HISTORY OF PRESENT ILLNESS: This is a (XX)-year-old white male who went to the emergency room with sudden onset of severe left flank and left lower quadrant abdominal pain associated with gross hematuria. The patient had a CT stone profile which showed no evidence of renal calculi. He was referred for urologic evaluation. When seen in our office, the patient continued to have mild left flank pain and no difficultly voiding. Urinalysis showed 1+ occult blood. Intravenous pyelogram was done which demonstrated a low-lying malrotated right kidney. There was no evidence of renal or ureteral calculi or hydronephrosis. Urine cytology was negative for malignant cells.

The patient subsequently had a CT renal scan with contrast. This showed what appeared to be an infarction of an area of the lower pole of the left kidney. It was suggested that a renal MRI be done for further delineation of this problem. He had a right kidney which was malrotated but was otherwise normal. The patient is admitted at this time for complete urologic evaluation.

PAST MEDICAL HISTORY: He had surgery on his right knee two years ago.

MEDICATIONS: He takes:

1. Diovan 80 mg with hydrochlorothiazide 12.5 mg daily.
2. Hydrocodone as needed for pain.

ALLERGIES: There are no known drug allergies.

SOCIAL HISTORY: He is single. Denies use of alcohol. Smokes one pack of cigarettes per day over the last 10 years.

FAMILY HISTORY: Father died of cancer, type unknown. Mother is living and well.

REVIEW OF SYSTEMS: Neurologic: Denies vertigo, syncope, convulsions or headaches. Musculoskeletal: No muscle or joint pain. Cardiorespiratory: Denies shortness of breath, dyspnea on exertion, chest pain, cough or hemoptysis. Gastrointestinal: He has occasional indigestion. Denies emesis, melena, constipation, diarrhea or rectal bleeding. Genitourinary: As noted in HPI.

PHYSICAL EXAMINATION:

VITAL SIGNS: Pulse is 72 and regular, respirations 18 and regular, blood pressure 122/78.

GENERAL: Well-developed, well-nourished white male in no acute distress. Alert and cooperative.

HEENT: Pupils are equal, round and reactive to light and accommodation. Extraocular movements are intact. Pharynx is clear. Tympanic membranes are normal.

NECK: Supple. No thyromegaly. No cervical adenopathy.

CHEST: Symmetrical with equal expansion.

LUNGS: Clear to percussion and auscultation.

HEART: No cardiomegaly. No thrills or murmurs. Normal sinus rate and rhythm.

ABDOMEN: There is slight left flank tenderness to deep palpation. There is no guarding or rebound tenderness. Bowel soundsare normal.

EXTREMITIES: No peripheral edema or varicosities.

GENITALIA: Normal external male genitalia. No penile lesions. Testes are descended bilaterally and are normal topalpation.

RECTAL: The prostate is small, benign and nontender.

IMPRESSION: Hematuria associated with left flank pain and left renal infarction.

PLAN: Admitted at the present time for further evaluation.

History and Physical Medical Transcription Sample Report #2

DATE OF ADMISSION: MM/DD/YYYY

HISTORY OF PRESENT ILLNESS: The patient is a (XX)-year-old Hispanic female with history of severe hypertension, diabetes mellitus, cerebrovascular disease, status post CVA x4 previously, and right-sided hemiplegia. She was found down at home by her niece about a week ago. Niece stated that she spoke to the patient a week ago, over the phone.

At that time, she noticed that the patient had some problems communicating with confusing statements and slurred speech. The patient's niece said she went over to evaluate the patient, at which time the patient had no additional complaints and was reported to be behaving at baseline. She stated, however, she was more sleepy than usual, and over the next three to four days, it was reported to the niece that she had been sleeping more throughout the day and eating little, which is a change from her daily routine. After approximately four to five days, the niece decided to take the patient to the emergency room for additional evaluation.

The patient was admitted to the emergency room. Evaluation took place. At that time, a CT scan of the head was obtained, results of which are not available at this time. The patient was however admitted for hypotension. At that time, she was found to have a blood pressure of approximately 58/42 and dehydration. Hospital stay was otherwise apparently uncomplicated with the exception of episodes of severe and almost malignant hypertension, which the patient has had in the past as well as renal insufficiency, acute on chronic in nature. Renal insufficiency was additionally treated with hydration and slowly resolved.

As for hypertension, it did respond to medication, although, the patient still continues to run with a systolic blood pressure of 170-190. She has had no additional sequelae and no new long-term neurological deficits were reported.

PAST MEDICAL HISTORY: Arterial occlusive disease, hypertension, type 2 diabetes and post CVA with right-sided hemiplegia. No anticoagulation. Right-side hemiplegia secondary to CVA, approximately one year ago. Mild expressive aphasia, status post CVA one year ago. History of acute renal insufficiency; history of chronic renal insufficiency with baseline creatinine of 1.4 to 1.5; history of anemia, type unknown; history of mental status change, possibly secondary to dehydration/hypotension; and history of dehydration.

PAST SURGICAL HISTORY: Numerous abdominal surgeries.

MEDICATIONS: Aspirin 81 mg daily, Imdur 60 mg daily, Colace 100 mg b.i.d., folic acid 1 daily, Ditropan XL 5 mg b.i.d., Glucophage 250 mg b.i.d., glyburide 1.25 mg b.i.d., Lopressor 100 mg daily, clonidine 0.3 mg a day and clonidine 1 mg q.4 h. for systolic blood pressures greater than 80.

ALLERGIES: SHE IS ALLERGIC TO SHELLFISH AND ADHESIVE TAPE.

SOCIAL HISTORY: She is retired. She lives at home. No history of tobacco or alcohol.

FAMILY HISTORY: Negative, except that she had a brother with CVA, as well as mother who died of an MI and had diabetes. There is no known history of claudication, sickle cell anemia or any neurological disorders.

REVIEW OF SYSTEMS: She has had right-sided hemiplegia. She has denied any additional signs or symptoms of ongoing CVA or TIAs. She denies amaurosis fugax. No auditory or visual changes. She denies any hair, nail or skin changes, weight changes,

heat or cold intolerance. No bladder or bowel changes, chest pain, shortness of breath or cough. No edema or erythema of her extremities.

PHYSICAL EXAMINATION:

GENERAL: The patient is a well-developed, well-nourished, obese Hispanic female, pleasant, in no apparent distress. She is afebrile.

VITAL SIGNS: Stable. Blood pressure 205/92, pulse 78 and regular, respiratory rate 18-22, unlabored.

SKIN: Warm and dry with good color. Lower extremity skin is rather cool but has good color. She has numerous surgical incisions, well healed. There is no rash. No tissue breakdown, bleeding or bruising. She has a small amount of bruising on the left extremity consistent with phlebotomy but otherwise unremarkable.

HEENT: Normocephalic and atraumatic. PERRLA. EOMI. No gross APD. She has conjugate gaze. Fundi appear otherwise unremarkable. Oral and nasal mucosa are unremarkable. She has had some left-sided facial droop but I appreciate none at this point in time. She has normal midline structures. Oral mucosa is moist and pink. She is edentulous.

NECK: Soft and supple. No gross thyromegaly or bruits. No anterior/posterior cervical adenopathy. Range of motion appears normal and unremarkable.

BACK AND SPINE: Nontender.

HEART: Regular rate and rhythm with 1/6 systolic ejection murmur. No rub or gallop.

CHEST: Fairly clear. She has faint expiratory wheezes, particularly on the left compared to the right. These are faint. Right side has fair breath sounds. She has fair respiratory effort. No coarse rhonchi or rales are appreciated. Equal chest wall expansion.

ABDOMEN: Obese. Healed surgical wounds. Bowel sounds are active. No rebound, guarding, pulsating mass or bruits. She has no CVA or suprapubic tenderness. She has numerous palpable hernias throughout her abdomen. There are no active bowel sounds in these areas.

PELVIC: Normal-appearing female.

EXTREMITIES: No clubbing or cyanosis. Trace edema, right side worse than left. As noted above, distal extremities are slightly cool to touch. However, distal pulses are 2+ and equal, symmetrical, dorsalis pedis, posterior tibial. There is no gross tissue breakdown.

NEUROLOGICAL: She is mildly hyperreflexive. Sensorium is intact in her upper and lower extremities. She has 1/5 strength and motion with just a mild palmar flexion in the right upper extremity. She has very faint movement of her foot on the right side, less than 1/5 in general. Left side is otherwise unremarkable with 4/5 strength. Grip as well as reflexes are normoreflexive. Neurologically, she appears grossly intact. She is aware of the month, date and time, as well as where she is presently located, also aware of the president and season. Do not appreciate any gross neurological deficits.

ASSESSMENT AND PLAN:

1. Mental status change, etiology unknown. CT scan was performed, results are not available at this time. Possibly secondary to hypertensive crisis/onset of cerebrovascular disease, new/transient ischemic attack. We will continue to treat blood pressure as well as blood sugars as necessary. I cannot appreciate any type of infection causing these reactions. However, I may consider followup blood cultures or follow up any additional tests obtained.

2. History of cerebrovascular accident/transient ischemic attack. The patient has a history of at least four in the past with residual right hemiplegia up until one year ago. At home, she states she is on aspirin only but was on Coumadin sometime in the past, but this stopped a number of years ago. I do not have any report finding consistent with

lower extremity deep venous thrombosis or cancer or other possible etiologies for embolic ischemic events. I may consider obtaining old medical records for evaluation of etiology. I placed the patient on Fragmin 5000 subcutaneous daily as well as continuing the aspirin daily.
3. Diabetes mellitus. Fingerstick blood sugars q.a.c. and h.s. Sliding scale insulin will be written for as well as routine medication. Continue to follow closely.
4. Hypertension. We will continue with clonidine as recommended and additional Lopressor and may consider nitroglycerin patch on a p.r.n. basis for elevated blood pressures. Consider obtaining electrocardiogram for baseline. Labs results, CBC, will be obtained.
5. Chronic renal insufficiency. I will obtain BUN and creatinine and continue to follow. PT/OT and speech consultations have been requested.

History and Physical Medical Transcription Sample Report #3

DATE OF ADMISSION: MM/DD/YYYY

HISTORY OF PRESENT ILLNESS: This is a (XX)-year-old previously healthy male who went out for a party a night and a half ago. Everyone in the party apparently had problems afterwards with regard to their belly. He awoke Sunday morning with pain in his abdomen. His pain continued, periumbilical and apparently now has traversed to the right lower quadrant. He states he is in significant pain. He had some nausea but no vomiting at present. He did vomit yesterday. He had a normal bowel movement today. No history of inflammatory bowel disease, colon cancer, abdominal operations or bleeding. No urinary tract symptomatology.

PAST MEDICAL HISTORY: History of back pain.

MEDICATIONS: None.

ALLERGIES: None.

SOCIAL HISTORY: Positive for marijuana. No smoking.

FAMILY HISTORY: Unremarkable.

REVIEW OF SYSTEMS: As per ER intake chart.

PHYSICAL EXAMINATION:

HEENT: No scleral icterus.
NECK: Unremarkable.
HEART: No findings.
LUNGS: No findings.
ABDOMEN: Exquisite right lower quadrant tenderness without rigidity. Positive focal rebound. No masses.
RECTAL: Deferred.
EXTREMITIES: Unremarkable.

LABORATORY AND DIAGNOSTIC STUDIES: White blood count is 22, otherwise unremarkable. A CAT scan was reviewed. The patient has clear-cut possible retrocecal appendicitis.

ASSESSMENT: Appendicitis.

RECOMMENDATIONS/PLAN: The patient has received antibiotics. The patient has received hydration. The patient has been consented for laparoscopic, possible open, appendectomy. We will place bilateral sequential compression devices and call the operating room to have him scheduled as soon as possible. I discussed with him the exact nature of the surgery and the risks including but not limited to bleeding, infection, death, injury. All questions were answered and he wished to proceed with surgery.