HISTORY OF PRESENT ILLNESS: , The patient is a 41-year-old African-American male previously well known to me. He has a previous history of aortic valve disease, status post aortic valve replacement on 10/15/2007, for which he has been on chronic anticoagulation. There is a previous history of paroxysmal atrial fibrillation and congestive heart failure, both of which have been stable prior to this admission. He has a previous history of transient ischemic attack with no residual neurologic deficits.,The patient has undergone surgery by Dr. X for attempted nephrolithotomy. The patient has experienced significant postoperative bleeding, for which it has been necessary to discontinue all anticoagulation. The patient is presently seen at the request of Dr. X for management of anticoagulation and his above heart disease.,PAST MEDICAL AND SURGICAL HISTORY:,1. Type I diabetes mellitus.,2. Hyperlipidemia.,3. Hypertension.,4. Morbid obesity.,5. Sleep apnea syndrome.,6. Status post thyroidectomy for thyroid carcinoma.,REVIEW OF SYSTEMS:,General: Unremarkable.,Cardiopulmonary: No chest pain, shortness of breath, palpitations, or dizziness.,Gastrointestinal: Unremarkable.,Genitourinary: See above.,Musculoskeletal: Unremarkable.,Neurologic: Unremarkable.,FAMILY HISTORY: , There are no family members with coronary artery disease. His mother has congestive heart failure.,SOCIAL HISTORY: ,The patient is married. He lives with his wife. He is employed as a barber. He does not use alcohol, tobacco, or illicit drugs.,MEDICATIONS PRIOR TO ADMISSION:,1. Clonidine 0.3 mg b.i.d.,2. Atenolol 50 mg

daily.,3. Simvastatin 80 mg daily.,4. Furosemide 40 mg daily.,5. Metformin 1000 mg b.i.d.,6. Hydralazine 25 mg t.i.d.,7. Diovan 320 mg daily.,8. Lisinopril 40 mg daily.,9. Amlodipine 10 mg daily.,10. Lantus insulin 50 units q.p.m.,11. KCl 20 mEq daily.,12. NovoLog sliding scale insulin coverage.,13. Warfarin 7.5 mg daily.,14. Levothyroxine 0.2 mg daily.,15. Folic acid 1 mg daily.,ALLERGIES: , None.,PHYSICAL EXAMINATION:,General: A well-appearing, obese black male.,Vital Signs: BP 140/80, HR 88, respirations 16, and afebrile.,HEENT: Grossly normal.,Neck: Normal. Thyroid, normal. Carotid, normal upstroke, no bruits.,Chest: Midline sternotomy scar.,Lungs: Clear.,Heart: PMI fifth intercostal space mid clavicular line. Normal S1 and prosthetic S2. No murmur, rub, gallop, or click.,Abdomen: Soft and nontender. No palpable mass or hepatosplenomegaly.