PROBLEM LIST:,1. Type 1 diabetes mellitus, insulin pump.,2. Hypertension.,3. Hyperlipidemia.,HISTORY OF PRESENT ILLNESS: , The patient is a 39-year-old woman returns for followup management of type 1 diabetes mellitus. Her last visit was approximately 4 months ago. Since that time, the patient states her health had been good and her glycemic control had been good, however, within the past 2 weeks she had a pump malfunction, had to get a new pump and was not certain of her pump settings and has been having some difficulty with glycemic control over the past 2 weeks. She is not reporting any severe hypoglycemic events, but is having some difficulty with hyperglycemia both fasting and postprandial. She is not reporting polyuria, polydipsia or polyphagia. She is not exercising at this point and has a diet that is rather typical of woman with twins and a young single child as well. She is working on a full-time basis and so eats on the run a lot, probably eats more than she should and not making the best choices, little time for physical activity. She is keeping up with all her other appointments and has recently had a good eye examination. She had lab work done at her previous visit and this revealed persistent hyperlipidemic state with a LDL of 144.,CURRENT MEDICATIONS:,1. Zoloft 50 mg p.o. once daily.,2. Lisinopril 40 mg once daily.,3. Symlin 60 micrograms, not taking at this point.,4. Folic acid 2 by mouth every day.,5. NovoLog insulin via insulin pump about 90 units of insulin per day.,REVIEW OF SYSTEMS:, She denies fever, chills, sweats, nausea, vomiting, diarrhea, constipation, abdominal pain, chest pain, shortness of breath,

difficulty breathing, dyspnea on exertion or change in exercise tolerance. She is not having painful urination or blood in the urine. She is not reporting polyuria, polydipsia or polyphagia.,PHYSICAL EXAMINATION:,GENERAL: Today showed a very pleasant, well-nourished woman, in no acute distress. VITAL SIGNS: Temperature not taken, pulse 98, respirations 20, blood pressure 148/89, and weight 91.19 kg. THORAX: Revealed lungs clear, PA and lateral without adventitious sounds. CARDIOVASCULAR: Demonstrated regular rate and rhythm. S1 and S2 without murmur. No S3, no S4 auscultated. ABDOMEN: Nontender. EXTREMITIES: Showed no clubbing, cyanosis or edema. SKIN: Intact and do not appear atrophic. Deep tendon reflexes were 2+/4 without a delayed relaxation phase.,LABORATORY DATA:, Dated 10/05/08 showed a total cholesterol of 223, triglyceride 140, HDL 54, and LDL 144. The hemoglobin A1c was 6.4 and the spot urine for microalbumin was 9.2 micrograms of protein, 1 mg of creatinine. Sodium 136, potassium 4.5, chloride 102, CO2 30 mEq, BUN 11 mg/dL, creatinine 0.6 mg, estimated GFR greater than 60, blood sugar 118, calcium 9.4, and her LFTs were unremarkable. TSH is 1.07 and free T4 is 0.81.,ASSESSMENT AND PLAN:,1. This is a return visit to the endocrine clinic for the patient, a 39-year-old woman with history as noted above. Plan today is to make adjustments to her pump based on a total daily dose of 90 units of insulin. Basal rate is as follows, 12 a.m. 1.5, 02:30 a.m. 1.75, and 6 a.m. 1.5. Her correction factor is 19. Her carb/insulin ratio is 6. Her active insulin time is 5 and her targets are at 12 a.m. 110

and 6 a.m. to midnight is 100. We made adjustments to her pump and the plan will be to see her back in approximately 2 months.,2. Hyperlipidemia. The patient is not taking statin, therefore, we will prescribe Lipitor 20 mg one p.o. once daily. Have her watch for side effects from the medication and plan to do a fasting lipid panel and CMP approximately 8 weeks from now.,3. We will get a hemoglobin A1c and spot urine for albumin in 8 weeks as well.