[redacted]

MRN: [redacted]

[redacted]

Progress Notes Signed

Encounter Date: [redacted]

Subjective

Patient ID: [redacted] is a 71 y.o. female with diabetes type 2, hypertension, hyperlipidemia, recurrent tonsillar hypertrophy declining tonsillectomy per ENT, allergy history presenting here face-to-face follow-up of chronic medical conditions consisting of hypertension,hearing deficit, obstructive sleep apnea and diabetes type 2 with her husband and daughter/caregiver.

Hypertension

This is a recurrent problem. The current episode started more than 1 year ago. The problem has been resolved since onset. Pertinent negatives include no anxiety, blurred vision, chest pain, headaches, malaise/fatigue, neck pain, orthopnea, palpitations, peripheral edema, PND, shortness of breath or sweats. There are no associated agents to hypertension. There are no known risk factors for coronary artery disease. There are no compliance problems.

Denies any polyuria polydipsia polyphagia. Denies any chest pain shortness of breath orthopnea PND. Patient declines metoprolol as home blood pressure log controlled. Awaiting audiology ENT follow-up and does report some benign positional vertigo improved with meclizine and no focal deficits. Requested mid shin height compression stockings for venous stasis which she is awaiting. Reports right LE sciatica radiating from lower back/buttock region without weakness nor urine/stool incontinence and awaiting physical therapy. Patient attributes elevated BP due to nervousness with reported normal BP home log with SBP range 100-129 and DBP range 70-80s. Got diabetic shoes but in need of rereferal to LL ENT for chronic otalgia. **Pain scale 8out of 10 today**

Review of Systems

Constitutional: Negative for malaise/fatigue.

Eyes: Negative for blurred vision.

Respiratory: Negative for shortness of breath.

Cardiovascular: Negative for chest pain, palpitations, orthopnea and PND.

Musculoskeletal: Negative for neck pain.

Neurological: Negative for headaches.

See HPI

Objective

Visit Vitals

BP	176/85 (BP Location: Left arm, Patient Position: Sitting)
Pulse	85
Temp	36.4 °C (97.6 °F) (Oral)
Resp	17

Physical Exam

[redacted]

[redacted]

Vitals reviewed.
Constitutional:
General: She is not in acute distress.
Appearance: She is not ill-appearing, toxic-appearing or diaphoretic.
HENT:
Right Ear: Tympanic membrane, ear canal and external ear normal. There is no impacted cerumen.
Left Ear: Tympanic membrane, ear canal and external ear normal. There is no impacted cerumen.
Neck:
Vascular: No carotid bruit.
Musculoskeletal:
General: Tenderness present.
Cervical back: Normal range of motion and neck supple. No rigidity or tenderness.
Comments: **Lumbar tenderness**
Lymphadenopathy:
Cervical: No cervical adenopathy.
Neurological:
General: No focal deficit present.
Mental Status: She is alert and oriented to person, place, and time. Mental status is at baseline.
Psychiatric:
Mood and Affect: Mood normal.
Behavior: Behavior normal.
Thought Content: Thought content normal.

Dx: most recent lab results reviewed

Assessment/Plan

1. Vertebral body hemangioma
Given MRI order to call/schedule with lab
- Comprehensive metabolic panel

2. Essential (primary) hypertension
Elevated due to White Coat based on Home BP log/asymptomatic

3. White coat syndrome with diagnosis of hypertension
See above

4. Controlled type 2 diabetes with neuropathy (CMS/HCC)
Controlled by recent A1c

5. Mixed hyperlipidemia
On statin/monitor

6. Chronic left ear pain
Renew LL ENT

7. HCM
Surveillance mammo up to date and due August 2024 and surveillance colonoscopy due 2026

[redacted]

[redacted]

Medicare Dual Choice Documentation:

Advanced Care Planning

Advanced Care Plan	Declines

Activities of Daily Living

Bathing	Independent
Dressing	Independent
Toileting	Independent
Ambulation/Transfers	Independent
Continence	Independent
Feeding	Independent

Cognitive Skills

Perception	Normal
Attention	Normal
Memory	Normal
Reasoning	Normal
Decision Making	Normal
Problem Solving	Normal

Health Education Discussed

Breast Self Health	No
Dental Health	No
Diagnosis/Prognosis	Yes
Injury Prevention	No
New Treatment	No
New Medication(s)	No
Nutrition/Exercise	No
Sexual Practices/STI	No
Smoking, Alcohol, or Drug Cessation	No

[redacted]

Office Visit on [redacted] *Note shared with patient*

Additional Documentation

Vitals: BP 176/85 (BP Location: Left arm, Patient Position: Sitting) Pulse 85 Temp 36.4 °C (97.6 °F) (Oral) Resp 17 Ht 1.575 m (5' 2") Wt 73.7 kg (162 lb 7.7 oz) BMI 29.72 kg/m² BSA 1.8 m² Pain Sc 8 (Loc: Back)

Flowsheets: [redacted] Attributed ACG Score, Vital Signs

Additional Documentation

[redacted]

[redacted]

Vitals: BP 176/85 (BP Location: Left arm, Patient Position: Sitting) Pulse 85 Temp 36.4 °C (97.6 °F) (Oral) Resp 17
Ht 1.575 m (5' 2") Wt 73.7 kg (162 lb 7.7 oz) BMI 29.72 kg/m² BSA 1.8 m² Pain Sc 8 (Loc: Back)

Flowsheets: [redacted] Attributed ACG Score, Vital Signs

Orders Placed

Comprehensive metabolic panel (Resulted [redacted] Abnormal)
Ambulatory referral to ENT Pending Review

Medication Changes

As of [redacted]

None

Visit Diagnoses

Primary: **Vertebral body hemangioma** D18.09
Essential (primary) hypertension I10
White coat syndrome with diagnosis of hypertension I10
Controlled type 2 diabetes with neuropathy (CMS/HCC) E11.40
Mixed hyperlipidemia E78.2
Chronic left ear pain H92.02, G89.29

Immunizations Given

RSV Vaccine

Cosigning User

Cosigning User

Orders Placed

Comprehensive metabolic panel (Resulted 2/28/2024, Abnormal)
Ambulatory referral to ENT Pending Review

Medication Changes

As of [redacted]

None

Medication List at End of Visit

As of [redacted]

	Refills	Start Date	End Date
albuterol (Ventolin HFA) 90 mcg/actuation inhaler Every 4-6 Hours as needed for Wheezing Patient-reported medication	—	[redacted]	—
alcohol swabs pads, medicated Daily	—	[redacted]	—

[redacted]

[redacted]

	Refills	Start Date	End Date
Patient-reported medication			
amoxicillin-pot clavulanate (Augmentin) 875-125 mg tablet Twice A Day Patient-reported medication	—	[redacted]	—
atorvastatin (Lipitor) 40 mg tablet Take 1 tablet (40 mg) by mouth at bedtime. - oral	3/3	[redacted]	—
brompheniramine-pseudoeph-DM (Bromfed DM) 2-30-10 mg/5 mL syrup Every 6 Hours As Needed as needed for Cough Patient-reported medication	—	[redacted]	—
docusate sodium (Colace) 100 mg capsule Take 1 capsule (100 mg) by mouth if needed in the morning and at bedtime (constipation). - oral	3/3	[redacted]	—
gabapentin (Neurontin) 100 mg capsule At Bedtime Patient-reported medication	—	[redacted]	—
lisinopril 10 mg tablet Twice A Day	3/3	[redacted]	—
loratadine (Claritin) 10 mg tablet Every Day As Needed as needed for Allergies Patient-reported medication	—	[redacted]	—
magnesium 200 mg tablet Take 1 tablet (200 mg) by mouth in the morning. - oral	3/3	[redacted]	[redacted]
meclizine (Antivert) 25 mg tablet Take 1 tablet (25 mg) by mouth if needed in the morning, at noon, and at bedtime for dizziness. - oral	0/0	[redacted]	—
triamcinolone (Kenalog) 0.1 % cream Twice A Day Patient-reported medication	—	[redacted]	—

Visit Diagnoses

Primary: **Vertebral body hemangioma** D18.09
Essential (primary) hypertension I10
White coat syndrome with diagnosis of hypertension I10
Controlled type 2 diabetes with neuropathy (CMS/HCC) E11.40
Mixed hyperlipidemia E78.2
Chronic left ear pain H92.02, G89.29

Immunizations Given

RSV Vaccine

[redacted]