

PATIENT:Blose, Carolyn - 07/29/1932 Generated on 2017-07-21 - ViSolve Clinic 000-000-0000

ViSolve Clinic

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[Carolyn Blose](#)

Generated on: 2017-07-21

Patient Data:

Who Name: Mr. Carolyn V. Blose External ID: 530-79-5301

DOB: 1932-07-29

Sex: Female

History Data:

General Risk Factors: Hypertension

Exams/Tests:

Lifestyle Tobacco: Never smoker (SNOMED-CT:266919005) nonsmoker **Status:** Never

Coffee:

Alcohol: not consume alcohol

Recreational Drugs: No history of recreational drug use.

Counseling:

Exercise Patterns:

Hazardous Activities:

Insurance Data:

Primary Insurance Data:

Subscriber Date of Birth:

0000-00-00

Secondary Insurance Data:

Subscriber Date of Birth:

0000-00-00

Tertiary Insurance Data:

Subscriber Date of Birth:

0000-00-00

Billing Information:

Patient Immunization:

Patient Notes:

2017-07-19: Admitting diagnoses: Bloody diarrhea Shortness of breath congestive heart failure Discharge diagnosis: Diverticulitis Valvular insufficiency Congestive Heart Failure HISTORY OF PRESENT ILLNESS: The patient is an 84-year-old female admitted for evaluation of abdominal pain and bloody stools. The patient has colitis and also diverticulitis, undergoing treatment. During the hospitalization, the patient complained of shortness of breath, which

worsened. The patient underwent an echocardiogram, which shows severe mitral regurgitation and also large pleural effusion. Per the patient, she has limited activity level with shortness of breath for many years. She also was told that she has a heart murmur, which was not followed through for a diagnosis. CORONARY RISK FACTORS: History of hypertension, no history of diabetes mellitus, nonsmoker, cholesterol status unclear, no prior history of coronary artery disease, and family history noncontributory. FAMILY HISTORY: Nonsignificant. PAST SURGICAL HISTORY: No major surgery. MEDICATIONS: Presently on Lasix, potassium supplementation, Levaquin, hydralazine 10 mg b.i.d., antibiotic treatments, and thyroid supplementation. ALLERGIES: AMBIEN, CARDIZEM, AND IBUPROFEN. PERSONAL HISTORY: She is a nonsmoker. Does not consume alcohol. No history of recreational drug use. PAST MEDICAL HISTORY: Basically GI pathology with diverticulitis, colitis, hypothyroidism, arthritis, questionable hypertension, no prior history of coronary artery disease, and heart murmur. REVIEW OF SYSTEMS CONSTITUTIONAL: Weakness, fatigue, and tiredness. HEENT: History of cataract, blurred vision, and hearing impairment. CARDIOVASCULAR: Shortness of breath and heart murmur. No coronary artery disease. RESPIRATORY: Shortness of breath. No pneumonia or valley fever. GASTROINTESTINAL: No nausea, vomiting, hematemesis, or melena. UROLOGICAL: No frequency or urgency. MUSCULOSKELETAL: Arthritis and severe muscle weakness. SKIN: Nonsignificant. NEUROLOGICAL: No TIA or CVA. No seizure disorder. ENDOCRINE/HEMATOLOGICAL: As above. PHYSICAL EXAMINATION VITAL SIGNS: Pulse of 84, blood pressure of 168/74, afebrile, and respiratory rate 16 per minute. HEENT/NECK: Head is atraumatic and normocephalic. Neck veins flat. No significant carotid bruits appreciated. LUNGS: Air entry bilaterally fair. No obvious rales or wheezes. HEART: PMI displaced. S1, S2 with systolic murmur at the precordium, grade 2/6. ABDOMEN: Soft and nontender. EXTREMITIES: Chronic skin changes. Feeble pulses distally. No clubbing or cyanosis. DIAGNOSTIC DATA: EKG: Normal sinus rhythm. No acute ST-T changes. Echocardiogram was reviewed showing severe mitral regurgitation. LABORATORY DATA: H&H 13 and 39. BUN and creatinine within normal limits. Potassium within normal limits. BNP 9290. IMPRESSION: 1. The patient admitted for gastrointestinal pathology, under working treatment. 2. History of prior heart murmur with Echocardiogram findings as above. Basically revealed normal left ventricular function with left atrial enlargement, large pleural effusion, and severe mitral regurgitation and tricuspid regurgitation. Discharge Recommendations: 1. Finish antibiotics, High fiber diet for diverticulitis. PCP follow up in 30 days 2. From cardiac standpoint, conservative treatment. Possibility of a transesophageal echocardiogram to assess valvular insufficiency adequately well discussed extensively. After extensive discussion, given her age 86, limited activity level, and no intention of undergoing any treatment in this regard from a surgical standpoint, the patient does not wish to proceed with a transesophageal echocardiogram. 3. Based on the above findings, we will treat her cardiac disease medically with ACE inhibitors and diuretics and see how she fares. She has a normal LV function.

Patient Transactions:

Patient Communication sent:

Recurrent Appointments:

None

Issues

Allergies:

AMBIEN:
CARDIZEM:
IBUPROFEN:

Medications:

Lasix:
potassium supplementation:
Levaquin:
hydralazine 10 mg b.i.d.:
antibiotic treatments:
thyroid supplementation:

New Patient Encounter

(2017-07-19) Provider: Administrator Administrator

Facility: ViSolve Clinic

Reason: HISTORY OF PRESENT ILLNESS: The patient is an 84-year-old female admitted for evaluation of abdominal pain and bloody stools. The patient has colitis and also diverticulitis, undergoing treatment. During the hospitalization, the patient complained of shortness of breath, which worsened. The patient underwent an echocardiogram, which shows severe mitral regurgitation and also large pleural effusion. Per the patient, she has limited activity level with shortness of breath for many years. She also was told that she has a heart murmur, which was not followed through for a diagnosis.

Review Of Systems

(2017-07-19)

Weakness: YES	Fatigue: YES	Shortness Of Breath: YES	History Murmur: YES	Vomiting: YES	Hematemesis: YES
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TIA: NO

Vitals

(2017-07-19)

Blood Pressure: 168/74 **Pulse:** 84 per min **Respiration:** 16 per min

Review of Systems Checks

(2017-07-19)

Cataracts: yes **Blurred Vision:** yes **Shortness Of Breath:** yes

Signature: _____