

**Good Health Clinic Consultation note**

Consultant: Robert Dolin, MD

Date: April 7, 2000

Sex: Male

Patient: Henry Levin, the 7th

MRN: 12345

Birthdate: September 24, 1932

**History of Present Illness**

Henry Levin, the 7th is a 67 year old male referred for further asthma management. Onset of asthma in his teens. He was hospitalized twice last year, and already twice this year. He has not been able to be weaned off steroids for the past several months.

**Past Medical History**

Asthma

Osteoarthritis, right knee

Hypertension

**Medications**

Theodur 200mg BID

Proventil inhaler 2puffs QID PRN

Prednisone 20mg qd

HCTZ 25mg qd

**Allergies**

Penicillin - Hives

Aspirin - Wheezing

**Social history**

Smoking :: 1 PPD between the ages of 20 and 55, and then he quit.

Alcohol :: Rare

**Physical Exam**

Vital Signs :: BP 118/78; Wt 185lb; Resp 16 and unlabored; T 98.6F; FM 86 and regular

Skin :: Erythematous rash, palmar surface, left index finger.

Lungs :: Clear with no wheeze. Good air flow.

Cardiac :: RRR with no murmur, no S3, no S4.

**Labs**

CXR 02/03/1999: Hyperinflated. Normal cardiac silhouette, clear lungs.

Peak Flow today: 260 l/m.

**Assessment**

Asthma, with prior smoking history. Difficulty weaning off steroids. Will try gradual taper.

Hypertension, well-controlled.

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Contact dermatitis on finger.

**Plan**

Complete PFI's with lung volumes.

Chem-7

Provide educational material on inhaler usage and peak flow self-monitoring.

Decrease prednisone to 20q0D alternating with 18q0D.

Hydrocortisone cream to finger BID.

RTC 1 week.

Sig. by: Robert Dolin, MD April 8, 2000