CHIEF COMPLAINT:, Weak and shaky.,HISTORY OF PRESENT ILLNESS:, The patient is a 75-year-old, Caucasian female who comes in today with complaint of feeling weak and shaky. When questioned further, she described shortness of breath primarily with ambulation. She denies chest pain. She denies cough, hemoptysis, dyspnea, and wheeze. She denies syncope, presyncope, or palpitations. Her symptoms are fairly longstanding but have been worsening as of late.,PAST MEDICAL HISTORY:, She has had a fairly extensive past medical history but is a somewhat poor historian and is unable to provide details about her history. She states that she has underlying history of heart disease but is not able to elaborate to any significant extent. She also has a history of hypertension and type II diabetes but is not currently taking any medication. She has also had a history of pulmonary embolism approximately four years ago, hyperlipidemia, peptic ulcer disease, and recurrent urinary tract infections. Surgeries include an appendectomy, cesarean section, cataracts, and hernia repair.,CURRENT MEDICATIONS:, She is on two different medications, neither of which she can remember the name and why she is taking it.,ALLERGIES: , She has no known medical allergies.,FAMILY HISTORY:, Remarkable for coronary artery disease, stroke, and congestive heart failure.,SOCIAL HISTORY:, She is a widow, lives alone. Denies any tobacco or alcohol use.,REVIEW OF SYSTEMS:, Dyspnea on exertion. No chest pain or tightness, fever, chills, sweats, cough, hemoptysis, or wheeze, or lower extremity

swelling.,PHYSICAL EXAMINATION:,General: She is alert but seems somewhat confused and is not able to provide specific details about her past history.,Vital Signs: Blood pressure: 146/80. Pulse: 68. Weight: 147 pounds.,HEENT: Unremarkable.,Neck: Supple without JVD, adenopathy, or bruit.,Chest: Clear to auscultation.,Cardiovascular: Regular rate and rhythm.,Abdomen: Soft.,Extremities: No edema.,LABORATORY:, O2 sat 100% at rest and with exertion. Electrocardiogram was normal sinus rhythm. Nonspecific S-T segment changes. Chest x-ray pending.,ASSESSMENT/PLAN:,1. Dyspnea on exertion, uncertain etiology. Mother would be concerned about the possibility of coronary artery disease given the patient's underlying risk factors. We will have the patient sign a release of records so that we can review her previous history. Consider setting up for a stress test.,2. Hypertension, blood pressure is acceptable today. I am not certain as to what, if the patient's is on any antihypertensive agents. We will need to have her call us what the names of her medications, so we can see exactly what she is taking.,3. History of diabetes. Again, not certain as to whether the patient is taking anything for this particular problem when she last had a hemoglobin A1C. I have to obtain some further history and review records before proceeding with treatment recommendations.