Sample Type / Medical Specialty: General Medicine

Sample Name: Gen Med Progress Note - 10
Description: Patient comes in for two-month followup - Hypertension, family history of CVA, Compression fracture of L1, and osteoarthritis of knee.

(Medical Transcription Sample Report)

CHIEF COMPLAINT: The patient is here for two-month followup.

HISTORY OF PRESENT ILLNESS: The patient is a 55-year-old Caucasian female. She has hypertension. She has had no difficulties with chest pain. She has some shortness of breath only at walking up the stairs. She has occasional lightheadedness only if she bends over then stands up quickly. She has had no nausea, vomiting, or diarrhea. She does have severe osteoarthritis of the left knee and is likely going to undergo total knee replacement with Dr. XYZ in January of this coming year. The patient is wanting to lose weight before her surgery. She is concerned about possible coronary disease or stroke risk. She has not had any symptoms of cardiac disease other than some shortness of breath with exertion, which she states has been fairly stable. She has had fairly normal lipid panel, last being checked on 11/26/2003. Cholesterol was 194, triglycerides 118, HDL 41, and LDL 129. The patient is a nonsmoker. Her fasting glucose in November 2003 was within normal limits at 94. Her fasting insulin level was normal. Repeat nonfasting glucose was 109 on 06/22/2004. She does not have history of diabetes. She does not exercise regularly and is not able to because of knee pain. She also has had difficulties with low back pain. X-ray of the low back did show a mild compression fracture of L1. She has had no falls that would contribute to a compression fracture. She has had a normal DEXA scan on 11/07/2003 that does not really correlate with having a compression fracture of the lumbar spine; however, it is possible that arthritis could contribute to falsely high bone density reading on DEXA scan. She is wanting to consider treatment for prevention of further compression fractures and possible osteoporosis.

CURRENT MEDICATIONS: Hydrochlorothiazide 12.5 mg a day, Prozac 20 mg a day, Vioxx 25 mg a day, vitamin C 250 mg daily, vitamin E three to four tablets daily, calcium with D 1500 mg daily, multivitamin daily, aspirin 81 mg daily, Monopril 40 mg daily, Celexa p.r.n.

ALLERGIES: Bactrim, which causes nausea and vomiting, and adhesive tape.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Depression.
3. Myofascitis of the feet.
4. Severe osteoarthritis of the knee.
5. Removal of the melanoma from the right thigh in 1984.
6. Breast biopsy in January of 1997, which was benign.
7. History of Holter monitor showing ectopic beat. Echocardiogram was normal. These were in 1998.
8. Compression fracture of L1, unknown cause. She had had no injury. Interestingly, DEXA scan was normal 11/07/2003, which is somewhat conflicting.

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

REVIEW OF SYSTEMS: As per the HPI.

PHYSICAL EXAMINATION:
General: This is a well-developed, well-nourished, pleasant Caucasian female, who is overweight.
Vital signs: Weight: Refused. Blood pressure: 148/82, on recheck by myself