inovalon™

PHYSICIAN NETWORK

Visit Date: 11/05/15

History of Present Illness
This year old male presents with:
1. diabetes
Pertinent negatives include chest pain, foot ulcers and hypoglycemic episodes. Comorbidity: Hyperlipidemia, Hypertension and Peripheral Neuropathy. Patient is compliant with medication and office visits. Additional information: Checks his blood sugar daily when he remembers. Last eye exam 6 months ago. Has occassional burning sensation in his feet.
2. hyperlipidemia
Patient compliance with diet is good, with exercise is fair, with medication is good and with follow up is good. Reasons for screening include diabetes mellitus, diet, hypertension, obesity and sedentary life style. Reasons for screening do not include alcohol use and tobacco use. Associated symptoms include myalgia. Pertinent negatives include abdominal pain, chest pain, dizziness, fatigue, malaise and muscle weakness. Additional information: His Cholesterol med causes minor aches,nothing he feels serious.
3. hypertension
Comorbid conditions include diabetes mellitus. Risk factors include age over age , male gender and obesity. Pertinent negatives include chest pain, diaphoresis, dyspnea, fatigue and irregular heartbeat/palpitations.
4. insomnia
The patient presents for insomnia. Relevant history: time to fall asleep is 0 hours per night, awakenings at night occur 4 times per night and a BMI of 30.67. The patient does not have: smoking or use of alcohol. The patient is experiencing awakening with shortness of breath and difficulty maintaining sleep. The patient denies awakening with choking, difficulty initiating sleep, increased fatigue or snoring (reported by patient).
5. MI
Pt states he had MI has not seen Cardiologist. Pt states he is unsure of last stress test, and echo was

Chronic Problems
HTN (hypertension)
Diabetes
Shortness of breath
HLD (hyperlipidemia)
Past Medical History
Reviewed, no changes

Family History
Reviewed, no changes

Social History
Reviewed, no changes

Medications reviewed.

Allergies
No known allergies.
Allergies reviewed, no changes.

Review of Systems
Constitutional:
Negative for fatigue, increased fatigue and malaise.

HEENT:
Negative for snoring.

Respiratory:
Positive for:
- Awakening with shortness of breath.

Negative for dyspnea.

Vascular / Cardiovascular:
Negative for chest pain and irregular heartbeat/palpitations.

Gastrointestinal:
Negative for abdominal pain and awakenings with choking or heartburn.

Metabolic/Endocrine:
Negative for diaphoresis and hypoglycemic episodes.

Neuro/Psychiatric:
Positive for:
- Difficulty maintaining sleep.

Negative for difficulty initiating sleep and dizziness.

Dermatologic:
Negative for foot ulcers.

Musculoskeletal:
Positive for:
- Myalgia.

Negative for muscle weakness.

Vital Signs
Height

Time	ft	in	Ht/Inches	cm	Last Measured	Method	%
10:33 AM	6.00		72.00			measured	

Weight / BSA / BMI

Time	lb	oz	kg	Context	%	BMI kg/m2	BSA m2	BMI %
10:33 AM	226.20			dressed with shoes		30.67		

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
10:33 AM	137/84	sitting	left	arm	automatic	adult

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse/min	Pattern	Resp/min
10:33 AM	97.7		oral	79		18

Measured By

Time
10:33 AM

Screening Summary
Lead risk assessment has not been done.
The following were reviewed: alcohol use, caffeine use, drugs of abuse and date of last psa.
Educational factors have not been reviewed.

Physical Exam
Constitutional:
Well developed.
Eyes:
Right
No injection.
PERRLA.
Left
No injection.
PERRLA.
Ears:
Right
Unremarkable to inspection. Hearing grossly intact.
Left
Unremarkable to inspection. Hearing grossly intact.
Neck / Thyroid:
Inspection reveals symmetry. Palpation reveals trachea midline and mobile.
Lymphatic: No cervical or supraclavicular adenopathy.
Respiratory:
Chest can be described as symmetric. Lungs clear to auscultation. Respiratory effort is normal.
Cardiovascular:
No edema is present.
Vascular:
Bruits
Carotid bruits: absent.
Abdomen:
Symmetric - no distention.
There is no abdominal tenderness.
Integumentary:
No impressive skin lesions present.
Musculoskeletal:
Normal range of motion, muscle strength, and stability in all extremities with no pain on inspection.
Extremities:
Monofilament exam is normal.
No edema is present.
Neurological:
Memory: Intact .
Cranial nerves:
Cranial nerves II-XII grossly intact.
Psychiatric:
The patient is oriented to time, place, person, and situation.
The patient has normal insight, exhibits normal judgment,
The patient demonstrates the appropriate mood and affect.

Assessment/ Plan
Diabetes Mellitus Type 2, Uncomplicated (250.00)
Hemoglobin A1c to be performed 6 Months.
Encouraged exercise and eating healthy. Recheck in 6 months with fasting labs prior.
Other and unspecified hyperlipidemia (272.4)
CBC w/diff, Lipid Panel and CMP to be performed 6 Months.
Encouraged exercise and eating healthy. Recheck in 6 months with fasting labs prior.
Unspecified essential hypertension (401.9)
Continue current medication.
Insomnia (780.52)
Increase Xanax to 1mg at night. Return to clinic for any problems or concerns.
Lung nodule (793.11)
CT chest ordred.

Shortness of breath (786.05)
Further diagnostic evaluations ordered today include CT THORAX W/ & W/O CONTRAST to be performed.
MI (mitral incompetence) (424.0)
Referral: Cardiology. Evaluate and treat.
Refer to Cardiology-

Medications (active at completion of this visit)

Brand	Dose	Qty	Description
Xanax	1 Mg	90	take 1 tablet by ORAL route every bedtime as needed
Acetaminophen Pm	500 Mg-25 Mg	0	
Nitroglycerin	0.4 Mg	30	place 1 tablet by sublingual route at the 1st sign of attack; may repeat every 5 min until relief; if pain persists after 3 tablets in 15 min, prompt medical attention is recommended
Losartan-hydrochlorothiazide	100 Mg-25 Mg	90	take 1 tablet by oral route every day
Fenofibrate	160 Mg	90	take 1 tablet (160MG) by oral route every day
Vicodin	5 Mg-500 Mg	30	take 1 tablet by oral route every bedtime as needed for pain
Pravastatin Sodium	40 Mg	90	take 1 tablet (40MG) by oral route every day
Niacin	500 Mg	60	take 1 tablet (500MG) by oral route every day x2 weeks; then take twice a day
Vitamin D	1,000 Unit	otc	take one cap PO daily
Metformin Hcl	500 Mg	180	take 1 tablet (500MG) by oral route 2 times every day with morning and evening meals
Metoprolol Tartrate	50 Mg	180	take 1 tablet (50MG) by oral route 2 times every day with meals
Alkaline Batteries		180	Test twice daily
Aspirin	325 Mg		take 1 tablet (325MG) by oral route every day
Fish Oil	1,000 Mg		

Medications (prescribed or renewed this visit)

Brand Name	Dose	Rx Quanity	Directions
Xanax	0.5 Mg	90	take 1 tablet (0.5MG) by oral route every evening
Nitroglycerin	0.4 Mg	30	place 1 tablet by sublingual route at the 1st sign of attack; may repeat every 5 min until relief; if pain persists after 3 tablets in 15 min, prompt medical attention is recommended
Acetaminophen Pm	500 Mg-25 Mg	0	
Xanax	1 Mg	90	take 1 tablet by ORAL route every bedtime as needed

Office Services

Instructions / Education

Status	Completed	Order	Reason
completed		Weight loss discussion	

To Be Scheduled/Ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	DeviceID
ordered	CT THORAX W/ & W/O CONTRAST			786.05		

Lab Studies

Status	Lab Study	Timeframe	Date	Comments	Interpretation	Value
ordered	CBC w/diff	6 Months				
ordered	CMP	6 Months				
ordered	Hemoglobin A1c					
ordered	Lipid Panel	6 Months				

Referrals Ordered Today

Status	Referral/Phone
scheduled	Referral: Cardiology. Evaluate and treat.

Referral Appointment(s) Scheduled

Date/Time/Location

Referral: Cardiology. Evaluate and treat.

Counseling / Educational Factors

Counseling / educational factors reviewed.

inovalon™

Date of Service: 11/06/15

CHIEF COMPLAINT: Est Care, CAD

IMPRESSIONS AND RECOMMENDATIONS
-CAD: The patient has had prior PCI with bare metal stent. This condition is stable. The patient is having no angina. Preserved LV function. A return office visit will be scheduled with Dr. [redacted] in one year. Abdominal Aorta Duplex to be done before next visit. Carotid Duplex to be done before next visit. Appropriate medical management at this time with BP and lipids at goal. 12 Lead ECG to be done for today.
-DM Type 2
-Hypertension

FINAL MEDICATION LIST

Vitamin D	1,000 Unit	take one daily
Niacin	500 Mg	take 1 Tablet by oral route 2 times every day
Losartan/hydrochlorothiazide	100 Mg-25 Mg	take 1 tablet by oral route every day
Metformin Hcl	500 Mg	take 1 tablet by oral route 2 times every day with morning and evening meals
Xanax	1 Mg	take 1 tablet by oral route every bedtime as needed
Fish Oil	1,000 Mg	take 1 Tablet by Oral route 2 times every day
Fenofibrate	160 Mg	take 1 tablet by oral route every day
Aspirin	325 Mg	take 1 tablet by oral route every day
Metoprolol Tartrate	50 Mg	take 1 tablet by oral route 2 times every day with meals
Pravastatin Sodium	40 Mg	take 1 tablet by oral route every day
Nitroglycerin	0.4 Mg	place 1 tablet by sublingual route at the 1st sign of attack; may repeat every 5 min until relief; if pain persists after 3 tablets in 15 min, prompt medical attention is recommended
Acetaminophen Pm	500 Mg-25 Mg	take as directed

HISTORY OF PRESENT ILLNESS
: Establishment of care. Asymptomatic from CAD s/p BMS in [redacted] RCA. Tolerating medications without issue. Preserved EF.
LIPIDS 4.2013 LDL 76, HDL 36
The patient visits the office to be evaluated for coronary artery disease (CAD).
The patient was treated with PCI. The patient currently complains of no symptoms,. The patient is currently on the

following: ARB (losartan-hydrochlorothiazide 100 mg), Antiplatelet (aspirin 325 mg tablet), Beta Blocker (metoprolol tartrate 50 mg tablet), Lipid Lowering (fenofibrate 160 mg tablet, Fish Oil 1,000 mg capsule, niacin 500 mg tablet, pravastatin 40 mg tablet). He is not on the following: ACEI due to Prescribed ARB. He is compliant with medical therapy. The patient is tolerating the medications well. There are lab results available for the following: LDL.
The patient denies orthopnea, PND, DOE, or edema. has not had palpitations, syncope or near syncope.

CARDIAC HISTORY
CAD:
1 Stent
Risk Factors:
1 Type 2 Diabetes
2 Dyslipidemia

CARDIOVASCULAR PROCEDURES
Venous Duplex (No DVT, bilateral LE) -
Echo (EF 0.60, Mild PR, Mild AR, LVH, LAE, Abnormal diastolic relaxation, Dilated aortic root, Aneurysmal intraatrial n) -
Chest CT (Nonspecific 5 mm pleural-based nodule w/ in R lower lobe) -
CXR -
(1997 and 2000 : PCI w/ BMS each time to RCA (oakwood and WBH.))

INTERIM HISTORY: None

PAST MEDICAL HISTORY: Insomnia, Lung Nodule, Obesity, Peripheral Neuropathy

ALLERGIES/INTOLERANCES
Allergies reviewed, no changes.
None

SOCIAL HISTORY
FAMILY: Single
EXERCISE: sedentary
ALCOHOL: none
PRIMARY LANGUAGE: English

REVIEW OF SYSTEMS: RESP - Negative for snoring, hemoptysis, dyspnea. CONST - Negative for weight gain, weight loss, fever. EYES - Negative for visual changes. ENT - Negative for hearing loss. CARD - Negative for chest pain, diaphoresis, orthopnea, palpitation, syncope, pnd. VASC - Negative for claudication, edema. GI - Negative for nausea, reflux, bleeding. GU - Negative for hematuria, nocturia. NEURO - Negative for dizziness, memory loss, seizures. PSYCH - Negative for depression, hallucinations. HEMAT - Negative for acute anemia, thrombocytopenia.

PHYSICAL EXAM: CONST - The patient is 6ft tall, and weighs 227lbs. The BMI is 30.9 kg/m2. Blood pressure in the left arm is 128/80 mmHg in the sitting position. The pulse is 60/min and regular. Nourishment - Obese. Appearance - Well Developed. EYES - Lids/External - Bilateral Normal. Conjunctiva - Bilateral Normal. NMT - Oral Mucosa - Moist, No Cyanosis, No Pallor. NECK - JVP - Less Than 8. RESP - Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Rhonchi - Absent. Wheezes - Absent. CARDIAC - Rhythm - Regular. Palpation - PMI Normal. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Extra Sounds - None. Murmurs - None. VASC - Carotid - Bilateral Normal Pulse. Radial - Bilateral Normal Pulse. Posterior Tibial - Bilateral Normal Pulse. ABD - Tenderness - None. Hepatomegaly - Absent. Splenomegaly - Absent. M/S - Gait - Normal. Able to Exercise - Yes. EXT - Clubbing - Absent. Lower Extremity Edema - Absent. SKIN - Venous Stasis Ulcers - Absent. PS, YCH - Orientation - Oriented to Time, Person and Place. Mood - Appropriate.

Thank you for referring this patient to us. Please feel free to contact me with any questions.

Sincerely,