Sample Type / Medical Specialty: General Medicine

Sample Name: Gen Med Consult - 9
Description: Comprehensive Evaluation - Diabetes, hypertension, irritable bowel syndrome, and insomnia.

(Medical Transcription Sample Report)

SUBJECTIVE: The patient is well-known to me. He comes in today for a comprehensive evaluation. Really, again he borders on health crises with high blood pressure, diabetes, and obesity. He states that he has reached a critical decision in the last week that he understands that he cannot continue with his health decisions as they have been made, specifically the lack of exercise, the obesity, the poor eating habits, etc. He knows better and has been through some diabetes training. In fact, interestingly enough, with his current medications which include the Lantus at 30 units along with Actos, glyburide, and metformin, he achieved ideal blood sugar control back in August 2004. Since that time he has gone off of his regimen of appropriate eating, and has had sugars that are running on average too high at about 178 over the last 14 days. He has had elevated blood pressure. His other concerns include allergic symptoms. He has had irritable bowel syndrome with some cramping. He has had some rectal bleeding in recent days. Also once he wakes up he has significant difficulty in getting back to sleep. He has had no rectal pain, just the bleeding associated with that.

MEDICATIONS/ALLERGIES: As above.

PAST MEDICAL/SURGICAL HISTORY: Reviewed and updated - see Health Summary Form for details.

FAMILY AND SOCIAL HISTORY: Reviewed and updated - see Health Summary Form for details.

REVIEW OF SYSTEMS: Constitutional, Eyes, ENT/Mouth, Cardiovascular, Respiratory, GI, GU, Musculoskeletal, Skin/Breasts, Neurologic, Psychiatric, Endocrine, Heme/Lymph, Allergies/Immune all negative with the following exceptions: None.

PHYSICAL EXAMINATION:
VITAL SIGNS: As above.
GENERAL: The patient is alert, oriented, well-developed, obese male who is in no acute distress.
HEENT: PERRLA. EOMI. TMs clear bilaterally. Nose and throat clear.
NECK: Supple without adenopathy or thyromegaly. Carotid pulses palpably normal without bruit.
CHEST: No chest wall tenderness or breast enlargement.
HEART: Regular rate and rhythm without murmur, clicks, or rubs.
LUNGS: Clear to auscultation and percussion.
ABDOMEN: Significantly obese without any discernible organomegaly. GU: Normal male genitalia without testicular abnormalities, inguinal adenopathy, or hernia.
RECTAL: Smooth, nonenlarged prostate with just some irritation around the rectum itself. No hemorrhoids are noted.
EXTREMITIES: Some slow healing over the tibia. Without clubbing, cyanosis, or edema. Peripheral pulses within normal limits.
NEUROLOGIC: Cranial nerves II-XII intact. Strength, sensation, coordination, and reflexes all within normal limits.
SKIN: Noted to be normal. No subcutaneous masses noted.
LYMPH SYSTEM: No lymphadenopathy noted.
BACK: He has pain in his back in general.

ASSESSMENT/PLAN: