HISTORY OF PRESENT ILLNESS: , The patient is a 71-year-old woman with history of coronary artery disease for which she has had coronary artery bypass grafting x2 and percutaneous coronary intervention with stenting x1. She also has a significant history of chronic renal insufficiency and severe COPD. The patient and her husband live in ABC but they have family in XYZ. She came to our office today as she is in the area visiting her family. She complains of having shortness of breath for the past month that has been increasingly getting worse. She developed a frequent nonproductive cough about 2 weeks ago. She has also had episodes of paroxysmal nocturnal dyspnea, awaking in the middle of the night, panicking from dyspnea and shortness of breath. She has also gained about 15 pounds in the past few months and has significant peripheral edema. In the office, she is obviously dyspnea and speaking in 2 to 3 word sentences.,PAST MEDICAL HISTORY: , Coronary artery disease, anemia secondary to chronic renal insufficiency, stage IV chronic kidney disease, diabetic nephropathy, hypertension, hyperlipidemia, COPD, insulin-dependent diabetes, mild mitral valve regurgitation, severe tricuspid valve regurgitation, sick sinus syndrome, gastritis, and heparin-induced thrombocytopenia.,PAST SURGICAL HISTORY: , Status post pacemaker implantation, status post CABG x4 in 1999 and status post CABG x2 in 2003, status post PCA stenting x1 to the left anterior descending artery, cholecystectomy, back surgery, bladder surgery, and colonic polypectomies.,SOCIAL HISTORY: ,The patient is married.

Lives with her husband. They are retired from ABC.,MEDICATIONS:,1. Plavix 75 mg p.o. daily.,2. Aspirin 81 mg p.o. daily.,3. Isosorbide mononitrate 60 mg p.o. daily.,4. Colace 100 mg p.o. b.i.d.,5. Atenolol 50 mg p.o. daily.,6. Lantus insulin 15 units subcutaneously every evening.,7. Protonix 40 mg p.o. daily.,8. Furosemide 40 mg p.o. daily.,9. Norvasc 5 mg p.o. daily.,ALLERGIES: , SHE IS ALLERGIC TO HEPARIN AGENTS, WHICH CAUSE HEPARIN-INDUCED THROMBOCYTOPENIA.,REVIEW OF SYSTEMS,CONSTITUTIONAL: Positive for generalized fatigue and malaise.,HEAD AND NECK: Negative for diplopia, blurred vision, visual disturbances, hearing loss, tinnitus, epistaxis, vertigo, sinusitis, and gum or oral lesions.,CARDIOVASCULAR: Positive for epigastric discomfort x2 weeks, negative for palpitations, syncope or near-syncopal episodes, chest pressure, and chest pain.,RESPIRATORY: Positive for dyspnea at rest, paroxysmal nocturnal dyspnea, orthopnea, and frequent nonproductive cough. Negative for wheezing.,ABDOMEN: Negative for abdominal pain, bloating, nausea, vomiting, constipation, melena, or hematemesis.,GENITOURINARY: Negative for dysuria, polyuria, hematuria, or incontinence.,MUSCULOSKELETAL: Negative for recent trauma, stiffness, deformities, muscular weakness, or atrophy.,SKIN: Negative for rashes, petechiae, and hair or nail changes. Positive for easy bruising on forearms.,NEUROLOGIC: Negative for paralysis, paresthesias, dysphagia, or dysarthria.,PSYCHIATRIC:

Negative for depression, anxiety, or mood swings.,All other systems reviewed are negative.,PHYSICAL EXAMINATION,VITAL SIGNS: Her blood pressure in the office was 188/94, heart rate 70, respiratory rate 18 to 20, and saturations 99% on room air. Her height is 63 inches. She is weighs 195 pounds and her BMI is 34.6.,CONSTITUTIONAL: A 71-year-old woman in significant distress from shortness of breath and dyspnea at rest.,HEENT: Eyes: Pupils are reactive. Sclera is nonicteric. Ears, nose, mouth, and throat.,NECK: Supple. No lymphadenopathy. No thyromegaly. Swallow is intact.,CARDIOVASCULAR: Positive JVD at 45 degrees. Heart tones are distant. S1 and S2. No murmurs.,EXTREMITIES: Have 3+ edema in the feet and ankles bilaterally that extends up to her knees. Femoral pulses are weakly palpable. Posterior tibial pulses are not palpable. Capillary refill is somewhat sluggish.,RESPIRATORY: Breath sounds are clear with some bilateral basilar diminishment. No rales and no wheezing. Speaking in 2 to 3 word sentences. Diaphragmatic excursions are limited. AP diameter is expanded.,ABDOMEN: Soft and nontender. Active bowel sounds x4 quadrants. No hepatosplenomegaly. No masses are appreciated.,GENITOURINARY: Deferred.,MUSCULOSKELETAL: Adequate range of motion along with extremities.,SKIN: Warm and dry. No lesions or ulcerations are noted.,NEUROLOGIC: Alert and oriented x3. Head is normocephalic and atraumatic. No focal, motor, or sensory deficits.,PSYCHIATRIC: Normal

affect.,IMPRESSION,1. Coronary artery disease.