CHIEF COMPLAINT: ,Followup diabetes mellitus, type 1., ,SUBJECTIVE:, Patient is a 34-year-old male with significant diabetic neuropathy. He has been off on insurance for over a year. Has been using NPH and Regular insulin to maintain his blood sugars. States that he is deathly afraid of having a low blood sugar due to motor vehicle accident he was in several years ago. Reports that his blood sugar dropped too low which caused the accident. Since this point in time, he has been unwilling to let his blood sugars fall within a normal range, for fear of hypoglycemia. Also reports that he regulates his blood sugars with how he feels, rarely checking his blood sugar with a glucometer., ,Reports that he has been worked up extensively at hospital and was seeing an Endocrinologist at one time. Reports that he had some indications of kidney damage when first diagnosed. His urine microalbumin today is 100. His last hemoglobin A1C drawn at the end of December is 11.9. Reports that at one point, he was on Lantus which worked well and he did not worry about his blood sugars dropping too low. While using Lantus, he was able to get his hemoglobin A1C down to 7. His last CMP shows an elevated alkaline phosphatase level of 168. He denies alcohol or drug use and is a non smoker. Reports he quit drinking 3 years ago. I have discussed with patient that it would be appropriate to do an SGGT and hepatic panel today. Patient also has a history of gastroparesis and impotence. Patient requests Nexium and Viagra, neither of which are covered under the Health Plan. , ,Patient reports that he was in a scooter accident one week ago, fell off his scooter, hit his head. Was

not wearing a helmet. Reports that he did not go to the emergency room and had a headache for several days after this incident. Reports that an ambulance arrived at the scene and he was told he had a scalp laceration and to go into the emergency room. Patient did not comply. Reports that the headache has resolved. Denies any dizziness, nausea, vomiting, or other neurological abnormalities., ,PHYSICAL EXAMINATION: , WD, WN. Slender, 34-year-old white male. VITAL SIGNS: Blood sugar 145, blood pressure 120/88, heart rate 104, respirations 16. Microalbumin 100. SKIN: There appears to be 2 skin lacerations on the left parietal region of the scalp, each approximately 1 inch long. No signs of infection. Wound is closed with new granulation tissue. Appears to be healing well. HEENT: Normocephalic. PERRLA. EOMI. TMs pearly gray with landmarks present. Nares patent. Throat with no redness or swelling. Nontender sinuses. NECK: Supple. Full ROM. No LAD. CARDIAC: