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	359	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
- Repeat BMP in 1 week

Anxiety (F41.9)
- 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 cardio, to follow patient

Discussed with nursing, AP
Medications, labs, chart reviewed

Heather Sandler, APN