Date of Admission: June 12, 2010
Attending Physician: Dr. John Smith, MD
Admitting Service: Internal Medicine
Patient Name: Mr. Robert Thompson
DOB: 04/15/1949 (61 years old)
Sex: Male
MRN: 12345678

History & Physical (H&P)
Chief Complaint
"Shortness of breath and swelling in my legs for the past three days."
History of Present Illness (HPI)
Mr. Robert Thompson is a 61-year-old male with a history of congestive heart failure (CHF), coronary artery disease (CAD) with prior myocardial infarction (MI) in 2005, hypertension (HTN), type 2 diabetes mellitus (T2DM), chronic kidney disease (CKD) stage 3, and atrial fibrillation (AF) on anticoagulation, who presents with worsening dyspnea and lower extremity edema over the past three days.
He reports that over the last week, he has noticed increasing **shortness of breath on minimal exertion**, waking up multiple times at night due to breathlessness (**paroxysmal nocturnal dyspnea**) and needing extra pillows to sleep (**orthopnea**). He also reports **bilateral lower extremity swelling** that has progressively worsened.
No acute chest pain, palpitations, diaphoresis, or syncope. No fever or chills. **Denies recent illness, travel history, or sick contacts.**
He admits to **dietary indiscretions** (increased salt intake) due to a family gathering recently and notes that he may have **missed some doses of his diuretic due to difficulty affording medications this month**. He has also noted decreased urinary output.
Past Medical History
1. Congestive Heart Failure (CHF) with reduced ejection fraction (HFrEF) - Last documented EF 30% in 2009
2. Coronary Artery Disease (CAD) with prior MI in 2005
3. Atrial Fibrillation on chronic anticoagulation (Warfarin)
4. Hypertension (HTN)
5. Type 2 Diabetes Mellitus (T2DM) - Poor glycemic control
6. Chronic Kidney Disease (CKD) Stage 3 (Baseline Cr ~1.8-2.0)
7. Hyperlipidemia
8. History of deep vein thrombosis (DVT) in 2006

Past Surgical History
- Coronary artery bypass grafting (CABG) x3 vessels in 2005
- Bilateral knee replacements (2008)
- Cholecystectomy (1989)

Medications
1. Lisinopril 10 mg daily
2. Metoprolol succinate 50 mg daily
3. Furosemide 40 mg daily (patient admits to noncompliance)
4. Warfarin 5 mg daily (last INR unknown)
5. Aspirin 81 mg daily
6. Atorvastatin 40 mg nightly
7. Insulin glargine 20 units at bedtime
8. Insulin aspart sliding scale with meals
9. Amlodipine 5 mg daily

Allergies
- No known drug allergies

Family History
- Father: Deceased at 72 from myocardial infarction

- Mother: Deceased at 79 from complications of diabetes
- Siblings: Brother with diabetes and heart disease

Social History

- **Former smoker**: 1 pack per day for 30 years, quit in 2005 after MI
- **Alcohol use**: Occasional, 1-2 drinks per week
- Illicit drugs: Denies
- **Marital status**: Married, lives with wife
- **Occupation**: Retired factory worker
- **Diet**: High salt intake reported recently
- **Exercise**: Limited due to dyspnea

Review of Systems (ROS)

General: Fatigue, mild unintentional weight gain (~5 lbs over last week)
Cardiovascular: Dyspnea on exertion, orthopnea, lower extremity edema, no acute chest pain
Pulmonary: Mild, non-productive cough, no hemoptysis
Gastrointestinal: No nausea, vomiting, or abdominal pain
Genitourinary: Decreased urine output
Musculoskeletal: Bilateral leg swelling, no acute joint pain
Neurological: No confusion, numbness, or focal weakness
Endocrine: Poorly controlled diabetes, no recent episodes of hypoglycemia

Physical Examination

Vital Signs

- **Temperature**: 98.4°F (36.9°C)
- **Heart Rate**: 88 bpm, irregularly irregular
- Blood Pressure: 162/94 mmHg
- **Respiratory Rate**: 18 breaths per minute
- Oxygen Saturation: 94% on room air

General:

Mildly dyspneic but alert, cooperative, and in no acute distress.

Cardiac:

- Irregularly irregular rhythm (consistent with atrial fibrillation)
- Audible **S3 gallop**
- No new murmurs
- 2+ bilateral pitting edema to mid-shins

Pulmonary:

- Bibasilar **crackles**
- No wheezing or rhonchi

Abdominal:

- Soft, non-tender, non-distended
- No hepatosplenomegaly

Extremities:

- 2+ bilateral pitting edema
- No erythema, warmth, or tenderness

Neurologic:

- No focal deficits

Laboratory & Imaging Results (Initial Workup Pending Further Testing)

Labwork

- **BNP**: 980 pg/mL (elevated, consistent with CHF exacerbation)
- **Creatinine**: 2.1 mg/dL (baseline ~1.8, slight worsening)
- **BUN**: 38 mg/dL
- **K+**: 4.8 mmol/L
- **Na+**: 135 mmol/L

- **Glucose**: 210 mg/dL
- **Hgb A1c**: 9.2% (poor diabetes control)
- **INR**: 2.1 (therapeutic)

Chest X-ray

- **Findings**: Cardiomegaly, bilateral pulmonary congestion, mild pleural effusions

ECG

- **Findings**: Atrial fibrillation, no acute ischemic changes

Assessment & Plan

Principal Diagnosis:

1. Acute decompensated heart failure exacerbation due to dietary indiscretion and diuretic noncompliance
2. Hypertension - Poorly controlled
3. Chronic kidney disease - Worsening kidney function likely secondary to heart failure
4. Atrial fibrillation - Anticoagulated, no arrhythmic symptoms
5. Uncontrolled diabetes mellitus

Plan

1. **Diuresis** with IV furosemide
2. Monitor renal function closely
3. Titrate antihypertensives carefully
4. Continue anticoagulation with warfarin
5. Strict I/Os & daily weights
6. Low sodium and fluid restriction
7. Cardiology & nephrology consults
8. Diabetes management consult

John Smith, MD
6/12/10