MEDICAL REPORT

Comprehensive Patient Evaluation

PATIENT INFORMATION

- **Name:** John Sample
- **DOB:** 05/15/1972 (53 years old)
- **Medical Record #:** MR-20250228-JS
- **Date of Examination:** February 28, 2025
- **Referring Physician:** Dr. Sarah Chen

CHIEF COMPLAINT

Patient presents with persistent fatigue, increased thirst, frequent urination, and unexplained weight loss over the past 3 months.

HISTORY OF PRESENT ILLNESS

Mr. Sample is a 53-year-old male who reports experiencing increasing fatigue for approximately 3 months. He describes the fatigue as persistent throughout the day, not alleviated by rest. Additionally, he reports polydipsia (drinking 10-12 glasses of water daily), polyuria (urinating 8-10 times daily including 2-3 times nightly), and unintentional weight loss of 15 pounds over this period despite no changes in diet or exercise habits.

Patient denies fever, chills, night sweats, chest pain, shortness of breath, abdominal pain, nausea, vomiting, or changes in vision. He reports mild tingling in his feet bilaterally for the past month, primarily in the evenings.

PAST MEDICAL HISTORY

- Hypertension (diagnosed 2018)
- Hyperlipidemia (diagnosed 2019)
- Appendectomy (1995)
- No known history of diabetes
- No known history of thyroid disease
- No previous cardiovascular events

FAMILY HISTORY

- Father: Type 2 diabetes, hypertension, died at age 72 from myocardial infarction
- Mother: Hypertension, alive at 80 with no diabetes
- Brother: Type 2 diabetes diagnosed at age 48
- No known family history of autoimmune disorders

SOCIAL HISTORY

- Occupation: Accountant (sedentary job)
- Marital Status: Married with 2 adult children
- Smoking: Never smoker
- Alcohol: Social drinker (2-3 drinks per week)
- Exercise: Minimal (walks 15-20 minutes 1-2 times weekly)
- Diet: Reports high carbohydrate intake, frequent fast food consumption (3-4 times weekly)

CURRENT MEDICATIONS

1. Lisinopril 10mg daily (for hypertension)
2. Atorvastatin 20mg daily (for hyperlipidemia)
3. Multivitamin daily
4. No herbal supplements

ALLERGIES

No known drug allergies.

REVIEW OF SYSTEMS

General: Fatigue, unintentional weight loss of 15 pounds over 3 months. Denies fever, chills.

HEENT: Denies headaches, vision changes, hearing problems, sinus congestion.

Cardiovascular: Denies chest pain, palpitations, edema. No history of heart murmur.

Respiratory: Denies shortness of breath, cough, wheezing.

Gastrointestinal: Denies abdominal pain, nausea, vomiting, diarrhea, constipation. Reports increased appetite despite weight loss.

Genitourinary: Reports polyuria, nocturia. Denies dysuria, hematuria.

Musculoskeletal: Denies joint pain, muscle weakness, back pain.

Neurological: Reports mild paresthesia (tingling) in feet bilaterally. Denies weakness, dizziness, syncope.

Psychological: Denies depression, anxiety, sleep disturbances.

Endocrine: Reports polydipsia, polyuria, weight loss. Denies heat or cold intolerance.

Hematologic: Denies easy bruising or bleeding.

Immunologic: Denies recurrent infections.

PHYSICAL EXAMINATION

Vital Signs:

- BP: 142/88 mmHg
- HR: 84 bpm, regular
- RR: 16 breaths/min
- Temp: 98.6°F (37.0°C)
- SpO2: 98% on room air
- Height: 5'10" (178 cm)
- Weight: 198 lbs (90 kg)
- BMI: 28.4 kg/m²

General Appearance: Alert, oriented, appears stated age, in no acute distress.

HEENT: Normocephalic, atraumatic. PERRLA. Oropharynx clear without exudates. Dry mucous membranes noted.

Neck: Supple, no lymphadenopathy, no thyromegaly, no carotid bruits.

Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs. PMI at 5th ICS MCL.

Respiratory: Clear to auscultation bilaterally. No wheezes, rales, or rhonchi.

Abdominal: Soft, non-tender, non-distended. No hepatosplenomegaly. No masses. Normal bowel sounds.

Extremities: No cyanosis, clubbing, or edema. Pulses 2+ and symmetric throughout.

Neurological:

- CN II-XII intact
- Motor strength 5/5 in all extremities
- DTRs 2+ bilaterally
- Sensation to light touch slightly diminished in distal lower extremities bilaterally

- Proprioception intact

Skin: Warm, dry. No rashes, lesions, or ulcerations.

LABORATORY RESULTS

Hematology:

- WBC: 7.5 x 10^3/µL (ref: 4.5-11.0)
- Hemoglobin: 15.2 g/dL (ref: 13.5-17.5)
- Hematocrit: 45% (ref: 41-53%)
- Platelets: 256 x 10^3/µL (ref: 150-450)

Chemistry:

- **Glucose (fasting): 198 mg/dL** (ref: 70-99) [ELEVATED]
- **HbA1c: 8.4%** (ref: <5.7%) [ELEVATED]
- BUN: 18 mg/dL (ref: 7-20)
- Creatinine: 0.9 mg/dL (ref: 0.6-1.2)
- eGFR: >90 mL/min/1.73m^2
- Sodium: 138 mEq/L (ref: 135-145)
- Potassium: 4.2 mEq/L (ref: 3.5-5.0)
- Chloride: 102 mEq/L (ref: 98-107)
- CO2: 24 mEq/L (ref: 22-29)
- Calcium: 9.4 mg/dL (ref: 8.6-10.2)
- **Total Cholesterol: 228 mg/dL** (ref: <200) [ELEVATED]
- **LDL Cholesterol: 142 mg/dL** (ref: <100) [ELEVATED]
- HDL Cholesterol: 38 mg/dL (ref: >40) [BORDERLINE LOW]
- **Triglycerides: 242 mg/dL** (ref: <150) [ELEVATED]
- AST: 28 U/L (ref: 10-40)
- ALT: 32 U/L (ref: 7-56)
- Total Bilirubin: 0.8 mg/dL (ref: 0.1-1.2)
- Albumin: 4.2 g/dL (ref: 3.4-5.0)

Urinalysis:

- **Glucose: Positive (2+)** [ABNORMAL]
- Protein: Negative
- Ketones: Negative
- Blood: Negative
- Leukocyte esterase: Negative
- Nitrites: Negative
- pH: 5.5 (ref: 5.0-7.5)
- Specific gravity: 1.025 (ref: 1.005-1.030)

Additional Tests:

- **Urine Microalbumin: 42 mg/g creatinine** (ref: <30) [ELEVATED]
- **Fasting C-peptide: 3.8 ng/mL** (ref: 0.8-3.5) [SLIGHTLY ELEVATED]
- GAD65 Antibodies: Negative

IMAGING STUDIES

Chest X-ray (02/28/2025): PA and lateral views show clear lung fields. Normal heart size. No pleural effusions. No acute cardiopulmonary disease.

Abdominal Ultrasound (02/28/2025): Liver normal in size and echogenicity. Moderate hepatic steatosis noted. No focal lesions. Gallbladder, biliary tree, pancreas, spleen, and kidneys appear normal. No abnormal fluid collections.

ASSESSMENT

1. **Type 2 Diabetes Mellitus, newly diagnosed**
    - Based on elevated fasting glucose, HbA1c, and classic symptoms
    - Evidence of early complications: mild peripheral neuropathy and microalbuminuria
    - Negative autoimmune markers suggesting Type 2 rather than Type 1
2. **Hypertension, inadequately controlled**
    - Current BP 142/88 mmHg on Lisinopril 10mg daily
    - Increased cardiovascular risk with coexisting diabetes
3. **Dyslipidemia**
    - Elevated LDL, total cholesterol, and triglycerides
    - Low HDL
    - Currently on Atorvastatin 20mg daily
4. **Non-alcoholic Fatty Liver Disease (NAFLD)**
    - Moderate hepatic steatosis on ultrasound
    - Normal liver enzymes
    - Associated with metabolic syndrome
5. **Overweight**
    - BMI 28.4 kg/m²
    - Central adiposity (noted on physical exam)
    - Recent unintentional weight loss likely due to hyperglycemia
6. **Early Diabetic Nephropathy**

- Microalbuminuria (42 mg/g creatinine)
- Normal renal function (eGFR >90)

7. **Early Diabetic Peripheral Neuropathy**

    - Mild distal symmetric paresthesia
    - Slightly diminished sensation to light touch in distal lower extremities

---

PLAN

1. **Diabetes Management:**

    - Initiate Metformin 500mg PO with dinner for 1 week, then increase to 500mg BID
    - Diabetes education referral for glucose monitoring, dietary guidance, and diabetes self-management
    - Blood glucose monitoring: fasting and 2 hours postprandial daily
    - Target HbA1c <7.0%
    - HbA1c follow-up in 3 months

2. **Hypertension Management:**

    - Increase Lisinopril to 20mg daily
    - Target BP <130/80 mmHg given diabetic status
    - Home BP monitoring recommended

3. **Dyslipidemia Management:**

    - Increase Atorvastatin to 40mg daily
    - Target LDL <70 mg/dL given diabetic status
    - Repeat lipid panel in 3 months

4. **Lifestyle Modifications:**

    - Dietary consultation for diabetic diet planning
    - Weight loss goal of 5-10% body weight over 6 months
    - Exercise prescription: start with 30 minutes of moderate activity 5 days per week
    - Complete smoking abstinence (patient is non-smoker)
    - Limit alcohol consumption

5. **Diabetic Complications Screening:**

    - Comprehensive eye examination with dilation
    - Comprehensive foot examination
    - Urine albumin-to-creatinine ratio in 3 months
    - Depression screening

6. **Follow-up:**

- Return visit in 2 weeks to assess medication tolerance and glucose readings
- Complete laboratory workup in 3 months

PROGNOSIS

With appropriate medication management, lifestyle modifications, and regular monitoring, Mr. Sample has a good prognosis. Early diagnosis and intervention for his diabetes, hypertension, and dyslipidemia should help prevent major complications. The presence of early microalbuminuria and peripheral neuropathy indicates the need for aggressive management to prevent progression of these complications.

Report prepared by:

Dr. Michael Rodriguez, M.D.
Board Certified in Internal Medicine
State License #: MD12345
Metropolitan Medical Center
123 Health Avenue
Anytown, USA 12345
Tel: (555) 123-4567

Date of Report: March 3, 2025