

**PARAGON CLINICAL PROGRESS NOTE**

Patient Name: Rose Ballog  
 DOB: 1/7/37  
 Reason for Visit: Acute visit: hyponatremia

Room: 243B  
 Date of Service: 12/4/2019

**HPI:** 82 year old female patient of Dr. Olson's at St. Paul's for LTC. PMH significant for 11/21-11/25 hospitalization for PNA and hypertensive urgency. PNA treated with Zosyn. HTN treated with hydralazine, clonidine in ED. Losartan increased to 50 mg BID, started on amlodipine. Anxiety likely contributing factor, Ativan increased. Hospital echo with 70-75 LVEF. Also seen by speech with recommendation for thin liquid/soft diet. Patient discharged to SPH on Levaquin. Saw patient today at staff request for lab review. Patient alert, cooperative, NAD. Patient denies any n/v/d, increased confusion, urinary issues. Pt reports chronic BLE and R shoulder pain. Reports Norco remains helpful for pain. Denies other pain, CP, abdominal pain, SOB, DOE, fever/chills, malaise. No other new concerns from nursing.

**PMH/PSH:** CHF, anemia, HTN, HL, anxiety, DJD, OA, R TKA, CAD, GERD, COPD, bradycardia, BLE arterial stenosis, COPD (50 pack year hx smoking), dementia  
**ALLERGIES:** NKDA

**ROS:**

**General:** Denies fever/chills, malaise. +BLE pain, R shoulder pain  
**HEENT:** Denies sore throat, rhinitis, epistaxis, bleeding gums, vision changes, eye discharge  
**CV:** Denies CP, palpitations, dizziness, +BLE edema  
**PULM:** Denies SOB, DOE, wheezing, cough  
**GI:** Denies abdominal pain, v/d, constipation  
**GU:** Denies dysuria, urgency, hematuria, nocturia, +frequency (chronic complaint with Lasix)  
**MSK:** Denies, arthralgia, myalgia, swelling, falls, +gait disorder  
**NEURO:** Denies headache, syncope, +gen weakness  
**SKIN:** Denies rash, wounds, bruising.  
**PSYCH:** No hallucinations, sleep disturbance, depression, anxiety  
**PE:**  
**General:** Pt calm, cooperative, NAD  
**HEENT:** MMM, Conjunctiva pink, no exudate.  
**CV:** +S1, S2, RRR, +murmur. No rubs, thrills. +BLE edema with ACE wraps in place  
**PULM:** RR regular & unlabored, lungs with no wheezes, crackles, +scattered BL rhonchi R>L  
**GI:** Abd soft, non-distended, bowel sounds WNL, non-tender to palpation  
**GU:** No suprapubic tenderness, no CVA tenderness, no hematuria  
**MSK:** No swelling, erythema, BL shoulder ROM limited  
**NEURO:** alert and oriented. No focal weakness, PERRLA.  
**SKIN:** Visible skin dry and intact, warm. No wounds or rash. No erythema.  
**PSYCH:** pleasant, normal mood

**LABS**

Date:	12/4/19	11/26/19	8/21/19	5/28/19	9/3/18	7/31/18
NA	134	131	136	138	130	
K	4	4.3	3.8	3.7	3.5	
CL	31	4.3	94	96	85	
CO2	93	31	31	30	31	
BUN	22	6	10	10	9	
Creat	0.89	0.63	0.50	0.41	0.50	
WBC	9.22	9.08	8.28	9.88	10.47	6.95
HGB	10.8	12.5	11.9	10.9	9.9	11.1
HCT	35.8	41.3	38.7	35.2	30.1	35.6
PLT	339	432	469	342	652	315

**ASSESSMENT/PLAN:****Hyponatremia (E87.1)**

- Continues 1 L fluid restriction, hyponatremia improved from 12/2 value of 129  
 - Urine osmolality pending

**Anxiety (F41.9)**

- Repeat BMP in 1 week  
 - Continues fluoxetine, lorazepam  
 - In house psych to follow for medication management, requested patient be seen ASAP

**Pain (R52), weakness (R53.1)**

- Continue skilled therapy, encouraged patient to participate  
 - Continues q12h Norco 10s, PRN Norco 5s remain available, continue rest of pain regimen as ordered  
 - Patient may be seen by OP Ortho for further pain management

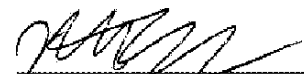
**HTN (I10)**

- Continues amlodipine, furosemide, losartan, metoprolol

**BLE edema (R60.0), CHF (I50.9)**

- Continues 20 mg furosemide QD, ACE wraps to BLE, 1 L fluid restriction  
 - Dr Gill, in house cardiac, to follow patient

Discussed with nursing, AP  
 Medications, labs, chart reviewed



Heather Sandler, APN