PAST MEDICAL HISTORY

Patient has a past medical history of Anxiety, Disease of thyroid gland, Migraine, Obstructive sleep apnea i Prediabetes.

She has no past medical history of Angina pectoris (CMS/HCC), Arthritis, Asthma, Atrial fibrillation (CMS/HCC), Awareness under anesthesia, Basal cell carcinoma, Cancer (CMS/HCC), Chronic kidney disease, Chronic pain disorder, Chronic renal failure, COPD (chronic obstructive pulmonary disease) (CMS/HCC), Deep vein thrombosis (CMS/HCC), Delayed emergence from general anesthesia, Depression, Diabetes mellitus type I (CMS/HCC), Diabetic retinopathy (CMS/HCC), Dry eyes, Epilepsy (CMS/HCC), Eye trauma, GERD (gastroesophageal reflux disease), Glaucoma, Hard to intubate, Heart disease, Heart murmur, Hiatal hemia, HIV disease (CMS/HCC), Hypertension, Hypertensive retinopathy, Infectious viral hepatitis, Macular degeneration, Malignant hyperthermia, Melanoma (CMS/HCC), Mitral valve prolapse, Motion sickness, Myocardial infarction (CMS/HCC), Parkinson's disease (CMS/HCC), Peptic ulceration, PONV (postoperative nausea and vomiting), Pseudocholinesterase deficiency, attack), Tuberculosis, Type 2diabetes mellitus (CMS/HCC), or Valvular disease. PA S T

VACCINE HISTORY

1. Polio
2. Measles
3. ChickenPox
4. COVID
5. Tetnaus, Diphtheria
6. Flu Shot
7. Yellow Fever
8. Rabies

SURGICAL HISTORY

1. Pr explore parathyroid glands n/a. Procedure: neck exploration with parathyroidectomy
2. Pr strabismus surg, two horiz muscle
3. Right Procedure: strabismus surgery, right eye, Ophthalmology
4. Skin Graft: suffered burns and skin grafts from truck explosion
5. Tubal Ligation

SOCIAL HISTORY

Reports that she has been smoking cigarettes. She has quit using smokeless tobacco. She reports current alconol use of about 3.0 standard drinks of alcohol per week. She reports that she does not use drugs.

VITALS

Patient performed vitals:
There were no vitals filed for this visit.

VIDEO EXAM VIA TELEMEDICINE

1. **General:** well appearing. does not appear to be in acute distress.
2. **Eyes:** Conjunctiva clear.
3. **Cardiac:** Well perfused skin, no flushing, none cyanosis noted
4. **Pulmonary:** Pulmonary effort regular, no distress. Speaking in full sentences without respiratory distress. Cough was not audible during the video visit.
5. **Neuro:** alert and oriented times 3. Patient is answering questions appropriately

ASSESSMENT & PLAN

1. Generalized anxiety disorder (Primary) - LORazepam; TAKE 1 TO 2 TABLETS BY MOUTH EVERY 6 HOURS AS NEEDED -FOR ANXIETY Dispense: 30 tablet; Refill: 0
2. Hypothyroidism, unspecified type
3. Prediabetes.
4. Generalized anxiety disorder. Refill lorazepam.
5. Hypothyroid-continue levothyroxine
6. Prediabetes-check hemoglobin A1c
7. Medication(s) use, benefits, and side effects reviewed. If symptoms persist, make a folow up appointment. For worsening or new onset of symptoms, go to Urgent Care or Emergency room.
8. ER precautions advised. Patient verbalized understanding and is agreeable to plan of care. Patient's question(s) were answered

FOLLOW UP

No follow-ups on file.

SIGNATURE

I saw this patient via an interactive audio and video telecommunications system.