Patient Note 3

Patient Name: Rajesh Patel
Age: 60
Gender: Male

Current Problem List:

- Type 2 Diabetes (5 years, A1c 7.5%)
- Hypertension (10 years)
- Fatty Liver Disease

Past Medical History:

- Type 2 Diabetes
- Hypertension
- Non-alcoholic fatty liver disease (NAFLD)
- Gallbladder removal (cholecystectomy, 8 years ago)

Allergy:

- None

Family History:

- Father: Type 2 Diabetes
- Mother: Hypertension, Dyslipidemia

Social History:

- Non-smoker
- Alcohol: Social drinker
- Diet: Frequently consumes high-fat meals

History of Present Illness: Reports mild fatigue and occasional right upper abdominal discomfort. Recent lab tests show elevated ALT/AST levels. Blood pressure is controlled at home. Admits to occasional dietary indiscretions.

Physical Examination:

- Vital Signs: BP 128/78 mmHg, HR 72 bpm, BMI 30 kg/m²
- HEENT: No abnormalities
- Cardiovascular: Normal S1, S2; no murmurs
- Abdominal: Mild tenderness in right upper quadrant
- Extremities: No edema

Assessment:

1. Type 2 Diabetes, moderately controlled
2. Hypertension, well controlled
3. Worsening liver enzymes suggestive of NAFLD progression

Diagnosis:

- Type 2 Diabetes, moderately controlled
- Hypertension (controlled)
- NAFLD with elevated transaminases

Plan:

- Increase Metformin to 1000 mg BID
- Start Pioglitazone 15 mg daily
- Reinforce low-fat, low-sugar diet
- Monitor liver function tests every 3 months
- Encourage regular exercise

Follow-Up: Return in 8 weeks to reassess liver enzymes and diabetes control.

Medications:

- Metformin 1000 mg BID
- Pioglitazone 15 mg daily
- Amlodipine 10 mg daily
- Atorvastatin 20 mg nightly

Recurring Questions for Monitoring:

1. Have you experienced any abdominal pain or jaundice?
2. What are your average blood glucose readings?
3. Are you adhering to the recommended diet?
4. Have you experienced any side effects from medications?
5. How often are you engaging in physical activity?