CHART REVIEW COVER SHEET

CHART ID	196811
SITE ID	4759965
	315 E ELM
	.DWELL, ID 83605
PROVIDER NAME	ART, M.D., 'LYNDA B.,
PROJECT	100231000 WAVE1 2011

Please scan this cover sheet for the Chart ID listed above.

4759965

ALLERGIES:
See Medication Summary

Adult Problem List & Health Data

Primary Provider _____

Phone Contact _____ Living Will Yes No Code Status

Date	Problem List	Reviewed Date/Initial
	Arthritis	/
	Asthma	/
	Diabetes	/
	Epilepsy	/
	Glaucoma mild	/
	Hypertension	/
	Hypercholesterolemia	/
	Migraine	/
	SI	/
	Bladder cut during HYST	/
	Sleep apnea CPAP @ 12	/
	MVA 8/2011 broken nose	/
		/
		/
		/
		/
		/
		/

Surgeries

Bladder repair x3
Pin in left arm + right foot

Appy Chole CABG Hernia
Vas Tubal (Hyst) Ooph

Immediate Family History

HTN M DM M
Chol M Early ASVD M
Cancer

Social

S M D (W) Spouse _____
Children C4P4
Occupation disabled Education 10th
Alcohol socially Drug Use +Pot

Health Maintenance

Date (Month/Year), **Initials**	8/18/09								
Exercise Amount									
Diet									
Tobacco Use 2yr hx	T2nd°								
Tetanus									
Influenza (annually >65)									
Pneumonia (high risk & > 65)									
Physical Exam									
Glucose (1-3 after 45)									
Chol (every 3-5 yrs)									
HDL									
LDL									
TG									
Mammogram (annually>50)	DUE 2010								
Pap (every 1-3 yrs)	NA								
Chylamdia/STD Screen									
Colon Screen (>50)	DONE								
PSA/DRE (>45, or High Risk)									
Bone Density (High Risk or 65)									
Other (e.g. Safety, Vision, Hearing, Depression, Fall Risk)									

EMPI # 112.843

on Back

Name: APPLOAD ,Robin
Sex: F DOB: 02/20/53

Diabetes or Cardiovascular Flow Sheet

Primary Care Physician: _____

	Date	8/18/09	8/18/09	9/[illegible]/09	10/22/09	04/15/10	6/15/10		
Weight / BMI (18.5-24.9)									
BP < 130/80 Yes or No									
ANNUAL EXAMS	Complete Physical Exam								
	Retinal Exam - DM	Due 10/09							
	Sensory Foot Exam			✓	✓				
	Dental Exam								
	Orthostatics								
ANNUAL LABS	HbA1C <7% - if DM Quarterly or Biannual	Due	7.2	✓	10/10 7.2	10.5	9.6		
	Total Cholesterol < 200mg/dl		210	✓	159		213		
	LDL <100mg/dl or <70 if CAD		116	✓	92		116		
	HDL >45 men; >55 women		43	✓	38		40		
	Triglycerides <150mg/dl		255	✓	146		287		
	Microalb/Cr spot urine Or 24h Cr/Cl, GFR, 24h protein		0.4	✓					
	Serum Cr / Bun			✓					
	Other: TB screen, TSH,								
MEDICATIONS	ACE/ARB for high risk	✓	✓	✓	✓				
	Lipid lowering	✓	✓	✓	✓				
	Anti-platelet Rx: >40 or high risk			✓	✓				
	B-Blocker for MI or CAD								
	Anti-coagulation for Afib								
COUNSELING	Diet Education								
	Exercise: how often								
	Diabetes Education/meter use								
	Smoking Cessation								
	Immunizations								
IMAGING	EKG								
	Echo (EF%) high risk, CHF								
	Carotid Exam for TIA, CVA	done at WVMC							
	Cerebral Exam for CVA								
Provider Initials		[illegible]	[illegible]	[illegible]	[illegible]				

EMPI # 112,843

Name: APPLOAD Robin

s - Y/N or Date; Labs – values; Meds – Y/N or CI/R
cated or Refused); Counseling or Imaging – Y/N or Date

List no-shows on this page

Height 5'1"

Date / Time	Wt	BP	T	P	R	O_2 Sat	Pain	Reason for Visit/Initials	Provider	Allergy Updated Y/N	Dictation Number
10/12/11 @130	238.4	124/80	97.9	88		—	2-4/10	F/u	KAT	Y mc	
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EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

Right Top/VSVFS
Rev 11-2010
Form 0012

Vital Signs/Visit Flow Sheet

List no-shows on this page

Height 5'1"

Date	Wt	BP	T	P	R	O2 Sat	Pain	Reason for Visit/Initials	Provider	Allergy Updated Y/N
8/13/09	238	112/72	97	76	–	–	Ø	~~Flu labs~~ Establish car	sart	mc
8/24/09	249.2	103/79	98.3	75	–	–	Ø	Flu labs	sart	mc
9/17/09	246.8	136/98	97.6	68	–	–	Ø	ER F/U - mercy - DM	sart	N mc
10/22/09	248	116/70	97.5	73	–	–	Ø	Lab result	sart	Y mc
11/20/09	246	116/73	97.6	68	20	97%	Ø	asthma	sart	NKDA
12-21-09	249	136/101	97.4	79	—		2	Depression, Note to Keep dog at home.	sart	[illegible]
12/29/09								cancel	sart	AS
4/15/10	224.2	116/82	97.0	79	/	/	Ø	F/U Hosp. wwm	sart	mc
4/29/10	227.6	136/86	97.2	65	/	/	Ø	med refill/labs	sart	mc
6/18/10					/	/		cancel	sart	AS
6/15/10	223.6	118/79	96.8	66	/	/	Ø	F/U meds	sart	Y mc
9/5/10	218.8	108/74	97.4	68	/	/	HA 3/10	DM ✓/	sart	Y mc
4/4/11	227	116/70	97.2	78	-	-	5/10	MVA #9517195	[illegible]	Y Ba
4-12-11	226.8	13?/70	97.2	76	-	-	2/10	CK black stools	sart	NKDA
4/21/11		/						no show	sart	[illegible]
[illegible]/11	227	[illegible]	—	80	16	—	[illegible]	F/U labs	sart	CE
8/4/11	244	107/71	97.6	68	-	-	10	MVA - Broken Ribs	sart	RS
9/6/11	240	138/86	95.9	88	/	/	2/10	F/U Broken Ribs MVA	sart	NKDA

EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

Dict. Prov:
Date of Service: 09/12/2011

Job Number: U150208 **Version:** 1

OFFICE PROGRESS NOTE

CHIEF COMPLAINT:
Followup MVA, broken ribs.

HISTORY OF PRESENT ILLNESS:
The patient presents today to follow up from recent MVA accident where she suffered some broken ribs on the right side on 07/28. The patient reports that she was seen in the ER at that time and then followed up with one of my partner's. She reports that she is continuing to have pain that is slowly getting better.

REVIEW OF SYSTEMS:
Otherwise, today is negative.

PAST MEDICAL HISTORY, FAMILY HISTORY, SOCIAL HISTORY:
Reviewed in the chart and unchanged.

PHYSICAL EXAMINATION:
VITAL SIGNS: Heart rate 88, blood pressure 138/86, temperature 95.9, height 5 feet 1 inches, weight 240 pounds.
CONSTITUTIONAL: The patient is alert and oriented in no apparent distress.
HEENT: External ears, eyes, nose, mouth, throat are clear.
CARDIOVASCULAR: Regular rate and rhythm, no murmurs, gallops or rubs.
RESPIRATORY: Clear to auscultation bilaterally, no crackles, wheezes or rhonchi.
EXTREMITIES: Warm and well perfused. No clubbing, cyanosis or edema.
PSYCHIATRIC: Mood and affect are appropriate.

ASSESSMENT AND PLAN:
Motor vehicle accident with 3 rib fractures on the right hand side. At this point in time, patient is continuing to have pain, difficulty with bending and lifting. Advised patient to not close her case at this time as she may require ongoing treatment and followup. Will follow up again in 1 month to assess how she is doing.

Dictation electronically signed by
ART, MD****

OFFICE PROGRESS NOTE

MBM:tjl
D: 09/12/2011 07:20:26
T: 09/12/2011 13:54:54
J: U150208
T: 4319948
cc:

Dictation electronically signed by
ART, MD****

EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

Dict. Prov:
Date of Service: 08/04/2011

Job Number: U136489 **Version:** 1

OFFICE PROGRESS NOTE

SUBJECTIVE:
This patient is here today because of a motor vehicle accident on 07/28/2011. She was seen in the ER that day and was found to have multiple rib fractures and cervical strain. She also had loss of consciousness. In the ER, she was prescribed Vicodin 10/660 mg tablets. She has been taking a half tab about 4-5 times a day and this has helped with her pain. She is not having constipation with it. She is also doing incentive spirometry every day. The ribs are still is painful as they were when she first received the injury.

OBJECTIVE:
VITAL SIGNS: Weight 244 pounds, BP 107/71, temperature 97.6, pulse 68.
HEART: Regular rate, no murmurs.
LUNGS: Clear to auscultation bilaterally.
CHEST: Tenderness on the right ribs underneath the breast and under the breast.

ASSESSMENT AND PLAN:
Right-sided rib fractures. She was given a refill on Vicodin #90 and will slowly wean off this over time and will make an appointment to follow up on her other medical problems, with her regular doctor. She also is having a small amount of swelling in her legs that she thought may have been from the Vicodin and she will elevate her legs above her heart several times a day for this.

Dictation electronically signed by
ART, MD****

DSK:dgw
D: 08/04/2011 11:48:30
T: 08/05/2011 05:21:49
J: U136489
T: 4268308
cc:

EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

Dict. Prov:

Date of Service: 05/05/2011

Job Number: U104056 **Version:** 1

OFFICE PROGRESS NOTE

CHIEF COMPLAINT:
Followup labs.

HISTORY OF PRESENT ILLNESS:
Patient presented today to follow up on her recent labs which showed hemoglobin A1c greater than 10. Patient, when reviewing her medications, reports that she has been taking them all as scheduled. However, it appears that she has somewhere along the line lost her glyburide prescription, which may contribute to the increased levels of sugars. In addition, I strongly suspected that there is a history of noncompliance with her medication, so I went ahead and contacted the pharmacy to find out that she in fact had not filled her metformin either for several months, demonstrating clear noncompliance. When I confronted patient about this, she made up an excuse that she had some extra metformin at home and therefore did not need to fill those prescriptions.

REVIEW OF SYSTEMS:
Today otherwise was negative.

PAST MEDICAL HISTORY, FAMILY HISTORY, SOCIAL HISTORY:
Reviewed in the chart and unchanged.

PHYSICAL EXAMINATION:
VITAL SIGNS: Today heart rate 80, blood pressure 117/77, weight 227 pounds.
CONSTITUTIONAL: Patient is alert and oriented, in no apparent distress.
HEENT: External ears, eyes, nose, mouth, throat are clear.
LUNGS: Respirations nonlabored.
EXTREMITIES: Warm, well perfused. No clubbing, cyanosis or edema.
PSYCH: Mood and affect are appropriate.

ASSESSMENT AND PLAN:
1. Type 2 diabetes. Elevated A1c with clear pattern of medication noncompliance. We phoned in all of the appropriate medications to the pharmacy today and advised patient to encourage her to pick these up and continue with being compliant to decrease her blood sugars and the complications of type 2 diabetes that is poorly controlled.
2. Patient is due for a pelvic exam. We will reschedule her for followup in 3 months to assess how she is doing and do pelvic exam at that appointment.

OFFICE PROGRESS NOTE

Dictation electronically signed by
ART, MD****

MBM:sem
D: 05/05/2011 07:20:11
T: 05/07/2011 13:30:59
J: U104056
T: 4142396
cc:

EMPI # 112,843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

Dict. Prov:

Date of Service: 04/16/2011

Job Number: U96929 **Version:** 1

OFFICE PROGRESS NOTE

CHIEF COMPLAINT:
Diabetes followup and black stools.

HISTORY OF PRESENT ILLNESS:
The patient presents today for followup on her type 2 diabetes. She does not bring in her meter today. She reports that her blood sugars have been well controlled since our last visit. She also reports she had a colonoscopy several months ago, she thinks in Nampa but recently she has had some occasional melanotic stools with no other symptoms.

REVIEW OF SYSTEMS:
Otherwise today is negative.

PAST MEDICAL HISTORY, FAMILY HISTORY AND SOCIAL HISTORY:
Reviewed in the chart and unchanged.

PHYSICAL EXAMINATION:
VITAL SIGNS: Today heart rate is 76, blood pressure 113/76, temperature 97.2, height 5 feet 1 inch, weight 226.8 pounds.
GENERAL: The patient is alert and oriented in no apparent distress.
HEENT: External ears, eyes, mouth, nose, and throat are clear.
LUNGS: Respirations are nonlabored.
EXTREMITIES: Warm and well perfused with no cyanosis, clubbing, or edema.
PSYCH: Mood and affect are appropriate.

ASSESSMENT AND PLAN:
1. Type 2 diabetes. The patient has had a history of poorly controlled diabetes. She has an irregular support system and has been frequently homeless in the past. She claims that she has been doing well and is stable the last several months. We will go ahead and obtain labs today, including A1c to assess where she is at.
2. Melena. The patient reports that she recently had colonoscopy done. Will go ahead and attempt to find these records in Nampa to assess any findings and followup pending those results.

Dictation electronically signed by

EMPI # 112.843

Name: APPLOAD ,Robin

Sex: F DOB: 02/20/53

OFFICE PROGRESS NOTE

on 04/24/2011 09:35:51

Dictation electronically signed by

MBM:wma
D: 04/16/2011 16:41:55
T: 04/19/2011 21:20:55
J: U96929
T: 4115777
cc: