PROBLEM LIST:,1. HIV stable.,2. Hepatitis C chronic.,3. History of depression, stable off meds.,4. Hypertension, moderately controlled.,CHIEF COMPLAINT: , The patient comes for a routine followup appointment.,HISTORY OF PRESENTING ILLNESS: , This is a 34-year-old African American female who comes today for routine followup. She has no acute complaints. She reports that she has a muscle sprain on her upper back from lifting. The patient is a housekeeper by profession. It does not impede her work in anyway. She just reports that it gives her some trouble sleeping at night, pain on 1 to 10 scale was about 2 and at worse it is 3 to 4 but relieved with over-the-counter medication. No other associated complaints. No neurological deficits or other specific problems. The patient denies any symptoms associated with opportunistic infection.,PAST MEDICAL HISTORY:,1. Significant for HIV.,2. Hepatitis.,3. Depression.,4. Hypertension.,CURRENT MEDICATIONS:,1. She is on Trizivir 1 tablet p.o. b.i.d.,2. Ibuprofen over-the-counter p.r.n.,MEDICATION COMPLIANCE: , The patient is 100% compliant with her meds. She reports she does not miss any doses.,ALLERGIES: , She has no known drug allergies.,DRUG INTOLERANCE: ,There is no known drug intolerance in the past.,NUTRITIONAL STATUS: , The patient eats regular diet and eats 3 meals a day.,REVIEW OF SYSTEMS: , Noncontributory except as mentioned in the HPI.,LABORATORY DATA: , Most recent labs from 11/07.,RADIOLOGICAL DATA:, She has had no recent radiological procedures.,IMMUNIZATIONS: ,

Up-to-date.,SEXUAL HISTORY: , She has had no recent STDs and she is not currently sexually active. PPD status was negative in the past. PPD will be placed again today.,Treatment adherence counseling was performed by both nursing staff and myself. Again, the patient is a 100% compliant with her meds. Last dental exam was in 11/07, where she had 2 teeth extracted. Last Pap smear was 1 year ago was negative. The patient has not had mammogram yet, as she is not of the age where she would start screening mammogram. She has no family history of breast cancer.,MENTAL HEALTH AND SUBSTANCE ABUSE: , The patient has a history of depression. No history of substance abuse.,ADVANCED DIRECTIVE: , Unknown.,PHYSICAL EXAMINATION:,GENERAL: This is a thinly built female, not in acute distress. VITAL SIGNS: Temperature 36.5, blood pressure 132/89, pulse of 82, and weight of 104 pounds. HEAD AND NECK: Reveals bilaterally reactive pupils. Supple neck. No thrush. No adenopathy. HEART: Heart sounds S1 and S2 regular. No murmur. LUNGS: Clear bilaterally to auscultation. ABDOMEN: Soft and nontender with good bowel sounds. NEUROLOGIC: She is alert and oriented x3 with no focal neurological deficit. EXTREMITIES: Peripheral pulses are felt bilaterally. She has no pitting pedal edema, clubbing or cyanosis. GU: Examination of external genitalia is unremarkable. There are no lesions.,LABORATORY DATA: , From 11/07 shows hemoglobin and hematocrit of 16 and 46. Creatinine of 0.6. LFTs within normal limits. Viral load of less than 48 and CD4 count of 918.,ASSESSMENT:,1. Human

immunodeficiency virus, stable on Trizivir.,2. Hepatitis C with stable transaminases.,3. History of depression, stable off meds.