PARAGON CLINICAL PROGRESS NOTE

Patient Name: Kertgen, Laurel **Room:** 170
DOB: 7/28/1938 **Date of Service:** 12/19/2019
Reason for Visit: Acute visit: cough

HPI: 81 y.o. female patient of Dr Olson's PMH per below seen today for cough. Saw patient today while sitting upright in chair. Patient alert, cooperative, NAD. Patient reports new cough that started last night and continues this morning. Patient reports cough is non productive. Denies SOB, DOE, wheezing, fever/chills, malaise. Continues to ambulate with cane. Patient reports moderate L shoulder pain currently controlled, aggravated by movement. No new concerns from nursing.

PMH/PSH: Alzheimer's dementia, HTN, DM2, HL, CVA
ALLERGIES: NKA

ROS:
General: Denies fever/chills, malaise. *+chronic BLE pain, L shoulder pain controlled*
HEENT: Denies sore throat, rhinitis, epistaxis, bleeding gums, vision changes, eye discharge
CV: Denies CP, palpitations, dizziness
PULM: Denies SOB, DOE, wheezing, *+cough*
GI: Denies abd pain, n/v/d, constipation, melena, anorexia
GU: Denies dysuria, frequency, urgency, hematuria, nocturia
MSK: Denies myalgia, swelling, *+generalized weakness, +amb with cane, +history of falls*
NEURO: Denies headache, syncope, confusion, vertigo, paraesthesias
SKIN: Denies rash, wounds, pruritus, bruising.
PSYCH: No hallucinations, sleep disturbance, depression, anxiety

PE:
General: Pt calm, cooperative, NAD
HEENT: MMM, Conjunctiva pink, no exudate. No pharyngeal erythema/exudate. No lymphadenopathy.
CV: +S1, S2, RRR, no murmurs, rubs, thrills. No edema
PULM: RR regular & unlabored, lungs clear, no wheezes, crackles, rhonchi.
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. *+L shoulder with crepitus*
NEURO: Pt A&Ox2. No focal weakness, PERRLA.
SKIN: Visible skin dry and intact, warm. No wounds or rash.
PSYCH: pleasant, normal mood

LABS A1c 6.7 7/3/2019, 2/25/19: TSH 1.73, HGBA1c 6.5

Date:	12/5/19	7/3/19	2/25/19	10/4/18	1/3/18
NA	142	143	142	144	143
K	3.9	4.3	4	4	4.6
CL	105	105	105	106	107
CO2	30	30	30	30	31
BUN	12	14	13	12	12
Creat	1.04	1.09	1.04	1.05	1.02
WBC	4.47		4.63		3.83
HGB	9.5		9.9		9.3
HCT	29.8		30.6		28.0
PLT	172		179		181

ASSESSMENT/PLAN:
Cough (R05): PRN cough syrup available, encouraged patient to request. Inform NP/AP if cough worsens, fails to improve, patient becomes febrile. CTM
DM2 (E11.9): HGBA1c 6.8 on 12/7/19, well controlled. Repeat HGBA1c 3/6/20. Continue QD accuchecks, 50 mg Januvia QD. CTM.
Anemia (D64.9): HGB decreased to 9.5. Increased Fe to BID on 12/5/19
Gait disorder (R26.9): Continue fall/safety precautions, activity as tolerated. PRN APAP available for pain. CTM
HTN (I10): Recent BPs reviewed, remain controlled, 130/80 today. Continues metoprolol 50 mg BID, hydralazine 10 mg TID. CTM.
L shoulder pain (M25.512): Symptoms consistent with OA. PRN APAP available. Patient may see ortho PRN. CTM

Endorsed to nursing
Medications, labs, chart reviewed

Heather Sandler, CNP