South Avenue Digestive Disease

1110 South Avenue, Suite 303
Staten Island, NY 10314
Ph: 718.982.1315
Fax: 718.477.3692

SAMPLE CONSULTATION REPORT

PATIENT NAME : Lynn Grevas
PATIENT ID : LYNGRE000
DATE OF BIRTH : 8/25/1955 **AGE :** 60 **SEX :** Female

ATTENDED BY : John W. Hart, M.D.
REFERRED BY : Peterson, Mark M.D.
EXAM DATE : 10/14/2015

CHIEF COMPLAINT:

Evaluation for colonoscopy

PRESENT ILLNESS:

The patient is referred for a colonoscopy. Last colonoscopy 25 years ago for shigella infection. No repeat procedure noted. Patient has a baseline history of anemia. Patient presently receiving iron infusions. Denied melena, rectal bleeding, nausea, emesis, change in bowel habits. Prior EGD for duodenal ulcer 10 years ago.

MEDICATIONS:

Iron
Lantus
Aspirin 81 mg
Vitamin B
Vitamin D
Vitamin C
Metformin
Glipizide
Metoprolol
Furosemide
Simvastatin

ALLERGIES:

Latex
Cipro
Dust mite extract

MEDICAL HISTORY:

DM, anemia, occipital migraines, renal insufficiency

HOSPITALIZATION AND SURGERY:

Cardiac cath, C-section, left foot surgery

FAMILY HISTORY:

Skin CA (Father), Bone CA (Father), Liver cancer (Mother)

SOCIAL HISTORY:

SMOKING : Patient denies smoking.
ALCOHOL : Patient denies drinking alcohol.
DRUGS : Patient denies taking drugs.

SYSTEMS REVIEW:

GENERAL: No weakness, weight change, fever, chills, heat/cold, intolerance.

SKIN: No rashes, yellow skin/jaundice.

ENDOCRINE: Normal tolerance to cold. Normal tolerance to heat.

EYES: Cataract surgery (bilateral).

HEENT: No headaches, visual changes, photophobia, nosebleeds, hoarseness, sinus.

CARDIAC/RESPIRATORY: No cough, shortness of breath, sputum production, chest pain, orthopnes/edema.

MUSCULOSKELETAL: No back pain, joint pain.

NEUROLOGICAL: No weakness, altered coordination/sensation, memory/mood change.

PHYSICAL EXAMINATION:

BP: 140/90 mmHg Height: 64.0 inches Weight: 300.0 lbs BMI: 51.5

GENERAL: Morbid obesity, soft, nontender, no rebound. Non cachetic. No stigmata of CLD.

ABDOMEN: Abdomen is soft. Non distended. No evidence of ascites. Bowel sounds present. No hepatomegaly. No evidence of inguinal hernia. Liver and spleen not palpable. No masses palpable. No surgical scars. No tenderness. The umbilicus appears normal in position. No spenomegaly.

NEUROLOGICAL: Alert. Grossly non focal.

SKIN: Normal skin color. No evidence of jaundice. No rashes. No spider angiomata.

LYMPHATICS: No lymphadenopathy.

EYES: No evidence of conjunctivitis, discharge or visual abnormalities.

ENT: Hearing seems normal. Tongue in mid line, no fasciculation seen. Tonsils not enlarged.

HEAD & NECK: Thyroid gland not enlarged. Trachea central in position.

LUNGS: Equal breath sounds. No evidence of rales. No evidence of rhonchi.

CARDIOVASCULAR : No Gallops S1 and S2 appear normal. No S3, S4 or murmur.

RECTAL: Deferred.

EXTREMITIES: No clubbing. No cyanosis. No pedal edema.

BACK: Patient does not complain of back pain. No CVA tenderness.

IMPRESSIONS:

Anemia, unspecified - D64.9
Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation - K26.9

COMORBIDITY:

DM,occipital migraines, renal insufficiency

PLAN:

High fiber diet
Acquire blood work from PMD
+/- capsule study
PROCEDURE:
EGD - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.
Colonoscopy Moviprep (diabetic) - discussed the risks, benefits, and alternatives also provided written information regarding the procedure.

PROCEDURE CODE :

L4 99204

Follow up in 1 month

Follow up for Colonoscopy

Signature: John Hart, MD

John W. Hart, M.D.

on 10/15/2015 10:55:26 AM signed off by John W. Hart, MD