

PROBLEM LIST: 1. Generalized osteoarthritis and osteoporosis with very limited mobility. 2. Adult failure to thrive with history of multiple falls, none recent. 3. Degenerative arthritis of the knees with chronic bilateral knee pain. 4. Chronic depression. 5. Hypertension. 6. Hyperthyroidism. 7. Aortic stenosis with history of CHF and bilateral pleural effusions. 8. Right breast mass, slowly enlarging. Patient refusing workup. 9. Status post ORIF of the right wrist, now healed. 10. Anemia of chronic disease. 11. Hypoalbuminemia. 12. Chronic renal insufficiency.

CURRENT MEDICATIONS: Acetaminophen 325 mg 2 tablets twice daily, Coreg 6.25 mg twice daily, Docusate sodium 100 mg 1 cap twice daily, ibuprofen 600 mg twice daily with food, Lidoderm patch 5% to apply 1 patch to both knees every morning and off in the evening, one vitamin daily, ferrous sulfate 325 mg daily, furosemide 20 mg q.a.m., Tapazole 5 mg daily, potassium chloride 10 mEq daily, Zoloft 50 mg daily, Ensure t.i.d., and p.r.n. medications.

ALLERGIES: NKDA.

CODE STATUS: DNR, healthcare proxy, durable power of attorney.

DIET: Regular with regular consistency with thin liquids and ground meat.

RESTRAINTS: , None. She does have a palm protector in her right hand.

INTERVAL HISTORY: No significant change over the past month has occurred. The patient mainly complains about pain in her back. On a scale from 1 to 10, it is 8 to 10, worse at night before she goes to bed. She is requesting something more for the pain. Other than that, she complains about her generalized pain. There has been no significant change in her

weight. No fever or chills. No complaint of headaches or visual changes, chest pain, shortness of breath, dyspnea on exertion, orthopnea, or PND. No hemoptysis or night sweats. No change in her bowels, abdominal pain, bright red rectal bleeding, or melena. No nausea or vomiting. Her appetite is fair. She is a picky eater but definitely likes her candy. There has been no change in her depression. It seems to be stable on the Zoloft 50 mg daily, which she has been on since October 17, 2006. She denies feeling depressed to me but complains of being bored, stating she just sits and watches TV or sometimes may go to activities but not very seldom due to her back pain. No history of seizures. She denies any tremors. She is hyperthyroid and is on replacement.,PHYSICAL EXAMINATION: , An elderly female, sitting in a wheelchair, in no acute distress, very kyphotic. She is very pleasant and alert. Vital signs per chart. Skin is normal in texture and turgor for her age. She does have dry lips, which she picks at and was picking at her lips while I was talking with her. HEENT: Normocephalic, atraumatic. She has nevi above her left eye, which she states she has had since birth and has not changed. Pupils are equal, round and reactive to light and accommodation. No exophthalmos or lid lag. Anicteric sclerae. Conjunctivae pink, nasal passages clear. She is edentulous but does have her upper dentures in. No mucosal ulcerations. External ears normal. Neck is supple. No increased JVD, cervical or supraclavicular adenopathy. No thyromegaly or masses. Trachea is midline. Her chest is very kyphotic, clear to A&P.; Heart: Regular rate and rhythm with a

2-3/6 systolic murmur heard best at the left sternal border. Abdomen: Soft. Good bowel sounds. Nontender. Unable to appreciate any organomegaly or masses as she is sitting in a wheelchair. Extremities are without edema, cyanosis, clubbing, or tremor. She does have Lidoderm patches over both of her knees and is wearing a brace in her right hand.,LABORATORY TESTS: , Albumin was 3.2 on 12/06/06. Dietary is aware. Electrolytes done 11/28/06, her sodium was 144, potassium 4.4, chloride 109, bicarbonate 26, anion gap 9, BUN 28, creatinine 1.2, GFR 44. Digoxin was done and was less than 0.9, but she is not on digoxin. CBC showed a white count of 7400, hemoglobin 11.1, hematocrit 35.9, MCV of 95.2, and platelet count of 252,000. Her TSH was 1.52. No changes were made in her Tapazole.,ASSESSMENT AND PLAN:, We will continue present therapy except we will add Tylenol No. 3 to take 1 tablet before bed as needed for her back pain. If she does develop drowsiness from this, then the CNS side effects will help her sleep. During the day, her daughter likes the patient to remain alert and will use the ibuprofen at that time as long as she does not develop any GI symptoms. We will make sure that she is taking the ibuprofen with food. No further laboratory tests will be done at this time.