Sex: F **Age:** 73 years

Nurse Note:
Since your last visit with us, have you been evaluated or treated by any other clinicians?

Yes No
Since your last visit with us, have you been to the ER or Urgent Care? Yes No

Do you feel that you have adequate shelter & access to food? yes no, resources provided Do you feel safe at home? yes no, resources given

Are there any medication discrepancies? yes no
Are you able to afford your medications? yes no, resources provided

Barriers to Learning:
☑ No Barriers
☐ Visually Impaired
☐ Blind
☐ Hard of Hearing
☐ Deaf
☐ Does not Read English
☐ Requires Interpreter
☐ Dementia
☐ Low Health Literacy
☐ Cognitive Impairment
☐ Stressors
☐ Values Beliefs

Learning Preferences
No Preference
Practice/Demonstration
Reading/Handouts
Q & A

Date: 07/19/2021
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Are you exposed to second hand smoke? Yes No Declined to specify

Nurse note completed by: Brittany Allen, RMA

Subjective
CC: Patient presents for a check on her migraines
HPI: Patient is a 73 YO female who presents for a check on her migraines. At her last appointment patient was started on a trial of topiramate. Patient has tried amitriptyline, aimovig, enjovy with no real relief.
ROS:
CV: Denies cardiovascular symptoms.
Resp: Denies respiratory symptoms.

Current Meds: Topiramate 25 mg, Sumatriptan Succinate 25 mg, Sumatriptan Succinate 50 mg
Medication Assessments:
Does the patient/family understand the medications? Yes No
Medication side effects and/or med-adherence difficulty? Yes No
Barriers to med-adherence? Yes No
Allergies: Penicillins

PMH:
Problem List: Mixed hyperlipidemia, Migraine
Reviewed, no changes.
FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)
Reviewed, no changes.
SH:
Reviewed, no changes.

Objective
BP: 120/70 **Pulse:** 68 **T:** 97.8 **Ht:** 63.75" 5'3.75" **Wt:** 124lb **Wt Prior:** 128lb as of 06/21/21 **Wt Dif:** -4lb **BMI:** 21.4 **Wt kg:** 56.246 **Wt kg Prior:** 58.061 as of 06/21/21 **Wt kg Dif:** -1.815 **IBW:** 115 **Ht cm:** 161.9 **T:** 36.6C

Exam:
Const: Appears healthy and well developed.
Resp: Lungs are clear bilaterally.
CV: Rhythm is regular. No heart murmur appreciated. **Extremities:** No clubbing, cyanosis or edema.

Dental assessment performed: findings were negative.

Advance Directive

☑ ON FILE & DISCUSSED
The importance of advance care planning has been discussed with patient. Current advance care planning document(s)
on file have been reviewed and discussed with
any questions and concerns addressed. The importance of keeping these documents updated has been discussed. Patient advised that if they were to update their advance
care planning document(s) to notify our office and bring any newer copies in to be kept on file, as part of their medical record.
Date: 07/19/2021
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Assessment #1: Migraine, unspecified, not intractable, without status migrainosus
Care Plan:

Comments : -Patient has tried amitriptyline, aimovig, enjovy for prophylaxis
-She has tried a trial of topiramate and feeling better
-She had two migraines this past month and the sumatriptan helped right away.
-Patient tolerated the topiramate well
Med Current : Topiramate 25 mg one tablet nightly

Assessment #2: Body mass index [BMI] 21.0-21.9, adult
Care Plan:

Comments : -Currently stable

Assessment #3: Insomnia, unspecified
Care Plan:

Comments : -Patient is sleeping better
-Patient is taking the Unisom and topirmate and sleeping well
-Patient does not feel groggy in the AM

Assessment #4: Mixed hyperlipidemia
Care Plan:

Comments : -Patient will try over the counter medications fish/krill oil supplements (at least 1000mg of omega-3) and/or red yeast rice
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity

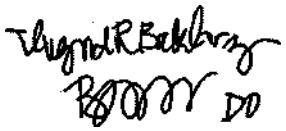
Assessment #5: Chronic kidney disease, stage 3a **Care Plan:**

Comments : -Will continue to monitor
-Make sure to drink 6-8 cups of water daily

Plan Other:

Med Current : Sumatriptan Succinate 25 mg
take one tab as needed for migraines.
if no relief may repeat dose after 2 hours
Sumatriptan Succinate 50 mg
take one tablet at the start of a
migraine. take another one 2 hours later if no improvement
Follow Up : -FU in 3 months for a check on migraines
-Schedule mammo after August
-Call CVS in Paxton Square for shingrix shot records (Pt thinks she had it there)

Counseling and/or Coordination of Care:
Patient instructions given and understood.



Seen by: Electronically signed by Ingrid R.Bakalorz Blubaugh, D.O. on 07/19/2021 at 1:23 pm

06/21/21
Sex: F **Age:** 73 years

Nurse Note:
Since your last visit with us, have you been evaluated or treated by any other clinicians?
Yes No
Since your last visit with us, have you been to the ER or Urgent Care? Yes No

Do you feel that you have adequate shelter & access to food? yes no, resources provided Do you feel safe at home? yes no, resources given

Are there any medication discrepancies? yes no
Are you able to afford your medications? yes no, resources provided

Barriers to Learning:
☑ No Barriers
☐ Visually Impaired
☐ Blind
☐ Hard of Hearing
☐ Deaf
☐ Does not Read English
☐ Requires Interpreter
☐ Dementia
☐ Low Health Literacy
☐ Cognitive Impairment
☐ Stressors
☐ Values Beliefs

Learning Preferences
No Preference
Practice/Demonstration
Reading/Handouts
Q & A

Date: 06/21/2021
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Are you exposed to second hand smoke? Yes No Declined to specify

Nurse note completed by: Brittany Allen, RMA

Subjective
CC: Patient presents for a check on her insomnia
HPI: Patient is a 73 YO female who presents for a check on her insomnia. At her last appointment patient was started on trazadone.
ROS:
CV: Denies cardiovascular symptoms.
Resp: Denies respiratory symptoms.

Current Meds: Sumatriptan Succinate 25 mg, Sumatriptan Succinate 50 mg, Trazodone HCL 50 mg
Medication Assessments:
Does the patient/family understand the medications? Yes No
Medication side effects and/or med-adherence difficulty? Yes No
Barriers to med-adherence? Yes No
Allergies: Penicillins

PMH:
Problem List: Mixed hyperlipidemia, Migraine
Reviewed, no changes.
FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)
Reviewed, no changes.
SH:
Reviewed, no changes.

Objective
BP: 128/70 **Pulse:** 74 **T:** 97.3 **Wt:** 128lb **Wt Prior:** 131lb as of 05/17/21 **Wt Dif:** -3lb **Wt kg:** 58.061 **Wt kg Prior:** 59.422 as of 05/17/21 **Wt kg Dif:** -1.361 **T:** 36.3C

Exam:
Const: Appears healthy and well developed.
Resp: Lungs are clear bilaterally.
CV: Rhythm is regular. No heart murmur appreciated. **Extremities:** No clubbing, cyanosis or edema.

Dental assessment performed: findings were negative.

Advance Directive

☑ ON FILE & DISCUSSED
The importance of advance care planning has been discussed with patient. Current advance care planning document(s)
on file have been reviewed and discussed with
any questions and concerns addressed. The importance of keeping these documents updated has been discussed. Patient advised that if they were to update their advance
care planning document(s) to notify our office and bring any newer copies in to be kept on file, as part of their medical record.

Assessment #1: Insomnia, unspecified
Care Plan:

Comments : -At last appointment patient was started on trazadone
-Since starting on the medication patient was not able to sleep
-Patient was able to sleep with Unisom
-If no improvement will try try remeron, belsomra or doxepin
Med Discont : Trazodone HCL 50 mg take 1 tablet at bedtime for sleep

Assessment #2: Migraine, unspecified, not intractable, without status migrainosus
Care Plan:

Comments : -Take medications as directed
-If migraine is not being relieved by medication, call the office for a potential toradol shot
-Patient did a trial of ubrelevy (100mg) with no real relief
-Continue to monitor
-Patient has tried amitryptline, aimovig, enjovy in the past
-Will consider topiramate for prophylaxis in the future
-Will do a trial of topiramate 25mg.
-If no relief in 2 weeks, ok to take 2 x 25mg (50mg).

-FU in 4 weeks

Med New : Topiramate 25 mg one tablet nightly

Assessment #3: Mixed hyperlipidemia
Care Plan:

Comments : -Patient will try over the counter medications fish/krill oil supplements (at least 1000mg of omega-3) and/or red yeast rice
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity

Assessment #4: Chronic kidney disease, stage 3a
Care Plan:

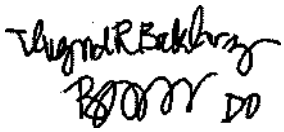
Comments : -Will continue to monitor
-Make sure to drink 6-8 cups of water daily

Plan Other:

Med Current : Sumatriptan Succinate 25 mg
take one tab as needed for migraines.
if no relief may repeat dose after 2 hours
Sumatriptan Succinate 50 mg
take one tablet at the start of a
migraine. take another one 2 hours later if no improvement

Follow Up : -FU in 4 weeks for migraines

Counseling and/or Coordination of Care:
Patient instructions given and understood.



Seen by: Electronically signed by Ingrid R.Bakalorz Blubaugh, D.O. on 06/21/2021 at 1:18 pm

COV1D-19 Vacicikaadon Recall Card

RIFEnryiereEcottiitremmntioatl,Aitehiirdimmaliir Alf _____
allsoastathewasetessapaselhemenerehitsell.
P." gum* est. IssOela de _ inforrnachin
medic-a as racer:1s t€u recibido.

_____ . • _of _____

&sagaWeft n
arattehhharte fnfam

Rattathetentberfiratteratiesentharllfreesteltruettffti

Vaccine	Product Illsmennonaracturer Date Lot Plumber		Healthcare Professional or Clinic Site
rrrrr. GIDNID-TID j.	— Ferzer	rn. 33sy	GGet
2.Mvar 1:10x4Imns	ere,	_M mm dtt·	
Other		mm ad yy	
Miter		math dhl'l/,S'	

05/17/21
Sex: F **Age:** 73 years

Nurse Note:
Since your last visit with us, have you been evaluated or treated by any other clinicians?
Yes No
Since your last visit with us, have you been to the ER or Urgent Care? Yes No

Do you feel that you have adequate shelter & access to food? yes no, resources provided Do you feel safe at home? yes no, resources given

Are there any medication discrepancies? yes no
Are you able to afford your medications? yes no, resources provided

Barriers to Learning:
☑ No Barriers
☐ Visually Impaired
☐ Blind
☐ Hard of Hearing
☐ Deaf
☐ Does not Read English
☐ Requires Interpreter
☐ Dementia
☐ Low Health Literacy
☐ Cognitive Impairment
☐ Stressors
☐ Values Beliefs

Learning Preferences
No Preference
Practice/Demonstration
Reading/Handouts
Q & A

Date: 05/17/2021
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Are you exposed to second hand smoke? Yes No Declined to specify

Falls Risk 65+
A. No falls in the past year or one fall w/o an injury?
If No falls *(do nothing further)*

O R

B. Two or more falls in the past year or one fall resulting in injury?
If Yes patient given fall prevention handout

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☑	☐	☐	☐
2. Feeling down, depressed, or hopeless	☑	☐	☐	☐

Total: 0

3. Do you feel that you get the emotional & social support that you need? yes no, resources provided

Nurse note completed by: Zuleyca Gutierrez, MA

Subjective
CC: Patient presents for a check on chronic conditions
HPI: Patient is a 73 YO female who presents for a check on chronic conditions and bloodwork review.
Patient states that she feels good. No specific concerns.
Patient is taking all medications as prescribed. No recent hospitalizations.

ROS:
Const: Denies constitutional symptoms. General health stated as good. All other systems negative except as listed below.
CV: Denies cardiovascular symptoms.
Resp: Denies respiratory symptoms.
GI: Denies gastrointestinal symptoms.
GU: Denies urinary symptoms.
Musculo: Denies musculoskeletal symptoms.
Neuro: Denies neurologic symptoms.

Current Meds: Sumatriptan Succinate 25 mg, Sumatriptan Succinate 50 mg
Medication Assessments:
Does the patient/family understand the medications? Yes No
Medication side effects and/or med-adherence difficulty? Yes No
Barriers to med-adherence? Yes No
Allergies: Penicillins

PMH:
Problem List: Mixed hyperlipidemia, Migraine
Reviewed, no changes.
FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)
Reviewed, no changes.
SH:
Reviewed, no changes.

Objective
BP: 126/80 **T:** 97.8 **Ht:** 63.75" 5'3.75" **Wt:** 131lb **Wt Prior:** 135lb as of 11/09/20 **Wt Dif:** -4lb **BMI:** 22.7 **Wt kg:** 59.422 **Wt kg Prior:** 61.236 as of 11/09/20 **Wt kg Dif:** -1.814 **IBW:** 115 **Ht cm:** 161.9 **T:** 36.6C

Exam:
Const: Appears healthy and well developed.
Eyes: Conjunctivae clear. Pupils equal round and reactive to light and accomodation. No abnormalities of the irides.
ENMT: Tympanic membranes: WNL. Moistness and normal color of the nasal mucosae. Oropharynx: Appears normal.
Neck: Supple and symmetric. Thyroid is normal in size and texture.
CV: Rhythm is regular. S1 is normal. S2 is normal. No heart murmur appreciated. Carotids: 2+ and equal bilaterally, without bruits. **Extremities:** No clubbing, cyanosis or edema.
Abdomen: Abdomen is nontender. No palpable hernias. No palpable hepatosplenomegaly.
Lymph: No visible or palpable cervical lymphadenopathy.
Skin: Dry and warm with no rash.
Neuro: Alert and oriented x3. Displays comfort and cooperation during encounter. Sensation grossly intact to light touch. Reflexes: DTR's are 2+ bilaterally.
Cranial Nerves: Cranial nerves II-XII intact.

Dental assessment performed: findings were negative.

Advance Directive

☑ ON FILE & DISCUSSED
The importance of advance care planning has been discussed with patient. Current advance care planning document(s)
on file have been reviewed and discussed with
any questions and concerns addressed. The importance of keeping these documents updated has been discussed. Patient advised that if they were to update their advance
care planning document(s) to notify our office and bring any newer copies in to be kept on file, as part of their medical record.
Date: 05/17/2021
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Assessment #1: Mixed hyperlipidemia
Care Plan:

Comments : -Reviewed patient's lipid panel
-It has worsened slightly
-Per ACC guidelines patient should be started on a statin
-Patient will try over the counter medications fish/krill oil supplements (at least 1000mg of omega-3) and/or red yeast rice
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity

Assessment #2: Migraine, unspecified, not intractable, without status migrainosus
Care Plan:

Comments : -Take medications as directed
-If migraine is not being relieved by medication, call the office for a potential toradol shot
-Will do a trial of ubrelevy (100mg)
-Continue to monitor
-Patient has tried amitryptline, aimovig, enjovy in the past
-Will consider topiramate for prophylaxis in the future

Assessment #3: Insomnia, unspecified
Care Plan:

Comments : -Patient does not have much relief with unisom
-Will do a trial of trazadone
-FU in 1 month
-If no improvement will try try remeron, belsomra or doxepin
Med New : Trazodone HCL 50 mg take 1 tablet at bedtime for sleep

Assessment #4: Chronic kidney disease, stage 3a
Care Plan:

Comments : -Reviewed Comprehensive Metabolic Panel
-Patient's kidney function is slightly decreased but holding steady
-Will continue to monitor
-Make sure to drink 6-8 cups of water daily

Assessment #5: Body mass index [BMI] 22.0-22.9, adult
Care Plan:

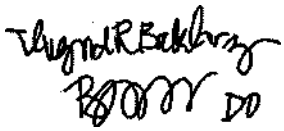
Comments : -Currently stable

Plan Other:

Med Current : Sumatriptan Succinate 25 mg
take one tab as needed for migraines.
if no relief may repeat dose after 2 hours
Sumatriptan Succinate 50 mg
take one tablet at the start of a
migraine. take another one 2 hours later if no improvement

Follow Up : -FU in 1 month for a check on insomnia
-FU in 3 months for a check on lipids, Comprehensive Metabolic Panel done the week before
-Copy of covid vax card

Counseling and/or Coordination of Care:
Patient instructions given and understood.



Seen by: Electronically signed by Ingrid R.Bakalorz Blubaugh, D.O. on 05/17/2021 at 11:30 am

I, Joan M. Donovan, give consent to Lebanon Valley Family Medicine, Inc. to retrieve and use my medication history from SureScripts.

Electronically signed on 05/17/2021 at 10:53 am

11/09/20
Sex: F **Age:** 73 years

Nurse Note:
Since your last visit with us, have you been evaluated or treated by any other clinicians?
Yes No
Since your last visit with us, have you been to the ER or Urgent Care? Yes No

Do you feel that you have adequate shelter & access to food? yes no, resources provided Do you feel safe at home? yes no, resources given

Are there any medication discrepancies? yes no
Are you able to afford your medications? yes no, resources provided

Barriers to Learning:
☑ No Barriers
☐ Visually Impaired
☐ Blind
☐ Hard of Hearing
☐ Deaf
☐ Does not Read English
☐ Requires Interpreter
☐ Dementia
☐ Low Health Literacy
☐ Cognitive Impairment
☐ Stressors
☐ Values Beliefs

Learning Preferences
No Preference
Practice/Demonstration
Reading/Handouts
Q & A

Date: 11/09/2020
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Are you exposed to second hand smoke? Yes No Declined to specify

Nurse note completed by: Zuleyca Gutierrez, MA

Subjective
CC: Patient presents for a check on chronic conditions
HPI: Patient is a 73 YO female who presents for a check on chronic conditions.
Patient states that she feels good. No specific concerns.
Patient is taking all medications as prescribed. No recent hospitalizations.

ROS:
Const: Denies constitutional symptoms. General health stated as good. All other systems negative except as listed below.
CV: Denies cardiovascular symptoms.
Resp: Denies respiratory symptoms.
GI: Denies gastrointestinal symptoms.
GU: Denies urinary symptoms.
Musculo: Denies musculoskeletal symptoms.

Neuro: Denies neurologic symptoms.

Current Meds: Sumatriptan Succinate 25 mg, Sumatriptan Succinate 50 mg
Medication Assessments:
Does the patient/family understand the medications? Yes No
Medication side effects and/or med-adherence difficulty? Yes No
Barriers to med-adherence? Yes No
Allergies: Penicillins

PMH:
Problem List: Mixed hyperlipidemia, Migraine
Reviewed, no changes.
FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)
Reviewed, no changes.
SH:
Reviewed, no changes.

Objective
BP: 130/62 **Pulse:** 76 **T:** 99.3 **Wt:** 135lb **Wt Prior:** 133lb as of 05/11/20 **Wt Dif:** +2lb **Wt kg:** 61.236 **Wt kg Prior:** 60.329 as of 05/11/20 **Wt kg Dif:** +0.907 **T:** 37.4C

Exam:
Const: Appears healthy and well developed.
Eyes: Conjunctivae clear. Pupils equal round and reactive to light and accomodation. No abnormalities of the irides.
ENMT: Tympanic membranes: WNL. Moistness and normal color of the nasal mucosae. Oropharynx: Appears normal.
Neck: Supple and symmetric. Thyroid is normal in size and texture.
CV: Rhythm is regular. S1 is normal. S2 is normal. No heart murmur appreciated. Carotids: 2+ and equal bilaterally, without bruits. **Extremities:** No clubbing, cyanosis or edema.
Abdomen: Abdomen is nontender. No palpable hernias. No palpable hepatosplenomegaly.
Lymph: No visible or palpable cervical lymphadenopathy.
Skin: Dry and warm with no rash.
Neuro: Alert and oriented x3. Displays comfort and cooperation during encounter. Sensation grossly intact to light touch. Reflexes: DTR's are 2+ bilaterally.
Cranial Nerves: Cranial nerves II-XII intact.

Dental assessment performed: findings were negative.

Date: 11/09/2020
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Assessment #1: Migraine, unspecified, not intractable, without status migrainosus
Care Plan:

Comments : -Take medications as directed
-If migraine is not being relieved by medication, call the office for a potential toradol shot

-Continue to monitor

Assessment #2: Mixed hyperlipidemia
Care Plan:

Comments : -At last bloodwork patient had elevations in total cholesterol and triglycerides
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity
-Will continue to monitor

Assessment #3: Abnormal finding of blood chemistry, unspecified
Care Plan:

Comments : -At last bloodwork, kidney function is slightly decreased
-Will recheck at next appointment
-Will continue to monitor
-Make sure to drink 6-8 cups of water daily

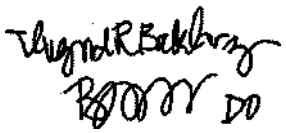
Assessment #4: Insomnia, unspecified
Care Plan:

Comments : -Will do a trial of unisom (doxyalamine succinate)
-If no improvement will call to let me know. I would then try trazadone, remeron, belsomra or doxepin

Plan Other:

Med Current : Sumatriptan Succinate 25 mg
Take one tab as needed for migraines.
If no relief may repeat dose after 2 hours
Follow Up : -FU in 6 months with cmp, lipids, hep c done the week before
-Patient will drop off adv Directive
-Pneumococcal 23
-Patient will call insurance to see where to receive Shingrix shot series

Counseling and/or Coordination of Care:
Patient instructions given and understood.



Seen by: Electronically signed by Ingrid R.Bakalorz Blubaugh, D.O. on 11/09/2020 at 12:00 pm

SEX: Female

Patient Class: Outpatient

Patient Location:

Performing Location:

Reason for Exam: screening mammo
Comments:

UPMC Imaging Hershey
Imaging Result

Procedure Performed: Breast Imaging Screening Mammogram w/CAD Bilateral **Exam Date & Time:** 08/28/202012:49 PM

EXAM:
81 SCREENING MAMMOGRAM BILATERAL W/CAD

HISTORY:
Joan Donovan "Joan" is a 72 y.o. female and is seen for breast cancer screening. Surgical history includes bilateral breast biopsy, 1980's (all neg). History of breast cancer in Other, Mother.

COMPARISON TO PREVIOUS EXAMINATION(S):
Compared to: 07/19/2019 Breast Imaging Screening Mammogram Bilateral w/CAD, 07/11/2018 Breast Imaging Screening Mammogram Bilateral w/CAD, and 03/29/2017 Breast Imaging Screening Mammogram Bilateral w/CAD

FINDINGS:
The breasts have scattered areas of fibroglandular density.

Bilateral
There is no evidence of suspicious masses, calcifications, or other abnormal findings.

Stable benign glandular asymmetry is present in the upper-outer quadrant of the right breast. A benign round calcification is present on the right. A biopsy clip is present on the left.

Digital breast tomosynthesis images were obtained and reviewed.

Computer-aided detection (CAD) was used in the interpretation of this mammogram.

Encounter Date: 08/28/2020

IMPRESSION:
No evidence of malignancy_

BI-RADS® ATLAS category: 2 - Benign
BI-RADS® ATLAS category (overall): 2 Benign

RECOMMENDATIONS:
Mammogram in 1 Yr. is recommended

Lifetime Risk of Breast Cancer: 11.9 %

The American Cancer Society has recommended consideration of screening breast MRI in patients whose Gail model lifetime risk assessment for invasive breast cancer exceeds 20%.

Signed By: Tamra L Heimert, MD on 8/31/2020 3:22 PM

If a physician has questions regarding this report, a Quantum Radiologist can be reached by phone at **717-932-8030.**

Todays date: 05/11/20 **HISTORY SUMMARYN**

Sex: F **Age:** 72 years

PMH:

FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)

SH:

05/11/20
Sex: F **Age:** 72 years

Nurse Note:
Since your last visit with us, have you been evaluated or treated by any other clinicians?
Yes No
Since your last visit with us, have you been to the ER or Urgent Care? Yes No

Do you feel that you have adequate shelter & access to food? yes no, resources provided Do you feel safe at home? yes no, resources given

Are there any medication discrepancies? yes ☑ no
Are you able to afford your medications? ☑ yes ☐ no, resources provided

Barriers to Learning:
☑ No Barriers
☐ Visually Impaired
☐ Blind
☐ Hard of Hearing
☐ Deaf
☐ Does not Read English
☐ Requires Interpreter
☐ Dementia
☐ Low Health Literacy
☐ Cognitive Impairment
☐ Stressors
☐ Values Beliefs

Learning Preferences
No Preference
Practice/Demonstration
Reading/Handouts
Q & A

Date: 05/11/2020
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Are you exposed to second hand smoke? Yes No Declined to specify

Falls Risk 65+
A. No falls in the past year or one fall w/o an injury?
If No falls *(do nothing further)*

O R

B. Two or more falls in the past year or one fall resulting in injury?
If Yes patient given fall prevention handout

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☑	☐	☐	☐
2. Feeling down, depressed, or hopeless	☑	☐	☐	☐

Total: 0

3. Do you feel that you get the emotional & social support that you need? yes no, resources provided

Nurse note completed by: Samantha Yeagley, CNA

Subjective
CC: Patient presents to establish care and for a check on her chronic conditions
HPI: Patient is a 72 YO female who presents to establish care and for a check on her chronic conditions
Patient states that she feels pretty good. No specific concerns.
Patient is taking all medications as prescribed. No recent hospitalizations.
Patient was seen by Dr. Monsanto in Harrisburg.

ROS:
Const: Denies constitutional symptoms. General health stated as good. All other systems negative except as listed below.
CV: Denies cardiovascular symptoms.
Resp: Denies respiratory symptoms.
GI: Denies gastrointestinal symptoms.
GU: Denies urinary symptoms.
Musculo: Denies musculoskeletal symptoms.
Neuro: Denies neurologic symptoms.

Current Meds: Sumatriptan Succinate 25 mg, Naproxen Sodium 550 mg
Medication Assessments:
Does the patient/family understand the medications? Yes No
Medication side effects and/or med-adherence difficulty? Yes No
Barriers to med-adherence? Yes No
Allergies: Penicillins

PMH:
Problem List: Migraine
Reviewed and updated.
FH:
Father:
. (Hx) . (Father Text)
Mother:
. (Hx) . (Mother Text)
Reviewed and updated.
SH:
Reviewed and updated.

Objective
BP: 126/72 **Pulse:** 76 **T:** 98.8 **Ht:** 64.25" 5'4.25" **Wt:** 133lb **Wt kg:** 60.329 **BMI:** 22.6 **IBW:** 120 **Ht cm:** 163.2 **T:** 37.1C

Exam:
Const: Appears healthy and well developed.
Eyes: Conjunctivae clear. Pupils equal round and reactive to light and accomodation. No abnormalities of the irides.
ENMT: Tympanic membranes: WNL. Moistness and normal color of the nasal mucosae. Oropharynx: Appears normal.
Neck: Supple and symmetric. Thyroid is normal in size and texture.
CV: Rhythm is regular. S1 is normal. S2 is normal. No heart murmur appreciated. Carotids: 2+ and equal bilaterally, without bruits. **Extremities:** No clubbing, cyanosis or edema.
Abdomen: Abdomen is nontender. No palpable hernias. No palpable hepatosplenomegaly.

Lymph: No visible or palpable cervical lymphadenopathy.
Skin: Dry and warm with no rash.
Neuro: Alert and oriented x3. Displays comfort and cooperation during encounter. Sensation grossly intact to light touch. Reflexes: DTR's are 2+ bilaterally.
Cranial Nerves: Cranial nerves II-XII intact.

Dental assessment performed: findings were negative.

Date: 05/11/2020
Was the patient queried about tobacco behavior? Yes No
Does the patient currently use tobacco? Cigarette Use: Never Smoked Cigarettes.

Assessment #1: Migraine, unspecified, not intractable, without status migrainosus **Care Plan:**

Comments : -Take medications as directed
-If migraine is not being relieved by medication, call the office for a potential toradol shot
-Continue to monitor

Assessment #2: Encounter for screening for lipoid disorders
Care Plan:

Comments : -Will do bloodwork and call with results
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity

Assessment #3: Encounter for screening for other suspected endocrine disorder
Care Plan:

Comments : -Will do bloodwork and call with results
-Instructed patient to follow a low salt, low fat, low carb diet
-Encouraged daily physical activity

Assessment #4: Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Care Plan:

Comments : -Will do bloodwork today
-Will call with results

Assessment #5: Body mass index (BMI) 22.0-22.9, adult
Care Plan:

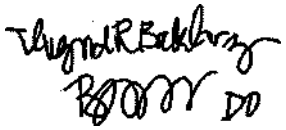
Comments : -Currently stable

Plan Other :

Follow Up : -Patient had guillian-barre so she won't get a flu shot (put alert in chart)
-BW today cbc, cmp, lipids, thyroid stimulating hormone

-Colonoscopy results done at Hershey Medical Center in 2019
-Get dexa results from Tristan
-FU in 6 months

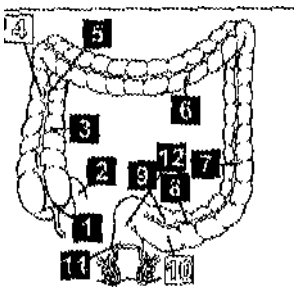
Counseling and/or Coordination of Care:
Patient instructions given and understood.



Seen by: Electronically signed by XXXXX, D.O. on 05/11/2020 at 2:29 pm

Patient Name: **Date of Birth:**
MRN: **Account Number:**
Procedure Date: 1/31/2020 8:02 AM **Attending MD:** XXXXX, MD
Order #: **Instrument Name:** Fuji EN580T-362

Procedure: Colonoscopy
Indications: High risk colon cancer su ▸ veillance: Personal history of sessile serrated colon polyp (less than 10 mm in size) with no dysplasia
Providers: Charles E Dye, MD (Doctor), Bridget Flick, BSN, RN, CGRN (Nurse), Janessa Rebuck, LPN (Technician), Charles E. Dye, MD (Ordering Provider)
Medicines: Deep sedation was administered, Sedation Administered by an Anesthesia Professional
Complications: No immediate complications.
Procedure: Pre-Anesthesla Assessment:



The Colon

Prior to the procedure, a History and Physical was performed, and patient medications and allergies were reviewed. The risks and benefits of the procedure and the sedation options and risks were discussed with the patient. All questions were answered and informed consent was obtained. Patient identification and proposed procedure were verified by the physician, the nurse and the anesthetist in the procedure room. Mental Status Examination; alert and oriented. Airway Examination: Documented by anesthesia providers. Respiratory Examination: No respiratory distress. No abdominal exam findings precluding endoscopy. CV Examination: regular rate and rhythm. Prophylactic Antibiotics: The patient does not require prophylactic antibiotics, Prior Anticoagulants;
The patient has taken naproxen, last close was 3 days prior to procedure. ASA Grade Assessment: II - A patient with mild systemic disease. After reviewing the risks and benefits, the patient was deemed in satisfactory condition to undergo the procedure. The anesthesia plan was to use deep sedation / analgesia. This assessment was completed before the administration of sedation at 08:10 AM- unit centered/anesthesia provider centered
- Additional history or physical exam or study comment; Using enteroscopy equipment due to long and redundant colon and prior history of single transverse colon sessile serrated polyp
Ali staff in attendance for the performed procedure act In the role of the Chaperone.
After I obtained informed consent, the scope was passed under direct vision. Throughout the procedure, the patients blood pressure, pulse, and oxygen saturations were monitored continuously. The Enteroscope was introduced through the anus and advanced to the terminal ileum. The colonoscopy was somewhat difficult due to a redundant colon. The quality of the bowel preparation was adequate. The terminal Ileum, ileocecal valve, appendiceal orifice, and rectum were photographed.

Findings:

The perianal and digital rectal examinations were normal,

The terminal ileum appeared normal.

Multiple small and large-mouthed diverticula were found In the sigmoid colon, descending colon and transverse colon.

A small post polypectomy scar was found In the transverse colon. There was no evidence of the previous polyp.

The exam was otherwise without abnormality on direct and retrofiexion views.

PennState Health

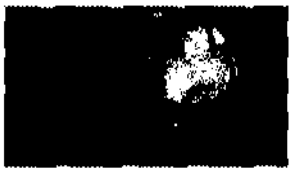
Milton 5. Hershey Medical Center

Endoscopy Suite

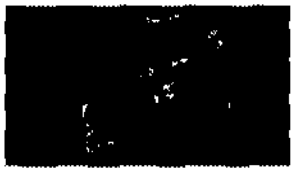
Patient Name:	XXXX	Date of Birth;	XXXX
MRN:	XXXX	Account Number:	XXXX
Procedure Date:	1/31/2020 8:07 AM	Attending MD:	XXXX, MD
Order #:	XXXX	Instrument Name:	

U Appendiceal Orifice

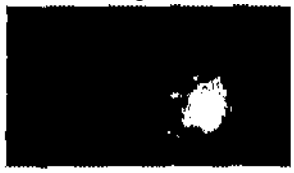
II Terminal ilecrn



IN Ascending Colon



Hit Ascending Colon



Impression: Reassuring colonoscopy possible via use of single **balloon enteroscopy equipment given very long and** redundant colon

Patient should be lower risk for developing colorectal **cancer at this point**

Given prior issues tolerating bowel purge including **today and one area of sigmoid colon with solid stool** balls, suggest two day low volume split dose **prep and home phenergan or zofran for any future** colonoscopy attempts: see below for recommendations **moving forward**

Recommendation: - Patient has a contact number available for emergencies. **The signs and symptoms of potential** delayed complications were discussed with the **patient. Return to normal activities tomorrow.** Written discharge instructions were provided to the patient.
- Resume previous diet today,
- Continue present medications.
- Return to primary care physician,
- Suggest have a FIT/DNA test in 5 years (currently = cologuard testing) **and refer to GI if positive to** arrange **overtube assisted colonoscopy** with enteroscopy equipment **if positive**
- Repeat colonoscopy via device assisted enteroscopy If FIT/DNA testing **positive on an every 5 year** cycle.
- Resume previous NSAID medication today if necessary at prior dose.

Attending Participation:

I personally performed the entire procedure.

PenaState Health
Milton 5. Hershey Medical Center

Patient Name:	XXXX	**Date of Birth:**	XXXXX
MRN:	XXXX	**Account Number:**	XXXX
Procedure Date:	$^{1}/_{3}{}^{1}/_{2}$020 8:02 AM	**Attending MD:**	XXXX, MD
Order #:	XXXX		

XXXX MD

XXXXX, MD
Signed Date: 1131/2020 9:19:31 AM
This report has been signed electronically by XXXX, MD.

Number of Addenda: 0

Note Initiated On: 1/31/2020 8:02:42 AM

Scope Withdrawal Time:

18 Minutes 36 Seconds

Total Procedure Duration Time:

44 Minutes 19 Seconds

CC Letter to: XXXX, MD 805 Sir Thomas Court 2nd Floor Harrisburg, PA 17109

Time (am/pm) _____

FACSIMILE COVER LETTER

ATTENTION: RECIPIENT INFORMATION	
ADDRESSEE (FIRST NAME, LAST NAME):	Executive Medical Care
ADDRESSEE'S HEALTH INSURANCE NAME:	
ADDRESSEE'S STREET ADDRESS:	
ADDRESSEE'S CITY, STATE:	
ADDRESSEE'S HEALTH PROGRAM:	
ADDRESSEE'S FAX NUMBER:	717-838-6707
SENDER INFORMATION (PLEASE PRINT)	
FIRST NAME: [illegible] LAST NAME: [illegible] TELEPHONE: [illegible]	
ORGANIZATION NAME:	[illegible]
ORGANIZATION'S TELEPHONE NUMBER:	717-651-3057
ORGANIZATION'S FAX NUMBER:	717-651-3067

(Cont'd)

11/18/20 2020 Discharge, H&P

Medication List. Blood cultures chest xray [illegible]

PATIENT'S NAME (INCLUDED TO CONFIRM):	
PAGES:	5 (4)

CONFIDENTIALITY STATEMENT

Please notify us immediately if you received this communication in error.

The documents accompanying this fax transmission contain information from [illegible] which is confidential and/or privileged. The information is intended only for the use of the individual or entity named on this transmission sheet. If you are not the named recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of any action in reliance on the contents of this information is strictly prohibited. Thank you.

Order-Level Documents: (continued)

1/31/2020

XXXXX, MD
B05 Sir names Court
2nd Floor
Harrisburg, PA 17109

Re : Colonoscopy procedure for Joan Donovan, DOB: 10127/1947

Dear Dr. XXXX°

This procedure was performed on Friday, January 31, 2020. My impressions and recommendations are as follows:

impressions
Reassuring colonoscopy possible via use of single balloon enteroscopy equipment given very long and redundant colon

Patientshould be lower risk for developing colorectal cancer at this point

Given prior issues tolerating bowel purge including today and one area of sigmoid colon with solid stool balls, suggest two day low volume split dose prep and home phenergan or zofran for any future colonoscopy attempts: see below for recommendations moving forward

Recommendations:
- Patient has a contact number available for emergencies. The signs and symptoms of potential delayed compUcations were discussed with the patient. Return to normal activities tomorrow. Written discharge instructions were provided to the patient
- Resume previous diet today.
- Continue present medications.
- Return to primary care physician.
- Suggest have a FIT/DNA test in 5 years (currently = cologuard testing) and refer to GI If positive to arrange overtube assisted colonoscopy with enteroscopy equipment If positive
- Repeat colonoscopy via device assisted enteroscopy if FIT/DNA testing positive on an every year cycle-
- Resume previous NSA medication today if necessary at prior dose.

My findings are described in the full procedure note, which is enclosed. If I can be of further assistance, please feel free to contad me at 717-631-3834.

Sincerely,

Page 1