HISTORY AND CLINICAL DATA: ,The patient is an 88-year-old gentleman followed by Dr. X, his primary care physician, Dr. Y for the indication of CLL and Dr. Z for his cardiovascular issues. He presents to the Care Center earlier today with approximately a one-week history of increased progressive shortness of breath, orthopnea over the course of the past few nights, mild increase in peripheral edema, and active wheezing with dyspnea presenting this morning.,He reports no clear-cut chest discomfort or difficulty with angina. He has had no dizziness, lightheadedness, no near or true syncope, nothing supportive of CVA, TIA, nor peripheral vascular claudication.,REVIEW OF SYSTEMS:, General review of system is significant for difficulty with intermittent constipation, which has been problematic recently. He reports no fever, shaking chills, nothing supportive of GI or GU blood loss, no productive or nonproductive cough.,PAST MEDICAL HISTORY:, Remarkable for hypertension, diabetes, prostate cancer, status post radium seed implant, COPD, single vessel coronary disease, esophageal reflux, CLL, osteopenia, significant hearing loss, anxiety, and degenerative joint disease.,SOCIAL HISTORY: , Remarkable for being married, retired, quit smoking in 1997, rare use of alcohol, lives locally with his wife.,MEDICATIONS AT HOME:, Include, Lortab 7.5 mg up to three times daily for chronic arthritic discomfort, Miacalcin nasal spray once daily, omeprazole 20 mg daily, Diovan 320 mg daily, Combivent two puffs t.i.d., folate, one adult aspirin daily, glyburide 5 mg daily, atenolol 50 mg daily, furosemide 40 mg daily, amlodipine 5 mg daily, hydralazine

50 mg p.o. t.i.d., in addition to Tekturna 150 mg daily, Zoloft 25 mg daily.,ALLERGIES: ,He has known history of allergy to clonidine, Medifast does fatigue.,DIAGNOSTIC AND LABORATORY DATA: , Chest x-ray upon presentation to the Ellis Emergency Room this evening demonstrate significant congestive heart failure with moderate-sized bilateral pleural effusions.,A 12-lead EKG, sinus rhythm at a rate of 68 per minute, right bundle-branch block type IVCV with moderate nonspecific ST changes. Low voltage in the limb leads.,WBC 29,000, hemoglobin 10.9, hematocrit 31, platelets 187,000. Low serum sodium at 132, potassium 4, BUN 28, creatinine 1.2, random glucose 179. Low total protein 5.7. Magnesium level 2.3, troponin 0.404 with the B-natriuretic peptide of 8200.,PHYSICAL EXAMINATION: ,He is an elderly gentleman, who appears to be in no acute distress, lying comfortably flat at 30 degrees, measured pressure of 150/80 with a pulse of 68 and regular. JVD difficult to assess. Normal carotids with obvious bruits. Conjunctivae pink. Oropharynx clear. Mild kyphosis. Diffusely depressed breath sounds halfway up both posterior lung fields. No active wheezing. Cardiac Exam: Regular, soft, 1-2/6 early systolic ejection murmur best heard at the base. Abdomen: Soft, nontender, protuberant, benign. Extremities: 2+ bilateral pitting edema to the level of the knees. Neuro Exam: Appears alert, oriented x3. Appropriate manner and affect, exceedingly hard of hearing.,OVERALL IMPRESSION:, An 88-year-old white male with the following major medical issues:,1. Presentation consists with subclinical congestive heart failure possibly

systolic, no recent echocardiogram available for review.,2. Hypertension with suboptimal controlled currently.,3. Diabetes.,4. Prostate CA, status post radium seed implant.,5. COPD, on metered-dose inhaler.,6. CLL followed by Dr. Y.,7. Single-vessel coronary disease, no recent anginal quality chest pain, no changes in ECG suggestive of acute ischemia; however, initial troponin 0.4 - to be followed with serial enzyme determinations and telemetry.,8. Hearing loss, anxiety.,9. Significant degenerative joint disease.,PLAN:,1. Admit to A4 with telemetry, congestive heart failure pathway, intravenous diuretic therapy.,2. Strict I&O;, Foley catheter has already been placed.,3. Daily BMP.,4. Two-dimensional echocardiogram to assess left ventricular systolic function. Serum iron determination to exclude the possibility of a subclinical ischemic cardiac event. Further recommendations will be forthcoming pending his clinical course and hospital.