SUBJECTIVE:, The patient is in with several medical problems. She complains of numbness, tingling, and a pain in the toes primarily of her right foot described as a moderate pain. She initially describes it as a sharp quality pain, but is unable to characterize it more fully. She has had it for about a year, but seems to be worsening. She has little bit of paraesthesias in the left toe as well and seem to involve all the toes of the right foot. They are not worse with walking. It seems to be worse when she is in bed. There is some radiation of the pain up her leg. She also continues to have bilateral shoulder pains without sinus allergies. She has hypothyroidism. She has thrombocythemia, insomnia, and hypertension.,PAST MEDICAL HISTORY:, Surgeries include appendectomy in 1933, bladder obstruction surgery in 1946, gallbladder surgery in 1949, another gallbladder surgery in 1954, C-section in 1951, varicose vein surgery in 1951 and again in 1991, thyroid gland surgery in 1964, hernia surgery in 1967, bilateral mastectomies in 1968 for benign disease, hysterectomy leaving her ovaries behind in 1970, right shoulder surgery x 4 and left shoulder surgery x 2 between 1976 and 1991, and laparoscopic bowel adhesion removal in October 2002. She had a Port-A-Cath placed in June 2003, left total knee arthroplasty in June 2003, and left hip pinning due to fracture in October 2003, with pins removed in May 2004. She has had a number of colonoscopies; next one is being scheduled at the end of this month. She also had a right total knee arthroplasty in 1993. She was hospitalized for synovitis of the left knee in April 2004, for zoster and infection

of the left knee in May 2003, and for labyrinthitis in June 2004.,ALLERGIES: , Sulfa, aspirin, Darvon, codeine, NSAID, amoxicillin, and quinine.,CURRENT MEDICATIONS:, Hydroxyurea 500 mg daily, Metamucil three teaspoons daily, amitriptyline 50 mg at h.s., Synthroid 0.1 mg daily, Ambien 5 mg at h.s., triamterene/hydrochlorothiazide 75/50 daily, and Lortab 5/500 at h.s. p.r.n.,SOCIAL HISTORY:, She is a nonsmoker and nondrinker. She has been widowed for 18 years. She lives alone at home. She is retired from running a restaurant.,FAMILY HISTORY:, Mother died at age 79 of a stroke. Father died at age 91 of old age. Her brother had prostate cancer. She has one brother living. No family history of heart disease or diabetes.,REVIEW OF SYSTEMS:,General: Negative.,HEENT: She does complain of some allergies, sneezing, and sore throat. She wears glasses.,Pulmonary history: She has bit of a cough with her allergies.,Cardiovascular history: Negative for chest pain or palpitations. She does have hypertension.,GI history: Negative for abdominal pain or blood in the stool.,GU history: Negative for dysuria or frequency. She empties okay.,Neurologic history: Positive for paresthesias to the toes of both feet, worse on the right.,Musculoskeletal history: Positive for shoulder pain.,Psychiatric history: Positive for insomnia.,Dermatologic history: Positive for a spot on her right cheek, which she was afraid was a precancerous condition.,Metabolic history: She has hypothyroidism.,Hematologic history: Positive for essential thrombocythemia and anemia.,OBJECTIVE:,General: She is

a well-developed, well-nourished, elderly female in no acute distress.,Vital Signs: Her age is 81. Temperature: 98.0. Blood pressure: 140/70. Pulse: 72. Weight: 127.,HEENT: Head was normocephalic. Pupils equal, round, and reactive to light. Extraocular movements are intact. Fundi are benign. TMs, nares, and throat were clear.,Neck: Supple without adenopathy or thyromegaly.,Lungs: Clear.,Heart: Regular rate and rhythm without murmur, click, or rub. No carotid bruits are heard.,Abdomen: Normal bowel sounds. It is soft and nontender without hepatosplenomegaly or mass.,Breasts: Surgically absent. No chest wall mass was noted, except for the Port-A-Cath in the left chest. No axillary adenopathy is noted.,Extremities: Examination of the extremities reveals no ankle edema or calf tenderness x 2 in lower extremities. There is a cyst on the anterior portion of the right ankle. Pedal pulses were present.,Neurologic: Cranial nerves II-XII grossly intact and symmetric. Deep tendon reflexes were 1 to 2+ bilaterally at the knees. No focal neurologic deficits were observed.,Pelvic: BUS and external genitalia were atrophic. Vaginal rugae were atrophic. Cervix was surgically absent. Bimanual exam confirmed the absence of uterus and cervix and I could not palpate any ovaries.,Rectal: Exam confirmed there is brown stool present in the rectal vault.,Skin: Clear other than actinic keratosis on the right cheek.,Psychiatric: Affect is normal.,ASSESSMENT:,1. Peripheral neuropathy primarily of the right foot.,2. Hypertension.,3. Hypothyroidism.,4. Essential thrombocythemia.,5. Allergic rhinitis.,6. Insomnia.,PLAN: