

Robert D

Home: 9889758248 Male DOB: 04/04/1950	Immediate Contact: Steve R 9886728748
--	--

Patient Information

Name: Robert D	Home Phone: 9889758248
Address: 4444 Coffee Ave Goa	Office Phone:
Patient ID: 0000-44444	Fax:
Birth Date: 04/04/1950	Status: Active
Gender: Male	Marital Status: Married
Aadhar No: 444-444-4444	Language: English
Home Doctor: Carl M	
Contact By: Phone	Emp. Status: Full-time
Email:	
Home LOC Hospital : WeServe Clinic	External Relative ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd

Last Refill: #30 x 2 : Carl Savem MD (08/27/2010)

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac
breakfast

Last Refill: #600 u x 0 : Carl Savem MD (08/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

3/18/2011 - Office Visit: F/u Diabetes

Provider: Carl Savem MD

Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness

Reason for visit: Routine follow up

Chief Complaint: No complaints

History

Diabetes Management

Hyperglycemic Symptoms

Polyuria: no

Polydipsia: no

Blurred vision: no

Sympathomimetic Symptoms

Diaphoresis: no

Agitation: no

Tremor: no

Palpitations: no

Insomnia: no

Neuroglycopenic Symptoms

Confusion: no

Lethargy: no

Somnolence: no

Amnesia: no

Stupor: no

Seizures: no

Review of Systems

General: denies fatigue, malaise, fever, weight loss

Eyes: denies blurring, diplopia, irritation, discharge

Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat

Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis

Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation

Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence

Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain

Skin: denies rashes, itching, lumps, sores, lesions, color change

Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias

Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia

Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance

Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats

Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Ht: **64 in.** Wt: **140 lbs.** T: **98.0** degF. T

site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress

Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL

Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL

Respiratory: clear to auscultation and percussion, respiratory effort normal

Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities

Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Problems (including changes): Blood pressure is lower. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. Will work harder on diet. Will increase insulin by 2 units.

Home Glucose Monitoring:

AC breakfast 110 to 220

AC breakfast mean 142

AC dinner 100 to 250

AC dinner mean 120

03/18/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Tests:

(1) Metabolic Panel(ML-03CHEM)

ALK PHOS	72	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2

PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test

HbA1c level 6.0%

(3) Lipid Profile

Cholesterol, Total 210 mg/dl

Triglycerides 236 mg/dl

HDL Cholesterol 36

LDL Cholesterol 107

WeServe Clinic	<i>March 24, 2011</i>
-----------------------	-----------------------

Male DOB: 04/04/1950

0000-44444

	Date 03/18/2011
HEIGHT (in)	64
WEIGHT (lb)	140
TEMPERATURE (deg F)	98
TEMP SITE	oral

PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	
BG RANDOM (mg/dL)	125
CXR	
EKG	
FLU VAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	Complete

Robert D

Home: 9889758248

Male

DOB: 04/04/1950

Date: 4/5/1955

Diagnosed with: Dengue fever

Symptoms:

Aching muscles and joints

Body rash that can disappear and then reappear

High fever

Intense Headache

Pain behind the eyes

Vomiting and feeling nauseous

Medication:

Acetaminophen (Tylenol) can alleviate pain and reduce fever.)

Aspirin, ibuprofen (Advil, Motrin IB) and naproxen sodium (To Avoid pain relievers that can increase bleeding complications)

Care provided by: Will MD, Adam's Clinic

Contact : 9865497258

Robert D

Home: 9889758248 Male DOB: 04/04/1950	Immediate Contact: Steve R 9886728748
--	--

Patient Information

Name: Robert D	Home Phone: 9889758248
Address: 4444 Coffee Ave Goa	Office Phone:
Patient ID: 0000-44444	Fax:
Birth Date: 04/04/1950	Status: Active
Gender: Male	Marital Status: Married
Aadhar No: 444-444-4444	Language: English
Home Doctor: Carl M	
Contact By: Phone	Emp. Status: Full-time
Email:	
Home LOC Hospital : WeServe Clinic	External Relative ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd

Last Refill: #30 x 2 : Carl Savem MD (08/27/2010)

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac
breakfast

Last Refill: #600 u x 0 : Carl Savem MD (08/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

3/18/2011 - Office Visit: F/u Diabetes

Provider: Carl Savem MD

Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness

Reason for visit: Routine follow up

Chief Complaint: No complaints

History

Diabetes Management

Hyperglycemic Symptoms

Polyuria: no

Polydipsia: no

Blurred vision: no

Sympathomimetic Symptoms

Diaphoresis: no

Agitation: no

Tremor: no

Palpitations: no

Insomnia: no

Neuroglycopenic Symptoms

Confusion: no

Lethargy: no

Somnolence: no

Amnesia: no

Stupor: no

Seizures: no

Review of Systems

General: denies fatigue, malaise, fever, weight loss

Eyes: denies blurring, diplopia, irritation, discharge

Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat

Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis

Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation

Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence

Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain

Skin: denies rashes, itching, lumps, sores, lesions, color change

Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias

Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia

Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance

Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats

Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Ht: **64 in.** Wt: **140 lbs.** T: **98.0** degF. T

site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress

Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL

Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL

Respiratory: clear to auscultation and percussion, respiratory effort normal

Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities

Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Problems (including changes): Blood pressure is lower. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. Will work harder on diet. Will increase insulin by 2 units.

Home Glucose Monitoring:

AC breakfast 110 to 220

AC breakfast mean 142

AC dinner 100 to 250

AC dinner mean 120

03/18/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Tests:

(1) Metabolic Panel(ML-03CHEM)

ALK PHOS	72	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2

PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test

HbA1c level 6.0%

(3) Lipid Profile

Cholesterol, Total 210 mg/dl

Triglycerides 236 mg/dl

HDL Cholesterol 36

LDL Cholesterol 107

WeServe Clinic	<i>March 24, 2011</i>
-----------------------	-----------------------

Male DOB: 04/04/1950

0000-44444

	Date 03/18/2011
HEIGHT (in)	64
WEIGHT (lb)	140
TEMPERATURE (deg F)	98
TEMP SITE	oral

PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	
BG RANDOM (mg/dL)	125
CXR	
EKG	
FLU VAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	Complete

Robert D

Home: 9889758248

Male

DOB: 04/04/1950

Date: 4/5/1955

Diagnosed with: Dengue fever

Symptoms:

Aching muscles and joints

Body rash that can disappear and then reappear

High fever

Intense Headache

Pain behind the eyes

Vomiting and feeling nauseous

Medication:

Acetaminophen (Tylenol) can alleviate pain and reduce fever.)

Aspirin, ibuprofen (Advil, Motrin IB) and naproxen sodium (To Avoid pain relievers that can increase bleeding complications)

Care provided by: Will MD, Adam's Clinic

Contact : 9865497258

Robert D

Home: 9889758248 Male DOB: 04/04/1950	Immediate Contact: Steve R 9886728748
--	--

Patient Information

Name: Robert D	Home Phone: 9889758248
Address: 4444 Coffee Ave Goa	Office Phone:
Patient ID: 0000-44444	Fax:
Birth Date: 04/04/1950	Status: Active
Gender: Male	Marital Status: Married
Aadhar No: 444-444-4444	Language: English
Home Doctor: Carl M	
Contact By: Phone	Emp. Status: Full-time
Email:	
Home LOC Hospital : WeServe Clinic	External Relative ID: MR-111-1111

Problems

DIABETES MELLITUS (ICD-250.)

HYPERTENSION, BENIGN ESSENTIAL (ICD-401.1)

Medications

PRINIVIL TABS 20 MG (LISINOPRIL) 1 po qd

Last Refill: #30 x 2 : Carl Savem MD (08/27/2010)

HUMULIN INJ 70/30 (INSULIN REG & ISOPHANE (HUMAN)) 20 units ac
breakfast

Last Refill: #600 u x 0 : Carl Savem MD (08/27/2010)

Directives

Allergies and Adverse Reactions (! = critical)

Services Due

FLU VAX, PNEUMOVAX, MICROALB URN

3/18/2011 - Office Visit: F/u Diabetes

Provider: Carl Savem MD

Location of Care: WeServeEveryone Clinic

OFFICE VISIT

History of Present Illness

Reason for visit: Routine follow up

Chief Complaint: No complaints

History

Diabetes Management

Hyperglycemic Symptoms

Polyuria: no

Polydipsia: no

Blurred vision: no

Sympathomimetic Symptoms

Diaphoresis: no

Agitation: no

Tremor: no

Palpitations: no

Insomnia: no

Neuroglycopenic Symptoms

Confusion: no

Lethargy: no

Somnolence: no

Amnesia: no

Stupor: no

Seizures: no

Review of Systems

General: denies fatigue, malaise, fever, weight loss

Eyes: denies blurring, diplopia, irritation, discharge

Ear/Nose/Throat: denies ear pain or discharge, nasal obstruction or discharge, sore throat

Cardiovascular: denies chest pain, palpitations, paroxysmal nocturnal dyspnea, orthopnea, edema
Respiratory: denies coughing, wheezing, dyspnea, hemoptysis

Gastrointestinal: denies abdominal pain, dysphagia, nausea, vomiting, diarrhea, constipation

Genitourinary: denies hematuria, frequency, urgency, dysuria, discharge, impotence, incontinence

Musculoskeletal: denies back pain, joint swelling, joint stiffness, joint pain

Skin: denies rashes, itching, lumps, sores, lesions, color change

Neurologic: denies syncope, seizures, transient paralysis, weakness, paresthesias

Psychiatric: denies depression, anxiety, mental disturbance, difficulty sleeping, suicidal ideation, hallucinations, paranoia

Endocrine: denies polyuria, polydipsia, polyphagia, weight change, heat or cold intolerance

Heme/Lymphatic: denies easy or excessive bruising, history of blood transfusions, anemia, bleeding disorders, adenopathy, chills, sweats

Allergic/Immunologic: denies urticaria, hay fever, frequent UTIs; denies HIV high risk behaviors

Vital Signs

Ht: **64 in.** Wt: **140 lbs.** T: **98.0** degF. T

site: **oral** P: **72** Rhythm: **regular** R: **16** BP: **158/90**

Physical Exam

General Appearance: well developed, well nourished, no acute distress

Eyes: conjunctiva and lids normal, PERRLA, EOMI, fundi WNL

Ears, Nose, Mouth, Throat: TM clear, nares clear, oral exam WNL

Respiratory: clear to auscultation and percussion, respiratory effort normal

Cardiovascular: regular rate and rhythm, S1-S2, no murmur, rub or gallop, no bruits, peripheral pulses normal and symmetric, no cyanosis, clubbing, edema or varicosities

Skin: clear, good turgor, color WNL, no rashes, lesions, or ulcerations

Problems (including changes): Blood pressure is lower. Feet are inspected and there are no callouses, no compromised skin. No vision complaints.

Impression: Sub optimal sugar, control with retinopathy and neuropathy, high glucometer readings. Will work harder on diet. Will increase insulin by 2 units.

Home Glucose Monitoring:

AC breakfast 110 to 220

AC breakfast mean 142

AC dinner 100 to 250

AC dinner mean 120

03/18/2011 - Lab Report: Metabolic Panel Provider: Carl Savem MD

Tests:

(1) Metabolic Panel(ML-03CHEM)

ALK PHOS	72	35-100
BG RANDOM	125 mg/dl	70-125
BUN	16 mg/dl	7-25
CALCIUM	9.6 mg/dl	8.2-10.2
CHLORIDE	101 mmol/l	96-109
CO2	27 mmol/l	23-29
CREATININE	0.7 mg/dl	0.6-1.2

PO4	2.9 mg/dl	2.5-4.5
POTASSIUM	4.5 mmol/l	3.5-5.3
SGOT (AST)	31 U/L	0-40
BILI TOTAL	0.7 mg/dl	0.0-1.3
URIC ACID	4.8 mg/dl	3.4-7.0
LDH, TOTAL	136 IU/L	0-200
SODIUM	135 mmol/l	135-145

(2) HbA1c Test

HbA1c level 6.0%

(3) Lipid Profile

Cholesterol, Total 210 mg/dl

Triglycerides 236 mg/dl

HDL Cholesterol 36

LDL Cholesterol 107

WeServe Clinic	<i>March 24, 2011</i>
-----------------------	-----------------------

Male DOB: 04/04/1950

0000-44444

	Date 03/18/2011
HEIGHT (in)	64
WEIGHT (lb)	140
TEMPERATURE (deg F)	98
TEMP SITE	oral

PULSE RATE (/min)	72
PULSE RHYTHM	
RESP RATE (/min)	16
BP SYSTOLIC (mm Hg)	158
BP DIASTOLIC (mm Hg)	90
CHOLESTEROL (mg/dL)	
HDL (mg/dL)	
LDL (mg/dL)	
BG RANDOM (mg/dL)	125
CXR	
EKG	
FLU VAX	
TD BOOSTER	0.5 ml g
Foot Exam	
Eye Exam	Complete

Robert D

Home: 9889758248

Male

DOB: 04/04/1950

Date: 4/5/1955

Diagnosed with: Dengue fever

Symptoms:

Aching muscles and joints

Body rash that can disappear and then reappear

High fever

Intense Headache

Pain behind the eyes

Vomiting and feeling nauseous

Medication:

Acetaminophen (Tylenol) can alleviate pain and reduce fever.)

Aspirin, ibuprofen (Advil, Motrin IB) and naproxen sodium (To Avoid pain relievers that can increase bleeding complications)

Care provided by: Will MD, Adam's Clinic

Contact : 9865497258