Name: Bo Shang | DOB: 6/6/1988 | MRN: 71453119 | PCP: Wei Yang, MD | Legal Name: Bo Shang

Progress Notes

Wei Yang, MD at 5/10/2023 3:20 PM

CC/Reason for Visit: New patient follow-up

HPI:

34-year-old Asian female 34-year-old Asian male, history of ADHD, anxiety, overweight presented for the first time to me for follow-up.

He brought in his medical record including neural psychological evaluation report from 2017.

He carries a diagnosis of anxiety. Currently not on any medication. He reports that his anxiety was exacerbated by his father's recent violence. Currently his father got a restraining order. Patient felt safe at home living with his mother.

On Vyvanse 70 mg for ADHD inattentive type from his psych provider at Bedford. He usually visit him once a months. He felt the medication was helpful. Denied any headache, insomnia, palpitations, chest pain, diarrhea. But his heart rate was high in the office.

I reviewed his lab from epic. LFT in June 2022 was elevated AST 45 and ALT 120, lipid profile shows TG 626, vitamin D 323, normal CBC and TSH,

Patient also had gout flareup 1 months ago and resolved after ibuprofen treatment. He had flareup once a year.

He drinks alcohol 2 hard liquor daily.

Has dropped 14 pounds in the past months by watching his calorie.

Denied any chills, fever, body ache, cough, short of breath, chest pain, hemoptysis, nausea, vomiting, anorexia, abdominal pain, diarrhea, depression, dysuria, rashes or joint pain.

I reviewed the following during the visit.

There is no problem list on file for this patient.

No past medical history on file.

No past surgical history on file.

Current Outpatient Medications on File Prior to Visit:

Current Outpatient Medications on File Prior to Visit:

Medication	Sig
• VYVANSE 70 mg capsule	
• zolpidem 10 mg tablet	
• multivitamin Oral capsule	Take 1 capsule daily (available over the counter)

No Known Drug Allergies.

Family History

Problem	Relation	Name	Age of Onset
• Other (healthy [Other]) *parents*	Unknown		
• Other (unknown [Other]) *grandparents*	Unknown		
• Other (only child [Other])	Unknown		
• Other (no known CAD, cancer [Other])	Unknown		

Social History

Occupational History
- Occupation: data scientist

Tobacco Use
- Smoking status: Never
- Smokeless tobacco: Never

Substance and Sexual Activity
- Alcohol use: Yes
  - Alcohol/week: 8.3 standard drinks
  - Types: 10 drink(s) per week
- Drug use: No
  - *Comment: not now*
- Sexual activity: Yes
  - *Comment: condom*

Other Topics	Concern
• Occupational Exposure	No
• Special Diet	No
• Exercise	Yes
Comment: 3x week	
• Seat Belt	Yes

Social History Narrative
Single
Lives with roomates

Social Determinants of Health

Transportation Needs: Unmet Transportation Needs
- Lack of Transportation (Medical): Patient refused
- Lack of Transportation (Non-Medical): Yes

Request Assistance: Medium Risk
- Requests Assistance: Yes
- Urgent Assistance Needed: No

Housing Stability: Low Risk
- Housing Situation: Has housing
- Worry about housing loss: No
- Housing Conditions: None of the Above

Safety : Low Risk
- Feels safe at home: Yes

Food Insecurity: Unknown
- Worried About Running Out of Food in the Last Year: Patient refused
- Ran Out of Food in the Last Year: Patient refused

Social Isolation: Medium Risk
- Loneliness or Isolation: Often

Family Needs: Low Risk
- Patient or Family Needs: No needs

Self-management Confidence: Low Risk
- Health self-management confidence: 10

Depression: Low Risk
- Last PHQ-2: 2

ROS: SEE HPI; All other ROS negative

BP (!) 129/90 | Pulse (!) 121 | Ht 5' 8.5" (1.74 m) | Wt 174 lb (78.9 kg) | SpO2 96% | BMI 26.07 kg/m²

Vitals:

	05/10/23 1520	05/10/23 1526	05/10/23 1817
BP:	**(!) 135/92**	**(!) 129/90**	110/70
Pulse:	**(!) 121**		
SpO2:	96%		
Weight:	174 lb (78.9 kg)		
Height:	5' 8.5" (1.74 m)		

PHYSICAL EXAM:

GENERAL APPEARANCE: Alert oriented x3, in no acute distress, speaks in full sentences.
HEAD: Atraumatic. No tenderness or masses noted.
EYES: Anicteric, conjunctivae/corneas clear. PERRLA. EOMI.
NECK: Neck supple. No tenderness. No adenopathy. No carotid bruits and no thyromegaly
BACK: No tenderness over the spine or paraspinal area, full ROM, Straight leg raise negative b/l. No CVA tenderness.
LUNGS: Breath sounds are heard equally in all lung fields. There are no rales, rhonchi, wheezes. There is no cough or dyspnea
CARDIOVASCULAR: RRR. No murmurs, rubs, or gallops.
ABDOMEN: Abdomen soft, non-tender. BS normal. No masses, organomegaly, or hernia. No bruits. NO CVA tenderness.
EXTREMITIES: No joint deformities, edema, or skin discoloration.
PULSES: pulses normal in all 4 extremities.
SKIN: No spider nevi or palmar erythema.
LYMPH NODES: No palpable lymph nodes
NEUROLOGIC: Mental status normal. Reflexes normal and symmetric. Cranial nerves 2-12 intact. Muscle strength 5/5 throughout. Sensation grossly intact. No tremor

ASSESSMENT AND PLAN:

1. Attention deficit hyperactivity disorder (ADHD), predominantly inattentive type
Seems to be well controlled. Continue current dose of Vyvanse. Continue to follow his psych providers. Refer patient to our behavior department for second opinion per request from patient.

- VYVANSE 70 mg capsule
- REFERRAL TO PSYCHIATRY/BEHAVIORAL HEALTH

2. Anxiety
Active. Provided active listening, stress management and relaxation skills. Refer to our behavior department for second opinion per patient's request.
- REFERRAL TO PSYCHIATRY/BEHAVIORAL HEALTH

3. Vitamin D deficiency
Vitamin D3 2000 units daily.
- VITAMIN D 25-HYDROXY TOTAL ONLY; Future

4. Hypertriglyceridemia
Check lab and follow for further management. Advised on low low-fat diet and exercise.
- REFERRAL TO NUTRITION
- LIPID PROFILE; Future

5. LFTs abnormal
ALT was higher than AST. Most likely fatty liver. Less likely alcohol hepatitis. But advised patient to avoid alcohol. Ordered hepatitis work-up.
- HEPATITIS C ANTIBODY W/REFLEX TO PCR; Future
- HEPATITIS B SURFACE ANTIGEN; Future
- HEPATITIS B SURFACE ANTIBODY IMMUNITY QUANTITATIVE; Future
- HEPATITIS B CORE ANTIBODY TOTAL; Future
- BASIC HEMOGRAM NO DIFFERENTIAL; Future

6. Overweight (BMI 25.0-29.9)
Advised on weight loss with calorie watching and exercise. Refer to nutrition for follow-up.
- REFERRAL TO NUTRITION

7. Acute gout of foot, unspecified cause, unspecified laterality
Check uric acid and follow for further management. Currently he is just having flareup once a year. No maintenance needed. Advised on low purine diet and avoid alcohol.
- URIC ACID; Future
- REFERRAL TO NUTRITION

8. Alcohol use
Advised on alcohol abstinence.

9. Tachycardia
EKG in the office showed normal sinus rhythm with a ventricular rate of 98. Patient was assured. This is most likely secondary to Vyvanse or nervousness. But ordered lab to rule out hyperthyroidism and anemia as the cause of tachycardia.
- TSH W/REFLEX; Future
- EKG; Future
- BASIC HEMOGRAM NO DIFFERENTIAL; Future

- EKG

10. Laboratory examination ordered as part of a complete physical examination
Scheduled physical with me in 1 months.
- HEPATITIS C ANTIBODY W/REFLEX TO PCR; Future
- HEPATITIS B SURFACE ANTIGEN; Future
- HEPATITIS B SURFACE ANTIBODY IMMUNITY QUANTITATIVE; Future
- HEPATITIS B CORE ANTIBODY TOTAL; Future
- HEMOGLOBIN A1C; Future
- LIPID PROFILE; Future

11. Primary insomnia
- zolpidem 10 mg tablet

Total time 60 minutes including pre-charting review and post visit documentation.

Have questions about medical language? Medline Plus is a great resource for exploring medical terms and abbreviations.