

CHIEF COMPLAINT:, Altered mental status.,HISTORY OF PRESENT ILLNESS:, The patient is a 69-year-old male transferred from an outlying facility with diagnosis of a stroke. History is taken mostly from the emergency room record. The patient is unable to give any history and no family member is present for questioning. When asked why he came to the emergency room, the patient replies that it started about 2 PM yesterday. However, he is unable to tell me exactly what started at 2 PM yesterday. The patient's speech is clear, but he speaks nonsensically using words in combinations that don't make any sense. No other history of present illness is available.,PAST MEDICAL HISTORY:, Per the emergency room record, significant for atrial fibrillation, hypertension, and hyperlipidemia.,PAST SURGICAL HISTORY:, Unknown.,FAMILY HISTORY:, Unknown.,SOCIAL HISTORY:, The patient denies smoking and drinking.,MEDICATIONS:, Per the emergency room record, medications are Lotensin 20 mg daily, Toprol 50 mg daily, Plavix 75 mg daily and aspirin 81 mg daily.,ALLERGIES:, UNKNOWN.,REVIEW OF SYSTEMS:, Unobtainable secondary to the patient's condition.,PHYSICAL EXAMINATION:,VITAL SIGNS: Temperature: 97.9. Pulse: 79. Respiratory rate: 20. Blood pressure: 117/84.,GENERAL: Well-developed, well-nourished male in no acute distress.,HEENT: Eyes: Pupils are equal, round and reactive. There is no scleral icterus. Ears, nose and throat: His oropharynx is moist. His hearing is normal.,NECK: No JVD. No thyromegaly.,CARDIOVASCULAR: Irregular rhythm. No

lower extremity edema.,RESPIRATORY: Clear to auscultation bilaterally with normal effort.,ABDOMEN: Nontender.

Nondistended. Bowel sounds are

positive.,MUSCULOSKELETAL: There is no clubbing of the digits. The patient's strength is 5/5

throughout.,NEUROLOGICAL: Babinski's are downgoing bilaterally. Deep tendon reflexes are 2+

throughout.,LABORATORY DATA:, By report, head CT from the outlying facility was negative. An EKG showed atrial fibrillation with a rate of 75. There is no indication of any acute cardiac ischemia. A chest x-ray shows no acute pulmonary process, but does show cardiomegaly.,Labs are as follows:

White count 9.4, hemoglobin 17.2, hematocrit 52.5, platelet count 219. PTT 24, PT 13, INR 0.96. Sodium 135, potassium 3.6, chloride 99, bicarb 27, BUN 13, creatinine 1.4, glucose 161, calcium 9, magnesium 1.9, total protein 7, albumin 3.7, AST 22, ALT 41, alkaline phosphatase 85, total bilirubin 0.7, total cholesterol 193. Cardiac isoenzymes are negative times one with a troponin of 0.09.,ASSESSMENT AND PLAN:,1.

Probable stroke. The patient has an expressive aphasia. He does not have dysarthria, however. Also, his strength is not affected. I suspect that the patient has had strokes or TIAs in the past because he was taking aspirin and Plavix at home. Head CT is reportedly negative. I will ask our radiologist to re-read the head CT. I will also order MRI and MRA, carotid Doppler ultrasound and echocardiogram in addition to a fasting lipid profile. I will consult neurology to evaluate and continue his aspirin and Plavix.,2. Atrial fibrillation. The

patient's rate is controlled currently. I will continue him on his amiodarone 200 mg twice daily and consult CHI to evaluate him.,3. Hypertension. I will continue his home medications and add clonidine as needed.,4. Hyperlipidemia. The patient takes no medications for this currently. I will check a fasting lipid profile.,5. Hyperglycemia. It is unknown whether the patient has a history of diabetes. His glucose is currently 171. I will start him on sliding scale insulin for now and monitor closely.,6. Renal insufficiency. It is also unknown whether the patient has a history of this and what his baseline creatinine might be. Currently he has only mild renal insufficiency. This does not appear to be prerenal. Will monitor for now.