Sample Type / Medical Specialty: General Medicine

Sample Name: Gen Med Consult - 30

Description: Patient was found to have decrease in mental alertness

(Medical Transcription Sample Report)

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CHIEF COMPLAINT: Mental changes today.

HISTORY OF PRESENT ILLNESS: This patient is a resident from Mazatlan, Mexico, visiting her son here in Utah, with a history of diabetes. She usually does not take her meal on time, and also not having her regular meals lately. The patient usually still takes her diabetic medication. Today, the patient was found to have decrease in mental alertness, but no other GI symptoms. Some sweating and agitation, but no fever or chills. No other rash. Because of the above symptoms, the patient was treated in the emergency department here. She was found to glucose in 30 range, and hypertension. There was some question whether she also take her blood pressure medication or not. Because of the above symptoms, the patient was admitted to the hospital for further care. The patient was given labetalol IV and also Norvasc blood pressure, and also some glucose supplement. At this time, the patient's glucose was in the 175 range.

PAST MEDICAL HISTORY: Diabetes, hypertension.

PAST SURGICAL HISTORY: None.

FAMILY HISTORY: Unremarkable.

ALLERGIES: No known drug allergies.

MEDICATIONS: In Spanish label. They are the diabetic medication, and also blood pressure medication. She also takes aspirin a day.

SOCIAL HISTORY: The patient is a Mazatlan, Mexico resident, visiting her son here.

PHYSICAL EXAMINATION:

GENERAL: The patient appears to be no acute distress, resting comfortably in bed, alert, oriented x3, and coherent through interpreter.

HEENT: Clear, atraumatic, normocephalic. No sinus tenderness. No obvious head injury or any laceration. Extraocular movements are intact. Dry mucosal linings.

HEART: Regular rate and rhythm, without murmur. Normal S1, S2.

LUNGS: Clear. No rales. No wheeze. Good excursion.

ABDOMEN: Soft, active bowel sounds in 4 quarters, nontender, no organomegaly.

EXTREMITIES: No edema, clubbing, or cyanosis. No rash.

LABORATORY FINDINGS: On Admission: CPK, troponin are negative. CMP is remarkable for glucose of 33. BMP is remarkable for BUN of 60, creatinine is 4.3, potassium 4.7. Urinalysis shows specific gravity of 10.30. CT of the brain showed no hemorrhage. Chest x-ray showed no acute cardiomegaly or any infiltrates.

IMPRESSION:

1. Hypoglycemia due to not eating her meals on a regular basis.

2. Hypertension.

3. Renal insufficiency, may be dehydration, or diabetic nephropathy.

PLAN: Admit the patient to the medical ward, IV fluid, glucometer checks, and adjust the blood pressure medication and also diabetic medication.