Patient name:	John Doe
Medical Record Number:	123456789
Date admitted:	July 1, 2050
Date discharged:	July 3, 2050
Attending Physician:	Dr. Will Teachwell
Resident Physician:	Dr. Bea Goodoc
Diagnosis:	Left-sided systolic congestive heart failure
	EF of 35% on echo performed 3 months ago
Other diagnoses:	Type 2 Diabetes
	Stage 2 Hypertension
	Osteoarthritis

History:

Mr. Doe is a 72 year old gentleman with a history of CHF who presented with a 3 day history of gradually worsening lower extremity edema, weight gain, and shortness of breath. Today while trying to mow his lawn he had to stop multiple times to catch his breath and developed some chest tightness leading him to come to the emergency room. He denies any other decrease in exercise tolerance or chest pain leading up to this event. He reports good understanding and adherence to his medications, but does report that when his daughter was visiting town 4 days prior to admission that he and his wife took her out for a special Mexican dinner and he indulged in several baskets of chips and salsa.

Problems:

1. CHF – On admission he had 3+ lower extremity pitting edema, rales from the bases to midlung bilaterally, elevated jugular venous pressure and a CXR consistent with volume overload. He was diuresed and was able to quickly wean off supplemental oxygen and exam revealed resolution of his edema and rales at discharge. Discharge weight is 202 lbs. Given that dietary indiscretion led to the exacerbation, it was not felt necessary to change his home diuretic regimen at this time. He was re-educated on diet and taking daily weights including information about weight gain that should trigger him to call his primary doctor. He will follow up with his doctor at the end of this week for volume reassessment and electrolyte labs.

2. Chest pain – due to chest pain while mowing, he was ruled out for an MI with serial EKGs and enzymes. His EKGs remained unchanged from previous and his enzyme curve remained normal. Chest pain was attributed to his hypoxia from his CHF and no further work-up was pursued at this time. On

follow-up, should readdress and make sure that he remains without change in his exercise tolerance and remains pain free now that he is back to euvolemia.

3. Type 2 Diabetes – His HgbA1C was 7.3 which is good control for him at this time. No changes were made to his diabetic regimen. On health maintenance questioning he revealed it has been 18 months since his last eye appointment and we recommended he make an appointment as soon as he can get in.

4. Hypertension – Though initially elevated at the time of admission, his BP came down nicely with diuresis and was 142/82 once euvolemic. In keeping with JNC-7 guidelines, we increased his lisinopril to 40 mg/day and his metoprolol to 50mg BID for optimal BP control given his diabetes. He resonded well to this without complications and was 126/72 at discharge.

5. Osteoarthritis – His knee pain was well controlled with Tylenol prn.

Medications:

New medications:	None
Medications discontinued:	None
Medications continued with dose changes:	Metorolol 50 mg PO BID
	Lisinopril 40 mg PO qd
Medications continued unchanged:	ASA 81 mg PO qd
	Furosemide 40 mg PO BID
	Spironolactone 50 mg PO qd
	Metformin 1000 mg PO BID
	Glipizide 10 mg PO BID
	Tylenol 325 mg PO q 4 hours as needed for pain

Functional status: He is at baseline, no assistance needed, independent ADLs .

Pending Results:	None
Follow up:	Dr. Primary Care - Friday, July 7 at 11:30
	Dr. Regular Cardiologist – Thursday, July 27 at 2:30
Cc:	Dr. Primary Care – fax 123-456-7890
	Dr. Regular Cardiologist – fax 123-098-7654