Joe Smith

Male – 52 years old, Blood Pressure: 145/115, Pulse: 83, Height: 6'1", Weight: 210 lb, Temperature: 96.5F, Respiratory: 57

CC: diabetes follow up. A1C is too high and can't really control it properly

Encounter: add on the left encounter note as follows:

Eyes:

- No xanthelasma, no ptosis, no scleral jaundice, no redness, no discharge of conjunctiva. No periorbital hematoma, subconjunctival hemorrhage. No foreign body, no hyphema. No corneal abrasion. No stye. No conjunctival injection. No foreign body.
- Pupils equal, round, reactive to light and accommodation, no pupillar dilation, no anisocoria.
- Extraocular movements intact. No nystagmus.
- Gross visual field by confrontation normal bilaterally.
- Ophthalmoscopic examination of fundi reveals no opacity of lenses, no evidence of A-V nicking, no hemorrhage, no exudates, no arteriolar narrowing. No papilledema. No microaneurysm.

Neck:

- Supple. No jugular venous distension. Trachea in the midline.
- Thyroid is normal in size and symmetric. No nodules, no tenderness.

Cardiovascular:

- PMI palpable in 5th Intercostal space in midclavicular line. S1, S2 normal. No thrills, no lift. No palpable S3, S4
- Regular sinus rhythm, no flutter or fibrillation. No S3, no S4 gallops. No systolic or diastolic murmurs. No friction rub. No opening snaps, no clicks.
- Blood pressure in upper and lower extremities is normal, symmetric bilaterally.
- Carotid arteries 2+ symmetric bilaterally, no bruits.

Impression/Plan: add the following:

General appearance**:** Alert, well developed, well nourished, well-groomed appearance in no acute distress.

Put this in history under 'documents' Diabetes uncontrolled

CC: Perspiration, tremor, hunger, nervousness, palpitation.

HPI: Hypoglycemic symptoms related to diabetes.
Onset:
Control:
Time course:
Associated with:

Review of systems:

Constitutional: Denies weight change, anorexia. Denies fatigue, weakness. Denies fever, sweating, chills. Denies insomnia, irritability.

General: Denies heat or cold intolerance. Denies change in head, glove, shoe size. Denies polydipsia, polyphagia

Cardiovascular: Denies chest pain. Has palpitation, denies syncope. Denies PND, orthopnea, peripheral edema. Denies leg/calf pain or cramps. Denies history of heart murmurs.

Gastrointestinal: Denies dysphagia, heartburn, bloating, belching and flatulence. Denies nausea, vomitng, hematemesis. Denies abdominal pain. Denies food intolerance. Denies history of hepatitis, jaundice. Denies hematochezia. Denies change in bowel habits. Denies diarrhea, constipation.

Nervous system: Denies history of stroke or seizures. Denies motor weakness, atrophy of muscles. Denies tremor, fasciculation. Denies anesthesia, paresthesia. Denies memory loss. Denies difficulty of walking, denies difficulty with speech.

Physical examination:

Constitutional:

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Gastrointestinal:

- Abdomen soft, non-tender, no mass. No abdominal distension.
- No guarding, no rigidity, no rebound tenderness.

Skin:

- Normal color, no diaphoresis, no pallor, no cyanosis. Skin warm and dry. Normal skin turgor.
- No rashes, no lesions, no ulcers, no stasis dermatitis, no xanthomas, café-au-lait spots, no petechiae.
- No induration of skin or subcutaneous tissue, no nodules.
- Normal hair distribution in scalp, eyebrow, face, chest and pubic area

Neurological:

- Cranial nerves II-XII normal.
- Normal finger-to-nose, heel/knee/shin test, rapid alternating movements in the upper and lower extremities. Normal Romberg test.
- Normal deep tendon reflex in ankle, wrists. Babinski reflex downgoing.
- No sensory deficit with normal touch sensation, normal pin prick sensation, normal vibration sensation, normal proprioception.
- Speech normal, not disoriented, not inappropriate, not incoherent, present/absent.

Psychiatric:

- Oriented to time, oriented to place, oriented to person.
- Normal recent memory, normal remote memory.
- No anxiety, no agitation, no depressed affect.