REASON FOR CONSULTATION:, Syncope.,HISTORY OF PRESENT ILLNESS: , The patient is a 78-year-old lady followed by Dr. X in our practice with history of coronary artery disease, status post coronary artery bypass grafting in 2005 presented to the emergency room following a syncopal episode. According to the patient and the daughter who was with her, she was shopping when she felt abdominal discomfort with nausea, profuse sweating, and passed out. As soon as she was laid on the floor and her leg raised up, she woke up with no post-event confusion. According to the daughter, she has had episodes of weakness, but no syncope. She has blood pressure medications and has had some postural hypotensions, which has been managed by Dr. X. She also states there was a history of pulmonary embolism and the presentation at that time was very similar when she had a syncopal episode. At that time, she was admitted at Hospital, had a V/Q scan, which was positive for PE. Initial V/Q scan done at Hospital was negative. She was anticoagulated with Coumadin resulting in severe GI bleed. Anticoagulation was stopped and an IVC filter was placed at that time. She has a history of malignant hypertension and has had a renal stent placed in February 2007. She also has peripheral vascular disease with stent placements. There is a history of spinal canal stenosis and iron deficiency anemia, currently on Procrit injections every two weeks done by Dr. Y. The patient denies any chest pain or any worsening of any shortness of breath. There are no acute EKG changes or cardiac enzyme elevations. She has had no stress test done

following a bypass surgery.,PAST MEDICAL HISTORY,1. Coronary artery disease, status post coronary artery bypass grafting.,2. History of mitral regurgitation, unable to repair the valve.,3. History of paroxysmal atrial fibrillation, on amiodarone.,4. Gastroesophageal reflux disease.,5. Hypertension.,6. Hyperlipidemia.,7. History of abdominal aortic aneurysm.,8. Carotid artery disease, mild-to-moderate on recent carotid ultrasound.,9. Peripheral vascular disease.,10. Hypothyroidism.,11. Pulmonary embolism.,PAST SURGICAL HISTORY,1. Coronary artery bypass grafting.,2. Hysterectomy.,3. IVC filter.,4. Tonsillectomy and adenoidectomy.,5. Cosmetic surgery to breast and abdomen.,HOME MEDICATIONS,1. Aspirin 81 mg once a day.,2. Klor-Con 10 mEq once a day.,3. Lasix 40 mg once a day.,4. Levothyroxine 125 mcg once a day.,5. Lisinopril 20 mg once a day.,6. Pacerone 200 mg once a day.,7. Protonix 40 mg once a day.,8. Toprol 50 mg once a day.,9. Vitamin B once a day.,10. Zetia 10 mg once a day.,11. Zyrtec 10 mg once a day.,ALLERGIES:, CODEINE, ERYTHROMYCIN, SULFA, VICODIN, AND ZOCOR.,REVIEW OF SYSTEMS,CONSTITUTIONAL: The patient denies any fevers, chills, recent weight gain or weight loss. She has had abdominal symptoms with diarrhea.,EYES: Decreased visual acuity.,ENT: Sinus drainage.,CARDIOVASCULAR: As described above. Denies any chest pains.,RESPIRATORY: He has chronic shortness of breath. No cough or sputum production.,GI: History of reflux symptoms.,GU: No history of dysuria or hematuria.,ENDOCRINE: No history of

diabetes.,MUSCULOSKELETAL: Denies arthritis, but has leg pain.,SKIN: No history of rash.,PSYCHIATRIC: No history of anxiety or depression.