

Donnie Miller: Patient Information
Patient Record Number:6283

Texas Physician House Calls (H)
2925 Skyway Circle North, Irving, TX, USA,
75038-3510
www.texas-housecalls.com, Phone:(972) 675-
7313, Fax:(972) 675-7310,
Email:hhsupport@texas-housecalls.com

To

Type: Home Health Agency
Organization: Prosperity Health Services
Name: Linda
Work Phone: 972-296-1901
Email: Linda.Paiz@prosperityhs.com
Fax: 972-296-5590
Street: 1615 N Hampton Rd St 130
City: Desoto

Fax Number

972-296-5590

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Name: Donnie Miller **DOB:** 1960-04-07
External ID: 6283 **Sex:** Female

Address: 3200 S Lancaster Rd **Postal Code:** 75216
City: Dallas **Country:** USA
State: Texas

Donnie Miller: Vitals
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Seen by Derrick Love-Jones
Seen on 26-August-2016

Service Date	BPS	BPD	Wt	Ht	Temperature	RR	Note	BMI	Head circ
2016-08-26	103	71	180.00	67.00	98.20	18.00	~	0.0	0.00

Chief Complaint:

Who invented service to prevent further decline of the following chronic medical conditions of schizophrenia, manic depression, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, hypertension, benign prostatic hyperplasia, epilepsy, insomnia, and osteoarthritis. Patient complains of knee pain and low back pain.

History of Present illness:

Patient is a 56-year-old African-American male in NAD multiple chronic conditions of the following schizophrenia, manic depression, coronary artery disease, hyperlipidemia, gastroesophageal reflux disease, hypertension, benign prostatic hyperplasia, epilepsy, insomnia, and osteoarthritis. Patient complains of knee pain and low back pain that is chronic and has been for several years. Patient has a previous history of her partial colon removal, history of seizures, and a history of TIA. Patient also has a history of mental illness. Patient denies any other issues upon examination. Patient denies any CP, HA, nausea/vomiting.

Past Medical History:

Family History:

Social History:

Review of Systems:

Constitutional:

- No Weight Change
- No Weakness
- No Fever
- No Chills
- Insomnia YES
- No Change In Appetite

Eyes:

- No Change In Vision
- No Eye Pain
- No Double Vision

Ears, Nose, Mouth, Throat:

- No Hearing Loss
- No ENT Pain
- No Tinnitus
- No Hoarseness

Neck:

- No Neck Pain
- No Masses
- No Tenderness

Respiratory:

- No Cough
- No Shortness Of Breath
- No Asthma

Cardiovascular:

- No Chest Pain
- No Palpitation
- No Edema

Gastrointestinal:

- No Dysphagia
- No Nausea
- No Vomiting
- No Gastro Pain
- No Changed Bowel
- No Diarrhea
- No Constipation

Genitourinary General:

No Polyuria
No Polydypsia
No Dysuria
No Incontinence

Musculoskeletal:

Joint Pain YES
No Musc Swelling
Arthritis YES
No Gout
Back Pain YES
No Limitation In Range Of Motion

Extremities:

No Spasms
No Extreme Tremors

Neurologic:

No Seizures
No Intellectual Decline
No Dementia
No Tremors
No Migraines

Psychiatric:

Psych Diagnosis YES
Psych Medication YES
Depression YES
Anxiety YES
No Suicide Thoughts

Endocrine:

No Thyroid Problems
No Diabetes
No Heat Intolerance

Physical Exam:**GEN:**

Appearance-Within Normal Limits .
Awake, Alert, Oriented, in No Acute Distress-Within Normal Limits .

HEAD:

Normocephalic, Autramatic-Within Normal Limits .

EYE:

Conjunctiva, Pupils-Within Normal Limits .
PERRLA, EOMI-Within Normal Limits .

ENT:

Nasal Mucosa Pink, Septum Midline-Within Normal Limits .
Oral Mucosa Pink, Throat Clear-Within Normal Limits .

NECK:

Supple,Thyromegaly, Carotid of the Nasal Septum, JVD, lymphadenopathy-Within Normal Limits .

BACK:

Normal Curvature, Tenderness-Within Normal Limits .

CV:

RRR-Within Normal Limits .

RESP:

Lungs CTAB-Within Normal Limits .
Respirator Effort Unlabored-Within Normal Limits .

GI:

Soft, Non Tender, Non Distended, Masses-Within Normal Limits .
Bowel Sounds present in all four quadrants-Within Normal Limits .

MUSC:

Strength-Within Normal Limits .

NEURO:

CN2-12 Intact-Within Normal Limits .

PSYCH:

Normal Affect, Judgement and Mood, Alert and Oriented X3-Within Normal Limits .
Patient Appears To Be In Good Mood-Within Normal Limits .
Able To Answer Questions Qppropriately-Within Normal Limits .

SKIN:

Clean & Intact with Good Skin Turgor-Within Normal Limits .

Assessment:

Patient states that he has chronic pin in both knees and his legs. Patient rates his pain currently at 7/10 and states he does get relief from current pain medication. Educated patient on the importance of low salt, low-fat, low cholesterol diet and daily exercises tolerated. Medical complexity risk of complications medium. Patient denies any chest pain, headache, nausea/vomiting at this time. Education material was given to the patient. Reviewed labs.

Patient diagnoses are,

1. Lumbago with chronic pain.
2. Osteoarthritis with chronic pain.
3. Hypertension with vascular complications.
4. Benign prostatic hyperplasia.
5. Chronic pain syndrome.
6. Coronary artery disease.
7. Gastroesophageal reflux disease.
8. Osteoarthritis with chronic pain.
9. Insomnia.
10. Epilepsy.
11. Schizophrenia.

Plan Note:

Continue same treatment plan his previous provider. Reviewed and continue same medications, maybe medications noted this visit. Medication adherence education was given to the patient and the patient educated on the benefits of low salt, low-fat, low cholesterol diet with current medical conditions. Patient was instructed to go to the air for symptoms of chest pain, shortness of breath, excessive headache, blurry vision or systolic blood pressure greater than 200. Patient encouraged to exercise daily as tolerated. Full set of labs of the following ordered: CBC, CMP, UA, TSH, A1C, VIT D, LIPID LDL/HDL. Patient verbalized understanding of the above plan and was given the office number for any questions or concerns. Prognosis is fair and patient is stable.

1. Lumbago with chronic pain, continue current plan.
2. Osteoarthritis with chronic pain, continue current plan.
3. Hypertension with vascular complications, continue current plan.
4. Benign prostatic hyperplasia, continue current plan.
5. Chronic pain syndrome, continue current plan.
6. Coronary artery disease, continue current plan.
7. Hyperlipidemia, continue current plan.
8. Gastroesophageal reflux disease, continue current plan.
9. Osteoarthritis with chronic pain, continue current plan.
10. Insomnia, continue current plan.
11. Epilepsy, continue current plan.
12. Schizophrenia, continue current plan.

Medication refills as follows:

Seriquel 200 mg b.i.d.
ASA 81mg q.d.
Atrovastatin 10 mg q.h.s.
Dicystonine 20 mg b.i.d.
Keppra 750 mg b.i.d.
Lisinopril 10 mg b.i.d.
Nitro 0.4 mg sq p.r.n.
Tamsulosin 0.4 mg q.d.
Trazodone 100 mg b.i.d.
Norco 10/325 mg t.i.d.

Quality Of Care

1. Provided Education Resource(s).
2. Medication Reconciliation.
3. Documentation of current medications.
4. Patient Decision Aids / Education Materials Given.

Medical Problem:

Description	Status	Start Date	End Date
Low back pain (ICD10:M54.5 Low back pain) Unknown or N/A	Active	2016-08-26	
Other chronic pain (ICD10:G89.29 Other chronic pain) Unknown or N/A	Active	2016-08-26	
Chronic venous hypertension (idiopathic) without complications of unspecified lower extremity (ICD10:I87.309 Chronic venous hypertension (idiopathic) without complications of unspecified lower extremity) Unknown or N/A	Active	2016-08-26	
Enlarged prostate with lower urinary tract symptoms			

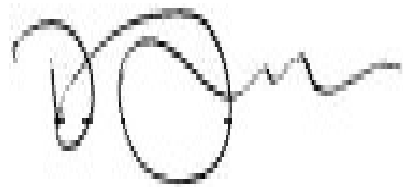
(ICD10:N40.1 Enlarged prostate with lower urinary tract symptoms) Unknown or N/A	Active	2016-08-26
Primary generalized (osteo)arthritis (ICD10:M15.0 Primary generalized (osteo)arthritis) Unknown or N/A	Active	2016-08-26
Polyosteoarthritis, unspecified (ICD10:M15.9 Polyosteoarthritis, unspecified) Unknown or N/A	Active	2016-08-26

Allergies:

Description	Status	Start Date	End Date
No known drug allergies. Unknown or N/A	Active		

Surgeries:

Description	Status	Start Date	End Date
Partial colon removal 10 years ago. Unknown or N/A	Active		
Hospitalized for TIA. Unknown or N/A	Active		



Electronically Signed by **Derrick Love-Jones** on **2016-09-02 at 10:32**.

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