PATIENT:Garcia, Stephan - 04/03/1957 Generated on 2017-07-21 - ViSolve Clinic 000-000-0000

ViSolve Clinic

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000-000-0000
Stephan Garcia
Generated on: 2017-07-21

Patient Data:

Who **Name:** Mr. Stephan Garcia **External ID:** EX1234567
DOB: 1957-04-03 **Sex:** Male

History Data:

General	**Risk Factors:**	Hypertension	**Exams/Tests:**
Lifestyle	**Tobacco:**	50 pack years, but only smoking a few cigarettes a day for past year.	
	Coffee:		
	Alcohol:	Moderate alcohol, several hard liquor drinks weekly, does not drink to excess.	
	Recreational Drugs:		
	Counseling:		
	Exercise Patterns:	Exercise history: minimal in the last 5 years.	
	Hazardous Activities:		
Other	**Additional History:**	Family history of prostate cancer and melanoma.	

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: PAST MEDICAL HISTORY: The patient is a 59-year-old Hispanic male who has not been seen by his previous PCP in 6 months. He is known to have a history of COPD and labile hypertension. He has a previous history

of pneumonia requiring hospitalization 3 years ago. He has developed a steady productive cough in the last 3 years, of about one-half cup of sputum every day. He has noticed a few flecks of blood occasionally but no hemoptysis this past year. His exercise tolerance has decreased significantly in the last 5 years so he has not exercised in the last year, but he is not short of breath at rest. SOCIAL HISTORY: Moderate alcohol, several hard liquor drinks weekly, does not drink to excess. Smoking history: 50 pack years, but only smoking a few cigarettes a day for past year. Family history of prostate cancer and melanoma. Exercise history: minimal in the last 5 years. PHYSICAL EXAMINATION: VITAL SIGNS: Weight 190, height 6 feet 1 inch, blood pressure 128/67, heart rate 84. HEENT: PERRLA. EOM intact. Oropharynx is clear of lesions. NECK: Supple. No lymphadenopathy. No thyromegaly. LUNGS: Clear to auscultation and percussion bilateral, breath sounds diminished throughout. CARDIOVASCULAR: Regular rate and rhythm. No murmurs, rubs, or gallops. ABDOMEN: Not tender, not distended. Splenomegaly about 4 cm under the costal margin. No hepatomegaly. Bowel sounds present. MUSCULOSKELETAL: No cyanosis, no clubbing, no pitting edema. NEUROLOGIC: Nonfocal. No asterixis. No costovertebral tenderness. PSYCHE: The patient is oriented x4, alert and cooperative. ALLERGIES: Erythromycin. PAST SURGERIES: Appendectomy. Prostate biopsy. LABORATORY DATA: None available. ASSESSMENT AND PLAN: The patient is a 59-year-old with established diagnosis of COPD and a substantial smoking history. He has not had any recent chest xrays or pulmonary function testing. He will be sent for comprehensive baseline testing including CBC with differential, Chem 20 panel, urinalysis, chest xray, and pulmonary function tests. The patient and his wife were advised to contact the office once they have finished the prescribed testing for a follow up appointment. We also discussed nutrition and smoking issues.

Patient Transactions:

Patient Communication sent:

Recurrent Appointments:

None

Issues

Allergies:

Erythromycin:

New Patient Encounter

(2017-07-19) Provider: Administrator Administrator

Facility: ViSolve Clinic
Reason: Patient is new to the practice, having recently moved to the area from Florida, where his extended family remains.

Vitals

(2017-07-19)

Blood Pressure:	**Weight:**	**Height:**	**Pulse:**	**BMI:**	**BMI Status:**
128/67	190.00 lb (86.18 kg)	71.87 in (182.6 cm)	84 per min	26 kg/m^2	Normal BL

Signature: _____