CHIEF COMPLAINT:, Intractable nausea and vomiting.,HISTORY OF PRESENT ILLNESS:, This is a 43-year-old black female who was recently admitted and discharged yesterday for the same complaint. She has a long history of gastroparesis dating back to 2000, diagnosed by gastroscopy. She also has had multiple endoscopies revealing gastritis and esophagitis. She has been noted in the past multiple times to be medically noncompliant with her medication regimen. She also has very poorly controlled hypertension, diabetes mellitus and she also underwent a laparoscopic right adrenalectomy due to an adrenal adenoma in January, 2006. She presents to the emergency room today with elevated blood pressure and extreme nausea and vomiting. She was discharged on Reglan and high-dose PPI yesterday, and was instructed to take all of her medications as prescribed. She states that she has been compliant, but her symptoms have not been controlled. It should be noted that on her hospital admission she would have times where she would feel extremely sick to her stomach, and then soon after she would be witnessed going outside to smoke.,PAST MEDICAL HISTORY:,1. Diabetes mellitus (poorly controlled).,2. Hypertension (poorly controlled).,3. Chronic renal insufficiency.,4. Adrenal mass.,5. Obstructive sleep apnea.,6. Arthritis.,7. Hyperlipidemia.,PAST SURGICAL HISTORY:,1. Removal of ovarian cyst.,2. Hysterectomy.,3. Multiple EGDs with biopsies over the last six years. Her last EGD was in June, 2005, which showed esophagitis and gastritis.,4. Colonoscopy in June, 2005, showing diverticular

disease.,5. Cardiac catheterization in February, 2002, showing normal coronary arteries and no evidence of renal artery stenosis.,6. Laparoscopic adrenalectomy in January, 2006.,MEDICATIONS:,1. Reglan 10 mg orally every 6 hours.,2. Nexium 20 mg orally twice a day.,3. Labetalol.,4. Hydralazine.,5. Clonidine.,6. Lantus 20 units at bedtime.,7. Humalog 30 units before meals.,8. Prozac 40 mg orally daily.,SOCIAL HISTORY:, She has a 27 pack year smoking history. She denies any alcohol use. She does have a history of chronic marijuana use.,FAMILY HISTORY:, Significant for diabetes and hypertension.,ALLERGIES:, NO KNOWN DRUG ALLERGIES.,REVIEW OF SYSTEMS:,HEENT: See has had headaches, and some dizziness. She denies any vision changes.,CARDIAC: She denies any chest pain or palpitations.,RESPIRATORY: She denies any shortness of breath.,GI: She has had persistent nausea and vomiting. She denies diarrhea, melena or hematemesis.,NEUROLOGICAL: She denies any neurological deficits.,All other systems were reviewed and were negative unless otherwise mentioned in HPI.,PHYSICAL EXAMINATION:,VITAL SIGNS: Blood pressure: 220/130. Heart rate: 113. Respiratory rate: 18. Temperature: 98.,GENERAL: This is a 43-year-old obese African-American female who appears in no acute distress. She has a depressed mood and flat affect, and does not answer questions elaborately. She will simply state that she does not feel well.,HEENT: Normocephalic, atraumatic, anicteric. PERRLA. EOMI. Mucous membranes moist. Oropharynx is clear.,NECK: Supple. No JVD. No

lymphadenopathy.,LUNGS: Clear to auscultation bilaterally, nonlabored.,HEART: Regular rate and rhythm. S1 and S2. No murmurs, rubs, or gallops.