Greenfield Medical Center

Provider History & Physical

Patient Name: Yoder, Sherman
DOB: 06/26/19XX **Age:** 80 years **MRN:** 64646428

CHIEF COMPLAINT:
Abdominal Pain & Diabetic Foot Ulcer

HISTORIAN: Client is a reliable historian; provided medical history

HISTORY OF PRESENT ILLNESS:
Sherman “Red” Yoder is an 80-year-old male, who presented to the Greenfield Medical Center emergency department with worsening abdominal pain, loss of appetite, nausea/vomiting. The patient recently developed a diabetic ulcer, which was being treated by home care nurses. Upon arrival, Mr. Yoder’s pain was 8/10. Morphine was administered. Obstruction series showed dilated small bowel loops, but no free air. Small bowel obstruction was diagnosed. Patient made NPO and NG tube was place to low intermittent wall suction. Surgical services was consulted for possible surgical intervention. Cardiology was consulted to manage the patient’s cardiac history and for cardiac clearance in case surgery is needed. IVF with potassium chloride started; an EKG was completed; and labs sent.

PAST MEDICAL HISTORY:
Atrial Fibrillation
Coronary Artery Disease
Diabetes Type II (Recently diagnosed)
Hyperlipidemia
Hypertension
Right great toe ulcer
Benign Prostatic Hypertrophy

PAST SURGICAL HISTORY:
L4-5 Laminectomy

MEDICATIONS (indicates patient’s HOME Meds):
Cardizem SR 240 mg, PO, QD
Clindamycin 300 mg, PO, 4x/day
Coumadin 5 mg, PO, QD
Insulin Glargine 10 units, SQ, QHS
Lisinopril 5mg, PO, QD
Metformin 500 mg, PO, BID
Zocor 20mg, PO, QD

FAMILY HISTORY:
Mr. Yoder stated both his parents had high blood pressure and his father died of a heart attack.

SOCIAL HISTORY:
Mr. Yoder lives at home alone in a 2-story farmhouse that has 3 stairs to enter, a first-floor full bath, and 2nd floor only bedrooms. He is retired. The patient’s son Jon helps with farm crops and caring for a few farm animals. The patient assists with some household/farm tasks, such as collecting eggs, etc. Daughter-in-law Judy assists with the patient’s medical care. Mr. Yoder describes his home-life as sedentary and denies following any type of special diet. He states that he is a social drinker but denies any illicit drug use.

DIAGNOSTIC DATA:
Labs results show K = 3.3, BUN = 23, Cr = 1.3, INR = 1.6, Hgb/Hct = 14/40. Cardiac enzymes negative. Total cholesterol = 320. WBC = 11. Chest x-ray shows mild cardiac enlargement. EKG revealed normal sinus rhythm.

PHYSICAL EXAMINATION:
Mr. Yoder is stable, pleasant and cooperative. Vital Signs: 130/80, 92, 18, 98.8 F, 92% on 2L NC. Neuro: Alert & oriented to person, time, & place. Respiratory: Lungs reveal diminished breath sounds throughout. Neck No JVD or carotid bruits. Cardiac: Auscultated S1 S2, no murmurs or rubs. Tele shows NSR. GI: Abdomen slightly firm, distended, and tender with hypoactive bowel sounds x 4 quadrants. NG tube placed to low intermittent suction draining greenish fluid; Skin: pink, warm, dry, & intact.

ASSESSMENT and PLAN:
1. Abdominal pain managed with morphine, NPO, & NGT.
2. Consult Cardiology for cardiac management
3. Consult Surgical Services

Frank Baker, MD

Frank Baker, MD
Department of Family Medicine
Greenfield Medical Center