as the following:
Symptoms include anxiety, excessive worry, insomnia, nervousness and sleep disruption. Symptoms are exacerbated by new situations (robbed on Dec. 9, 2010 at gunpoint). Note for "Anxiety":
Ran out of Alprazolam ER 0.5mg after taking more than prescribed.
He's still feeling anxious and having difficulty sleeping because of the robbery. He is requesting an early refill and possibly increase in dose.

Allergies (N W 03/22/2011 08:48am)
ACE INHIBITORS 05/20/2004; cough with Monopril

03/22/2011 08:47am
Weight: 216 lb Height: 68.75 in
Body Surface Area: 2.18 m^2 Body Mass Index: 32.13 kg/m^2
Pulse: 63 (Regular)
BP: 142/75 Manual (Sitting, Left Arm, Standard)

Physical Exam (DK; 03/28/2011
The physical exam findings are as follows:
General
Mental Status – Alert General Appearance – Cooperative and well groomed
Integumentary: General Characteristics: Overall examination of the patient's skin reveals – no rashes.

Problem #1:
Description: Appearance—actinic damage
Size: 2-D Measurement – 1.6 mm (length) x 1.8 mm (width)
Location: Back – left upper
Head and Neck
Thyroid Gland Characteristics – normal size and consistency and no palpable nodules
Eye: Sclera/Conjunctiva- Bilateral – Normal. Pupil – Bilateral – Normal, Accommodating and Direct reaction to light normal.
Palpation: Brachial pulse – Left – Normal. Right – Normal Radial pulse – Left – Normal. Right – Normal.
Lower Extremity Inspection – Left – Inspection Normal. Right – Inspection Normal.

Palpation: Dorsalis pedis pulse – Left – Normal. Right – Normal. Posterior tibial pulse – Left – Normal. Right – Normal. Edema – Bilateral – Trace edema.
Neurologic: Neurologic evaluation reveals – alert and oriented x 3 with no impairment of recent or remote memory, normal attention span and ability to concentrate, able to name objects and repeat phrases. Appropriate fund of knowledge and normal coordination.
Neuropsychiatric: Mental status exam performed with findings of – demonstrates appropriate judgment and insight. The patient's mood and affect are described as – anxious (We spent 35 minutes discussing his recent break-in, robbery and mugging. He needed to work through the event). Not angry.
Lymphatic: General Lymphatics Description – Normal

Assessment & Plan (D K 03/28/2011)

HTN Heart/CKD, bgn w/o HF w/CKD V/ERSD (404.12) Onset: 07/31/2007
Current Plans:

Furosemide 40mg, 1 tablet at 7am and 1 p.o. at 2pm, #180, 90 days starting 03/22/2011, Ref. x1. Active.

Norvasc 10mg, 1 tablet daily, #90, 90 days starting 03/22/2011, Ref. x3. Active.

Hydrochlorothiazide 25mg, 1 tablet daily, #90, 90 days starting 03/22/2011, Ref. x3. Active.

Medical Decision Making (System Manager; 03/28/2011 01:35 pm)
More than half of this 55 minute visit was spent in counseling. DK, MD

PROGRESS NOTE #4

Patient : Anne Janson

Date of Birth: 11/14/1946
Date 11/15/2011
Visit type: Office Visit—established GYN Patient

Chief Complaint/Reason for Visit:
This 65 year old female presents with postmenopausal bleeding.

History of Present Illness:
1. Postmenopausal Bleeding
Onset: 2 month(s) ago. Severity level is mild-moderate. Location/source of the bleeding is vaginal. The patient describes it as light bleeding. Frequency: irregular. The problem is no change. Context: post-menopausal. Denies aggravating factors. Denies relieving factors. Associated symptoms include back pain and fatigue.
Additional information: She is not on menopausal hormone therapy.

Chronic Problems:
Hypertension Unspecified
Depression
Allergic Rhinitis-Cause Uns
Obstruct Chron Bronchitis w Acute Exacerbation
Diabetes Mellitus Type II or Unspec not stated as
Shortness of Breath
Osteoarthrosis-NSA Generalized/Local-Lower Leg
Dyspnea/Other Respiratory Abno
Hypothyroidism Unspecified
Osteoarthrosis-DJD Unspecified Gen/Local

Active Medications (started before visit):

Drug Name	Dose	Qty	Description
Cipro	250mg	14	Take 1 tablet (250mg) by oral route every 12 hours for 7 days
Symbicort	160mcg-4.5 mcg/actuation		Inhale 1 puff by inhalation route 2 times every day morning and evening
Singulair	10mg	30	Take 1 tablet (10mg) by oral route every day in the evening
Lisinopril	40mg	30	Take 1 tablet (40mg) by oral route every day
Spiriva	18mcg	1	Inhale every day the contents of one capsule
Lortab	7.5mg-500mg	60	Take 1-2 tablet every 4-6 hours prn pain
Proair HFA	90mcg	27	2pg3hr prn
Budesonide	0.5%mg/2mL	60	Use twice a day
Nizoral	2%		Apply by topical route every day to the affected area(s), lather, leave in place for 5 minutes, and then rinse off with water
Freestyle Lite Strips		100	Use as directed
Albuterol Sulfate	2.5mg/3mL (0.083%)		300 use 1 qid prn
Lorazepam	0.5mg	30	Take 1 tablet by oral route 2 times per day prn
Triamcinolone Acetonide	0.1%	15	Apply 2 times every day in thin film to the affected skin areas
Synthroid	25mcg	30	Take 1 tablet (25mcg) by oral route qd

Allergies
No known allergies

Obstetric History
Total pregnancies: Gravida: 3
Parity: Term: 3 Abortion: 0

Medical History	Year
Anxiety	
Thyroid Disease	
Arthritis	
Depression	
COPD	
Asthma	
Gallbladder Disease	
Cholecystectomy	1962
Tonsillectomy	1960

Past Medical History
Reviewed, no changes. Last detailed document: 10/04/2010.

Family History
Reviewed, no changes. Last detailed document: 10/04/2010.

Review of Systems
Genitourinary:
Positive for:
-Menarche age was 14.
-Menses. Last menses was 11/11/1111
-The patient is post-menopausal
Negative for hormone replacement therapy.

Vital Signs
Last menses 11/11/1111. Post-menopausal.

Time	BP	Temp	Pulse	Resp	Ht In	Wt Lb	Head Circ	BMI	Measured By
10:34am	123/70			68.0	288.0		43.79		Brandi Murray

Physical Exam
Constitutional: No apparent distress. Well-nourished and well developed.
Genitourinary:
External: Pubic hair is normally distributed. External genitalia is unremarkable. Glands do appear to be normal. Perineum is unremarkable. No perianal abnormalities. Urethra is normal in appearance, without erythema. Urethra meatus is normal.
Internal:
Vaginal mucosa appears normal. Cervix normal to inspection and palpation. Uterus normal in size and position. Adnexa normal to palpation, normal in size; no masses.
PAP test was done. Last PAP: 11/15/2011.
Pap Info:
L.M.P.: Last menses were 11/11/1111. Postmenopausal
Diagnostic code: V72.31 Diagnosis: PAP Smear routine

Endometrial Biopsy
Indication: Postmenopausal Bleeding
Description of Procedure:
A bivalve speculum was placed in the vagina and the cervix was prepped with Betadine solution. The uterine cavity was sounded at 8cm. The endometrial cavity was curetted for tissue sampling.
Plastic Curette Size:
Curette 1 –3mm

Specimen was sent to pathology. The patient tolerated the procedure well and was discharged home from the office.

Findings:

Size of Uterus: Normal
Adnexa: Normal
Cervix: Normal
Discharge instructions provided.

Pap Detail

Last menses were 11/11/1111. Postmenopausal

Assessment/Plan

Postmenopausal bleeding (627.1)

Check biopsy. Schedule a pelvic u.s.

Medications (added or continued this visit)

Dx	Drug Name	Dose	Qty	Start Date	Stop Date	Description
	Cipro	250mg	14	10/17/2011		Take 1 tablet (250mg) by oral route every 12 hours for 7 days
	Symbicort	160mcg-4.5 mcg/actuation			10/11/2011	Inhale 1 puff by inhalation route 2 times qd AM PM
	Singulair	10mg	30	10/09/2011		Take 1 tablet (10mg) by oral route qd
401.1	Lisinopril	40mg	30	09/07/2011		Take 1 tablet (40mg) by oral route qd
496	Spiriva	18mcg	1	09/07/2011		Inhale every day the contents of 1 capsule
715.96	Lortab	7.5mg-500mg	60	09/06/2011		Take 1-2 tablet q4-6 hrs prn
496	Proair Hfa	90mcg	27	08/08/2011		2pq3hr prn
496	Budesonide	0.5mg/2mL	60	02/15/2011		Use BID
	Nizoral	2%		02/15/2011		apply by topical route qd to affected area, lather, leave in place for 5 minutes & rinse
250.00	Freestyle Lite Strips		100	02/14/2011		Use as directed
	Albuterol Sulfate	2.5mg/3mL	300	02/14/2011		Use 1 qid prn
300.00	Lorazepam	0.5mg	30	02/14/2011		Take 1 tablet by oral route BID prn
	Triamcinolone Acetonie 01%		15	01/12/2011		Apply BID a thin film to affected skin area
	Synthroid	25mcg	30	10/05/2010		Take 1 tablet (25mcg) by oral route QD
	Ibuprofen		0	10/20/2009		prn

Orders/Procedures/Instructions/Education

Labs Dx Code

SURGICAL PATHOLOGY 627.1

Office Procedures/Services

Dx	Side	Site	Exp	Lot Num	Mfg
Comments	ReactionDetail				
V72.31					

Diagnostics/Procedures to be Scheduled

US PELVIS COMPLETE Dx Code: 627.1

ELECTRONICALLY SIGNED ……

PROGRESS NOTE #5

Patricia Cake 12/19/2011
4231 Circle Drive
Grainsville, KS

Randolph Scott, MD

NOVEMBER 30, 2011 OFFICE NOTE

Mrs. Cake is a very pleasant 72 year old white female who recently moved from Florida to the Grainsville area. She was previously followed by Dr. Henry Sampson in FL for many years. She reports no acute complaints today.

REVIEW OF SYSTEMS: Reveals rare palpitations with a history of a nodal reentry tachycardia that has been well controlled with beta blockade. No dysuria. Occasional mild overactive bladder and stress incontinence. Occasional leg cramps. No insomnia, anxiety or depression. Comprehensive review of systems is otherwise negative.

PAST MEDICAL HISTORY: Includes atrial tachycardia as noted above.

PAST SURGICAL HISTORY: Includes cholecystectomy, bilateral tubal ligation, tonsillectomy, left breast biopsy in 2011 that was benign, and a left ankle fracture approximately 2 years ago.

SOCIAL HISTORY: She is a nonsmoker and a nondrinker. She is married.

FAMILY HISTORY: Positive for a maternal grandmother with a breast cancer, mother with diabetes, a maternal grandfather with diabetes and heart disease, and a father who died of a heart attack at age 72.

HEALTH MAINTENANCE: Flu shot will be given today. Mammogram is up to date. EKG shows a sinus rhythm and some normal EKG. Bone mineral density was completed approximately 2010. Colonoscopy was done in 2011. They recommended 5 to 7 year follow-up.

EXAM: Blood pressure is 112/70, pulse is 64, weight is 190, height is 5 feet 0 inches.
HEENT: Atraumatic, normocephalic. NECK: Supple with thyromegaly. No carotid bruits as heard. CHEST: Clear. HEART: Regular rate and rhythm without murmur, rub or gallop. ABDOMEN: Soft. Positive bowel sounds in all four quadrants. Obese. There is a moderate sized umbilical hernia present with reducible bowel. EXTREMITIES: No edema is noted in the extremities. NEUROLOGICAL: Cranial nerves II through XII are intact. There is no evidence of cognitive impairment.

PLAN:
1. Flu shot was given
2. Check comprehensive labs
3. Refill her propranolol 200mg BID
4. Refer for umbilical hernia repair
5. Otherwise, follow up in 1 year RS,MD

PROGRESS NOTE #6

Date of Exam: April 8, 2011 Patient: Sarah James
Reason for Visit:
Here on consultation from Dr. Bruman for Diabetes.

HPI:
She has had diabetes mellitus for the last 40 years. She has been on an insulin pump for the last 7 years.
She has been getting her diabetes care from her nurse practitioner in Nashville, but she is getting tired of making this trip 4 times a year.

Hemoglobin A1C is said to be 7.1% 2 months ago.

Fasting blood sugar is near 146, but this can be as low as 55, by noontime her blood sugar is 158, going down to 49 at times. At supper time, her blood sugar is 210 on average. By bedtime, her blood sugar is near 72.
Her basal rate is running at:
2.25 0000
2.54 0300
1.85 0800
2.35 1200
2.80 1800

She boluses NovoLog 1 unit for every 6 g of carbohydrates with breakfast and lunch, 1 unit for every 4 g of carbohydrates with supper.

She is on Symlin 120mcg with each meal, Metformin 1000mg BID.
She has a history of hypertension and her blood pressure is rather high today. Dr. Lewis just added HCTZ to her regimen.
She is being treated for hyperlipidemia with Simvastatin 40mg daily.
Microalbumin was 34.0 on 03/23/11 and she has never seen a nephrologist.
Dilated eye exam was performed 2 months ago and she has had retinopathy. She has a history of retinal detachment and she is blind in the left eye.
She received a flu shot in September 2010.

Recently, she had some trouble swallowing and a thyroid ultrasound was performed on 04/06/11. On the right lobe, there was a 1.5-cm and a 1.7-cm nodule.

Allergies:
Codeine Derivatives
Novocain SOLN

Current Meds:
Multivitamins oral tablet; take one tablet daily, RPT
Zyrtec 10mg Tabs, take one tablet daily, RPT
NovoLog Soln; Inject SQ as directed, RPT
Folic Acid 1 mg oral tablet, take one tablet daily, RPT
Omeprazole 20mg, oral capsule delayed released, take one capsule daily, Rx
Simvastatin 40mg, oral tablet, take one tablet daily at bedtime, Rx
Cyclobenzaprine HCl 10mg oral tablet, take one tablet TID PRN, Rx
Metformin HCl 1000mg oral tablet; 1 BID CM – take one tablet by mouth twice daily with meals
BuPROPion HCl 200mg oral tablet ER 12 hour, tablet 1 table daily, Rx
Butorphanol Tartrate 10mg/mL nasal solution ; one spray in one nostril q24 hrs prn headache, Rx
Symlin 600mcg/mL SQ solution, Inject 10 mL TID, Rx
FLUoxetine HCl 20mg oral capsule, 1 QD, take one tablet PO QD, Rx

Metoprolol Tartrate 25mg oral tablet, 1 BID, take one tablet PO BID, Rx
Meloxicam 15mg oral tablet, FF- take one tablet QD, RPT
Lutein 20mg, oral capsule, take as directed, RPT
Fish Oil 1200mg oral capsule, take one capsule daily, RPT
Lisinopril-Hydrochlorothiazide 20-12.5 mg oral tablet, take two tablets daily, Rx

PSH:
Cesarean Section; times two
Neuroplasty Decompression Median Nerve At Carpal Tunnel; bilateral
Repair of Retinal Detachment; several times
Rotator Cuff Repair
Tonsillectomy

Family Hx
Family History of Cancer
Family History of Coronary Artery Disease
Family History of Diabetes Mellitus
Family History of Hypertension

Personal Hx
Behavioral: Never a smoker
Alcohol: Alcohol use
Work: Retired ex LPN

ROS
Systemic: Feeling tired (fatigue) and feeling poorly (malaise). No fever and no chills
Head: Headache
Otolaryngeal: No ear symptoms. Nasal symptoms nasal passage blockage and throat symptoms feeling of tightness in the throat
Cardiovascular: No chest pain of discomfort and no palpitations
Pulmonary: No shortness of breath and not during exertion. No paroxysmal nocturnal dyspnea, not sleeping upright or with extra pillows, no cough, not coughing up sputum and no wheezing
Gastrointestinal: Heartburn and nausea. No vomiting, no abdominal pain, no diarrhea and no constipation |
Genitourinary: No hematuria and no polyuria. No urinary loss of control and no dysuria
Hematologic: No tendency for easy bruising
Musculoskeletal: Myalgias. No arthralgias and no regional soft tissue swelling in both lower extremities. Pain localized to one or more joints
Neurological: No dizziness, no vertigo, no fainting, no confusion or disorientation, and no memory lapses or loss
Psychological: No anxiety, no depression and no insomnia
Skin: No dry skin, no pruritis, no erythema and a skin wound is not slow to heal.
The remainder of the review of systems was negative.

Vital Signs:
BP: 157/66
HR: 65 b/min
Height: 66in, Weight: 248 lb, BMI: 40kg/m2
BSA Calculated: 2.19
BMI Calculated: 40.03
Physical Exam:
Constitutional: The patient is alert, not in distress. Vital signs as noted.
Head: Face is not Cushingoid. No neck vein engorgement. No dental caries. No alopecia.
Eyes: Pink conjunctivae, anicteric sclerae. Full eye movements, no proptosis, no lid lag.
Neck: The thyroid is 30 grams in volume with no bruit, non-tender to touch.
No lymphadenopathy. No acanthosis. No skin tags.

Cardiovascular: Distinct heart sounds. Regular rate and rhythm. No murmur or thrills.
Lungs: Equal chest expansion with no rales, no wheezes, fair air entry
GI: Soft, flabby abdomen with no masses, no tenderness. No ascites, no organomegaly, no striae.
Extremities: Limited range of motion, no edema. No cyanosis, fair pulses. No ulcerations. Fair, foot care.
Back: No limitation of motion, no flank tenderness.
Neuro: Deep tendon reflexes are +1 with no tremors. Good muscle tone.
30% loss of sensation on vibration testing to both feet.

Results:
Fingerstick Blood Sugar – 117 Non-fasting per patient
Comp metabolic panel 23 Mar 2011 09:10am
-Glucose: 122 Reference Range: 65-99 Flag: H
-Creatinine: 1.11mg/dl Reference Range: 0.5-1.4
-AST: 24u/l Reference Range: 15-45
-ALT: 10u/l Reference Range: 0-43
TSH 23 Mar 2011 09:10am
-TSH: 1.170u/IU/ml Reference Range: 0.470-4.83
Microalbumin/Creat Ratio 23 Mar 2011 09:10am
-Microalbumin/Creat Ratio: 34.0 Reference Range: 0.0-30.0 Flag: H.

Assessment:
-Benign essential hypertension (401.1)
-Hyperlipidemia (272.4)
-Nontoxic multinodular goiter (241.1)
-Type 2 diabetes with neurological complications—uncontrolled (250.62)

Order:
Hemoglobin A1C: requested for 08 Apr 2011
LC – GAD-65 Antibody, requested for 08 Apr 2011
Glucose 4 GM oral tablet chewable; take two tablets as needed for low blood sugar, qty 60; R3

Plan:
Today, we will need a Hemoglobin A1C and a GAD-65

Her basal rate will run at:

2.00 0000
2.40 0300
1.85 0800
2.50 1200
2.00 2000

She will bolus NovoLog 1 unit for every 6 g of carbohydrates with breakfast and lunch, 1 unit for every 5 g of carbohydrates with supper.
She will continue Metformin 1000mg twice a day, Symlin 120mcg with meals.
She will check her blood sugar at least QID.
In 2 weeks, she will bring in her meter for a download. We can make dose adjustments at that time.
She will continue taking Lisinopril/HCT 20/12.5mg two tablets daily, Simvastatin 40mg daily.
We will have her see WKKS for microalbuminuria.

At her next visit, we can discuss getting an ultrasound guided biopsy of the 1.6-cm nodule on the right lobe, the 1.5cm and a 1.7-cm nodule on the left lobe.

We will see her in 3 months.
Electronically signed ……..

PROGRESS NOTE #7

Patient: Anna Leigh
Jack Walker, MD

USE OF FOLLOWING ABBREVIATION AND SYMBOLS ARE UNACCEPTABLE

Q.D/q.d.	Q.O.D/q.o.d	IU	U/u	MSO_4	Lack of leading zero (.5)o (hour symbol)
TIW/TIW	mg	$MgSO_4$		MS	Trailing zero after decimal point (3.0)

Note Progress of Case, Complications, Consultations, Change in Diagnosis, Condition on Discharge, Instruction to Patient

4/30/2011 10:30 AM General SOB, 1 ??? 1.01 Respr 54 BP 87/44
Dx: mild CHF – bradycardia
Rx: ↑ Coumadin 5 mg; ↓ Procardia 10 mg ῑ 8 hr.
JWalker, MD 04/30/11 Signature Date Time
Pastoral Paliative care Patient appears to be sleeping soundly No family present I prayed for patient Chaplian Smith 4/30/11

PROGRESS NOTE #8

Mann, Meredith
DOB: 12/15/1933

Diagnosis: Myasthenia gravis
Allergies: Magnesium

Date/Time	11/28/2011 12 noon
	Admit to Neurotele, Dr. Steven's Dx: myasthenia gravis & delirium Cond: guarded Vitals: q4hrs & neurochecks, no vitals or interruptions from 10pm-6am All: Magnesium Act: as tol with assistance Nursing: Fall risk, delirium risk Diet: Cardiac Ilo: Strict IVF: 50 cc/hr NSS x 1L then KVO Labs: CBC, CMP, Vit D 25 lvl, B12 lvl, B6 lvl, INR, PT/PTT, TSH, Free T4, UA with culture, CXR (r/o PNA) Call Dr. Hennigen & Dr. Stevens with room number when she arrives NIF/VC q6hrs call MD if NIF ≤ 15 or VL ≤ 1L

11/28/2011

Chief Complaint/Reason for Visit:
This 77 year old female presents with follow-up.

History of Present Illness:
1. Follow-Up
Additional Comments:
This 77 year old woman returns for further evaluation of her weakness. She was in the hospital in the end of September, was doing a little better. Steroids worked to improve her weakness, but she has deteriorated in the last several weeks. She had a UTI in November, treating with amoxicillin, is not sure if it has helped.
She is restless, up in the night, not using CPAP as well. She is having hallucinations, remembering things poorly, not recognizing family. She has been complaining of abdominal pain as well, no BM since Friday. She is not sleeping well.
Her PCP is Dr. Booth.

Past Medical History:
Reviewed, no changes. Last detailed document: 07/28/2010.

Family History:
Reviewed, no changes. Last detailed document: 07/28/2010.

Social History:
Reviewed, no changes. Last detailed document: 07/28/2010.

Active Medications (started before visit):

Drug Name	Dose	Qty	Rfl	Description
Gabapentin	400mg	1	0	Take one capsule (400mg) by PO QID
Pyridostigmine Bromide	60mg	90	6	Take one tablet (60mg) by PO TID
Hydrocodone-acetaminophen	5mg-500mg 1	0		Take one tablet by PO every day PRN pain
Tramadol HCl	50mg	1	0	Take one tablet PO TID PRN

Lisinopril-Hydrochlorothiazide	20-25mg		15	0	Take 0.5 tablet by PO QD
WarfarinSodium	5mg		30	0	Take one tablet by PO QD
Metoprolol Succinate	50mg		30	0	Take one tablet by PO QD
Super B Complex		30	0		Take one capsule by PO QD
Chlordiazepoxide-clidinium	5mg-2.5mg		60	0	Take one capsule by PO BID before meals
Synthroid	112mcg		30	0	Take one tablet by PO QD
Sertraline HCl	50mg		30	0	Take one tablet by PO QD
Whole Source			30	0	Take one tablet PO QD
Protonix	40mg		0		Take one tablet PO QD
Promethazine HCl	25mg/ml			0	Inject 0.5ml by IV q4hrs PRN
Claritin	5mg			0	Take one tablet BID
Temazepam	7.5mg			0	Take one capsule PO QHS PRN
Clonidine HCl	0.1mg			0	Take one tablet PO q4hrs PRN
Potassium Chloride	8 Meq			0	Take one tablet PO QD with food
Robitussin	100mg/5mL			0	Take 10mL PO q4hrs PRN
Bisacodyl	10mg			0	Insert 1 suppository by rectal route QD PRN
Magnesium Oxide	400mg			0	Take one tablet PO QD
Warfarin Sodium	3mg		0		Take one tablet PO QD
Lipitor	20mg		1	0	Take one tablet PO QD
Nexium	40mg		1	0	Take one capsule PO BID QD
Prinivil	10mg			0	Take two tablets PO QD
Toprol XI	50mg			0	Take one tablet PO QD
Kristalose	20gram			0	Take one packet PO QD dissolved in 4oz of water
Simvastatin	40mg			0	Take one tablet PO QPM
Furosemide	20mg			0	Take one tablet PO QAM
Urecholine	10mg		1	0	Take one tablet PO BID on empty stomach, 1 hour before or 2 hours after a meal
Maalox	200mg-200mg 20mg/5mL		0		Take 10mL PO between meals and HS PRN
Loperamide	1mg/5mL			0	Take 20mL PO after 1st loose stool and 10mL after subsequent bowel movement, do not exceed 80mL in 24hrs
Nitroglycerin	0.4mg			0	Place one tablet sublingual at the 1st sign of attack, may repeat every 5 min until relief; if pain persists after 3 tablets in 15min, prompt medical attention is recommended
Bethanechol Chloride	10mg			0	Take one tablet PO QID on an empty stomach, 1 hour before or 2 hours after a meal

Allergies:

No known allergies
Reviewed, no changes.

Review of Systems:

Constitutional:

Negative for fatigue, fever and night sweats.

HEENT:

Positive for:
-Ringing in ears

Respiratory:

Positive for:
-Dyspnea. This occurs at rest and activity/laying down.
Negative for asthma

Cardiovascular:

Positive for:
-Irregular heartbeat/palpitations
Negative for claudication
Comments: pacemaker

Gastrointestinal:
Positive for:
-Constipation
-Fecal Incontinence
Genitourinary:
Positive for:
-Urinary Incontinence
Negative for polyuria
Reproductive comments: not sexually active
Metabolic/Endocrine:
Negative for cold intolerance, excessive diaphoresis, heat intolerance, polydipsia and polyphagia
Neuro/Psychiatric:
Positive for:
-Depression
-Difficulty concentrating
-Gait Disturbance
-Gen. weakness
-Hallucinations
-Memory Impairment
-Mood Swings
-Psychiatric Symptoms
-Speech Changes
-Tremors
Negative for diff. w coordination
Dermatologic:
Negative for acne, change in shape/size of mole(s), excessive sun exposure, frequent skin infections, hair loss, hirsutism, nail changes, photosensitivity, pigment change, pruritus, rash, skin lesion and utricaria
Musculoskeletal:
Positive for:
-Bone/joint symptoms
Hematology:
-Negative for bleeding, bleeding diathesis, cytopenias, easy bruising, hypercoagulability, lymphadenopathy, petechiae and thromboembolic events
Immunology:
Negative for angioneurotic edema, animals at home, animals in work place, bee sting allergies, chemicals at home, chemicals in work place, contact allergy, contact dermatitis environmental allergies, food allergies and hay fever.

Vital Signs:

BP	Position	Pulse	Respiration	Temp F	Wt Kg	Wt Lb	Ht In
120/68	Sitting	67	16				

Physical Exam:
Neurological
Alert, but confused. Only oriented to self, not time or place. Language fluent, but words often times meaningless. Flight of ideas, not making sense. Follows simple commands appropriately. No drift, but weakness in BUE and LE, poor resistance throughout. Normal heart sounds and lung sounds, no bowel sounds.

Clinical Assessment:
The patient is a 77 year old female

Assessment/Plan:
Myasthenia gravis (358.00)
Recurrent pneumonia (486)
CHF (congestive heart failure) (428.0)

Delirium (780.09)
Gradually worsening debility since discharge from the hospital, worse delirium.
-steady decline since recent hospitalization
-steroids were a temporary measure but helped at the time
-admit to hospital for evaluation of possible infection, evaluation to see risk of immunosuppression with her history of recurrent PNA, and to get PT/OT/ST to see her, make sure her breathing is ok with PFTs. Repeat UA and culture to make sure UTI adequately treated.
-Will follow her in hospital, RTC in 1 month. KG,MD

Medications (added or continued this visit):

Drug Name	Dose	Qty	Rfl	Start Date	Description
Potassium Chloride	10meq	1	0	11/28/2011	Take 2 tablet PO BID with food
Gabapentin	400mg	1	0	07/22/2011	Take one capsule (400mg) by PO QID
Pyridostigmine Bromide	60mg	90	6	07/22/2011	Take one tablet (60mg) by PO TID
Hydrocodone-acetaminophen	7.5mg-500mg 1		0		Take one tablet by PO every day PRN pain
Tramadol HCl	50mg	1	0	09/27/2010	Take one tablet PO TID PRN
Super B Complex	30	0	07/28/2010		Take one capsule by PO QD
Chlordiazepoxide-clidinium	5mg-2.5mg	60	0	07/28/2010	Take one capsule by PO BID before meals
Synthroid	112mcg	30	0	07/28/2010	Take one tablet by PO QD
Sertraline HCl	50mg	30	0	07/28/2010	Take one tablet by PO QD
Whole Source		30	0	07/28/2010	Take one tablet PO QD
Clonidine HCl	0.2mg		0	11/28/2011	Take one tablet PO q4hrs PRN
Bisacodyl	10mg		0		Insert 1 suppository by rectal route QD PRN
Magnesium Oxide	400mg		0		Take one tablet PO QD
Warfarin Sodium 3mg		0			Take one tablet PO QD
Lipitor	20mg	1	0		Take one tablet PO QD
Nexium	40mg	1	0		Take one capsule PO BID QD
Prinivil	10mg		0		Take two tablets PO QD
Toprol XI	50mg		0		Take one tablet PO QD
Kristalose	20gram		0		Take one packet PO QD dissolved in 4oz of water
Simvastatin	40mg		0		Take one tablet PO QPM
Furosemide	20mg		0		Take one tablet PO QAM
Urecholine	10mg	1	0		Take one tablet PO BID on empty stomach, 1 hour before or 2 hours after a meal
Maalox	200mg-200mg 20mg/5mL	0			Take 10mL PO between meals and HS PRN
Loperamide	1mg/5mL		0		Take 20mL PO after 1st loose stool and 10mL after subsequent bowel movement, do not exceed 80mL in 24hrs
Nitroglycerin	0.4mg		0		Place one tablet sublingual at the 1st sign of attack, may repeat every 5 min until relief; if pain persists after 3 tablets in 15min, prompt medical attention is recommended
Bethanechol Chloride	10mg		0		Take one tablet PO QID on an empty stomach, 1 hour before or 2 hours after a meaL

Electronically signed …….

PROGRESS NOTE #9

Chelsie Jones
9/21/2011

Vital Sign

Date	BP	Position	HR	RR	T(F)	Wt	Ht	02
09/21/2011	128/78	Sitting	83	16		118lbs 0oz		5'4.5"
07/20/2011	110/76	Sitting	64	15	98.5	117lbs 0oz		5'4.5"
04/29/2011	135/73	Sitting	76	16		121lbs 0oz		5'4.5"
09/16/2010	143/88	Sitting	84	16		131lbs 0oz		5'4.5"
09/03/2010	129/80	Sitting	89	16	98.5	131lbs 0oz		5'4.5"
06/21/2010	123/77	Sitting	82	16				5'4.5"
05/24/2010	130/90	Sitting						
05/24/2010	144/81	Sitting	74	16		127lbs 0oz		5'4.5"
04/22/2010	150/96	Sitting						
04/22/2010	172/94	Sitting	94	16		133lbs 0oz		5'4.5"
06/12/2010	128/80	Sitting	62	18	99	127lbs 0oz		5'4.5"
01/12/2009	132/78	Sitting	82	16	99.1			

Orders Tracking

Order Date	Order Name	Status	A/N
07/20/2011	Ferritin (82728)	Returned	
04/29/2011	TSH; Thyroid Stimulating Hormone (84443)	Scheduled	

Clinical Alerts

Name	Alert Name	Description	Note
Colorectal Screening Reminder	Colorectal Screening Reminder		
Breast Cancer Screening Reminder	Breast Cancer Screening Reminder	(Mammograms, Self Breast Exams, Physician Directed	

Immunizations List: none listed

Review of Systems

Constitutional

Denies: fever, night sweats, weight loss, weight gain

Cardiovascular

Denies: cyanosis, varicosities, claudication, lightheadedness

Respiratory

Denies: wheezing, cough

Integument

Denies: itching, skin dryness

Musculoskeletal

Denies: limitation of motion, muscular weakness

Vitals

Date	Time	BP	Position	Body Sit	L/R	Cuff Site	HR	RR	Temp(F)	Wt	HT	BMI (kg/m2)	BSA m2	O2 Sat
09/21/2011	10:46AM	128/78	Sitting	83-R	16					118lbs 0oz	5'4.5"	19.94	1.56	

Physical Examination

Constitutional

Appearance: well-nourished, well-developed, alert, in no acute distress

Eyes

Conjunctivae: conjunctiva normal

Sclerae: sclera white

Pupils and Irises: pupils equal, round and reactive to light and accommodation bilaterally

Respiratory

Respiratory Effort: breathing unlabored

Auscultation of Lungs: normal breath sounds throughout

Cardiovascular

Heart:

Auscultation of Heart: regular rate and rhythm, no murmurs, gallops or rubs

Peripheral Vascular System:

Carotid Arteries: normal pulses bilaterally, no bruits present

Extremities: No cyanosis, clubbing or edema, normal capillary refill, distal hair distribution normal

Musculoskeletal

Right Upper Extremity:

Inspection/Palpation: tenderness to palpation present

Joint Stability: Shoulder, elbow and wrist joint stability normal

Range of Motion: range of motion normal, no joint crepitus or pain with motion present

Left Upper Extremity:

Inspection/Palpation: tenderness to palpation present

Joint Stability: Shoulder, elbow and wrist joint stability normal

Range of Motion: range of motion normal , no joint crepitus, no pain with joint motion

Right Lower Extremity:

Inspection/Palpation: tenderness to palpation present, no edema present, no ecchymosis

Joint Stability: joint stability within normal limits

Range of Motion: range of motion normal, no joint crepitations present, no pain on motion

Left Lower Extremity:

Inspection/Palpation: tenderness to palpation present, no edema present, no ecchymosis

Joint Stability: joint stability within normal limits

Range of Motion: range of motion normal, no joint crepitations present, no pain on motion

Assessment

-Benign essential hypertension – overall stable with satisfactory control 401.1

-Fibromyalgia – 729.1

-Hypothyroidism – 244.9

Plan

Medications:

Cozaar Oral tablet 50mg

Sig: take 1 tablet PO QD for 90 days

Disp: (90) tablets with 1 refill

Adjusted on 09/21/2011

Synthroid Oral tablet 100mcg

Sig: take 1 tablet (100mcg) PO QD for 90 days

Disp: (90) tablets with 3 refills

Adjusted on 09/21/2011

Hydrocodone-acetaminophen Oral tablet 10-500mg

Sig: take 1 tablet PO q4hrs PRN

Disp: (60) tablets with 5 refills

Refilled on 09/21/2011

Instructions:

Disability paper work filled out

Disposition:

Call or RTC if symptoms worsen or persist

RTC in/on 6 months +/- 2 days

Electronically signed b: L D, MD 9/21/11

Chief Complaint

-Routine BP Check
-Follow-up fibromyalgia

History of Present Illness

Chelsie Jones is a 57 year old white, not Hispanic or Latino female, who presents today for her regularly scheduled BP check. Since the last visit on 04/29/2011, she has done fairly well with no interim problems. She remains on Cozaar Oral Tablet 100mg for blood pressure control. She claims additional problems which need addressing at this time; has documented B/P down to 80 systolic at times and has been off meds for 5 days. Her most recent BMI is 19.77 kg/m2 (07/20/2011). There are no additional pertinent medical problems at this time.

The patient returns for a routine maintenance visit for fibromyalgia. The fibromyalgia symptoms have been most noted in the suprasternal notch area, antecubical area, peripatellar area, lesser trochanteric region, sciatic notch area, posterior paracervical and suprascapular region, greater trochanteric area, sternoclavicular joint area, and medial scapular border bilaterally. In the interval since the last office visit, she has been doing fairly well, overall, with respect to symptom control. She denies and additional symptoms potentially related to the disease processes or medications including: dyspepsia and nausea. Her full treatment regimen currently consists of medications including Hydrocodone-Acetaminophen Oral Tablet 10-500mg. Also continues with fatigue and hair loss. Repeat TSH was 4.1 following recent adjustment to 75mgm.

Past Medical History

Significant for ACE Cough; Fibromyalgia, Hypertension; Hypothyroidism

Medication List

Name	Date Started	Instructions
Cozaar oral tablet 100mg	04/29/2011	take 1 tablet (100mg) PO QD for 90 days
Femhrt 1/5 oral tablet 1-5 mg-mcg		take 1 tablet PO QD for 30 days
Hydrocodone-Acetaminophen oral tablet 10-500mg	04/29/2011	take 1 tablet PO q4hrs PRN pain for 10 days
Neurontin oral capsule 300mg	04/29/2011	take 1 capsule (300mg) PO TID for 90 days
Prilosec oral capsule, delayed release 20mg		take 1 capsule (20mg) PO QD AC for 30 days
Synthroid oral tablet 75mcg	05/09/2011	take 1 tablet (75mcg) PO for 30 days

Allergy List

Significant for Lodine

Social History

Significant for denies tobacco use; social alcohol

Electronically signed ……..

PROGRESS NOTE #10

Joan Wilson
2/15/2012

Reason for visit: Urgent care follow-up; elevated potassium
Has suspected low K when she presented with weakness. Eating lots of raisins, bananas, oranges. No HA, syncope, exertional sx, feels OK now, K back to normal, avoiding high K foods.
Allergies listed
Current medication listed (generated from EMR)
Active problems:
Abnormal glucose
Anxiety disorder
Benign polyps of large intestine 7/08
Hx cardiac cath 08/07
Depression
Feeling weak
Hyperlipidemia
Hypertensive heart disease
Mammogram screening
Need for pneumonia vaccine
Osteoarthritis
Osteopenia 09/06
Sinusitis
UTI
Visit for screening exam malignant neoplasm

PMH: cardiac cath 08/07; depression, feeling weak, need for vaccination pneumococcal; UTI;
PSH: appendectomy, breast biopsy, Hernia repair, bilateral, hysterectomy
Family Hx: Atherosclerosis in mother, father stroke and heart disease
Social history: never smoked
ROS
Systemic: not tired, no fever, no chills
Head: no headache
Cardio: no chest pain, no palpitations
Pulmonary: no Dyspnea, no cough, no wheeze
Gastro: no nausea, diarrhea, no heartburn
GU: no increase in urinary frequency
Musculo: no arthralgias, no regional soft tissue swelling
Neuro: no dizziness
Psychologic: no symptoms
Skin: no symptoms

Vitals: recorded by MA BP 120/78 HR: 68 Weight 163

Exam:
General appearance normal, no acute distress
Neck: thyroid not enlarged
Lungs: normal – respiratory movements normal, no decrease in breath sounds, no wheezing, no rhonchi, no rales or crackles
Cardiovascular: system normal – JVD not increased, heart rate is normal, heart sounds normal; no murmurs are heard, apical impulse is normal, no bruit in the carotid, arterial pulses are equal bilaterally and normal, no pitting edema.

Results:Metabolic panel, CBC, Hemaglobin,

Assessment: Hypertensive Heart disease 402.90
Hyperkalemia 276.7
Osteoarthritis 715.90

Plan: medications reviewed, labs reviewed, reviewed nutrition and hydration status
BP, CV stable
K back to normal; eat normally and avoid foods high in potassium.

Electronically signed: George Green, MD