CHIEF COMPLAINT:, Joints are hurting all over and checkup.,HISTORY OF PRESENT ILLNESS:, A 77-year-old white female who is having more problems with joint pain. It seems to be all over decreasing her mobility, hands and wrists. No real swelling but maybe just a little more uncomfortable than they have been. The Daypro generic does not seem to be helping at all. No fever or chills. No erythema.,She actually is doing better. Her diarrhea now has settled down and she is having less urinary incontinence, less pedal edema. Blood sugars seem to be little better as well.,The patient also has gotten back on her Zoloft because she thinks she may be depressed, sleeping all the time, just not herself and really is disturbed that she cannot be more mobile in things. She has had no polyuria, polydipsia, or other problems. No recent blood pressure checks.,PAST MEDICAL HISTORY:, Little over a year ago, the patient was found to have lumbar discitis and was treated with antibiotics and ended up having debridement and instrumentation with Dr. XYZ and is doing really quite well. She had a pulmonary embolus with that hospitalization.,PAST SURGICAL HISTORY:, She has also had a hysterectomy, salpingoophorectomy, appendectomy, tonsillectomy, two carpal tunnel releases. She also has had a parathyroidectomy but still has had some borderline elevated calcium. Also, hypertension, hyperlipidemia, as well as diabetes. She also has osteoporosis.,SOCIAL HISTORY:, The patient still smokes about a third of a pack a day, also drinks only occasional alcoholic drinks. The patient is married. She has

three grown sons, all of which are very successful in professional positions. One son is a gastroenterologist in San Diego, California.,MEDICATIONS:, Nifedipine-XR 90 mg daily, furosemide 20 mg half tablet b.i.d., lisinopril 20 mg daily, gemfibrozil 600 mg b.i.d., Synthroid 0.1 mg daily, Miacalcin one spray in alternate nostrils daily, Ogen 0.625 mg daily, Daypro 600 mg t.i.d., also Lortab 7.5 two or three a day, also Flexeril occasionally, also other vitamin.,ALLERGIES: , She had some adverse reactions to penicillin, sulfa, perhaps contrast medium, and some mycins.,FAMILY HISTORY:, As far as heart disease there is none in the family. As far as cancer two cousins had breast cancer. As far as diabetes father and grandfather had type II diabetes. Son has type I diabetes and is struggling with that at the moment.,REVIEW OF SYSTEMS:,General: No fever, chills, or night sweats. Weight stable.,HEENT: No sudden blindness, diplopia, loss of vision, i.e., in one eye or other visual changes. No hearing changes or ear problems. No swallowing problems or mouth lesions.,Endocrine: Hypothyroidism but no polyuria or polydipsia. She watches her blood sugars. They have been doing quite well.,Respiratory: No shortness of breath, cough, sputum production, hemoptysis or breathing problems.,Cardiovascular: No chest pain or chest discomfort. No paroxysmal nocturnal dyspnea, orthopnea, palpitations, or heart attacks.,GI: As mentioned, has had diarrhea though thought to be possibly due to Clostridium difficile colitis that now has gotten better. She has had some irritable bowel syndrome and bowel abnormalities for years.,GU: No urinary

problems, dysuria, polyuria or polydipsia, kidney stones, or recent infections. No vaginal bleeding or discharge.,Musculoskeletal: As above.,Hematological: She has had some anemia in the past.,Neurological: No blackouts, convulsions, seizures, paralysis, strokes, or headaches.,PHYSICAL EXAMINATION:,Vital Signs: Weight is 164 pounds. Blood pressure: 140/64. Pulse: 72. Blood pressure repeated by me with the patient sitting taken on the right arm is 148/60, left arm 136/58; these are while sitting on the exam table.,General: A well-developed pleasant female who is comfortable in no acute distress otherwise but she does move slowly.,HEENT: Skull is normocephalic. TMs intact and shiny with good auditory acuity to finger rub. Pupils equal, round, reactive to light and accommodation with extraocular movements intact. Fundi benign. Sclerae and conjunctivae were normal.,Neck: No thyromegaly or cervical lymphadenopathy. Carotids are 2+ and equal bilaterally and no bruits present.,Lungs: Clear to auscultation and percussion with good respiratory movement. No bronchial breath sounds, egophony, or rales are present.,Heart: Regular rhythm and rate with no murmurs, gallops, rubs, or enlargement. PMI normal position. All pulses are 2+ and equal bilaterally.,Abdomen: Obese, soft with no hepatosplenomegaly or masses.,Breasts: No predominant masses, discharge, or asymmetry.,Pelvic Exam: Normal external genitalia, vagina and cervix. Pap smear done. Bimanual exam shows no uterine enlargement and is anteroflexed. No adnexal masses or tenderness. Rectal exam

is normal with soft brown stool Hemoccult negative.,Extremities: The patient does appear to have some doughiness of all of the MCP joints of the hands and the wrists as well. No real erythema. There is no real swelling of the knees. No new pedal edema.,Lymph nodes: No cervical, axillary, or inguinal adenopathy.,Neurological: Cranial nerves II-XII are grossly intact. Deep tendon reflexes are 2+ and equal bilaterally. Cerebellar and motor function intact in all extremities. Good vibratory and positional sense in all extremities and dermatomes. Plantar reflexes are downgoing bilaterally.,LABORATORY: ,CBC shows a hemoglobin of 10.5, hematocrit 35.4, otherwise normal. Urinalysis is within normal limits. Chem profile showed a BUN of 54, creatinine 1.4, glucose 116, calcium was 10.8, cholesterol 198, triglycerides 171, HDL 43, LDL 121, TSH is normal, hemoglobin A1C is 5.3.,ASSESSMENT:,1. Arthralgias that are suspicious for inflammatory arthritis, but certainly seems to be more active and bothersome. I think we need to look at this more closely.,2. Diarrhea that seems to have resolved. Whether this is related to the above is unclear.,3. Diabetes mellitus type II, really fairly well controlled.