LOCAL TITLE: HISTORY AND PHYSICAL
STANDARD TITLE: PRIMARY CARE H & P NOTE
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AUTHOR: ADMINISTRATOR,SYSTE EXP COSIGNER:
URGENCY: STATUS: UNSIGNED

NAME: Campo, Ricardo
DOB: 01/02/1963
ID: 123456789
NOTE: History and Physical
AUTHOR: Miranda Bailey, MD.
DATE: 06/01/2017

HISTORY OF PRESENT ILLNESS:
The patient is a 55-year-old Hispanic male who was seen initially in the office on May 24, 2017 with epigastric and right upper quadrant abdominal pain, nausea, dizziness, and bloating. The patient at that time stated that he had established diagnosis of liver cirrhosis. Since the last visit the patient was asked to sign a lease of information form and we sent request for information from the doctor the patient saw before, Dr. Stone in Las Cruces and his primary care physician in Silver City. Unfortunately we did not get any information from anybody. Also the patient had admission in Gila Medical Center with epigastric pain, diarrhea, and confusion. He spent 3 days in the hospital. He was followed by Dr. Stone and unfortunately we also do not have the information of what was wrong with the patient. From the patient report he was diagnosed with some kind of viral infection. At the time of admission he had a lot of epigastric pain, nausea, vomiting, fever, and chills.

ALLERGIES:
Allergic to Penicillin

PHYSICAL EXAMINATION
VITAL SIGNS: BMI 24, Weight 180, height 61 inches, blood pressure 128/67, heart rate 74, saturation 98%; pain is 3/10 with localization of the pain in the epigastric area.
HEENT: PERRLA, slightly icteric. EOM intact. Oropharynx is clear of lesions.
NECK: Supple. No lymphadenopathy. No thyromegaly.
LUNGS: Clear to auscultation and percussion bilateral.
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.

LABORATORY DATA:

The patient told me today that he also got an ultrasound of the abdomen and the result was not impressive, but we do not have this result despite calling medical records in the hospital to release this information.

05/24/2017
We were able to collect lab results from Local Commnunity Hospital Organization:

Complete Blood Count Panel
Comprehensive Metabolic Panel
HCV Ab positive

WBC 9
ANC 68
HGB 16

HCT 46
Platelets 24,000
Creatinine 0.6
Glucose 79
Calcium 7.3
BUN 9
C02 23.7
Chloride 104
Potassium 3.5
Sodium 136
Albumin 2.5
ALT 68
AST 56
Alk Phos 165
T. Bili 5.63
Total Prot 5.9

06/07/2017
Additional Lab Tests

Protime
Fe (Blood Iron) 171
INR 3.84
tibc 607
Ferritin 494
Vitamin D 25-OH 18
AFP 30
HIV Ab <1 Negative
HCV Ab >1 Positive
HCV Genotype 2 positive
HCV Viral Load 210,000,000 IU/L

ASSESSMENT AND PLAN:

The patient is a 55-year-old with established diagnosis of liver cirrhosis, unknown cause.
HCV Antibody test was positive at today's visit.

1. Epigastric pain. The patient had chronic pain syndrome.
In the office twice the patient did not have any abdominal pain on physical exam.
His pain does not sound like obstruction of common bile duct and he had these episodes of abdominal pain almost continuously.

2. Chronic liver disease.
We need to find out the cause of the liver cirrhosis.
We do not have any information of any type of investigation in the past.
Patient was seen by gastroenterologist already in Las Cruces, Dr. EV Easley.
The patient was advised to contact Dr. Easley by himself to convince him to send available information because we already send release information form signed by the patient without any result.
It will be not reasonable to repeat unnecessary tests in that point in time.

3. History of Portal Hypertension.
We are waiting for the hepatitis panel and alpha-fetoprotein level.
We will also need to get information about ultrasound which was done in Gila Medical Center, but obviously no tumor was found on this exam of the liver.

Today, we will administer vaccinations against hepatitis A and B. My differential diagnosis probably is hepatitis C. The patient denied any excessive alcohol intake, but I could not preclude alcohol-related liver cirrhosis also. We will need to look for nuclear antibody if it is not done before. Rule out PSC, extremely unlikely but possible.

Wilson disease also possible diagnosis but again, we first have to figure out if these tests were done for the patient or not. Alpha1-antitrypsin deficiency will be extremely unlikely because the patient has no lung problem. On his end-stage liver disease we already know that he had low platelet count splenomegaly. We know that his bilirubin is elevated and albumin is very low. I suspect that at the time of admission to the hospital the patient presented with hepatic encephalopathy. We do not know if INR was checked to look for coagulopathy.

At this point in time, I recommended the patient take lactulose 50 mL 3 times daily and Inderal 10 mg twice daily. The patient tolerated it well; no diarrhea. We will gradually increase his dose until his heart rate will drop to 25% from 75% to probably 60-58.
The patient was educated how to use his medications.

Again, the patient and his wife were advised to contact all offices they have seen before to get information about what tests were already done and if on the next visit in 2 weeks we still do not have any information we will need to repeat all these tests I mentioned above.

We also discussed nutrition issues. The patient was provided information that his protein intake is supposed to be about 25 g per day.
He was advised not to over-eat protein and advised not to starve. He also was advised to stay away from alcohol. His next visit is in 2 weeks with all results available.