HEALTHAI MEDICAL CENTER

COMPREHENSIVE PATIENT MEDICAL RECORDS

Electronic Health Record System v2.5

Generated: December 12, 2025

CONFIDENTIAL MEDICAL INFORMATION

PATIENT SUMMARY

Name: Patricia Brown
Medical Record Number: MRN-698097
Date of Birth: 12/08/1982
Age: 43 years
Primary Care Physician: Dr. Sarah Mitchell, MD

Medical Record Contents:
• Progress Notes (Multiple Visits)
• Laboratory Results
• Diagnostic Imaging Reports
• Medication History
• Consultation Reports

PROGRESS NOTE - Visit #1
Date: 02/25/2024 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Furosemide 40mg QD
3. Omeprazole 20mg QD
4. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #2
Date: 04/03/2024 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Type 2 Diabetes Mellitus
3. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Insulin Glargine 20 units QHS
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #3
Date: 06/12/2024 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Hypertension
3. Type 2 Diabetes Mellitus
4. Sleep Apnea
5. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Warfarin 5mg QD
3. Sertraline 50mg QD
4. Aspirin 81mg QD
5. Gabapentin 300mg TID
6. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #1
Date Collected: 07/13/2024 16:17
Date Reported: 07/13/2024 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.9	12.0 - 16.0	g/dL	
WBC	4.5	4.5 - 11.0	K/uL	
Platelets	391.5	150 - 400	K/uL	
Glucose	79.1	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	137.5	135 - 145	mEq/L	
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	178.9	125 - 200	mg/dL	
LDL	76.2	0 - 100	mg/dL	
HDL	45.7	40 - 60	mg/dL	
Triglycerides	87.5	0 - 150	mg/dL	
HbA1c	3.9	4.0 - 5.6	%	L
TSH	0.3	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #5
Date: 10/08/2024 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Osteoarthritis

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Furosemide 40mg QD
3. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #6
Date: 12/20/2024 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Hypothyroidism
3. Asthma
4. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Warfarin 5mg QD
3. Levothyroxine 75mcg QD
4. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #7
Date: 02/17/2025 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Hyperlipidemia
3. Type 2 Diabetes Mellitus
4. Anxiety Disorder
5. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Sertraline 50mg QD
3. Albuterol MDI PRN
4. Metformin 1000mg BID
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #2
Date Collected: 04/23/2025 16:17
Date Reported: 04/23/2025 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.2	12.0 - 16.0	g/dL	
WBC	8.9	4.5 - 11.0	K/uL	
Platelets	361.6	150 - 400	K/uL	
Glucose	76.8	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	138.6	135 - 145	mEq/L	
Potassium	5.1	3.5 - 5.0	mEq/L	H
Total Cholesterol	151.4	125 - 200	mg/dL	
LDL	42.0	0 - 100	mg/dL	
HDL	55.0	40 - 60	mg/dL	
Triglycerides	89.6	0 - 150	mg/dL	
HbA1c	4.6	4.0 - 5.6	%	
TSH	4.7	0.4 - 4.0	mIU/L	H

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #9
Date: 06/25/2025 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Asthma

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Levothyroxine 75mcg QD
3. Lisinopril 10mg QD
4. Albuterol MDI PRN
5. Metformin 1000mg BID
6. Omeprazole 20mg QD
7. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #10
Date: 08/22/2025 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Lisinopril 10mg QD
3. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #11
Date: 10/26/2025 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Major Depressive Disorder
3. Osteoarthritis

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Metformin 1000mg BID
3. Omeprazole 20mg QD
4. Albuterol MDI PRN
5. Aspirin 81mg QD
6. Gabapentin 300mg TID
7. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #3
Date Collected: 01/10/2026 16:17
Date Reported: 01/10/2026 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.6	12.0 - 16.0	g/dL	
WBC	4.5	4.5 - 11.0	K/uL	
Platelets	276.1	150 - 400	K/uL	
Glucose	84.0	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	137.4	135 - 145	mEq/L	
Potassium	2.9	3.5 - 5.0	mEq/L	L
Total Cholesterol	149.2	125 - 200	mg/dL	
LDL	108.6	0 - 100	mg/dL	H
HDL	42.9	40 - 60	mg/dL	
Triglycerides	84.4	0 - 150	mg/dL	
HbA1c	3.6	4.0 - 5.6	%	L
TSH	2.3	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #13
Date: 02/22/2026 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Warfarin 5mg QD
3. Insulin Glargine 20 units QHS
4. Furosemide 40mg QD
5. Aspirin 81mg QD
6. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #14
Date: 05/13/2026 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Asthma

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Lisinopril 10mg QD
3. Aspirin 81mg QD
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #15
Date: 06/16/2026 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Sleep Apnea
3. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Furosemide 40mg QD
3. Omeprazole 20mg QD
4. Atorvastatin 20mg QHS
5. Warfarin 5mg QD
6. Gabapentin 300mg TID
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #4
Date Collected: 08/25/2026 16:17
Date Reported: 08/25/2026 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.0	12.0 - 16.0	g/dL	
WBC	10.9	4.5 - 11.0	K/uL	
Platelets	354.7	150 - 400	K/uL	
Glucose	83.0	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	L
Sodium	153.0	135 - 145	mEq/L	H
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	102.1	125 - 200	mg/dL	L
LDL	0.0	0 - 100	mg/dL	L
HDL	41.3	40 - 60	mg/dL	
Triglycerides	129.3	0 - 150	mg/dL	
HbA1c	6.6	4.0 - 5.6	%	H
TSH	2.1	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #17
Date: 10/26/2026 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Hypothyroidism
3. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Lisinopril 10mg QD
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #18
Date: 01/11/2027 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Osteoarthritis
3. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Furosemide 40mg QD
3. Insulin Glargine 20 units QHS
4. Levothyroxine 75mcg QD
5. Warfarin 5mg QD
6. Sertraline 50mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #19
Date: 03/22/2027 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hypothyroidism
3. Hypertension
4. Asthma

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Sertraline 50mg QD
3. Insulin Glargine 20 units QHS
4. Aspirin 81mg QD
5. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #5
Date Collected: 06/06/2027 16:17
Date Reported: 06/06/2027 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.1	12.0 - 16.0	g/dL	
WBC	5.3	4.5 - 11.0	K/uL	
Platelets	175.1	150 - 400	K/uL	
Glucose	95.6	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	136.3	135 - 145	mEq/L	
Potassium	5.8	3.5 - 5.0	mEq/L	H
Total Cholesterol	166.8	125 - 200	mg/dL	
LDL	116.8	0 - 100	mg/dL	H
HDL	40.3	40 - 60	mg/dL	
Triglycerides	166.9	0 - 150	mg/dL	H
HbA1c	5.4	4.0 - 5.6	%	
TSH	0.4	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #21
Date: 08/11/2027 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Hypothyroidism
3. Atrial Fibrillation
4. Major Depressive Disorder
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Gabapentin 300mg TID
3. Sertraline 50mg QD
4. Omeprazole 20mg QD
5. Warfarin 5mg QD
6. Insulin Glargine 20 units QHS
7. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #22
Date: 10/23/2027 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Type 2 Diabetes Mellitus
3. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Gabapentin 300mg TID
3. Aspirin 81mg QD
4. Albuterol MDI PRN
5. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #23
Date: 12/08/2027 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Hyperlipidemia
3. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Sertraline 50mg QD
3. Furosemide 40mg QD
4. Aspirin 81mg QD
5. Omeprazole 20mg QD
6. Atorvastatin 20mg QHS
7. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #6
Date Collected: 03/05/2028 16:17
Date Reported: 03/05/2028 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.6	12.0 - 16.0	g/dL	
WBC	8.5	4.5 - 11.0	K/uL	
Platelets	183.8	150 - 400	K/uL	
Glucose	94.3	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	140.3	135 - 145	mEq/L	
Potassium	5.4	3.5 - 5.0	mEq/L	H
Total Cholesterol	109.1	125 - 200	mg/dL	L
LDL	46.0	0 - 100	mg/dL	
HDL	48.4	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	4.4	4.0 - 5.6	%	
TSH	2.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #25
Date: 05/07/2028 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Major Depressive Disorder
3. Asthma

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Atorvastatin 20mg QHS
3. Sertraline 50mg QD
4. Aspirin 81mg QD
5. Insulin Glargine 20 units QHS
6. Levothyroxine 75mcg QD
7. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #26
Date: 07/01/2028 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Chronic Kidney Disease Stage 3
3. Osteoarthritis
4. Type 2 Diabetes Mellitus
5. Hypertension

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Albuterol MDI PRN
3. Insulin Glargine 20 units QHS
4. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #27
Date: 08/13/2028 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Osteoporosis

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Lisinopril 10mg QD
3. Metformin 1000mg BID
4. Omeprazole 20mg QD
5. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #7
Date Collected: 10/12/2028 16:17
Date Reported: 10/12/2028 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.0	12.0 - 16.0	g/dL	
WBC	4.8	4.5 - 11.0	K/uL	
Platelets	316.6	150 - 400	K/uL	
Glucose	86.6	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	H
Sodium	139.6	135 - 145	mEq/L	
Potassium	3.6	3.5 - 5.0	mEq/L	
Total Cholesterol	125.7	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	51.1	40 - 60	mg/dL	
Triglycerides	120.9	0 - 150	mg/dL	
HbA1c	3.7	4.0 - 5.6	%	L
TSH	3.1	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #29
Date: 11/16/2028 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Asthma
3. Atrial Fibrillation
4. Hypertension
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Insulin Glargine 20 units QHS
3. Lisinopril 10mg QD
4. Albuterol MDI PRN
5. Atorvastatin 20mg QHS
6. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #30
Date: 12/21/2028 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Chronic Obstructive Pulmonary Disease
3. Hypertension

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Lisinopril 10mg QD
3. Insulin Glargine 20 units QHS
4. Gabapentin 300mg TID
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #31
Date: 01/25/2029 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Warfarin 5mg QD
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #8
Date Collected: 04/05/2029 16:17
Date Reported: 04/05/2029 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.1	12.0 - 16.0	g/dL	
WBC	7.8	4.5 - 11.0	K/uL	
Platelets	268.2	150 - 400	K/uL	
Glucose	83.6	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	144.9	135 - 145	mEq/L	
Potassium	5.0	3.5 - 5.0	mEq/L	
Total Cholesterol	197.2	125 - 200	mg/dL	
LDL	24.4	0 - 100	mg/dL	
HDL	52.9	40 - 60	mg/dL	
Triglycerides	150.2	0 - 150	mg/dL	H
HbA1c	5.6	4.0 - 5.6	%	
TSH	0.4	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #33
Date: 06/01/2029 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Asthma
3. Hypothyroidism
4. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Warfarin 5mg QD
3. Sertraline 50mg QD
4. Albuterol MDI PRN
5. Metformin 1000mg BID
6. Atorvastatin 20mg QHS
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #34
Date: 07/10/2029 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Gastroesophageal Reflux Disease
3. Chronic Obstructive Pulmonary Disease
4. Sleep Apnea

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Warfarin 5mg QD
3. Insulin Glargine 20 units QHS
4. Gabapentin 300mg TID
5. Metformin 1000mg BID
6. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #35
Date: 09/26/2029 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Major Depressive Disorder
3. Coronary Artery Disease
4. Asthma

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Furosemide 40mg QD
3. Aspirin 81mg QD
4. Albuterol MDI PRN
5. Lisinopril 10mg QD
6. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #9
Date Collected: 11/18/2029 16:17
Date Reported: 11/18/2029 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.3	12.0 - 16.0	g/dL	
WBC	9.1	4.5 - 11.0	K/uL	
Platelets	131.9	150 - 400	K/uL	L
Glucose	83.3	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	135.6	135 - 145	mEq/L	
Potassium	4.6	3.5 - 5.0	mEq/L	
Total Cholesterol	227.0	125 - 200	mg/dL	H
LDL	108.8	0 - 100	mg/dL	H
HDL	54.0	40 - 60	mg/dL	
Triglycerides	97.6	0 - 150	mg/dL	
HbA1c	3.8	4.0 - 5.6	%	L
TSH	2.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #37
Date: 12/21/2029 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Metformin 1000mg BID
3. Omeprazole 20mg QD
4. Sertraline 50mg QD
5. Gabapentin 300mg TID
6. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #38
Date: 03/21/2030 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Metformin 1000mg BID
3. Atorvastatin 20mg QHS
4. Insulin Glargine 20 units QHS
5. Warfarin 5mg QD
6. Furosemide 40mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #39
Date: 04/27/2030 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Atrial Fibrillation
3. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Omeprazole 20mg QD
3. Aspirin 81mg QD
4. Albuterol MDI PRN
5. Lisinopril 10mg QD
6. Furosemide 40mg QD
7. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #10
Date Collected: 07/08/2030 16:17
Date Reported: 07/08/2030 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.4	12.0 - 16.0	g/dL	
WBC	10.0	4.5 - 11.0	K/uL	
Platelets	268.2	150 - 400	K/uL	
Glucose	70.9	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	141.6	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	182.0	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	43.8	40 - 60	mg/dL	
Triglycerides	12.6	0 - 150	mg/dL	
HbA1c	6.5	4.0 - 5.6	%	H
TSH	1.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #41
Date: 08/24/2030 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Lisinopril 10mg QD
3. Gabapentin 300mg TID
4. Sertraline 50mg QD
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #42
Date: 10/06/2030 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Osteoarthritis

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Albuterol MDI PRN
3. Furosemide 40mg QD
4. Warfarin 5mg QD
5. Sertraline 50mg QD
6. Metformin 1000mg BID
7. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #43
Date: 11/13/2030 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Osteoarthritis
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Sertraline 50mg QD
3. Insulin Glargine 20 units QHS
4. Albuterol MDI PRN
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #11
Date Collected: 01/24/2031 16:17
Date Reported: 01/24/2031 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	11.1	12.0 - 16.0	g/dL	L
WBC	6.5	4.5 - 11.0	K/uL	
Platelets	178.6	150 - 400	K/uL	
Glucose	85.5	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	162.3	135 - 145	mEq/L	H
Potassium	4.3	3.5 - 5.0	mEq/L	
Total Cholesterol	188.7	125 - 200	mg/dL	
LDL	113.3	0 - 100	mg/dL	H
HDL	42.1	40 - 60	mg/dL	
Triglycerides	76.5	0 - 150	mg/dL	
HbA1c	4.4	4.0 - 5.6	%	
TSH	3.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #45
Date: 03/25/2031 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Major Depressive Disorder
3. Sleep Apnea

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Metformin 1000mg BID
3. Aspirin 81mg QD
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #46
Date: 05/09/2031 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Levothyroxine 75mcg QD
3. Omeprazole 20mg QD
4. Sertraline 50mg QD
5. Gabapentin 300mg TID
6. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #47
Date: 07/06/2031 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Aspirin 81mg QD
3. Atorvastatin 20mg QHS
4. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #12
Date Collected: 08/30/2031 16:17
Date Reported: 08/30/2031 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.6	12.0 - 16.0	g/dL	
WBC	10.2	4.5 - 11.0	K/uL	
Platelets	242.0	150 - 400	K/uL	
Glucose	93.7	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	137.8	135 - 145	mEq/L	
Potassium	3.9	3.5 - 5.0	mEq/L	
Total Cholesterol	102.1	125 - 200	mg/dL	L
LDL	13.3	0 - 100	mg/dL	
HDL	48.7	40 - 60	mg/dL	
Triglycerides	95.5	0 - 150	mg/dL	
HbA1c	4.8	4.0 - 5.6	%	
TSH	2.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #49
Date: 11/05/2031 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Atorvastatin 20mg QHS
3. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #50
Date: 12/20/2031 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Albuterol MDI PRN
3. Insulin Glargine 20 units QHS
4. Aspirin 81mg QD
5. Gabapentin 300mg TID
6. Lisinopril 10mg QD
7. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #51
Date: 01/28/2032 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Chronic Obstructive Pulmonary Disease
3. Osteoporosis
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Metformin 1000mg BID
3. Lisinopril 10mg QD
4. Sertraline 50mg QD
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #13
Date Collected: 03/11/2032 16:17
Date Reported: 03/11/2032 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.4	12.0 - 16.0	g/dL	
WBC	9.7	4.5 - 11.0	K/uL	
Platelets	323.8	150 - 400	K/uL	
Glucose	86.2	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	H
Sodium	138.8	135 - 145	mEq/L	
Potassium	2.9	3.5 - 5.0	mEq/L	L
Total Cholesterol	163.6	125 - 200	mg/dL	
LDL	10.9	0 - 100	mg/dL	
HDL	53.9	40 - 60	mg/dL	
Triglycerides	14.4	0 - 150	mg/dL	
HbA1c	4.2	4.0 - 5.6	%	
TSH	3.4	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #53
Date: 04/15/2032 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Major Depressive Disorder
3. Coronary Artery Disease
4. Osteoarthritis
5. Asthma

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Gabapentin 300mg TID
3. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #54
Date: 07/05/2032 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Osteoporosis
3. Hypertension
4. Hypothyroidism

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Albuterol MDI PRN
3. Metformin 1000mg BID
4. Warfarin 5mg QD
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #55
Date: 09/12/2032 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Anxiety Disorder
3. Chronic Kidney Disease Stage 3
4. Major Depressive Disorder
5. Hypertension

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Furosemide 40mg QD
3. Aspirin 81mg QD
4. Omeprazole 20mg QD
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #14
Date Collected: 11/30/2032 16:17
Date Reported: 11/30/2032 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.4	12.0 - 16.0	g/dL	
WBC	5.3	4.5 - 11.0	K/uL	
Platelets	185.0	150 - 400	K/uL	
Glucose	79.6	70 - 100	mg/dL	
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	138.8	135 - 145	mEq/L	
Potassium	5.4	3.5 - 5.0	mEq/L	H
Total Cholesterol	133.7	125 - 200	mg/dL	
LDL	100.2	0 - 100	mg/dL	H
HDL	51.7	40 - 60	mg/dL	
Triglycerides	82.5	0 - 150	mg/dL	
HbA1c	4.7	4.0 - 5.6	%	
TSH	1.6	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #57
Date: 01/17/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hypertension

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Gabapentin 300mg TID
3. Lisinopril 10mg QD
4. Furosemide 40mg QD
5. Sertraline 50mg QD
6. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #58
Date: 03/17/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Chronic Kidney Disease Stage 3
3. Anxiety Disorder
4. Type 2 Diabetes Mellitus
5. Asthma

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Lisinopril 10mg QD
3. Aspirin 81mg QD
4. Atorvastatin 20mg QHS
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #59
Date: 05/09/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Sleep Apnea

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Omeprazole 20mg QD
3. Albuterol MDI PRN
4. Insulin Glargine 20 units QHS
5. Aspirin 81mg QD
6. Metformin 1000mg BID
7. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #15
Date Collected: 07/02/2033 16:17
Date Reported: 07/02/2033 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.7	12.0 - 16.0	g/dL	
WBC	6.0	4.5 - 11.0	K/uL	
Platelets	335.1	150 - 400	K/uL	
Glucose	96.0	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	146.0	135 - 145	mEq/L	H
Potassium	5.0	3.5 - 5.0	mEq/L	
Total Cholesterol	150.9	125 - 200	mg/dL	
LDL	24.5	0 - 100	mg/dL	
HDL	42.1	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	6.4	4.0 - 5.6	%	H
TSH	3.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #61
Date: 09/09/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Chronic Obstructive Pulmonary Disease
3. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Furosemide 40mg QD
3. Warfarin 5mg QD
4. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #62
Date: 10/25/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Osteoporosis

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Gabapentin 300mg TID
3. Omeprazole 20mg QD
4. Furosemide 40mg QD
5. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #63
Date: 12/13/2033 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Albuterol MDI PRN
3. Lisinopril 10mg QD
4. Omeprazole 20mg QD
5. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #16
Date Collected: 02/12/2034 16:17
Date Reported: 02/12/2034 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.5	12.0 - 16.0	g/dL	
WBC	9.8	4.5 - 11.0	K/uL	
Platelets	432.9	150 - 400	K/uL	H
Glucose	83.3	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	144.3	135 - 145	mEq/L	
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	185.4	125 - 200	mg/dL	
LDL	63.4	0 - 100	mg/dL	
HDL	41.5	40 - 60	mg/dL	
Triglycerides	55.0	0 - 150	mg/dL	
HbA1c	5.0	4.0 - 5.6	%	
TSH	3.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #65
Date: 03/19/2034 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Osteoporosis

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Omeprazole 20mg QD
3. Sertraline 50mg QD
4. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #66
Date: 04/21/2034 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hyperlipidemia
3. Sleep Apnea
4. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Warfarin 5mg QD
3. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #67
Date: 07/10/2034 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Major Depressive Disorder
3. Chronic Kidney Disease Stage 3
4. Atrial Fibrillation
5. Asthma

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Gabapentin 300mg TID
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #17
Date Collected: 10/02/2034 16:17
Date Reported: 10/02/2034 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.8	12.0 - 16.0	g/dL	
WBC	7.7	4.5 - 11.0	K/uL	
Platelets	143.5	150 - 400	K/uL	L
Glucose	76.5	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	L
Sodium	136.4	135 - 145	mEq/L	
Potassium	3.6	3.5 - 5.0	mEq/L	
Total Cholesterol	122.2	125 - 200	mg/dL	L
LDL	47.7	0 - 100	mg/dL	
HDL	52.5	40 - 60	mg/dL	
Triglycerides	162.1	0 - 150	mg/dL	H
HbA1c	5.0	4.0 - 5.6	%	
TSH	1.6	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #69
Date: 12/29/2034 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Osteoarthritis

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Warfarin 5mg QD
3. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #70
Date: 03/09/2035 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Anxiety Disorder
3. Gastroesophageal Reflux Disease
4. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Omeprazole 20mg QD
3. Albuterol MDI PRN
4. Aspirin 81mg QD
5. Lisinopril 10mg QD
6. Gabapentin 300mg TID
7. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #71
Date: 04/10/2035 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Chronic Kidney Disease Stage 3
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Gabapentin 300mg TID
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #18
Date Collected: 07/01/2035 16:17
Date Reported: 07/01/2035 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.5	12.0 - 16.0	g/dL	
WBC	9.4	4.5 - 11.0	K/uL	
Platelets	376.4	150 - 400	K/uL	
Glucose	59.8	70 - 100	mg/dL	L
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	135.0	135 - 145	mEq/L	
Potassium	4.8	3.5 - 5.0	mEq/L	
Total Cholesterol	137.3	125 - 200	mg/dL	
LDL	51.0	0 - 100	mg/dL	
HDL	41.3	40 - 60	mg/dL	
Triglycerides	113.1	0 - 150	mg/dL	
HbA1c	5.5	4.0 - 5.6	%	
TSH	2.1	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #73
Date: 08/27/2035 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Omeprazole 20mg QD
3. Insulin Glargine 20 units QHS
4. Gabapentin 300mg TID
5. Furosemide 40mg QD
6. Albuterol MDI PRN
7. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #74
Date: 10/08/2035 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Major Depressive Disorder
3. Coronary Artery Disease
4. Hyperlipidemia
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Aspirin 81mg QD
3. Albuterol MDI PRN
4. Levothyroxine 75mcg QD
5. Metformin 1000mg BID
6. Omeprazole 20mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #75
Date: 11/19/2035 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Gastroesophageal Reflux Disease
3. Major Depressive Disorder
4. Osteoporosis

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Metformin 1000mg BID
3. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #19
Date Collected: 01/19/2036 16:17
Date Reported: 01/19/2036 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.8	12.0 - 16.0	g/dL	
WBC	6.0	4.5 - 11.0	K/uL	
Platelets	389.9	150 - 400	K/uL	
Glucose	89.2	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	143.5	135 - 145	mEq/L	
Potassium	3.3	3.5 - 5.0	mEq/L	L
Total Cholesterol	184.3	125 - 200	mg/dL	
LDL	66.4	0 - 100	mg/dL	
HDL	39.0	40 - 60	mg/dL	L
Triglycerides	121.3	0 - 150	mg/dL	
HbA1c	5.4	4.0 - 5.6	%	
TSH	4.7	0.4 - 4.0	mIU/L	H

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #77
Date: 04/07/2036 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Hypothyroidism
3. Gastroesophageal Reflux Disease
4. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Insulin Glargine 20 units QHS
3. Metformin 1000mg BID
4. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #78
Date: 05/15/2036 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Major Depressive Disorder
3. Hypothyroidism
4. Type 2 Diabetes Mellitus
5. Hypertension

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Levothyroxine 75mcg QD
3. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #79
Date: 07/24/2036 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Hypertension
3. Atrial Fibrillation
4. Coronary Artery Disease
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Gabapentin 300mg TID
3. Aspirin 81mg QD
4. Levothyroxine 75mcg QD
5. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #20
Date Collected: 10/11/2036 16:17
Date Reported: 10/11/2036 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	19.2	12.0 - 16.0	g/dL	H
WBC	10.5	4.5 - 11.0	K/uL	
Platelets	303.7	150 - 400	K/uL	
Glucose	81.7	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	141.2	135 - 145	mEq/L	
Potassium	4.6	3.5 - 5.0	mEq/L	
Total Cholesterol	176.7	125 - 200	mg/dL	
LDL	23.0	0 - 100	mg/dL	
HDL	42.6	40 - 60	mg/dL	
Triglycerides	66.6	0 - 150	mg/dL	
HbA1c	4.8	4.0 - 5.6	%	
TSH	4.1	0.4 - 4.0	mIU/L	H

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #81
Date: 12/19/2036 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Hyperlipidemia
3. Hypothyroidism
4. Osteoarthritis
5. Osteoporosis

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Aspirin 81mg QD
3. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #82
Date: 02/19/2037 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Osteoporosis
3. Anxiety Disorder
4. Hyperlipidemia

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Warfarin 5mg QD
3. Omeprazole 20mg QD
4. Sertraline 50mg QD
5. Gabapentin 300mg TID
6. Albuterol MDI PRN
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #83
Date: 04/25/2037 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Aspirin 81mg QD
3. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #21
Date Collected: 06/09/2037 16:17
Date Reported: 06/09/2037 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.8	12.0 - 16.0	g/dL	
WBC	8.6	4.5 - 11.0	K/uL	
Platelets	256.6	150 - 400	K/uL	
Glucose	96.2	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	132.5	135 - 145	mEq/L	L
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	134.1	125 - 200	mg/dL	
LDL	23.0	0 - 100	mg/dL	
HDL	49.4	40 - 60	mg/dL	
Triglycerides	17.6	0 - 150	mg/dL	
HbA1c	4.7	4.0 - 5.6	%	
TSH	4.2	0.4 - 4.0	mIU/L	H

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #85
Date: 07/09/2037 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Hyperlipidemia
3. Coronary Artery Disease
4. Chronic Obstructive Pulmonary Disease
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Furosemide 40mg QD
3. Insulin Glargine 20 units QHS
4. Sertraline 50mg QD
5. Levothyroxine 75mcg QD
6. Lisinopril 10mg QD
7. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #86
Date: 08/29/2037 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Asthma
3. Major Depressive Disorder
4. Atrial Fibrillation
5. Anxiety Disorder

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Atorvastatin 20mg QHS
3. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #87
Date: 11/23/2037 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Osteoarthritis
3. Hyperlipidemia
4. Osteoporosis
5. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Omeprazole 20mg QD
3. Metformin 1000mg BID
4. Insulin Glargine 20 units QHS
5. Gabapentin 300mg TID
6. Furosemide 40mg QD
7. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #22
Date Collected: 02/18/2038 16:17
Date Reported: 02/18/2038 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.8	12.0 - 16.0	g/dL	
WBC	6.4	4.5 - 11.0	K/uL	
Platelets	130.5	150 - 400	K/uL	L
Glucose	93.3	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	121.4	135 - 145	mEq/L	L
Potassium	4.0	3.5 - 5.0	mEq/L	
Total Cholesterol	236.6	125 - 200	mg/dL	H
LDL	88.8	0 - 100	mg/dL	
HDL	45.5	40 - 60	mg/dL	
Triglycerides	122.1	0 - 150	mg/dL	
HbA1c	4.5	4.0 - 5.6	%	
TSH	0.4	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #89
Date: 04/29/2038 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Gastroesophageal Reflux Disease
3. Atrial Fibrillation
4. Hypertension
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Atorvastatin 20mg QHS
3. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #90
Date: 07/27/2038 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Levothyroxine 75mcg QD
3. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #91
Date: 10/12/2038 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Osteoarthritis
3. Osteoporosis
4. Hyperlipidemia
5. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Gabapentin 300mg TID
3. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #23
Date Collected: 12/13/2038 16:17
Date Reported: 12/13/2038 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.6	12.0 - 16.0	g/dL	
WBC	7.4	4.5 - 11.0	K/uL	
Platelets	197.4	150 - 400	K/uL	
Glucose	75.7	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	135.2	135 - 145	mEq/L	
Potassium	3.9	3.5 - 5.0	mEq/L	
Total Cholesterol	237.4	125 - 200	mg/dL	H
LDL	29.6	0 - 100	mg/dL	
HDL	49.7	40 - 60	mg/dL	
Triglycerides	23.8	0 - 150	mg/dL	
HbA1c	3.9	4.0 - 5.6	%	L
TSH	0.3	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #93
Date: 02/11/2039 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Sleep Apnea

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Omeprazole 20mg QD
3. Atorvastatin 20mg QHS
4. Furosemide 40mg QD
5. Aspirin 81mg QD
6. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #94
Date: 04/29/2039 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Anxiety Disorder
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Lisinopril 10mg QD
3. Omeprazole 20mg QD
4. Insulin Glargine 20 units QHS
5. Atorvastatin 20mg QHS
6. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #95
Date: 07/28/2039 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Hypertension
3. Type 2 Diabetes Mellitus
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Atorvastatin 20mg QHS
3. Aspirin 81mg QD
4. Sertraline 50mg QD
5. Lisinopril 10mg QD
6. Albuterol MDI PRN
7. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #24
Date Collected: 09/02/2039 16:17
Date Reported: 09/02/2039 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.0	12.0 - 16.0	g/dL	
WBC	6.4	4.5 - 11.0	K/uL	
Platelets	155.6	150 - 400	K/uL	
Glucose	76.4	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	143.1	135 - 145	mEq/L	
Potassium	3.2	3.5 - 5.0	mEq/L	L
Total Cholesterol	139.9	125 - 200	mg/dL	
LDL	79.3	0 - 100	mg/dL	
HDL	58.0	40 - 60	mg/dL	
Triglycerides	52.5	0 - 150	mg/dL	
HbA1c	4.4	4.0 - 5.6	%	
TSH	2.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #97
Date: 10/24/2039 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Gastroesophageal Reflux Disease
3. Type 2 Diabetes Mellitus
4. Hypothyroidism

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Sertraline 50mg QD
3. Furosemide 40mg QD
4. Omeprazole 20mg QD
5. Insulin Glargine 20 units QHS
6. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #98
Date: 12/18/2039 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hypertension
3. Osteoporosis
4. Sleep Apnea
5. Hypothyroidism

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Insulin Glargine 20 units QHS
3. Atorvastatin 20mg QHS
4. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #99
Date: 01/18/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Furosemide 40mg QD
3. Warfarin 5mg QD
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #25
Date Collected: 03/02/2040 16:17
Date Reported: 03/02/2040 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.5	12.0 - 16.0	g/dL	L
WBC	3.9	4.5 - 11.0	K/uL	L
Platelets	358.9	150 - 400	K/uL	
Glucose	93.1	70 - 100	mg/dL	
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	139.8	135 - 145	mEq/L	
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	180.3	125 - 200	mg/dL	
LDL	66.3	0 - 100	mg/dL	
HDL	53.5	40 - 60	mg/dL	
Triglycerides	147.5	0 - 150	mg/dL	
HbA1c	4.8	4.0 - 5.6	%	
TSH	1.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #101
Date: 04/12/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Coronary Artery Disease
3. Atrial Fibrillation
4. Chronic Obstructive Pulmonary Disease
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Lisinopril 10mg QD
3. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #102
Date: 06/19/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 16 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Type 2 Diabetes Mellitus
3. Hypertension
4. Asthma
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Warfarin 5mg QD
3. Levothyroxine 75mcg QD
4. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #103
Date: 07/22/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Hypertension

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Omeprazole 20mg QD
3. Furosemide 40mg QD
4. Atorvastatin 20mg QHS
5. Levothyroxine 75mcg QD
6. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #26
Date Collected: 09/07/2040 16:17
Date Reported: 09/07/2040 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.8	12.0 - 16.0	g/dL	
WBC	8.2	4.5 - 11.0	K/uL	
Platelets	309.3	150 - 400	K/uL	
Glucose	95.7	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	139.9	135 - 145	mEq/L	
Potassium	4.1	3.5 - 5.0	mEq/L	
Total Cholesterol	147.6	125 - 200	mg/dL	
LDL	81.9	0 - 100	mg/dL	
HDL	58.3	40 - 60	mg/dL	
Triglycerides	98.5	0 - 150	mg/dL	
HbA1c	4.5	4.0 - 5.6	%	
TSH	3.2	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #105
Date: 10/10/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Asthma
3. Major Depressive Disorder
4. Osteoporosis
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Metformin 1000mg BID
3. Insulin Glargine 20 units QHS
4. Gabapentin 300mg TID
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #106
Date: 11/15/2040 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Hypothyroidism
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Gabapentin 300mg TID
3. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #107
Date: 01/11/2041 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Type 2 Diabetes Mellitus
3. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Gabapentin 300mg TID
3. Omeprazole 20mg QD
4. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #27
Date Collected: 04/09/2041 16:17
Date Reported: 04/09/2041 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.2	12.0 - 16.0	g/dL	
WBC	3.9	4.5 - 11.0	K/uL	L
Platelets	244.6	150 - 400	K/uL	
Glucose	95.2	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	H
Sodium	108.2	135 - 145	mEq/L	L
Potassium	3.9	3.5 - 5.0	mEq/L	
Total Cholesterol	103.0	125 - 200	mg/dL	L
LDL	77.0	0 - 100	mg/dL	
HDL	33.1	40 - 60	mg/dL	L
Triglycerides	32.4	0 - 150	mg/dL	
HbA1c	4.4	4.0 - 5.6	%	
TSH	3.6	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #109
Date: 06/17/2041 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Albuterol MDI PRN
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #110
Date: 08/15/2041 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Aspirin 81mg QD
3. Albuterol MDI PRN
4. Levothyroxine 75mcg QD
5. Metformin 1000mg BID
6. Gabapentin 300mg TID
7. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #111
Date: 11/13/2041 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Osteoarthritis
3. Hypertension
4. Anxiety Disorder
5. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Aspirin 81mg QD
3. Gabapentin 300mg TID
4. Atorvastatin 20mg QHS
5. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #28
Date Collected: 01/29/2042 16:17
Date Reported: 01/29/2042 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.5	12.0 - 16.0	g/dL	
WBC	9.3	4.5 - 11.0	K/uL	
Platelets	308.5	150 - 400	K/uL	
Glucose	93.6	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	L
Sodium	142.2	135 - 145	mEq/L	
Potassium	4.9	3.5 - 5.0	mEq/L	
Total Cholesterol	199.4	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	69.7	40 - 60	mg/dL	H
Triglycerides	61.0	0 - 150	mg/dL	
HbA1c	5.4	4.0 - 5.6	%	
TSH	2.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #113
Date: 03/25/2042 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Gastroesophageal Reflux Disease
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Warfarin 5mg QD
3. Omeprazole 20mg QD
4. Albuterol MDI PRN
5. Insulin Glargine 20 units QHS
6. Metformin 1000mg BID
7. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #114
Date: 06/03/2042 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hypothyroidism
3. Osteoarthritis
4. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Lisinopril 10mg QD
3. Furosemide 40mg QD
4. Omeprazole 20mg QD
5. Albuterol MDI PRN
6. Insulin Glargine 20 units QHS
7. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #115
Date: 08/16/2042 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Atorvastatin 20mg QHS
3. Levothyroxine 75mcg QD
4. Insulin Glargine 20 units QHS
5. Furosemide 40mg QD
6. Gabapentin 300mg TID
7. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #29
Date Collected: 10/01/2042 16:17
Date Reported: 10/01/2042 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.2	12.0 - 16.0	g/dL	
WBC	4.6	4.5 - 11.0	K/uL	
Platelets	296.4	150 - 400	K/uL	
Glucose	80.0	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	138.9	135 - 145	mEq/L	
Potassium	4.0	3.5 - 5.0	mEq/L	
Total Cholesterol	155.4	125 - 200	mg/dL	
LDL	54.2	0 - 100	mg/dL	
HDL	46.6	40 - 60	mg/dL	
Triglycerides	148.1	0 - 150	mg/dL	
HbA1c	4.7	4.0 - 5.6	%	
TSH	1.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #117
Date: 11/24/2042 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Chronic Obstructive Pulmonary Disease
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Warfarin 5mg QD
3. Insulin Glargine 20 units QHS
4. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #118
Date: 12/28/2042 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Gabapentin 300mg TID
3. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #119
Date: 03/14/2043 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Chronic Kidney Disease Stage 3
3. Chronic Obstructive Pulmonary Disease
4. Type 2 Diabetes Mellitus
5. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Aspirin 81mg QD
3. Insulin Glargine 20 units QHS
4. Atorvastatin 20mg QHS
5. Omeprazole 20mg QD
6. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #30
Date Collected: 04/23/2043 16:17
Date Reported: 04/23/2043 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	17.7	12.0 - 16.0	g/dL	H
WBC	5.1	4.5 - 11.0	K/uL	
Platelets	161.0	150 - 400	K/uL	
Glucose	82.4	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	108.2	135 - 145	mEq/L	L
Potassium	4.3	3.5 - 5.0	mEq/L	
Total Cholesterol	167.4	125 - 200	mg/dL	
LDL	12.7	0 - 100	mg/dL	
HDL	48.7	40 - 60	mg/dL	
Triglycerides	157.9	0 - 150	mg/dL	H
HbA1c	4.7	4.0 - 5.6	%	
TSH	1.4	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #121
Date: 06/09/2043 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Sleep Apnea
3. Chronic Kidney Disease Stage 3
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Levothyroxine 75mcg QD
3. Aspirin 81mg QD
4. Atorvastatin 20mg QHS
5. Lisinopril 10mg QD
6. Omeprazole 20mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #122
Date: 08/30/2043 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Gabapentin 300mg TID
3. Aspirin 81mg QD
4. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #123
Date: 11/03/2043 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Coronary Artery Disease
3. Hyperlipidemia
4. Osteoporosis
5. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Sertraline 50mg QD
3. Furosemide 40mg QD
4. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #31
Date Collected: 01/21/2044 16:17
Date Reported: 01/21/2044 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.4	12.0 - 16.0	g/dL	
WBC	8.2	4.5 - 11.0	K/uL	
Platelets	284.3	150 - 400	K/uL	
Glucose	72.7	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	143.5	135 - 145	mEq/L	
Potassium	4.6	3.5 - 5.0	mEq/L	
Total Cholesterol	158.0	125 - 200	mg/dL	
LDL	60.7	0 - 100	mg/dL	
HDL	55.7	40 - 60	mg/dL	
Triglycerides	38.1	0 - 150	mg/dL	
HbA1c	3.5	4.0 - 5.6	%	L
TSH	2.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #125
Date: 03/18/2044 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Chronic Kidney Disease Stage 3
3. Sleep Apnea
4. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Aspirin 81mg QD
3. Omeprazole 20mg QD
4. Metformin 1000mg BID
5. Sertraline 50mg QD
6. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #126
Date: 04/23/2044 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Chronic Kidney Disease Stage 3
3. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Furosemide 40mg QD
3. Gabapentin 300mg TID
4. Insulin Glargine 20 units QHS
5. Aspirin 81mg QD
6. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #127
Date: 06/08/2044 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Coronary Artery Disease
3. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Sertraline 50mg QD
3. Albuterol MDI PRN
4. Metformin 1000mg BID
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #32
Date Collected: 08/29/2044 16:17
Date Reported: 08/29/2044 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	4.9	4.5 - 11.0	K/uL	
Platelets	368.0	150 - 400	K/uL	
Glucose	86.0	70 - 100	mg/dL	
Creatinine	1.4	0.6 - 1.2	mg/dL	H
Sodium	135.2	135 - 145	mEq/L	
Potassium	3.5	3.5 - 5.0	mEq/L	
Total Cholesterol	193.6	125 - 200	mg/dL	
LDL	88.8	0 - 100	mg/dL	
HDL	57.1	40 - 60	mg/dL	
Triglycerides	35.3	0 - 150	mg/dL	
HbA1c	4.7	4.0 - 5.6	%	
TSH	2.2	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #129
Date: 11/27/2044 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Gastroesophageal Reflux Disease
3. Hypothyroidism
4. Atrial Fibrillation
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Metformin 1000mg BID
3. Gabapentin 300mg TID
4. Albuterol MDI PRN
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #130
Date: 01/05/2045 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Hypothyroidism
3. Osteoporosis
4. Osteoarthritis
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Furosemide 40mg QD
3. Metformin 1000mg BID
4. Aspirin 81mg QD
5. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #131
Date: 03/03/2045 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Hyperlipidemia
3. Osteoarthritis
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Lisinopril 10mg QD
3. Atorvastatin 20mg QHS
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #33
Date Collected: 05/28/2045 16:17
Date Reported: 05/28/2045 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	12.3	4.5 - 11.0	K/uL	H
Platelets	219.7	150 - 400	K/uL	
Glucose	90.4	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	140.8	135 - 145	mEq/L	
Potassium	4.6	3.5 - 5.0	mEq/L	
Total Cholesterol	142.9	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	57.3	40 - 60	mg/dL	
Triglycerides	132.0	0 - 150	mg/dL	
HbA1c	4.6	4.0 - 5.6	%	
TSH	3.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #133
Date: 08/20/2045 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Sleep Apnea
3. Atrial Fibrillation
4. Chronic Obstructive Pulmonary Disease
5. Hypothyroidism

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Sertraline 50mg QD
3. Gabapentin 300mg TID
4. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #134
Date: 10/26/2045 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Anxiety Disorder
3. Osteoporosis
4. Sleep Apnea

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Furosemide 40mg QD
3. Gabapentin 300mg TID
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #135
Date: 12/29/2045 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hyperlipidemia
3. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Omeprazole 20mg QD
3. Aspirin 81mg QD
4. Lisinopril 10mg QD
5. Levothyroxine 75mcg QD
6. Gabapentin 300mg TID
7. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #34
Date Collected: 02/11/2046 16:17
Date Reported: 02/11/2046 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	17.8	12.0 - 16.0	g/dL	H
WBC	7.1	4.5 - 11.0	K/uL	
Platelets	142.3	150 - 400	K/uL	L
Glucose	68.8	70 - 100	mg/dL	L
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	135.2	135 - 145	mEq/L	
Potassium	4.6	3.5 - 5.0	mEq/L	
Total Cholesterol	200.6	125 - 200	mg/dL	H
LDL	86.1	0 - 100	mg/dL	
HDL	41.5	40 - 60	mg/dL	
Triglycerides	64.1	0 - 150	mg/dL	
HbA1c	5.4	4.0 - 5.6	%	
TSH	3.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #137
Date: 04/26/2046 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Gastroesophageal Reflux Disease
3. Hypertension
4. Asthma

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Warfarin 5mg QD
3. Omeprazole 20mg QD
4. Albuterol MDI PRN
5. Insulin Glargine 20 units QHS
6. Furosemide 40mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #138
Date: 05/27/2046 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Asthma
3. Gastroesophageal Reflux Disease
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Furosemide 40mg QD
3. Aspirin 81mg QD
4. Sertraline 50mg QD
5. Warfarin 5mg QD
6. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #139
Date: 06/30/2046 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Chronic Obstructive Pulmonary Disease
3. Asthma

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Omeprazole 20mg QD
3. Lisinopril 10mg QD
4. Sertraline 50mg QD
5. Metformin 1000mg BID
6. Gabapentin 300mg TID
7. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #35
Date Collected: 08/07/2046 16:17
Date Reported: 08/07/2046 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	18.8	12.0 - 16.0	g/dL	H
WBC	4.7	4.5 - 11.0	K/uL	
Platelets	208.4	150 - 400	K/uL	
Glucose	79.9	70 - 100	mg/dL	
Creatinine	1.3	0.6 - 1.2	mg/dL	H
Sodium	138.9	135 - 145	mEq/L	
Potassium	4.9	3.5 - 5.0	mEq/L	
Total Cholesterol	161.0	125 - 200	mg/dL	
LDL	47.2	0 - 100	mg/dL	
HDL	50.0	40 - 60	mg/dL	
Triglycerides	75.6	0 - 150	mg/dL	
HbA1c	5.3	4.0 - 5.6	%	
TSH	1.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #141
Date: 10/08/2046 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Sleep Apnea
3. Anxiety Disorder
4. Coronary Artery Disease
5. Hypertension

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Albuterol MDI PRN
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #142
Date: 12/18/2046 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Atrial Fibrillation
3. Hypertension
4. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Atorvastatin 20mg QHS
3. Sertraline 50mg QD
4. Warfarin 5mg QD
5. Metformin 1000mg BID
6. Furosemide 40mg QD
7. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #143
Date: 01/21/2047 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Type 2 Diabetes Mellitus
3. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Warfarin 5mg QD
3. Lisinopril 10mg QD
4. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #36
Date Collected: 04/09/2047 16:17
Date Reported: 04/09/2047 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	6.5	4.5 - 11.0	K/uL	
Platelets	449.2	150 - 400	K/uL	H
Glucose	62.3	70 - 100	mg/dL	L
Creatinine	0.6	0.6 - 1.2	mg/dL	L
Sodium	155.7	135 - 145	mEq/L	H
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	126.5	125 - 200	mg/dL	
LDL	77.5	0 - 100	mg/dL	
HDL	44.9	40 - 60	mg/dL	
Triglycerides	147.4	0 - 150	mg/dL	
HbA1c	4.6	4.0 - 5.6	%	
TSH	0.4	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #145
Date: 06/19/2047 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Chronic Obstructive Pulmonary Disease
3. Osteoporosis
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Warfarin 5mg QD
3. Sertraline 50mg QD
4. Lisinopril 10mg QD
5. Aspirin 81mg QD
6. Albuterol MDI PRN
7. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #146
Date: 09/17/2047 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Gabapentin 300mg TID
3. Lisinopril 10mg QD
4. Omeprazole 20mg QD
5. Aspirin 81mg QD
6. Atorvastatin 20mg QHS
7. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #147
Date: 12/07/2047 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 16 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Osteoporosis
3. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Albuterol MDI PRN
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #37
Date Collected: 02/14/2048 16:17
Date Reported: 02/14/2048 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	19.0	12.0 - 16.0	g/dL	H
WBC	5.9	4.5 - 11.0	K/uL	
Platelets	252.1	150 - 400	K/uL	
Glucose	90.3	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	135.4	135 - 145	mEq/L	
Potassium	4.7	3.5 - 5.0	mEq/L	
Total Cholesterol	130.4	125 - 200	mg/dL	
LDL	42.9	0 - 100	mg/dL	
HDL	43.0	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	5.0	4.0 - 5.6	%	
TSH	1.4	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #149
Date: 03/27/2048 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Metformin 1000mg BID
3. Levothyroxine 75mcg QD
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #150
Date: 05/07/2048 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Type 2 Diabetes Mellitus
3. Asthma

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Albuterol MDI PRN
3. Warfarin 5mg QD
4. Aspirin 81mg QD
5. Lisinopril 10mg QD
6. Furosemide 40mg QD
7. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #151
Date: 07/24/2048 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Atrial Fibrillation
3. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Furosemide 40mg QD
3. Insulin Glargine 20 units QHS
4. Levothyroxine 75mcg QD
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #38
Date Collected: 09/10/2048 16:17
Date Reported: 09/10/2048 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.7	12.0 - 16.0	g/dL	
WBC	9.4	4.5 - 11.0	K/uL	
Platelets	331.1	150 - 400	K/uL	
Glucose	59.3	70 - 100	mg/dL	L
Creatinine	0.5	0.6 - 1.2	mg/dL	L
Sodium	141.2	135 - 145	mEq/L	
Potassium	5.3	3.5 - 5.0	mEq/L	H
Total Cholesterol	190.7	125 - 200	mg/dL	
LDL	10.9	0 - 100	mg/dL	
HDL	53.6	40 - 60	mg/dL	
Triglycerides	163.8	0 - 150	mg/dL	H
HbA1c	4.6	4.0 - 5.6	%	
TSH	3.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #153
Date: 10/30/2048 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Albuterol MDI PRN
3. Warfarin 5mg QD
4. Furosemide 40mg QD
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #154
Date: 01/26/2049 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Type 2 Diabetes Mellitus
3. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Insulin Glargine 20 units QHS
3. Atorvastatin 20mg QHS
4. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #155
Date: 04/02/2049 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Coronary Artery Disease
3. Asthma

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Furosemide 40mg QD
3. Gabapentin 300mg TID
4. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #39
Date Collected: 05/16/2049 16:17
Date Reported: 05/16/2049 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	17.5	12.0 - 16.0	g/dL	H
WBC	7.8	4.5 - 11.0	K/uL	
Platelets	195.1	150 - 400	K/uL	
Glucose	116.9	70 - 100	mg/dL	H
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	139.7	135 - 145	mEq/L	
Potassium	4.1	3.5 - 5.0	mEq/L	
Total Cholesterol	188.0	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	41.1	40 - 60	mg/dL	
Triglycerides	10.2	0 - 150	mg/dL	
HbA1c	5.4	4.0 - 5.6	%	
TSH	3.6	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #157
Date: 07/31/2049 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Levothyroxine 75mcg QD
3. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #158
Date: 09/19/2049 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Chronic Kidney Disease Stage 3
3. Osteoporosis
4. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Omeprazole 20mg QD
3. Levothyroxine 75mcg QD
4. Warfarin 5mg QD
5. Atorvastatin 20mg QHS
6. Metformin 1000mg BID
7. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #159
Date: 12/06/2049 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Osteoarthritis
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Furosemide 40mg QD
3. Insulin Glargine 20 units QHS
4. Aspirin 81mg QD
5. Metformin 1000mg BID
6. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #40
Date Collected: 02/16/2050 16:17
Date Reported: 02/16/2050 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	16.8	12.0 - 16.0	g/dL	H
WBC	7.9	4.5 - 11.0	K/uL	
Platelets	424.2	150 - 400	K/uL	H
Glucose	76.7	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	138.3	135 - 145	mEq/L	
Potassium	3.5	3.5 - 5.0	mEq/L	
Total Cholesterol	163.8	125 - 200	mg/dL	
LDL	75.5	0 - 100	mg/dL	
HDL	61.1	40 - 60	mg/dL	H
Triglycerides	75.0	0 - 150	mg/dL	
HbA1c	4.7	4.0 - 5.6	%	
TSH	2.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #161
Date: 04/05/2050 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Asthma
3. Type 2 Diabetes Mellitus
4. Sleep Apnea
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Albuterol MDI PRN
3. Levothyroxine 75mcg QD
4. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #162
Date: 05/26/2050 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Hypothyroidism
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Metformin 1000mg BID
3. Levothyroxine 75mcg QD
4. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #163
Date: 07/18/2050 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Hypertension
3. Asthma

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Warfarin 5mg QD
3. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #41
Date Collected: 09/12/2050 16:17
Date Reported: 09/12/2050 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.2	12.0 - 16.0	g/dL	
WBC	10.3	4.5 - 11.0	K/uL	
Platelets	175.1	150 - 400	K/uL	
Glucose	96.2	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	138.6	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	176.5	125 - 200	mg/dL	
LDL	89.4	0 - 100	mg/dL	
HDL	49.5	40 - 60	mg/dL	
Triglycerides	80.5	0 - 150	mg/dL	
HbA1c	4.9	4.0 - 5.6	%	
TSH	1.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #165
Date: 11/21/2050 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Osteoporosis
3. Hypothyroidism
4. Hypertension

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Gabapentin 300mg TID
3. Furosemide 40mg QD
4. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #166
Date: 02/05/2051 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Chronic Kidney Disease Stage 3
3. Atrial Fibrillation
4. Anxiety Disorder
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Warfarin 5mg QD
3. Metformin 1000mg BID
4. Lisinopril 10mg QD
5. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #167
Date: 03/30/2051 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Coronary Artery Disease
3. Osteoarthritis

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Lisinopril 10mg QD
3. Insulin Glargine 20 units QHS
4. Warfarin 5mg QD
5. Albuterol MDI PRN
6. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #42
Date Collected: 06/21/2051 16:17
Date Reported: 06/21/2051 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	10.9	4.5 - 11.0	K/uL	
Platelets	294.0	150 - 400	K/uL	
Glucose	76.8	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	137.8	135 - 145	mEq/L	
Potassium	3.5	3.5 - 5.0	mEq/L	L
Total Cholesterol	192.8	125 - 200	mg/dL	
LDL	105.1	0 - 100	mg/dL	H
HDL	52.6	40 - 60	mg/dL	
Triglycerides	33.1	0 - 150	mg/dL	
HbA1c	4.0	4.0 - 5.6	%	
TSH	2.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #169
Date: 09/19/2051 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Asthma

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Gabapentin 300mg TID
3. Albuterol MDI PRN
4. Insulin Glargine 20 units QHS
5. Aspirin 81mg QD
6. Levothyroxine 75mcg QD
7. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #170
Date: 11/14/2051 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Chronic Kidney Disease Stage 3
3. Asthma

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Gabapentin 300mg TID
3. Atorvastatin 20mg QHS
4. Omeprazole 20mg QD
5. Albuterol MDI PRN
6. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #171
Date: 02/04/2052 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Atorvastatin 20mg QHS
3. Lisinopril 10mg QD
4. Sertraline 50mg QD
5. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #43
Date Collected: 04/01/2052 16:17
Date Reported: 04/01/2052 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.0	12.0 - 16.0	g/dL	L
WBC	6.1	4.5 - 11.0	K/uL	
Platelets	255.5	150 - 400	K/uL	
Glucose	84.5	70 - 100	mg/dL	
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	141.3	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	184.7	125 - 200	mg/dL	
LDL	82.5	0 - 100	mg/dL	
HDL	48.2	40 - 60	mg/dL	
Triglycerides	53.2	0 - 150	mg/dL	
HbA1c	6.0	4.0 - 5.6	%	H
TSH	1.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #173
Date: 05/21/2052 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Osteoporosis
3. Hypothyroidism
4. Osteoarthritis
5. Hypertension

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Warfarin 5mg QD
3. Albuterol MDI PRN
4. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #174
Date: 07/05/2052 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Albuterol MDI PRN
3. Metformin 1000mg BID
4. Aspirin 81mg QD
5. Insulin Glargine 20 units QHS
6. Atorvastatin 20mg QHS
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #175
Date: 08/14/2052 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Aspirin 81mg QD
3. Levothyroxine 75mcg QD
4. Lisinopril 10mg QD
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #44
Date Collected: 09/25/2052 16:17
Date Reported: 09/25/2052 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.6	12.0 - 16.0	g/dL	
WBC	10.6	4.5 - 11.0	K/uL	
Platelets	333.4	150 - 400	K/uL	
Glucose	71.7	70 - 100	mg/dL	
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	136.8	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	109.1	125 - 200	mg/dL	L
LDL	95.6	0 - 100	mg/dL	
HDL	50.8	40 - 60	mg/dL	
Triglycerides	15.9	0 - 150	mg/dL	
HbA1c	4.8	4.0 - 5.6	%	
TSH	1.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #177
Date: 11/26/2052 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Major Depressive Disorder
3. Asthma
4. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Sertraline 50mg QD
3. Warfarin 5mg QD
4. Gabapentin 300mg TID
5. Omeprazole 20mg QD
6. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #178
Date: 02/21/2053 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Major Depressive Disorder
3. Osteoporosis
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Lisinopril 10mg QD
3. Albuterol MDI PRN
4. Atorvastatin 20mg QHS
5. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #179
Date: 04/30/2053 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Metformin 1000mg BID
3. Gabapentin 300mg TID
4. Sertraline 50mg QD
5. Atorvastatin 20mg QHS
6. Insulin Glargine 20 units QHS
7. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #45
Date Collected: 05/30/2053 16:17
Date Reported: 05/30/2053 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.9	12.0 - 16.0	g/dL	L
WBC	6.4	4.5 - 11.0	K/uL	
Platelets	221.5	150 - 400	K/uL	
Glucose	74.4	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	142.8	135 - 145	mEq/L	
Potassium	4.3	3.5 - 5.0	mEq/L	
Total Cholesterol	137.0	125 - 200	mg/dL	
LDL	65.0	0 - 100	mg/dL	
HDL	48.3	40 - 60	mg/dL	
Triglycerides	132.1	0 - 150	mg/dL	
HbA1c	4.2	4.0 - 5.6	%	
TSH	3.1	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #181
Date: 08/24/2053 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hyperlipidemia
3. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Gabapentin 300mg TID
3. Albuterol MDI PRN
4. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #182
Date: 11/15/2053 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Warfarin 5mg QD
3. Sertraline 50mg QD
4. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #183
Date: 02/13/2054 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Osteoarthritis
3. Sleep Apnea
4. Anxiety Disorder
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Levothyroxine 75mcg QD
3. Metformin 1000mg BID
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #46
Date Collected: 05/08/2054 16:17
Date Reported: 05/08/2054 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.6	12.0 - 16.0	g/dL	
WBC	8.0	4.5 - 11.0	K/uL	
Platelets	202.4	150 - 400	K/uL	
Glucose	64.8	70 - 100	mg/dL	L
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	139.3	135 - 145	mEq/L	
Potassium	3.6	3.5 - 5.0	mEq/L	
Total Cholesterol	117.7	125 - 200	mg/dL	L
LDL	115.1	0 - 100	mg/dL	H
HDL	56.0	40 - 60	mg/dL	
Triglycerides	1.4	0 - 150	mg/dL	
HbA1c	6.0	4.0 - 5.6	%	H
TSH	3.2	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #185
Date: 06/17/2054 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Coronary Artery Disease
3. Atrial Fibrillation
4. Sleep Apnea
5. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Omeprazole 20mg QD
3. Atorvastatin 20mg QHS
4. Metformin 1000mg BID
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #186
Date: 08/30/2054 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Osteoporosis
3. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Omeprazole 20mg QD
3. Lisinopril 10mg QD
4. Levothyroxine 75mcg QD
5. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #187
Date: 10/17/2054 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Chronic Kidney Disease Stage 3
3. Hypothyroidism
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Omeprazole 20mg QD
3. Sertraline 50mg QD
4. Lisinopril 10mg QD
5. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #47
Date Collected: 12/13/2054 16:17
Date Reported: 12/13/2054 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.1	12.0 - 16.0	g/dL	
WBC	11.0	4.5 - 11.0	K/uL	
Platelets	296.8	150 - 400	K/uL	
Glucose	76.1	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	142.5	135 - 145	mEq/L	
Potassium	5.0	3.5 - 5.0	mEq/L	H
Total Cholesterol	180.7	125 - 200	mg/dL	
LDL	113.0	0 - 100	mg/dL	H
HDL	50.7	40 - 60	mg/dL	
Triglycerides	129.6	0 - 150	mg/dL	
HbA1c	5.8	4.0 - 5.6	%	H
TSH	0.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #189
Date: 01/31/2055 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Chronic Kidney Disease Stage 3
3. Major Depressive Disorder
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Insulin Glargine 20 units QHS
3. Metformin 1000mg BID
4. Lisinopril 10mg QD
5. Gabapentin 300mg TID
6. Furosemide 40mg QD
7. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #190
Date: 04/26/2055 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 20 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Anxiety Disorder
3. Type 2 Diabetes Mellitus
4. Hyperlipidemia

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Furosemide 40mg QD
3. Warfarin 5mg QD
4. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #191
Date: 06/07/2055 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hyperlipidemia
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Levothyroxine 75mcg QD
3. Warfarin 5mg QD
4. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #48
Date Collected: 08/01/2055 16:17
Date Reported: 08/01/2055 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.7	12.0 - 16.0	g/dL	L
WBC	4.9	4.5 - 11.0	K/uL	
Platelets	266.5	150 - 400	K/uL	
Glucose	75.5	70 - 100	mg/dL	
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	114.9	135 - 145	mEq/L	L
Potassium	3.8	3.5 - 5.0	mEq/L	
Total Cholesterol	173.9	125 - 200	mg/dL	
LDL	72.0	0 - 100	mg/dL	
HDL	46.6	40 - 60	mg/dL	
Triglycerides	28.4	0 - 150	mg/dL	
HbA1c	4.3	4.0 - 5.6	%	
TSH	3.3	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #193
Date: 09/21/2055 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Osteoarthritis
3. Anxiety Disorder
4. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Omeprazole 20mg QD
3. Furosemide 40mg QD
4. Metformin 1000mg BID
5. Aspirin 81mg QD
6. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #194
Date: 11/11/2055 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Type 2 Diabetes Mellitus
3. Hypertension
4. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Sertraline 50mg QD
3. Aspirin 81mg QD
4. Insulin Glargine 20 units QHS
5. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #195
Date: 01/05/2056 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Sleep Apnea
3. Coronary Artery Disease
4. Osteoporosis
5. Asthma

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Gabapentin 300mg TID
3. Insulin Glargine 20 units QHS
4. Metformin 1000mg BID
5. Furosemide 40mg QD
6. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #49
Date Collected: 04/04/2056 16:17
Date Reported: 04/04/2056 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	17.0	12.0 - 16.0	g/dL	H
WBC	4.6	4.5 - 11.0	K/uL	
Platelets	242.5	150 - 400	K/uL	
Glucose	96.2	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	146.5	135 - 145	mEq/L	H
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	149.7	125 - 200	mg/dL	
LDL	35.7	0 - 100	mg/dL	
HDL	59.9	40 - 60	mg/dL	
Triglycerides	104.2	0 - 150	mg/dL	
HbA1c	5.8	4.0 - 5.6	%	H
TSH	3.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #197
Date: 05/04/2056 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Type 2 Diabetes Mellitus
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Metformin 1000mg BID
3. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #198
Date: 06/06/2056 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Levothyroxine 75mcg QD
3. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #199
Date: 08/09/2056 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Gastroesophageal Reflux Disease
3. Coronary Artery Disease
4. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Gabapentin 300mg TID
3. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #50
Date Collected: 10/08/2056 16:17
Date Reported: 10/08/2056 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	11.5	12.0 - 16.0	g/dL	L
WBC	5.9	4.5 - 11.0	K/uL	
Platelets	269.6	150 - 400	K/uL	
Glucose	89.7	70 - 100	mg/dL	
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	144.4	135 - 145	mEq/L	
Potassium	4.9	3.5 - 5.0	mEq/L	
Total Cholesterol	140.2	125 - 200	mg/dL	
LDL	38.2	0 - 100	mg/dL	
HDL	60.4	40 - 60	mg/dL	H
Triglycerides	129.0	0 - 150	mg/dL	
HbA1c	4.8	4.0 - 5.6	%	
TSH	0.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #201
Date: 12/18/2056 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 20 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Major Depressive Disorder
3. Osteoarthritis
4. Asthma
5. Hypothyroidism

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Insulin Glargine 20 units QHS
3. Atorvastatin 20mg QHS
4. Furosemide 40mg QD
5. Warfarin 5mg QD
6. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #202
Date: 01/29/2057 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Anxiety Disorder
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Levothyroxine 75mcg QD
3. Lisinopril 10mg QD
4. Aspirin 81mg QD
5. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #203
Date: 03/30/2057 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Osteoporosis

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Levothyroxine 75mcg QD
3. Omeprazole 20mg QD
4. Gabapentin 300mg TID
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #51
Date Collected: 06/28/2057 16:17
Date Reported: 06/28/2057 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.1	12.0 - 16.0	g/dL	
WBC	5.1	4.5 - 11.0	K/uL	
Platelets	344.8	150 - 400	K/uL	
Glucose	97.3	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	144.2	135 - 145	mEq/L	
Potassium	3.1	3.5 - 5.0	mEq/L	L
Total Cholesterol	131.6	125 - 200	mg/dL	
LDL	74.5	0 - 100	mg/dL	
HDL	46.1	40 - 60	mg/dL	
Triglycerides	69.8	0 - 150	mg/dL	
HbA1c	3.2	4.0 - 5.6	%	L
TSH	1.3	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #205
Date: 07/28/2057 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Anxiety Disorder
3. Chronic Obstructive Pulmonary Disease
4. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Lisinopril 10mg QD
3. Gabapentin 300mg TID
4. Metformin 1000mg BID
5. Sertraline 50mg QD
6. Omeprazole 20mg QD
7. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #206
Date: 09/10/2057 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Coronary Artery Disease
3. Type 2 Diabetes Mellitus
4. Chronic Kidney Disease Stage 3
5. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Levothyroxine 75mcg QD
3. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #207
Date: 11/18/2057 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Gastroesophageal Reflux Disease
3. Asthma
4. Hypothyroidism
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Lisinopril 10mg QD
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #52
Date Collected: 01/21/2058 16:17
Date Reported: 01/21/2058 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.0	12.0 - 16.0	g/dL	
WBC	8.3	4.5 - 11.0	K/uL	
Platelets	456.7	150 - 400	K/uL	H
Glucose	68.4	70 - 100	mg/dL	L
Creatinine	0.6	0.6 - 1.2	mg/dL	
Sodium	141.2	135 - 145	mEq/L	
Potassium	2.9	3.5 - 5.0	mEq/L	L
Total Cholesterol	128.8	125 - 200	mg/dL	
LDL	74.7	0 - 100	mg/dL	
HDL	71.1	40 - 60	mg/dL	H
Triglycerides	168.3	0 - 150	mg/dL	H
HbA1c	5.5	4.0 - 5.6	%	
TSH	3.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #209
Date: 04/21/2058 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Atrial Fibrillation
3. Chronic Kidney Disease Stage 3
4. Asthma

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Insulin Glargine 20 units QHS
3. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #210
Date: 06/29/2058 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Atrial Fibrillation
3. Type 2 Diabetes Mellitus
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Lisinopril 10mg QD
3. Atorvastatin 20mg QHS
4. Omeprazole 20mg QD
5. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #211
Date: 08/14/2058 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Albuterol MDI PRN
3. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #53
Date Collected: 10/11/2058 16:17
Date Reported: 10/11/2058 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.6	12.0 - 16.0	g/dL	
WBC	5.6	4.5 - 11.0	K/uL	
Platelets	256.9	150 - 400	K/uL	
Glucose	57.2	70 - 100	mg/dL	L
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	135.5	135 - 145	mEq/L	
Potassium	4.4	3.5 - 5.0	mEq/L	
Total Cholesterol	101.9	125 - 200	mg/dL	L
LDL	15.9	0 - 100	mg/dL	
HDL	48.7	40 - 60	mg/dL	
Triglycerides	69.9	0 - 150	mg/dL	
HbA1c	3.8	4.0 - 5.6	%	L
TSH	2.9	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #213
Date: 11/30/2058 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Hyperlipidemia
3. Atrial Fibrillation
4. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Sertraline 50mg QD
3. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #214
Date: 01/06/2059 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Type 2 Diabetes Mellitus
3. Gastroesophageal Reflux Disease
4. Chronic Kidney Disease Stage 3
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Warfarin 5mg QD
3. Metformin 1000mg BID
4. Gabapentin 300mg TID
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #215
Date: 03/07/2059 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Metformin 1000mg BID
3. Gabapentin 300mg TID
4. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #54
Date Collected: 05/01/2059 16:17
Date Reported: 05/01/2059 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.6	12.0 - 16.0	g/dL	L
WBC	10.8	4.5 - 11.0	K/uL	
Platelets	282.9	150 - 400	K/uL	
Glucose	98.7	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	138.8	135 - 145	mEq/L	
Potassium	4.4	3.5 - 5.0	mEq/L	
Total Cholesterol	172.1	125 - 200	mg/dL	
LDL	77.1	0 - 100	mg/dL	
HDL	47.9	40 - 60	mg/dL	
Triglycerides	67.8	0 - 150	mg/dL	
HbA1c	3.7	4.0 - 5.6	%	L
TSH	4.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #217
Date: 07/17/2059 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Furosemide 40mg QD
3. Warfarin 5mg QD
4. Insulin Glargine 20 units QHS
5. Aspirin 81mg QD
6. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #218
Date: 10/14/2059 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Sleep Apnea
2. Chronic Obstructive Pulmonary Disease
3. Hyperlipidemia
4. Coronary Artery Disease
5. Hypertension

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Warfarin 5mg QD
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #219
Date: 12/10/2059 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Sleep Apnea
3. Type 2 Diabetes Mellitus
4. Hypertension

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Sertraline 50mg QD
3. Lisinopril 10mg QD
4. Levothyroxine 75mcg QD
5. Gabapentin 300mg TID
6. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #55
Date Collected: 02/05/2060 16:17
Date Reported: 02/05/2060 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.4	12.0 - 16.0	g/dL	
WBC	12.7	4.5 - 11.0	K/uL	H
Platelets	223.4	150 - 400	K/uL	
Glucose	87.1	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	164.4	135 - 145	mEq/L	H
Potassium	5.9	3.5 - 5.0	mEq/L	H
Total Cholesterol	176.0	125 - 200	mg/dL	
LDL	58.5	0 - 100	mg/dL	
HDL	48.1	40 - 60	mg/dL	
Triglycerides	58.8	0 - 150	mg/dL	
HbA1c	4.2	4.0 - 5.6	%	
TSH	1.6	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #221
Date: 04/01/2060 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Omeprazole 20mg QD
3. Lisinopril 10mg QD
4. Atorvastatin 20mg QHS
5. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #222
Date: 05/25/2060 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Chronic Obstructive Pulmonary Disease
3. Atrial Fibrillation
4. Coronary Artery Disease
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Furosemide 40mg QD
3. Omeprazole 20mg QD
4. Warfarin 5mg QD
5. Aspirin 81mg QD
6. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #223
Date: 08/20/2060 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.4 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Hypothyroidism

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Sertraline 50mg QD
3. Gabapentin 300mg TID
4. Furosemide 40mg QD
5. Albuterol MDI PRN
6. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #56
Date Collected: 10/01/2060 16:17
Date Reported: 10/01/2060 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.0	12.0 - 16.0	g/dL	
WBC	6.7	4.5 - 11.0	K/uL	
Platelets	130.3	150 - 400	K/uL	L
Glucose	81.4	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	142.8	135 - 145	mEq/L	
Potassium	3.6	3.5 - 5.0	mEq/L	
Total Cholesterol	137.0	125 - 200	mg/dL	
LDL	44.9	0 - 100	mg/dL	
HDL	47.3	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	4.0	4.0 - 5.6	%	L
TSH	4.4	0.4 - 4.0	mIU/L	H

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #225
Date: 12/29/2060 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Omeprazole 20mg QD
3. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #226
Date: 03/19/2061 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Osteoarthritis
3. Sleep Apnea
4. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Insulin Glargine 20 units QHS
3. Lisinopril 10mg QD
4. Albuterol MDI PRN
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #227
Date: 05/21/2061 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Atrial Fibrillation
3. Major Depressive Disorder
4. Osteoporosis

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Albuterol MDI PRN
3. Sertraline 50mg QD
4. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #57
Date Collected: 07/24/2061 16:17
Date Reported: 07/24/2061 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.5	12.0 - 16.0	g/dL	
WBC	7.5	4.5 - 11.0	K/uL	
Platelets	188.1	150 - 400	K/uL	
Glucose	98.4	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	163.8	135 - 145	mEq/L	H
Potassium	5.7	3.5 - 5.0	mEq/L	H
Total Cholesterol	109.3	125 - 200	mg/dL	L
LDL	0.0	0 - 100	mg/dL	L
HDL	33.9	40 - 60	mg/dL	L
Triglycerides	169.1	0 - 150	mg/dL	H
HbA1c	3.2	4.0 - 5.6	%	L
TSH	1.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #229
Date: 08/31/2061 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Anxiety Disorder
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Atorvastatin 20mg QHS
3. Insulin Glargine 20 units QHS
4. Levothyroxine 75mcg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #230
Date: 11/17/2061 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Gastroesophageal Reflux Disease
3. Anxiety Disorder
4. Coronary Artery Disease
5. Hyperlipidemia

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Warfarin 5mg QD
3. Albuterol MDI PRN
4. Metformin 1000mg BID
5. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #231
Date: 01/30/2062 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Osteoarthritis

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Gabapentin 300mg TID
3. Omeprazole 20mg QD
4. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #58
Date Collected: 04/25/2062 16:17
Date Reported: 04/25/2062 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.8	12.0 - 16.0	g/dL	
WBC	5.3	4.5 - 11.0	K/uL	
Platelets	361.8	150 - 400	K/uL	
Glucose	97.1	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	169.4	135 - 145	mEq/L	H
Potassium	3.9	3.5 - 5.0	mEq/L	
Total Cholesterol	160.3	125 - 200	mg/dL	
LDL	46.3	0 - 100	mg/dL	
HDL	42.5	40 - 60	mg/dL	
Triglycerides	137.5	0 - 150	mg/dL	
HbA1c	5.3	4.0 - 5.6	%	
TSH	4.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #233
Date: 06/19/2062 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hypothyroidism
3. Atrial Fibrillation
4. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Warfarin 5mg QD
3. Sertraline 50mg QD
4. Insulin Glargine 20 units QHS
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #234
Date: 08/01/2062 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Osteoporosis
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Gabapentin 300mg TID
3. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #235
Date: 09/25/2062 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Atrial Fibrillation
3. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Aspirin 81mg QD
3. Atorvastatin 20mg QHS
4. Levothyroxine 75mcg QD
5. Omeprazole 20mg QD
6. Metformin 1000mg BID
7. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #59
Date Collected: 12/02/2062 16:17
Date Reported: 12/02/2062 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	4.0	4.5 - 11.0	K/uL	L
Platelets	281.8	150 - 400	K/uL	
Glucose	58.5	70 - 100	mg/dL	L
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	143.9	135 - 145	mEq/L	
Potassium	4.0	3.5 - 5.0	mEq/L	
Total Cholesterol	195.7	125 - 200	mg/dL	
LDL	108.5	0 - 100	mg/dL	H
HDL	54.4	40 - 60	mg/dL	
Triglycerides	70.3	0 - 150	mg/dL	
HbA1c	6.6	4.0 - 5.6	%	H
TSH	2.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #237
Date: 01/28/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Atrial Fibrillation
2. Gastroesophageal Reflux Disease
3. Asthma
4. Sleep Apnea
5. Hypothyroidism

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Atorvastatin 20mg QHS
3. Levothyroxine 75mcg QD
4. Albuterol MDI PRN
5. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #238
Date: 04/18/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Insulin Glargine 20 units QHS
3. Lisinopril 10mg QD
4. Aspirin 81mg QD
5. Furosemide 40mg QD
6. Warfarin 5mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #239
Date: 05/31/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Type 2 Diabetes Mellitus
3. Hyperlipidemia

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Metformin 1000mg BID
3. Gabapentin 300mg TID
4. Atorvastatin 20mg QHS
5. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #60
Date Collected: 07/06/2063 16:17
Date Reported: 07/06/2063 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.4	12.0 - 16.0	g/dL	
WBC	3.6	4.5 - 11.0	K/uL	L
Platelets	147.8	150 - 400	K/uL	L
Glucose	102.6	70 - 100	mg/dL	H
Creatinine	1.1	0.6 - 1.2	mg/dL	
Sodium	144.2	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	183.8	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	42.5	40 - 60	mg/dL	
Triglycerides	75.1	0 - 150	mg/dL	
HbA1c	5.6	4.0 - 5.6	%	H
TSH	0.4	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #241
Date: 08/25/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Hypertension
3. Osteoporosis
4. Type 2 Diabetes Mellitus
5. Osteoarthritis

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Albuterol MDI PRN
3. Insulin Glargine 20 units QHS
4. Sertraline 50mg QD
5. Atorvastatin 20mg QHS
6. Lisinopril 10mg QD
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #242
Date: 11/12/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Type 2 Diabetes Mellitus
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Albuterol MDI PRN
3. Gabapentin 300mg TID
4. Levothyroxine 75mcg QD
5. Omeprazole 20mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #243
Date: 12/30/2063 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Major Depressive Disorder
3. Osteoporosis
4. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Lisinopril 10mg QD
3. Sertraline 50mg QD
4. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #61
Date Collected: 03/26/2064 16:17
Date Reported: 03/26/2064 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.4	12.0 - 16.0	g/dL	
WBC	7.1	4.5 - 11.0	K/uL	
Platelets	143.9	150 - 400	K/uL	L
Glucose	56.1	70 - 100	mg/dL	L
Creatinine	1.4	0.6 - 1.2	mg/dL	H
Sodium	136.7	135 - 145	mEq/L	
Potassium	5.0	3.5 - 5.0	mEq/L	
Total Cholesterol	192.9	125 - 200	mg/dL	
LDL	27.4	0 - 100	mg/dL	
HDL	59.3	40 - 60	mg/dL	
Triglycerides	105.7	0 - 150	mg/dL	
HbA1c	5.6	4.0 - 5.6	%	H
TSH	0.4	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #245
Date: 06/16/2064 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Coronary Artery Disease
3. Sleep Apnea
4. Gastroesophageal Reflux Disease
5. Anxiety Disorder

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Omeprazole 20mg QD
3. Metformin 1000mg BID
4. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #246
Date: 09/06/2064 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Anxiety Disorder
3. Osteoarthritis

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Insulin Glargine 20 units QHS
3. Omeprazole 20mg QD
4. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #247
Date: 11/04/2064 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Insulin Glargine 20 units QHS
3. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #62
Date Collected: 12/12/2064 16:17
Date Reported: 12/12/2064 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.8	12.0 - 16.0	g/dL	
WBC	4.9	4.5 - 11.0	K/uL	
Platelets	197.3	150 - 400	K/uL	
Glucose	85.8	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	138.7	135 - 145	mEq/L	
Potassium	3.5	3.5 - 5.0	mEq/L	
Total Cholesterol	170.9	125 - 200	mg/dL	
LDL	109.9	0 - 100	mg/dL	H
HDL	38.0	40 - 60	mg/dL	L
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	3.8	4.0 - 5.6	%	L
TSH	1.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #249
Date: 03/01/2065 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Gabapentin 300mg TID
3. Lisinopril 10mg QD
4. Atorvastatin 20mg QHS
5. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #250
Date: 05/01/2065 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Atrial Fibrillation
3. Chronic Obstructive Pulmonary Disease
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Sertraline 50mg QD
3. Furosemide 40mg QD
4. Warfarin 5mg QD
5. Albuterol MDI PRN
6. Omeprazole 20mg QD
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #251
Date: 06/06/2065 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Gastroesophageal Reflux Disease
3. Anxiety Disorder
4. Asthma
5. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Omeprazole 20mg QD
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #63
Date Collected: 08/01/2065 16:17
Date Reported: 08/01/2065 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.8	12.0 - 16.0	g/dL	
WBC	5.5	4.5 - 11.0	K/uL	
Platelets	213.9	150 - 400	K/uL	
Glucose	73.7	70 - 100	mg/dL	
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	160.4	135 - 145	mEq/L	H
Potassium	5.9	3.5 - 5.0	mEq/L	H
Total Cholesterol	134.7	125 - 200	mg/dL	
LDL	90.3	0 - 100	mg/dL	
HDL	59.2	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	5.4	4.0 - 5.6	%	
TSH	0.3	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #253
Date: 09/14/2065 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 72 bpm | RR: 14 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Chronic Kidney Disease Stage 3
3. Sleep Apnea
4. Osteoarthritis
5. Gastroesophageal Reflux Disease

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Sertraline 50mg QD
3. Insulin Glargine 20 units QHS
4. Lisinopril 10mg QD
5. Furosemide 40mg QD
6. Levothyroxine 75mcg QD
7. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #254
Date: 12/12/2065 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Hypothyroidism
3. Hypertension
4. Osteoarthritis

CURRENT MEDICATIONS:
1. Omeprazole 20mg QD
2. Sertraline 50mg QD
3. Metformin 1000mg BID
4. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #255
Date: 02/19/2066 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 68 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Sleep Apnea
3. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Lisinopril 10mg QD
3. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #64
Date Collected: 04/20/2066 16:17
Date Reported: 04/20/2066 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.1	12.0 - 16.0	g/dL	
WBC	7.8	4.5 - 11.0	K/uL	
Platelets	222.5	150 - 400	K/uL	
Glucose	64.3	70 - 100	mg/dL	L
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	136.4	135 - 145	mEq/L	
Potassium	4.1	3.5 - 5.0	mEq/L	
Total Cholesterol	197.8	125 - 200	mg/dL	
LDL	2.1	0 - 100	mg/dL	
HDL	42.3	40 - 60	mg/dL	
Triglycerides	53.9	0 - 150	mg/dL	
HbA1c	4.1	4.0 - 5.6	%	
TSH	1.2	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #257
Date: 06/20/2066 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Asthma
3. Chronic Obstructive Pulmonary Disease
4. Hypertension

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Omeprazole 20mg QD
3. Furosemide 40mg QD
4. Insulin Glargine 20 units QHS
5. Levothyroxine 75mcg QD
6. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #258
Date: 08/02/2066 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Anxiety Disorder
3. Hyperlipidemia
4. Hypertension

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Metformin 1000mg BID
3. Atorvastatin 20mg QHS
4. Lisinopril 10mg QD
5. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #259
Date: 09/01/2066 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 72 bpm | RR: 16 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Osteoporosis
3. Asthma
4. Chronic Kidney Disease Stage 3
5. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Omeprazole 20mg QD
3. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #65
Date Collected: 11/02/2066 16:17
Date Reported: 11/02/2066 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.0	12.0 - 16.0	g/dL	
WBC	7.9	4.5 - 11.0	K/uL	
Platelets	167.4	150 - 400	K/uL	
Glucose	90.4	70 - 100	mg/dL	
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	142.8	135 - 145	mEq/L	
Potassium	4.5	3.5 - 5.0	mEq/L	
Total Cholesterol	139.4	125 - 200	mg/dL	
LDL	0.0	0 - 100	mg/dL	L
HDL	46.7	40 - 60	mg/dL	
Triglycerides	176.8	0 - 150	mg/dL	H
HbA1c	6.2	4.0 - 5.6	%	H
TSH	0.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #261
Date: 01/06/2067 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Osteoarthritis
3. Osteoporosis

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Levothyroxine 75mcg QD
3. Furosemide 40mg QD
4. Omeprazole 20mg QD
5. Insulin Glargine 20 units QHS
6. Sertraline 50mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #262
Date: 03/24/2067 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 20 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Chronic Kidney Disease Stage 3
3. Hypothyroidism

CURRENT MEDICATIONS:
1. Lisinopril 10mg QD
2. Sertraline 50mg QD
3. Warfarin 5mg QD
4. Gabapentin 300mg TID
5. Metformin 1000mg BID
6. Aspirin 81mg QD
7. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #263
Date: 05/24/2067 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Type 2 Diabetes Mellitus
3. Gastroesophageal Reflux Disease
4. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Insulin Glargine 20 units QHS
3. Omeprazole 20mg QD
4. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #66
Date Collected: 08/21/2067 16:17
Date Reported: 08/21/2067 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	10.5	12.0 - 16.0	g/dL	L
WBC	10.3	4.5 - 11.0	K/uL	
Platelets	180.4	150 - 400	K/uL	
Glucose	96.7	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	140.6	135 - 145	mEq/L	
Potassium	4.2	3.5 - 5.0	mEq/L	
Total Cholesterol	194.2	125 - 200	mg/dL	
LDL	64.7	0 - 100	mg/dL	
HDL	39.4	40 - 60	mg/dL	L
Triglycerides	49.9	0 - 150	mg/dL	
HbA1c	5.0	4.0 - 5.6	%	
TSH	0.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #265
Date: 10/03/2067 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Osteoporosis
3. Gastroesophageal Reflux Disease
4. Sleep Apnea
5. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Insulin Glargine 20 units QHS
3. Lisinopril 10mg QD
4. Aspirin 81mg QD
5. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #266
Date: 12/07/2067 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Major Depressive Disorder
2. Osteoporosis
3. Chronic Obstructive Pulmonary Disease
4. Sleep Apnea

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Albuterol MDI PRN
3. Aspirin 81mg QD
4. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #267
Date: 01/20/2068 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 16 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Major Depressive Disorder
3. Sleep Apnea
4. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Gabapentin 300mg TID
3. Omeprazole 20mg QD
4. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #67
Date Collected: 02/27/2068 16:17
Date Reported: 02/27/2068 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.6	12.0 - 16.0	g/dL	
WBC	9.5	4.5 - 11.0	K/uL	
Platelets	187.0	150 - 400	K/uL	
Glucose	76.7	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	144.8	135 - 145	mEq/L	
Potassium	4.1	3.5 - 5.0	mEq/L	
Total Cholesterol	150.1	125 - 200	mg/dL	
LDL	99.8	0 - 100	mg/dL	
HDL	68.6	40 - 60	mg/dL	H
Triglycerides	130.4	0 - 150	mg/dL	
HbA1c	4.4	4.0 - 5.6	%	
TSH	0.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #269
Date: 05/22/2068 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.2 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Chronic Obstructive Pulmonary Disease
2. Hyperlipidemia

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Omeprazole 20mg QD
3. Albuterol MDI PRN
4. Lisinopril 10mg QD
5. Atorvastatin 20mg QHS
6. Sertraline 50mg QD
7. Gabapentin 300mg TID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #270
Date: 07/01/2068 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 72 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Anxiety Disorder

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Atorvastatin 20mg QHS
3. Omeprazole 20mg QD
4. Sertraline 50mg QD
5. Warfarin 5mg QD
6. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #271
Date: 08/18/2068 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 98.2 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Anxiety Disorder
3. Coronary Artery Disease

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Aspirin 81mg QD
3. Sertraline 50mg QD
4. Metformin 1000mg BID
5. Warfarin 5mg QD
6. Omeprazole 20mg QD
7. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #68
Date Collected: 10/09/2068 16:17
Date Reported: 10/09/2068 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.7	12.0 - 16.0	g/dL	
WBC	4.1	4.5 - 11.0	K/uL	L
Platelets	136.8	150 - 400	K/uL	L
Glucose	101.6	70 - 100	mg/dL	H
Creatinine	1.0	0.6 - 1.2	mg/dL	
Sodium	136.4	135 - 145	mEq/L	
Potassium	3.7	3.5 - 5.0	mEq/L	
Total Cholesterol	141.2	125 - 200	mg/dL	
LDL	42.4	0 - 100	mg/dL	
HDL	58.0	40 - 60	mg/dL	
Triglycerides	70.4	0 - 150	mg/dL	
HbA1c	5.2	4.0 - 5.6	%	
TSH	2.8	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #273
Date: 12/11/2068 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Chronic Obstructive Pulmonary Disease
3. Osteoporosis
4. Gastroesophageal Reflux Disease
5. Hypertension

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Metformin 1000mg BID
3. Sertraline 50mg QD
4. Omeprazole 20mg QD
5. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #274
Date: 01/11/2069 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Coronary Artery Disease
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Lisinopril 10mg QD
3. Warfarin 5mg QD
4. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #275
Date: 03/29/2069 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Asthma
3. Anxiety Disorder

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Atorvastatin 20mg QHS
3. Metformin 1000mg BID
4. Omeprazole 20mg QD
5. Gabapentin 300mg TID
6. Lisinopril 10mg QD
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #69
Date Collected: 05/17/2069 16:17
Date Reported: 05/17/2069 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.3	12.0 - 16.0	g/dL	
WBC	5.4	4.5 - 11.0	K/uL	
Platelets	262.6	150 - 400	K/uL	
Glucose	84.7	70 - 100	mg/dL	
Creatinine	1.2	0.6 - 1.2	mg/dL	
Sodium	138.0	135 - 145	mEq/L	
Potassium	3.6	3.5 - 5.0	mEq/L	
Total Cholesterol	211.5	125 - 200	mg/dL	H
LDL	109.5	0 - 100	mg/dL	H
HDL	57.7	40 - 60	mg/dL	
Triglycerides	56.4	0 - 150	mg/dL	
HbA1c	6.4	4.0 - 5.6	%	H
TSH	3.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #277
Date: 07/21/2069 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 88 bpm | RR: 18 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Anxiety Disorder
3. Hypothyroidism
4. Gastroesophageal Reflux Disease
5. Chronic Kidney Disease Stage 3

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Levothyroxine 75mcg QD
3. Omeprazole 20mg QD
4. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #278
Date: 08/26/2069 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 118/76 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Osteoporosis
3. Gastroesophageal Reflux Disease
4. Anxiety Disorder

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Atorvastatin 20mg QHS
3. Aspirin 81mg QD
4. Insulin Glargine 20 units QHS
5. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #279
Date: 11/17/2069 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 16 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Asthma
2. Hypothyroidism
3. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Furosemide 40mg QD
3. Lisinopril 10mg QD
4. Omeprazole 20mg QD
5. Warfarin 5mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #70
Date Collected: 01/10/2070 16:17
Date Reported: 01/10/2070 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	14.4	12.0 - 16.0	g/dL	
WBC	6.2	4.5 - 11.0	K/uL	
Platelets	161.9	150 - 400	K/uL	
Glucose	66.6	70 - 100	mg/dL	L
Creatinine	0.9	0.6 - 1.2	mg/dL	
Sodium	163.2	135 - 145	mEq/L	H
Potassium	4.0	3.5 - 5.0	mEq/L	
Total Cholesterol	142.2	125 - 200	mg/dL	
LDL	48.3	0 - 100	mg/dL	
HDL	44.2	40 - 60	mg/dL	
Triglycerides	95.8	0 - 150	mg/dL	
HbA1c	5.5	4.0 - 5.6	%	
TSH	0.7	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #281
Date: 03/16/2070 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 72 bpm | RR: 18 /min
Temp: 99.1 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Chronic Kidney Disease Stage 3
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Gabapentin 300mg TID
3. Omeprazole 20mg QD
4. Sertraline 50mg QD
5. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #282
Date: 05/14/2070 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 68 bpm | RR: 18 /min
Temp: 98.6 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Gastroesophageal Reflux Disease
2. Chronic Obstructive Pulmonary Disease
3. Atrial Fibrillation
4. Major Depressive Disorder

CURRENT MEDICATIONS:
1. Gabapentin 300mg TID
2. Sertraline 50mg QD
3. Levothyroxine 75mcg QD
4. Omeprazole 20mg QD
5. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #283
Date: 07/09/2070 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 14 /min
Temp: 98.4 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Asthma
3. Atrial Fibrillation
4. Hypothyroidism

CURRENT MEDICATIONS:
1. Metformin 1000mg BID
2. Gabapentin 300mg TID
3. Furosemide 40mg QD
4. Atorvastatin 20mg QHS
5. Sertraline 50mg QD
6. Warfarin 5mg QD
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:

Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #71
Date Collected: 09/13/2070 16:17
Date Reported: 09/13/2070 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.9	12.0 - 16.0	g/dL	
WBC	10.3	4.5 - 11.0	K/uL	
Platelets	326.9	150 - 400	K/uL	
Glucose	68.8	70 - 100	mg/dL	L
Creatinine	0.6	0.6 - 1.2	mg/dL	L
Sodium	117.2	135 - 145	mEq/L	L
Potassium	4.7	3.5 - 5.0	mEq/L	
Total Cholesterol	185.0	125 - 200	mg/dL	
LDL	77.2	0 - 100	mg/dL	
HDL	41.7	40 - 60	mg/dL	
Triglycerides	117.4	0 - 150	mg/dL	
HbA1c	4.3	4.0 - 5.6	%	
TSH	0.3	0.4 - 4.0	mIU/L	L

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #285
Date: 11/19/2070 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Osteoarthritis
2. Hypertension
3. Anxiety Disorder
4. Type 2 Diabetes Mellitus

CURRENT MEDICATIONS:
1. Warfarin 5mg QD
2. Atorvastatin 20mg QHS
3. Gabapentin 300mg TID
4. Furosemide 40mg QD
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #286
Date: 01/12/2071 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 82 bpm | RR: 14 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Coronary Artery Disease
2. Hyperlipidemia
3. Hypertension

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Atorvastatin 20mg QHS
3. Aspirin 81mg QD
4. Furosemide 40mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.

Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #287
Date: 03/05/2071 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 120/80 mmHg | HR: 88 bpm | RR: 14 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Chronic Obstructive Pulmonary Disease
3. Coronary Artery Disease
4. Anxiety Disorder
5. Hypothyroidism

CURRENT MEDICATIONS:
1. Aspirin 81mg QD
2. Furosemide 40mg QD
3. Atorvastatin 20mg QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #72
Date Collected: 05/14/2071 16:17
Date Reported: 05/14/2071 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	12.3	12.0 - 16.0	g/dL	
WBC	4.2	4.5 - 11.0	K/uL	L
Platelets	313.6	150 - 400	K/uL	
Glucose	95.5	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	136.8	135 - 145	mEq/L	
Potassium	4.5	3.5 - 5.0	mEq/L	
Total Cholesterol	208.1	125 - 200	mg/dL	H
LDL	44.3	0 - 100	mg/dL	
HDL	41.5	40 - 60	mg/dL	
Triglycerides	0.0	0 - 150	mg/dL	L
HbA1c	4.1	4.0 - 5.6	%	
TSH	2.0	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #289
Date: 07/06/2071 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 82 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Type 2 Diabetes Mellitus
2. Hypertension
3. Major Depressive Disorder
4. Asthma

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Sertraline 50mg QD
3. Levothyroxine 75mcg QD
4. Metformin 1000mg BID

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #290
Date: 09/18/2071 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 88 bpm | RR: 16 /min
Temp: 99.1 °F | SpO2: 99% on room air

ACTIVE PROBLEMS:
1. Hypothyroidism
2. Chronic Kidney Disease Stage 3
3. Asthma
4. Hypertension

CURRENT MEDICATIONS:
1. Furosemide 40mg QD
2. Sertraline 50mg QD
3. Warfarin 5mg QD
4. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #291
Date: 11/01/2071 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 68 bpm | RR: 20 /min
Temp: 98.2 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Osteoporosis
2. Gastroesophageal Reflux Disease
3. Type 2 Diabetes Mellitus
4. Hypothyroidism
5. Hypertension

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Omeprazole 20mg QD
3. Furosemide 40mg QD
4. Insulin Glargine 20 units QHS
5. Sertraline 50mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #73
Date Collected: 12/01/2071 16:17
Date Reported: 12/01/2071 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	15.2	12.0 - 16.0	g/dL	
WBC	8.1	4.5 - 11.0	K/uL	
Platelets	432.4	150 - 400	K/uL	H
Glucose	71.2	70 - 100	mg/dL	
Creatinine	0.8	0.6 - 1.2	mg/dL	
Sodium	141.3	135 - 145	mEq/L	
Potassium	3.3	3.5 - 5.0	mEq/L	L
Total Cholesterol	163.6	125 - 200	mg/dL	
LDL	17.4	0 - 100	mg/dL	
HDL	54.5	40 - 60	mg/dL	
Triglycerides	101.7	0 - 150	mg/dL	
HbA1c	3.6	4.0 - 5.6	%	L
TSH	3.3	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #293
Date: 02/02/2072 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 76 bpm | RR: 20 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Chronic Kidney Disease Stage 3
2. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Albuterol MDI PRN
2. Levothyroxine 75mcg QD
3. Insulin Glargine 20 units QHS
4. Lisinopril 10mg QD
5. Gabapentin 300mg TID
6. Metformin 1000mg BID
7. Aspirin 81mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.

Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #294
Date: 04/02/2072 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 130/82 mmHg | HR: 76 bpm | RR: 20 /min
Temp: 99.1 °F | SpO2: 96% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Coronary Artery Disease
3. Atrial Fibrillation

CURRENT MEDICATIONS:
1. Sertraline 50mg QD
2. Levothyroxine 75mcg QD
3. Metformin 1000mg BID
4. Omeprazole 20mg QD
5. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #295
Date: 05/23/2072 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 82 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 97% on room air

ACTIVE PROBLEMS:
1. Hypertension
2. Osteoporosis
3. Hyperlipidemia
4. Gastroesophageal Reflux Disease
5. Chronic Obstructive Pulmonary Disease

CURRENT MEDICATIONS:
1. Insulin Glargine 20 units QHS
2. Warfarin 5mg QD
3. Lisinopril 10mg QD

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

LABORATORY REPORT #74
Date Collected: 08/14/2072 16:17
Date Reported: 08/14/2072 20:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982
Ordering Physician: Dr. Sarah Mitchell, MD

COMPREHENSIVE METABOLIC PANEL WITH LIPID PANEL

Test	Result	Reference Range	Units	Flag
Hemoglobin	13.1	12.0 - 16.0	g/dL	
WBC	7.1	4.5 - 11.0	K/uL	
Platelets	386.2	150 - 400	K/uL	
Glucose	77.1	70 - 100	mg/dL	
Creatinine	0.7	0.6 - 1.2	mg/dL	
Sodium	112.4	135 - 145	mEq/L	L
Potassium	3.7	3.5 - 5.0	mEq/L	
Total Cholesterol	216.5	125 - 200	mg/dL	H
LDL	71.8	0 - 100	mg/dL	
HDL	65.6	40 - 60	mg/dL	H
Triglycerides	113.8	0 - 150	mg/dL	
HbA1c	5.3	4.0 - 5.6	%	
TSH	1.5	0.4 - 4.0	mIU/L	

Note: Results reviewed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #297
Date: 11/05/2072 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 135/85 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 97.8 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Hyperlipidemia
2. Osteoporosis
3. Chronic Obstructive Pulmonary Disease
4. Chronic Kidney Disease Stage 3
5. Anxiety Disorder

CURRENT MEDICATIONS:
1. Atorvastatin 20mg QHS
2. Metformin 1000mg BID
3. Insulin Glargine 20 units QHS

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.
Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.

Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD

PROGRESS NOTE - Visit #298
Date: 12/16/2072 16:17
Patient: Patricia Brown
MRN: MRN-698097
DOB: 12/08/1982 (Age: 43)

CHIEF COMPLAINT:
Follow-up visit for chronic disease management and medication review.

VITAL SIGNS:
BP: 142/90 mmHg | HR: 88 bpm | RR: 17 /min
Temp: 98.6 °F | SpO2: 98% on room air

ACTIVE PROBLEMS:
1. Anxiety Disorder
2. Major Depressive Disorder
3. Osteoarthritis
4. Hypothyroidism

CURRENT MEDICATIONS:
1. Levothyroxine 75mcg QD
2. Warfarin 5mg QD
3. Aspirin 81mg QD
4. Atorvastatin 20mg QHS
5. Furosemide 40mg QD
6. Albuterol MDI PRN

REVIEW OF SYSTEMS:
Constitutional: Denies fever, chills, or weight changes
Cardiovascular: Denies chest pain, palpitations, or edema
Respiratory: Denies shortness of breath or cough
Gastrointestinal: Denies nausea, vomiting, or abdominal pain
Musculoskeletal: Reports mild joint stiffness, improved with activity
Neurological: Denies headaches, dizziness, or weakness
Psychiatric: Reports stable mood, denies anxiety or depression

PHYSICAL EXAMINATION:
General: Alert and oriented x3, appears stated age, in no acute distress
HEENT: Normocephalic, atraumatic. PERRLA. TMs clear bilaterally
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Respiratory: Clear to auscultation bilaterally, no wheezes or rales
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Extremities: No edema, normal range of motion, pulses 2+ bilaterally

ASSESSMENT AND PLAN:
Patient continues to do well on current regimen. Vital signs stable.

Laboratory results reviewed and within acceptable ranges.
Will continue current medications with no changes at this time.
Patient counseled on diet, exercise, and medication compliance.
Follow-up appointment scheduled in 3 months or sooner if needed.

Electronically signed by Dr. Sarah Mitchell, MD