[redacted]

PATIENT: [redacted]
DATE OF BIRTH:
DATE:
VISIT TYPE: Office Visit

This 60 year old client presents for establishment and depression.

History of Present Illness:

1. establishment

pt here today for establishment. Prior PCP name unknown to patient
Transition of care due to change of insurance
Current Health Dx: Arthritis, Depression, RA, COPD
Surgical Hx: denies
ETOH last use > 5 years ago , Smoking pack a day > 30 years , Denies: Marijuana, illicit drugs
Denies: DEXA scan, Colonoscopy, Labs
Pain score 9/10, Falls, UI denies
Concurrent care with : denies
Concerns for today : referral to PM for chronic joint, back, knee and leg pain Onset 3 months ago, denies illness or injury prior to onset
pt was seen 1/10/2024 due to severe pain with difficulty walking
pt had xray 1 month ago via Apple UC. Reports acquired for review

Medication bottles provided for review. Denies Rx medications

2. depression

The client reports functioning as extremely difficult. The client presents with depressed mood, difficulty concentrating, difficulty falling asleep, difficulty staying asleep and diminished interest or pleasure.

Vital Signs:

Time	BP mm/Hg	Pulse /min	Resp /min	Temp F	Ht ft	Ht in	Wt lb	BMI kg/m2	O2 Sat%	Pain Score
2:02 PM	176/91	101		98.0						

Comments

Time	Comments
2:02 PM	Unable to obtain Height and Weight.

[redacted]

Measured By

Time	Measured by
2:02 PM	[redacted]

Screening Tools

Other Screenings

Encounter Date	Documented Date	Instrument	Score	Severity/Interpretation	MDD Classification
02/02/2024	02/02/2024	AUDIT-C Screening Instrument	0		
02/02/2024	02/02/2024	Patient Health Questionnaire (PHQ-9)	12	Moderate depression	

Patient Status:

Completed with information received for patient in a summary of care record.

Allergies:

Ingredient	Reaction (Severity)	Medication Name	Comment
NO KNOWN ALLERGIES			

Review of Systems:

System	Neg/Pos	Details
Constitutional	Positive	Fatigue.
ENMT	Positive	Sinus pressure.
Cardio	Negative	Chest pain.
GI	Negative	Abdominal pain and Change in stool pattern.
GU	Negative	Urinary incontinence.
Neuro	Positive	Difficulty initiating sleep, Difficulty maintaining sleep, Extremity weakness, Gait disturbance.
Neuro	Negative	Numbness in extremity.
Psych	Positive	Difficulty concentrating, Feeling down, depressed or hopeless (nearly every day), Little interest or pleasure in doing things (nearly every day).
Psych	Negative	Depression.
MS	Positive	Back pain, Joint pain.

Physical Exam:

Exam	Findings	Details
Constitutional	*	Overall appearance - slovenly, poor hygiene.
Nose/Mouth/Throat	*	Lips/teeth/gums - caries, missing teeth, periodontal disease.
Nose/Mouth/Throat	Comments	sounds congested
Respiratory	Normal	Inspection - Normal. Auscultation - Normal. Effort - Normal.
Cardiovascular	*	Rhythm - Regularly irregular.
Cardiovascular	Normal	Heart rate - Regular rate. Extremities - No edema.
Skin	Comments	BLE venous stasis dermatitis

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Musculoskeletal	*	Gait - wheelchair, unstable. Hands - Left: mild OA, Right: mild OA.
Extremity	Normal	No edema.
Neurological	Normal	Hand dominance - Right.
Psychiatric	Normal	Appropriate mood and affect.

Completed Orders (this encounter)

Order	Details	Side	Interpretation	Result	Region	Exp Date	Lot #
AUDIT-C Screening Instrument				0			
Patient Health Questionnaire (PHQ-9)			Moderate depression	12			

Assessment/Plan:

#	Detail Type	Description
1.	Assessment	Difficulty walking (R26.2).
	Patient Plan	will order MRI L-spine
2.	Assessment	Chronic pain of left knee (M25.562).
	Impression	left knee xray report of 10/16/2023 reviewed.
	Patient Plan	will refer to ortho
3.	Assessment	Other chronic pain (G89.29).
	Patient Plan	see above
4.	Assessment	Chronic left hip pain (M25.552).
	Impression	L-Hip xray report of 10/16/23 reviewed.
	Patient Plan	will refer to ortho
	Plan Orders	Arrowhead -Orthopaedics.
5.	Assessment	Chronic left-sided low back pain with left-sided sciatica (M54.42).
	Patient Plan	pt to do l-Spine xray and MRI
	Plan Orders	Further diagnostic evaluations ordered today include(s) MRI L-SPINE W/O to be performed. and X-RAY L-SPINE 4 VIEWS/W/OBLIQU to be performed.
6.	Assessment	Elevated blood pressure reading without diagnosis of hypertension (R03.0).
	Patient Plan	Pt to have BP check in 1 week.
7.	Assessment	Irregular heartbeat (I49.9).
	Impression	ECG.
	Patient Plan	will refer to Cardio
	Plan Orders	The patient had the following procedure(s) completed today: Electrocardiogram, complete (ECG). Anil Rastogi MD -Cardiology.
8.	Assessment	Abnormal ECG (R94.31).
	Impression	Sinus Rhythm with Marked Sinus Arrhythmia.
9.	Assessment	Chronic sinusitis, unspecified location (J32.9).
	Impression	associated with poor oral hygiene/ caries/missing teeth.
	Patient Plan	pt to do Sinus xray
	Plan Orders	Further diagnostic evaluations ordered today include(s) X-RAY SINUSES COMPLETE to be performed.

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10.	Assessment	Mild major depression (F32.0).
	Patient Plan	pt advised may self refer to mental health via Insurance member services. The Telephone number is on the back of the card.
11.	Assessment	Personal history of rheumatoid arthritis (Z87.39).
	Impression	per pt DX 18YO denies use of medication It never bothered me".
	Patient Plan	will check labs
12.	Assessment	Poor dental hygiene (Z91.89).
	Patient Plan	pt to see a dentist
13.	Assessment	Positive depression screening (Z13.31).
	Impression	PHQ-9 score -12 . Pt has concerns..
	Patient Plan	pt advised may self refer to mental health via Insurance member services. The Telephone number is on the back of the card.
	Plan Orders	C-Reactive Protein, Quant to be performed., CBC With Differential/Platelet to be performed., CK to be performed., Comp. Metabolic Panel (14) to be performed., Compl Drug Anl w/EtG+Nicotine to be performed., ESR Wes+ANA+RA Qn to be performed., Hgb A1c with eAG Estimation to be performed., Lipid Panel to be performed., Occult Blood, Fecal, IA to be performed., PSA (Reflex To Free) (Serial) to be performed., Thyroxine (T4) Free, Direct, S to be performed., TSH to be performed., UA/M w/rflx Culture, Routine to be performed., Uric Acid, Serum to be performed., Vitamin B12 to be performed. and Vitamin D, 25-Hydroxy to be performed.
14.	Assessment	Healthcare maintenance (Z00.00).
	Patient Plan	Pt to have labs 1-2 weeks before next eval. Fasting-nothing to eat or drink for 8-10 hours prior to labs. Please drink plenty of clear water.
15.	Assessment	Encounter to establish care with new doctor (Z76.89).
	Patient Plan	New pt forms completed. office policy's, Controlled substance agreement reviewed and discussed. Will request prior records.

Fall Risk Plan

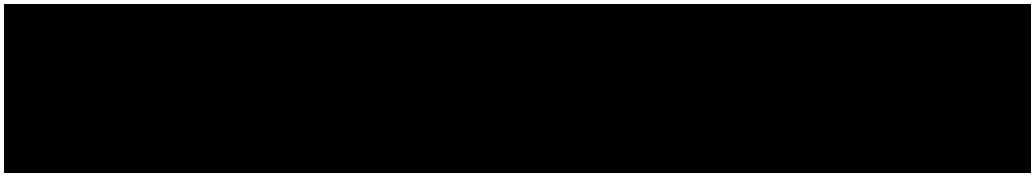
The patient has not fallen in the last year.The patient is not at risk for falls.

Patient Education:

#	Patient Education
1.	Learning About a Hip Bursa Injection

Medications (Added, Continued or Stopped today):

Start Date	Medication	Directions	Stop Date
02/02/2024	Tylenol 8 Hour 650 mg tablet,extended release	take 1 Tablet by oral route every 6 hours as needed swallowing whole with water. Do not break, crush, dissolve and/or chew.	



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