Sample Type / Medical Specialty: General Medicine

Sample Name: Patient with High Potassium
Description: Patient in emergency room due to high potassium value.

(Medical Transcription Sample Report)

CHIEF COMPLAINT: "My potassium is high"

HISTORY OF PRESENT ILLNESS: A 47-year-old Latin American man presented to the emergency room after being told to come in for a high potassium value drawn the previous day. He had gone to an outside clinic the day prior to presentation complaining of weakness and fatigue. Labs drawn there revealed a potassium of 7.0 and he was told to come here for further evaluation. At time of his assessment in the emergency room, he noted general malaise and fatigue for eight months. Over this same time period he had subjective fevers and chills, night sweats, and a twenty-pound weight loss. He described anorexia with occasional nausea and vomiting of non-bilious material along with a feeling of light-headedness that occurred shortly after standing from a sitting or lying position. He denied a productive cough but did note chronic left sided upper back pain located in the ribs that was worse with cough and better with massage. He denied orthopnea or paroxysmal nocturnal dyspnea but did become dyspneic after walking 2-3 blocks where before he had been able to jog 2-3 miles. He also noted that over the past year his left testicle had been getting progressively more swollen and painful. He had been seen for this at the onset of symptoms and given a course of antibiotics without improvement. Over the last several months there had been chronic drainage of yellowish material from this testicle. He denied trauma to this area. He denied diarrhea or constipation, changes in his urinary habits, rashes or skin changes, arthritis, arthralgias, abdominal pain, headache or visual changes.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: Mone.

MEDICATIONS: Occasional acetaminophen.

ALLERGIES: NKDA.

SOCIAL HISTORY: He drank a 6 pack of beer per day for the past 30 years. He smoked a pack and a half of cigarettes per day for the past 35 years. He was currently unemployed but had worked as a mechanic and as a carpet layer in the past. He had been briefly incarcerated 5 years prior to admission. He denied intravenous drug use or unprotected sexual exposures.

FAMILY HISTORY: There was a history of coronary artery disease and diabetes mellitus in the family.

PHYSICAL EXAM:
VITAL SIGNS - Temp 98.6° F, Respirations 16/minute Lying down - Blood pressure 109/70, pulse 70/minute Sitting - Blood pressure 78/65, pulse 79/minute Standing - Blood pressure 83/70, pulse 95/minute GENERAL: well developed, well nourished, no acute distress HEENT: Normocephalic, atraumatic. Sclerae anicteric. Oropharynx with hyperpigmented patches on the mucosa of the palate. No oral thrush. No lymphadenopathy. No jugular venous distension. No thyromegaly. Neck supple. LUNGS: Decreased intensity of breath sounds throughout without adventitious sounds. No dullness to percussion or changes in fremitus. CARDIOVASCULAR: Regular rate and rhythm. No murmurs, gallops, or rubs. Normal intensity of heart sounds. Normal peripheral pulses. ABDOMEN: Soft, non-tender, non-distended. Positive bowel sounds. No organomegaly. RECTAL: Normal sphincter tone. No masses. Normal prostate. Guaiac negative stool. GENITOURINARY: Left