

TRAMONTOZZI, KATHLEEN M

56 Y old Female, DOB: 03/21/1963 Account Number: 18945

4 PAUL COURT, WASHINGTONVILLE, NY-10992

Home: 845-496-8881 Guarantor: TRAMONTOZZI, KATHLEEN Insurance: BS ORANGEULSTER Payer ID: PAPER

PCP: Andrew Hirsch Referring: Andrew Hirsch, DO External Visit ID: 4613877

Appointment Facility: HMG Goshen

03/05/2020

Progress Note: Madeleine Ziegler, NP

Current Medications

GlyCogenics 1 per day by mouth

Red Yeast Rice 900 mg Capsule 2 tabs Orally daily

 Aspirin 8t MG Tablet Delayed Release 1 tablet Orally Once a day

DHA Omega 3 100 MG Capsule Orally

Amlodipine Besylate 5MG Tablet 1 tablet orally once a day

ProAir HFA 108 (90 Base) MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 6 hrs, Notes: PRN

Venlafaxine HCl 25MG Tablet 1 tablet orally once a day

Coreg CR 20MG Capsule Extended Release 24 Hour TAKE 1 CAPSULE ONCE DAILY WITH FOOD

 Fish Oil 1000 MG Capsule 1 capsule Orally Once a day

 B Complex - Tablet as directed Orally Discontinued

Cefdinir 300 MG Capsule 1 cap Orally twice a day

 Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension, Benign (401.1);. B12 Defic Anemia Ot (281.1);. Dis Iron Metabolism (275.0), comments:hemochromatosis carrier;. Benign Neo Bone Unspec (213.9), comments:osteoid osteoma skull;. Impaired Fasting Glucose (790.21):.

Hyperlipidemia (272.2);. Genetic Susceptibility To Other Disease

(V84.89), comments: •MTHFR 2copies A snp - homozygous ;.

Anomal SkullFace Bones (756.0) (since-04-30-2010);. Hand Injury Unspec (959.4) (since- 01-

28-2011); Impaired Fasting Glucose.

Lipoma.

Linoma.

History of hysterectomy.

History of Present Illness

Pre-Op:

Procedure: lump left arm.

Where: ormc. When: 3/11/20. Surgeon: Dr.peralo.

Pt is feeling generally well. Having lump removed from her left

arm. It has been there a few years but is starting to grow.

Pt denies any chest pain or SOB with walking up 2 flights of stairs or the length of the mall.

Vital Signs

Temp 97.4 F, BP 120/70 mm Hg, Ht 62.5 in, Wt 168 lbs, BMI 30.23 Index.

Examination

*General Examination:

GENERAL APPEARANCE: alert, in no distress.

EYES: extraocular movement full and smooth, sclera non-icteric, pupils equal, round, reactive to light and accommodation, conjunctiva

EARS: auditory canal clear, tympanic membrane intact, clear, hearing intact to whispered voice.

NOSE: nares patent B/L, sinuses nontender bilaterally.

ORAL CAVITY: mucosa moist, no lesions.

THROAT: no erythema, no exudate.

NECK/THYROID: no cervical lymphadenopathy, no thyromegaly, no carotid bruit.

SKIN: no rashes.

HEART: regular rate and rhythm, S1, S2 normal.

LUNGS: clear to auscultation bilaterally.

ABDOMEN: soft, nontender, no organomegaly.

MUSCULOSKELETAL: no joint swelling or tenderness.

EXTREMITIES: no bipedal edema.

NEUROLOGIC: alert and oriented, cranial nerves 2-12 grossly intact, motor strength normal upper and lower extremities, sensory exam intact, deep tendon reflexes 2+ symmetrical, no tremor.

Assessments

Patient: TRAMONTOZZI, KATHLEEN M DOB: 03/21/1963 Progress Note: Madeleine Ziegler, NP 03/05/2020

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Former smoker. Former smoker.

From:

Surgical History

hysterectomy sinus surgery 7/2014

Family History

Father: deceased, Heart attack, diagnosed with No Known Family History Mother: alive, No Known Family History Siblings: sister MI @ age 54 Children: son-25, SVT with arrest, defib in place

4 brother(s) , 1 sister(s) . 2 son(s) , 1 daughter (s) - healthy.

1 Brother deceased mva.

Social History

Tobacco Use: Tobacco Use/Smoking Are you a former smoker How long has it been since you last smoked? > 10 years

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems

General/Constitutional:

Fatigue denies. Fever denies. Weight gain denies. Weight loss denies. Ophthalmologie:

Blurred vision denies. Pain denies.

Ear pain admits. Sinus pain denies. Sore throat denics.

Respiratory

Patient denies cough, hemoptysis, shortness of breath, wheezing. Cardiovascular:

Patient denies chest pain, palpitations or dyspnea on exertion.

Gastrointestinal:

Abdominal pain denies. Change in bowel habits denies. Nausea denies. Vomiting denies.

Genitourinary:

Blood in urine denies. Frequent urination denies. Painful urination denies. Musculoskeletal:

Muscle aches denies. Painful

- 1. Preoperative clearance Zo1.818 (Primary)
- 2. Mass of left upper extremity R22.32

EKG reviewed with no significant change from previous 2014. Labs reviewed. Normal.

Pt is medically cleared for procedure.

Treatment

1. Preoperative clearance

Start Xyzal Allergy 24HR Tablet, 5 MG, 1 tablet in the evening, Orally, Once a day, 90 day(s), 90, Refills 3

IMAGING: Electrocardiogram (EKG)

Procedure Codes

93000 ELECTROCARDIOGRAM, COMPLETE

Follow Up

prn

Made Gr. Nt

Electronically signed by Madeleine Ziegler, NP on 03/05/2020 at 03:20 PM EST

Sign off status: Completed

HMG Goshen 30 Hatfield Lane GOSHEN, NY 10924 Tel: 845-294-2733 Fax: 845-615-9744

joints denies.

Skin:

Rash denies. Skin lesion(s) denies.

From:

<u>Neurologic</u>:

Dizziness denies. Headache denies. Loss of strength denies. Memory loss denies. Seizures denies.

Tingling/Numbness denies.

Tremor denies.

Psvehiatrie:

Anxiety denies. Depressed

mood denics.

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TRAMONTOZZI, KATHLEEN M, F, 03/21/1963



FINAL RESULT

	Accession ID: 1233452	Lab Ref ID; 8885089		
f				
1	Order Date: 03/03/2020	Result Recd: 03/04/2020 15:16:00		
ì	+-+			
í	Coll. Date: 03/04/2020 06:30:00	Report: 03/04/2020 06:30:00		
\	Requesting Physician: Peralo, John	Ordering Physician: Peralo, John		
	requesting raysician, retail, John	Ordering Physician: Perallo, Solin		

BMP

NAME	VALUE	REFERENCE RANGE				
F BUN	16	7-25 (mg/dL)				
F CREATININE	0.79	0.60-1.40 (mg/dL)				
F BUN/CREAT RATIO	20.3	8.0-36.0				
F SODIUM	141	135-145 (meg/L)				
F POTASSIUM	4.0	3.5-5.3 (meg/L)				
F CHLORIDE	104	98-109 (meg/L)				
F CO2	29	21-33 (meg/L)				
F CALCIUM	9.6	8.2-10.3 (mg/dL)				
F GLUCOSE	109 H	70-99 (mg/dL)				
- Non-Fasting reference range is	70-139 mg/dl					
F GFR	0.08					
- If the patient is African American, multiply the GFR by 1.210						
- Stages of chronic kidney disease and clinical action plans						
- Stage Description GFR Clinical Action Plan						
- 1 Kidney damage with => 90 Diagnosis and treatment, slow						
- normal or elevated GFR progression, CVD risk reduction						
- 2 Kidney damage with mild 60 - 89 Estimating progression						
- decrease GFR						
- 3 Moderate decrease GFR 30 -59 Evaluating and treating complications						
- 4 Severe decrease GFR 15 -29 Preparation for kidney replacement therapy						
- 5 Kidney Failure < 15 Kidney replacement therapy (if uremia						
- present and patient desirable)						
- National Kidney Foundation. K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease:						
- Evaluation, Classification and Stratification.						
FASTING						

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CBC (INCLUDES DIFF/PLATELET)

NAME	VALUE	REFERENCE RANGE				
F WBC	4.1	3.8-10.8 (K/uL)				
F RBC	4.79	4.00-6.00 (m/uL)				
F HGB	14.2	11.7-15.5 (g/dL)				
F HCT	43.7	34.0-49.0 (%)				
F MCV	91.2	80.0-99.9 (fL)				
F MCH	29.6	27.0-33.0 (pg)				
F MCHC	32.5	32.0-36.0 (g/dL)				
F RDW	13.1	11.0-15.0 (%)				
F PLATELET	S 224.0	150.0-400.0 (K/uL)				
F MPV	7.7	7.4-10.4				
F NEUTRO %	48.7	38.0-80.0 (%)				
F LYMPH %	40.6	20.0-50.0 (%)				
F MONO %	6.9	2.0-10.0 (%)				
F EOSIN %	3.3	0.0-8.0 (%)				
F BASO %	0.5	0.0-2.0 (%)				
F NEUTRO#	2.0	Z.0-8.0 (K/uL)				
F LYMPH#	1.7	1.0-5.0 (K/uL)				
F MONO#	0.3	0.1-1.1 (K/uL)				
F EOSIN#	0.1	0.0-0.4 (K/uL)				
F BASO#	0,0	0.0-0.2 (K/uL)				
FASTING						

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