Example # 1

- Chief Complaint: Patient presents with Bloody Nose

Bloody Nose The history is provided by the patient and spouse. This is a recurrent problem. The current episode started more than 1 week ago. The problem has been occurring every several days. The problem has been unchanged since onset. The problem is associated with nothing. The bleeding has been from the right nare. The bleeding continued in the ED. He has tried pressure (he gets these approximately twice a week and lately has been actually placing budgets soaked with vinegar in his nose to try and stop the bleeding.) for the symptoms. Level of Relief: usually they stop on their own but this one has been continuing for six hours now so he came in for treatment. His past medical history is significant for frequent nosebleeds (he was seen in ENT clinic in 2005 with some generalized mucosal friability and bleeding thought to be secondary to his CPAP).

- Past Medical History: HTN, Depression, Alcoholism, Diabetes

No Known Allergies.

- Family History: Coronary Heart Disease/MI Mother
- Social History: Marital Status: Married
- Tobacco Use: Quit in 2002
- Alcohol Use: No quit
- Drug Use: No
- Sexually Active: Yes -- Female partner(s)

  Birth Control/ Protection: Pill
- Exercise No
- Bike Helmet Yes
- Seat Belt Yes
- Self-exams No

Review of Systems

Constitutional: Negative. Negative for weakness.

Other than his epistatic cysts is entire review of systems are at baseline at this time.

HENT: Positive for nosebleeds.

Cardiovascular: **He has a significant heart history**

Skin: Negative. Respiratory: Negative. Gastrointestinal: Negative. Genitourinary: Negative.

Eyes: Negative. Musculoskeletal: Negative. Neurological: Negative. Psychiatric: Negative.

All other systems reviewed and are negative.

06/18/2008 2:35 AM 06/18/2008 3:09 AM 06/18/2008 3:30 AM 06/18/2008 4:01 AM

BP:	114/49	135/49	139/52	151/48
Pulse:	64	66	67	69
Resp:	13	11	13	13
Weight:				
SpO2:	93%	94%	95%	95%

Physical Exam

Nursing note and vitals reviewed.

Constitutional: He is oriented. He appears well-developed and well-nourished. He appears not diaphoretic.

Nose: Septal deviation present. No nasal septal hematoma. Epistaxis is observed.

Mouth/Throat: Uvula is midline. Posterior oropharyngeal erythema **(he has some blood in the posterior oropharynx)** present.

Eyes: Extraocular motions are normal. Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. Neck supple. No tracheal deviation present.

Cardiovascular: Normal rate, regular rhythm and normal heart sounds.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.

Abdominal: Bowel sounds are normal. He exhibits no distension. Soft. No tenderness.
Musculoskeletal: Normal range of motion. He exhibits no edema and no tenderness.
Neurological: He is alert and oriented. No cranial nerve deficit. He exhibits normal muscle tone.

Skin: Skin is warm and dry. He is not diaphoretic. No erythema. No pallor.
Psychiatric: He has a normal mood and affect. His behavior is normal. Judgment and thought content normal.

Labs with values returned at the time of this note: **Results for orders placed during the hospital encounter of 06/18/2008**

CBC WITH DIFFERENTIAL

Component	Value	Range
• White Cell Count.	8.0	3.8-10.5 (K/uL)
• Red Cell Count	3.6 (*)	4.4-5.8 (M/uL)
• Hemoglobin	10.2 (*)	13.6-17.2 (g/dL)
• Hematocrit	32 (*)	40-52 (%)
• MCV	90	80-97 (fL)
• MCHC	32	32-36 (g/dL RBC)
• RDW CV	15.4 (*)	11.7-14.7 (%)
• RDW SD	50.4 (*)	36.0-46.0 (fL)
• Platelet	349	160-370 (K/uL)
• % Neuts	63	40-75 (% WBC)

• % Lymphs	24	20-45 (% WBC)
• % Monos	10	2-12 (% WBC)
• % Eos	3	0-7 (% WBC)
• %Basos	0	0-2 (% WBC)
• Neutrophils	5020	1700-7500 (/uL)
• Lymphocytes	1880	1000-3500 (/uL)
• Monocytes	770	200-900 (/uL)
• Eosinophils	270	0-500 (/uL)
• Basophils	30	0-200 (/uL)
INR	1.0	0.9-1.1

BASIC METABOLIC PANEL

Component	Value	Range
• Sodium	140	135-144 (mmol/L)
• Potassium	3.7	3.5-4.8 (mmol/L)
• Chloride	99	97-106 (mmol/L)
• Carbon Dioxide Content	29	22-32 (mmol/L)
• Anion Gap	12	7-14 (mmol/L)
• Glucose	167 (*)	70-99 (mg/dL)
• BUN	27 (*)	7-20 (mg/dL)
• Creatinine	1.2	0.6-1.3 (mg/dL)
• e-GFR	65	60-120 (mL/min/1.73sqm)
• Calcium	9.4	8.5-10.2 (mg/dL)
• ABO Group	A	-
• RH Typing	Positive	-
• Antibody Screen	Negative	-

Medical Decision Making: He had a mixture of 4% lidocaine with oxymetazoline placed on a pledget and compressed. By the end of this time frame he had no more active bleeding that I could see. He did have blood further back under the turbinates but I can see no active site of leading and his posterior oropharynx was no longer having any blood. His hemoglobin is down approximately 3 g since April but he has no symptoms of that at this time and this is deemed to be a chronic loss rather than an acute loss. Discusses at length of the patient and he agrees to follow up with ENT later today. This was arranged with Dr. Hetland. He was given phenylephrine with thrombin mixture to use as a spray. He is planning to leave town in a day or two for a trip to the East Coast

Diagnosis: epistaxis/recurrent

Example # 2

No chief complaint on file.

HPI Comments: This is a 27-year-old who was playing Frisbee tonight. She was running at full speed & was struck by another player in the neck and knocked off her feet. She presents with left anterior neck pain and a sensation of fullness and trouble swallowing. She denies loss of consciousness. She has no neurologic symptoms. She had no other complaints.

Neck Problem

The history is provided by the patient, EMS personnel and friend. This is a new problem. The current episode started less than 1 hour ago. The problem has been occurring constantly. The problem has been unchanged since onset. The pain is associated with a fall. There has been no fever. The pain is present in the left side. The quality of the pain is aching. The pain does not radiate. The pain is moderate. The pain is the same all the time. Pertinent negatives include no bowel incontinence, no bladder incontinence, no paresis, no tingling and no weakness. She has tried nothing for the symptoms.

No past medical history on file. Allergies not on file. No family history on file.

- Social History: Marital Status: Single

Review of Systems

Constitutional: Negative for weakness.

Musculoskeletal: Positive for neck pain.

Neurological: Negative for tingling.

All other systems reviewed and are negative.

VITALS	06/18/2008 9:45 PM	06/18/2008 10:48 PM
BP:	114/86	125/83
Pulse:	64	60
Temp:	97.8 °F (36.6 °C)	
TempSrc:	Oral	
Resp:	16	18
SpO2:	100%	100%

Physical Exam

Nursing note and vitals reviewed.

Constitutional: She is oriented. She appears well-developed and well-nourished. She appears not diaphoretic. Cervical collar and backboard in place.

Head: Normocephalic and atraumatic.

Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.

Eyes: Conjunctivae are normal. Pupils are equal, round, and reactive to light. No scleral icterus.

Neck: Neck supple. Normal carotid pulses present. Carotid bruit is not present. No tracheal deviation present.

Tenderness and fullness in region of L carotid pulse.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress.

Abdominal: She exhibits no distension. Soft. No tenderness.
Musculoskeletal: Normal range of motion. She exhibits no edema and no tenderness.
C-spine non-tender. Meets clinical clearance criteria and taken out of collar p nl neuro exam and nl ROM w/o pain.
Neurological: She is alert and oriented. She has normal strength. No cranial nerve deficit. Coordination normal. GCS eye subscore is 4. GCS verbal subscore is 5. GCS motor subscore is 6.

Skin: Skin is warm and dry. She is not diaphoretic.
Psychiatric: She has a normal mood and affect.

Labs with values returned at the time of this note: **Results for orders placed during the hospital encounter of 06/18/2008**

BASIC METABOLIC PANEL

Component	Value	Range
• Sodium	140	135-144 (mmol/L)
• Potassium	3.6	3.5-4.8 (mmol/L)
• Chloride	103	97-106 (mmol/L)
• Carbon Dioxide Content	28	22-32 (mmol/L)
• Anion Gap	9	7-14 (mmol/L)
• Glucose	105 (*)	70-99 (mg/dL)
• BUN	9	7-20 (mg/dL)
• Creatinine	0.9	0.6-1.3 (mg/dL)
• e-GFR	80	60-120 (mL/min/1.73sqm)
• Calcium	8.8	8.5-10.2 (mg/dL)

Medical Decision Making: CT angio of neck done to look for evidence of vascular injury, reported neg. No new complaints.

Diagnosis: Neck contusion

Example 3

Chief Complaint: Syncope

History of Present Illness: A 65 year old gentleman who was admitted yesterday to the psychiatric unit due to generalized anxiety disorder woke up this morning feeling lightheaded and then promptly had a syncopal spell. The staff was alerted, they witnessed what appeared to be a clonic type activity. There was no postictal state or symptomatology. The episode lasted about 1-2 minutes. He currently denies any symptoms, such as chest pain, shortness of breath, presyncopal feelings. There were no other neurological symptoms. He did sleep well last night and it should be noted that he was started on Seroquel 200 mg for the first time last evening. He has had syncopal spells in the past with fairly extensive workup which did not reveal cardiac source. One was while he was working and another was recently in April; he had what appeared to be almost a presyncopal spell after a cardiac stress test.

Past Medical History:

1. Possible anxiety disorder or depression as he was started on fluoxetine prior to admission
2. Coronary artery disease status post percutaneous transluminal coronary angioplasty and stent to the right coronary artery in 3/2001
3. History of presyncope in 8/2001
4. History of bradycardia in 8/2001
5. Type 2 diabetes mellitus, diet controlled
6. Hyperlipidemia, on treatment
7. GERD

Medications:

1. Fluoxetine 10 mg daily
2. Lipitor 10 mg daily
3. Prilosec 20 mg daily
4. Aspirin 325 mg daily
5. Multivitamin 1 daily
6. ProAir 8.5 g as needed
7. Metamucil as needed

Medications that were started subsequent to admission include:

1. Cymbalta 60 mg daily
2. Seroquel 200 mg nightly
3. At the time of this dictation he was also started on Fosphenytion IV and Dilantin orally

ALLERGIES: No known Drug Allergies

SOCIAL HISTORY: He is married, he lives with his wife in This Town, He has 2 sons, 2 grandchildren. His relationship is good. He does not smoke or use tobacco products. He used to smoke 2 packs per day, quitting in 1989. He denies any illicit drug use. He drinks 2-3 martinis per day, on occasion, he drinks more than that.

FAMILY HISTORY: His father had Alzheimer's disease. Sister, alcohol problem. Son with depression and attempted suicide.

REVIEW OF SYSTEMS: As reviewed above, he denies any current chest pain, nausea, vomiting, abdominal pain or lightheadedness. No neurologic problems. All other systems per 11-paint review of systems were negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: This morning after the spell his blood pressure systolically was 80-90 over 50s. His heart rate was 50-60. Otherwise, his vitals have been stable and within normal limits.

GENERAL: He appears well, no acute distress
HEENT: There is a 1-2 cm very superficial laceration with some mild sanguineous discharge in a linear fashion on his forehead. This was quite shallow and the edges of the wound approximated quite well. PERRLA, EOMI
NECK: Supple, No lymphadenopathy. Neck was slightly tender posteriorly
LUNGS: Clear to auscultation bilaterally without wheeze, rhonchi or rales
HEART: Regular rate and rhythm without murmur, gallup or rub
ABDOMEN: Positive bowel sounds. Nontender, nondistended, No hepatosplenomegaly.
EXTREMITIES: No cyanosis or edema. All 4 extremities were warm to the touch. He had good 2+ radial pulses bilaterally
NEUROLOGIC: He moves all 4 extremities symmetrically and strength is 5/5 grip strength and toe raising bilaterally. PERRLA, EOMI. His affect is somewhat flat. His eye contact is a bit avoidant. His speech is normal and without tangentiality.
SKIN: Other than the wound on the forehead was within normal limits

Laboratories: Reveal a hemoglobin A1c of 6.6. His nonfasting blood sugar was in the 160s to 180s. His troponin I was negative. The rest of his electrolytes, including in addition to a proBNP, were within normal limits.
Electrocardiogram: EKG appears in the chart and shows a right bundle branch block. Unclear if this is old or new. I will investigate this further. Head CT is pending. Also has a pending chest X-ray.
ASSESSMENT AND PLAN:
A 65-year-old gentlemen with a history of coronary artery disease and currently was admitted for a generalized anxiety order and treatment who had a syncopal spell this morning. There was some clonic activity after but no obvious pre or post ictal state. He also was started on a new medication last evening. He has had a history of syncopal spells in the past with workup which apparently has been somewhat unrevealing. Dr XXXX was consulted and assessed the patient and made recommendations. See his dictation for further details.

A differential diagnosis at this point includes a cardiac source, such as a MI or arrhythmia; a neurologic source, such as seizure or neurocardiogenic syncope; or a vascular source, such as hypotension. There could also be a Medication source such as a side effect to the Seroquel or other medications that he was recently started on. Vasovagal reaction and possibly metabolic such as hypoglycemia. Will place him on telemetry, do close monitoring, rule out MI. Get an echocardiogram along with an EEG and head CT. Will do routine wound care for his forehead and continue on alcohol withdrawal protocol. If he does well, we could certainly transfer him back to psychiatry for continued treatment.

DR XXXXX, MD

Example 4

Chief Complaint: Dyspnea DOS 6/20/08

History of Present Illness: 2 hrs prior to admission, patient awoke at 2 a.m. with a sudden onset of shortness of breath. He was feeling quite well in the days preceding, no dyspnea on exertion or lower extremity edema. Upon awakening with SOB, he denied acute chest pain, palpitations, dizziness or cough. EMS arrived an hour after symptom onset, where is vital signs were normal with a BP of 126/82. On arrival to ER, his BP was extremely elevated at 221/94. His dyspnea dramatically improved with Lasix 80 mg IV and initially a nitroglycerin drip (10 mcg/min). A CXR confirmed mild pulmonary edema and cardiomegaly before treatment.

Past Medical History:

1. CAD, S/P CABG 4 vessel in 1997 – last PCI 3/06 included placement of 2 drug-eluting stents to the circumflex; 3 of 4 grafts were patent. Last adenoside SPECT stress test 9/07 was normal, EF 58% (followed by Cardiac Specialty)
2. History of ventricular tachycardia, S/P AICD in 1999
3. Type 2 diabetes, on glibizide – A1c 7.7% 4/08
4. Peripheral vascular disease, currently asymptomatic – S/P remote common femoral and SFA endarterectomies and bilateral iliac angioplasties
5. Cerebrovascular disease, asymptomatic – Dopplers 11/2007 showed an 80% left ICA stenosis, 50% on right.
6. Chronic kidney disease, Baseline creatinine 1.6 to 1.9
7. Hypertension
8. Hyperlipidemia – last lipids 4/08 showed a total cholesterol of 152, triglycerides 206, HDL 29, LDL 82 0 historically suboptimal response with Niaspan, on Pravachol only.
9. Peptic ulcer disease, hospitalized for upper GI bleed 11/06, due to NSAID use – was intubated due to respiratory failure at that admission.
10. Mild cognitive impairment, on Aricept since 2003

Past Surgical History:

1. TURP 1993
2. Right inguinal hernia repair 1995
3. Cholecystectomy 1976
4. Endovascular AAA repair 2/2006
5. CABG 4 vessel 11/1997
6. A/CD placement 1999

Allergies: NKDA

Nausea with Sulfa, Nausea/Vomiting with Augmentin, GI Bleed on Etodolac (NSAIDS)

Medications:

1. Metoprolol 25 mg twice a day
2. Lisinopril 20 mg daily
3. HCTZ 25 mg daily
4. Glipizide 10 mg daily
5. Pravachol 10 mg bedtime
6. Aspirin 325 mg daily
7. Fish oil1000 mg twice daily
8. Prilosec OTC 40 mg twice daily
9. Aricept 10 mg bedtime
10. Oxybutynin 5 mg ½ tablet twice daily
11. Multivitamin, Vitamin C 500 mg daily
12. Doxazosin 1 mg bedtime (started 6/2/08)
13. Finasteride 5 mg bedtime (started 6/2/08)

Social History: Retired, former insurance agent. Married. He lives with his wife in their own home, however due to mild cognitive impairment and memory issues, his wife provides assistance at home, He does not venture out much, spends time in workshop in the basement. Never smoked, no alcohol. He has two daughters who live 2-3 hours away.

Review of Systems: General: no fevers, night sweats, weight loss or gain. Ears: chronic hearing loss, wears hearing aids. Cardiovascular: see HPI, Pulmonary: see HPI, no wheezing, no hemoptysis. GI: no heartburn, N/V or abdominal pain, mild constipation uses Metamucil. GU: chronic urinary urgency and occasional incontinence and frequency 8-10xdaily with weak stream. All negative for Psych, Skin, Neurologic, Eyes, Endocrine systems.

Physical Exam: COMPREHENSIVE

Laboratories and Tests: CBC white count 7.5, Hemoglobin slightly low at 13.3, Hematocrit 39.2, Platelets 155, BMP was stable with sodium 138, potassium 4.2, chloride 104, bicarbonate 24, BUN 33, creatinine 1.9, platelets 179, Calcium 9.0, LFTs normal, INR 1.2, PTT 34, Cardiac enzymes CK 72

EKG confirms first-degree AV block, with no obvious ST or T-wave changes. No old Q waves. Observing telemetry, a sinus rhythm with a first degree AV block noted with occasional PACs. Chest X-Ray showed modest cardiomegaly and mild pulmonary edema. No definitive infiltrate.

Assessment and Plan: 87 year old male with known multivessel CAD and vasculopathy, admitted for an episode of flash pulmonary edema. He was initially hypertensive in the ER, but at onset of symptoms at home was normotensive. Question mild acute MI. Do not see an infection as a precipitant. There were no new murmurs that suggest acute valvulopathy. Question possibility for renal artery stenosis inducing pulmonary edema.

1. Flash pulmonary edema, mild CHF exacerbation. He is nearly at baseline with 80 mg of IV Lasix. Continue monitor I's and O's for now, see if further diuretic therapy is needed from baseline HCTZ. Check echocardiogram to check for new wall dysfunction or valvulopathy. Check cardiac enzymes to rule out an occult MI and monitor on telemetry.
2. Type 2 diabetes, presumably controlled, continue glyburide, insulin sliding scale as needed
3. Hyperlipidemia, continue Pravachol current dose
4. History of peptic ulcer disease due to NSAID 11/06, Decrease Prilosec to 20 mg daily
5. Lower urinary tract symptoms, recently started on doxazosin and finasteride. Discontinue both medications.
6. FULL CODE

Discharge expected tomorrow without significant intervention planned

DR XX

Example 5

Vitals
BLOOD PRESSURE: 142/68 mm Hg (left; sitting; large arm cuff) - repeat 140/68
PULSE: 72 bpm
BODY MASS INDEX: 34.2 kg/m^2
WEIGHT: 97.7 kg (215.50 lb)
HEIGHT: 168.91 cm (66.50 in)

Allergies and Alerts
Drug Allergies/Adverse Reactions: Niacin
No Known Non-Drug Allergies/Adverse Reactions (NKNDA)

Medications
Amitriptyline HCl 50 mg Tablet, 1/4 Tablet QD hs prn
Aspirin 81 mg Tablet, Chewable, 1 Tablet QD
Atorvastatin Calcium (Lipitor) 80 mg Tablet, 1/2 Tablet QD
Clopidogrel (Plavix) 75 mg Tablet, 1 Tablet QD
Gemfibrozil 600 mg Tablet, 1 Tablet BID
Hydrocortisone Ace-Pramoxine (Analpram-HC) Rectal 1-1 % Cream, Apply as directed up to QID prn
Isosorbide Mononitrate 30 mg Tablet Sustained Release 24HR, 1 Tablet QD
Metoprolol Tartrate 25 mg Tablet, 1 Tablet BID
Nitroglycerin Sublingual, prn

Discontinued: Ezetimibe (Zetia)

Reason for Visit: Mr XXXXXX is a 60-year-old gentleman who is well known to me from the Outpatient Clinic and who was last seen about 5 months ago. He presents now for follow-up.

History of Present Illness
He had been started on Zetia around that time and was reporting 1 to 2 loose stools at that juncture. He has subsequently had worsening diarrhea (3 to 4 times per day, non-bloody), and as a result of that, he did in the past week or so discontinue the Zetia. He has subsequently noted already significant improvement in those symptoms.

On complementary questioning, Mr XXXXXX denies difficulties with headache, syncope, lightheadedness, focal neurologic complaints, or change in either auditory or visual acuity. He similarly denies unexplained sore throats or hoarseness, dyspepsia, dysphagia, recurrent nausea and vomiting, abdominal pain, or change in either bowel (save for that reported above) or urinary habits. He denies changing exercise tolerance, chest pain, dyspnea, chronic cough, wheezing, lower extremity edema, or claudication. He denies rashes or inflammatory joint symptoms.

Past Medical History
SURGERIES: The patient is status post remote left knee arthroscopy, as well as partial medial meniscectomy, repair of a left 4th digital nerve injury, and off-pump coronary artery bypass grafting, the latter in 2004.
HEALTH MAINTENANCE: He did undergo colonoscopy in November of 2005, with 4 year follow-up then suggested. A PSA assay dates back to August of 2004, with a tetanus toxoid booster dating back to 2002. He has historically declined the influenza vaccination. Lipoprotein and glucose values have been serially monitored.

Family History Unchanged from dictations past.
Social History HABITS: Alcohol: Infrequent. Tobacco: None. Caffeine: Limited.
Review of Systems Noncontributory, except for the items listed earlier.

Examination
GENERAL: The patient is an alert and cooperative gentleman in no acute distress. Vital signs are as noted above and confirmed, with a repeated blood pressure again at approximately 140/68. Noted is a 5 to 8 pound weight loss over the past 6 months.
HEENT: Normocephalic. PERRLA. Normal fundi examination. Visual fields are normal. EOM intact. No ulcers or lesions of the tongue, mouth, or lips.

NECK: Reveals normal carotid upstroke without bruits. No evidence of thyromegaly.
LYMPH: No cervical, supraclavicular, axillary, or inguinal adenopathy.
CHEST: Symmetric and clear to auscultation and percussion.
CARDIAC EXAM: No jugular venous distention. Regular rate and rhythm and a normal S1 and S2 without S3, S4, rubs, or murmurs. PMI is appropriately placed. Pulses are full and symmetric.
BREASTS: Axillae are benign without adenopathy. The nipples and soft tissue structures are normal.
ABDOMEN: Modestly rotund, but soft and nontender, without masses, bruits, organomegaly, or ascites.
GENITALIA: Normal male external genitalia are noted. There are no palpable masses of the testicles and no penile lesions.
RECTAL EXAM: Reveals a smooth prostate which is symmetric and without nodules. Stool hemocculs are negative times 4. Examination of the uncircumcised male phallus shows an easily retractable foreskin that is of itself unremarkable, as is the shaft and the glans penis. I do not appreciate a rash, ulcerative lesion, condylomata, or the like.
EXTREMITIES: The upper and lower extremities demonstrate normal range of motion and strength. There is no cyanosis, clubbing, or edema. There are no joint deformities noted.
SKIN: No rash or suspicious nodules or lesions.
NEUROLOGICAL EXAM: The patient is alert and oriented times three with mental status grossly appropriate. Cranial nerves 2 through 12 are grossly normal. Muscle strength is 4+ and symmetric, and uppers are equal to lowers. Sensation is intact to light touch, pinprick, and proprioception. Deep tendon reflexes are symmetric and 2+. There is no clonus or pathologic reflexes.
Data: Laboratory data today includes a normal basic metabolic panel, urinalysis, and PSA assay. A Lipoprotein panel is pending at the time of today's dictation.
Assessment

1. Coronary artery disease, s/p off-pump coronary artery bypass grafting times 6, December 2004.
2. Hypertension, borderline control.
3. Hyperlipidemia; intolerance to high dose statin therapy and Zetia.
4. Impaired fasting glucose, currently normoglycemic.
5. History of hyperplastic and adenomatous colon polyps, status post colonoscopy in November 2005; positive family history of colon carcinoma and personal history of irritable bowel syndrome.
6. History of nocturnal myoclonus.
7. History of hepatitis.
8. Allergy to Niacin.
9. Status post remote left knee arthroscopy with medial meniscectomy and repair of left 4th digital nerve injury.

Plan: At this point, I have reviewed with Mr XXXXX the diagnoses above, as well as today's available laboratory studies. We have elected to make no changes in his medical management today, except to convert his atorvastatin to simvastatin, now at a dose of 80 mg per day for insurance coverage. Three month labs relative to that change are planned, particularly when we include the fact that his Zetia has been recently discontinued.

If patient has any concerns, return briefly at 3 months, otherwise return 6 months from now.

PRESCRIPTIONS:

Discontinue: Atorvastatin Calcium (Lipitor) 80 mg Tablet

New/Represcribed: Simvastatin 80 mg Tablet Disp: 60 Tablet(s) Refills: 1 year
Sig: 1 Tablet(s) (80 mg) by mouth daily in the evening

Renew (Modified):

Clopidogrel (Plavix) 75 mg Tablet Disp: 30 Tablet(s) Refills: 1 year
Sig: 1 Tablet(s) (75 mg) once daily

Hydrocortisone Ace-Pramoxine (Analpram-HC) Rectal 1-1 % Cream Disp: 30 gms; Refills: 1 year
Sig: Apply as directed up to four times daily as needed

Isosorbide Mononitrate 30 mg Tablet Sustained Release 24HR Disp: 90 Tablet(s) Refills: 1 year
Sig: 1 Tablet(s) (30 mg) once daily

Metoprolol Tartrate 25 mg Tablet Disp: 270 Tablet(s) Refills: 1 year
Sig: 1 Tablet(s) (25 mg) twice daily

John Smith, MD
Department of General Internal Medicine

Example 6

Vitals: TEMPERATURE: 37.1 °C (98.8 °F), BLOOD PRESSURE: 168/110 mm Hg
Allergies and Alerts: Haloperidol, Nitrofurantoin, Sulfa, Thiothixene, Metal
Medications
Acetaminophen (Tylenol Extra Strength) 500 mg Tablet, 2 Tabs q 4-6 hrs prn
Aluminum Hydroxide-Magnesium Hydroxide-Simethicone (Regular Strength Mylanta liquid) 200-200-20 mg/5 mL Suspension, 10 mls q 8 hrs prn
Amlodipine Besylate (Norvasc) 2.5 mg Tablet, 1 Tab bid
Aspirin 325 mg Tablet, 1 Tab QD
BusPIRone HCl (BuSpar) 5 mg Tablet, 1 Tab QD
Calcitonin (Salmon) (Miacalcin) Nasal 200 unit/Actuation Solution, 1 Spray QD, alternating nostrils
Calcium Carbonate-Vitamin D2 600-200 mg-unit Tablet, 1 Tab bid
Carbamazepine 200 mg Tablet, 1 Tab bid
Cyanocobalamin (Vitamin B-12) Injection 1,000 mcg/mL Solution, 1 ml once monthly
Cyclobenzaprine 10 mg Tablet, 1 Tab QD hs
Fiber Tablet, 1 Tab bid
Folic Acid 1 mg Tablet, 1 Tab QD
Gabapentin 100 mg Capsule, 1 Cap tid
Hydrocodone-Acetaminophen 5-500 mg Tablet, 1-2 Tabs qid prn
Lactulose (Generlac) 10 g/15 mL Solution, 30 Milliliter(s) PRN CONSTIPATION
Lansoprazole (Prevacid) 30 mg Tablet,Lingual Delayed Release, 1 Tab QD
Loratadine 10 mg Tablet, 1 Tab QD
Metoprolol Tartrate 25 mg Tablet, 1 Tab bid
Neomycin-Bacitracin-Polymyxin (Triple Antibiotic) Topical Ointment, Apply as directed bid prn
Nystatin (Nystop) Topical 100,000 unit/g Powder, Apply as directed bid to affected area, until clear.
Potassium Chloride 20 mEq Tab Sust.Rel. Particle/Crystal, 1 Tab QD
Rosuvastatin (Crestor) 5 mg Tablet, 1 Tab QD
Sennosides (Natural Senna Laxative) 8.6 mg Tablet, 1 Tab QD
Sertraline HCl (Zoloft) 100 mg Tablet, 1 Tab QD
Simethicone (Mylanta Gas), QD
Tolterodine Tartrate (Detrol LA) 4 mg Capsule, Sust. Release 24HR, 1 Cap QD
Trazodone HCl 50 mg Tablet, 1 Tab QD hs for insomnia
Reason for Visit: The patient is here today for follow-up of history of cerebral aneurysm, history of right CVA with left hemiparesis, hypertension, depression with anxiety, and osteoporosis. The patient is also here today for annual history and physical.
History of Present Illness
This is a follow-up on this 69-year-old white female with the above medical problems. She still resides in a group home with 1 other roommate. She has 24 hour care. She does not attend REACH or any of the working programs in the area. She generally stays home for most of the day. She states she spends a lot of her time during the day watching television up in her wheelchair. There is a concern by staff recently that patient has had a decline in mental status and decrease in function of her memory. She does not remember things that are told to her three times a day. Her appetite remains stable.
Past Medical History
SURGICAL HISTORY:
1. Intestinal resections.
2. Tubal ligation.
3. Brain surgery secondary to aneurysm and cerebrovascular accident.
4. Eye surgery on the left for an inverted eyelid x 2.

MEDICAL HISTORY:
1. Chronic shoulder pain, right.
2. Hypertension.
3. History of 2 cerebrovascular accidents with left hemiparesis.
4. Osteopenia.
5. History of seizure disorder.
6. Frequent urinary tract infections.

Family History: Mother is deceased at age 65 secondary to myocardial infarction. She had a history of cancer. Father deceased at age 75 secondary to pneumonia. Maternal aunt diagnosed with breast cancer.

Social History: The patient currently lives in a supportive home with 1 other person. She quit smoking 7 years ago, 1 pack/day before that. She denies any other drug use. She does not drink alcohol.

Review of Systems

GENERAL: Patient denies significant weight-loss, weight-gain, recurrent headaches, or night sweats.
HEENT: Patient denies change in vision or hearing acuity. Patient does complain of increasing nasal secretions and oral secretions. She would like something for that. She denies frequent upper respiratory infections.
CARDIOPULMONARY: Patient denies chest pain, shortness of breath or dyspnea on exertion.
GASTROINTESTINAL: No evidence of recurrent nausea, vomiting, diarrhea or constipation. Patient denies hematochezia or hematemesis. Patient denies history of hemorrhoids or hernias.
GENITOURINARY: Patient denies nocturia or pyuria.
NEUROMUSCULAR: The patient has left hemiparesis.
NEUROPSYCH: The patient is being followed by Psychiatry.

Examination

GENERAL: This is an alert, O x 3 female. She is sitting comfortably in a wheelchair.
HEENT: Ears: Tympanic membranes appear normal. Eyes: Sclera white. Conjunctiva pink. The patient appears to have status post cataract resection on the right. Extraocular movements are intact. Nose: Septum midline. Oral: The patient is partially edentulous with upper dentures in place. Tongue midline. Positive bilateral gag reflex.
NECK: Decreased range of motion; negative JVD, HJR. Negative thyromegaly or tracheal deviation.
BACK: Negative tenderness on palpation of the spinal column. Negative CVA tenderness.
LUNGS: Clear to auscultation and percussion without crackles, rhonchi or wheezes.
CHEST: Normal A/P diameter. Negative for mass or erythema on observation and palpation of the chest wall.
LYMPH NODES: Negative for axillary or cervical lymph nodes.
BREASTS: Symmetrical.
CARDIOVASCULAR: PMI is at the fourth intercostal space at the left mid-clavicular line; S1, S2 with normal splitting; negative S3, S4; no murmurs.
ABDOMEN: Obese. Bowel sounds are positive.
GENITOURINARY: Deferred.
RECTAL: Deferred.
SKIN: Turgor is normal. Negative cyanosis or clubbing.
EXTREMITIES: There is a brace in place over the left ankle and heel.
NEUROVASCULAR: Reflexes are 2+ bilaterally.

Data No labs are performed today.

Assessment

1. History of right CVA and cerebral aneurysm with left hemiparesis. This is unchanged.
2. Depression with anxiety, on therapy via Psychiatry.
3. Recurrent UTIs. No new symptoms at this point in time.
4. History of seizure disorder. The patient is on medication. No seizures over the course of the last year.
5. Health maintenance: The patient does need a flu vaccine today.
6. Hypertension. Fair control on current medication.
7. Osteoporosis, unchanged.

Plan:

1. The patient is to return to clinic in 2 months for follow-up.
2. Continue all other medications as prescribed.
3. Screening mammogram.
4. Flu vaccine given today.
5. The patient does not need a Pap smear because she is not sexually active and she is 69 years of age. She needs 1 every 5 years. The next one is due at age 73.

PRESCRIPTIONS:
New/Represcribed:
Guaifenesin (Mucinex) 600 mg Tablet Sustained Release Brand Name Medically Necessary Disp: 60 Tablet(s) Refills: 11 Sig: 1 Tablet(s) (600 mg) every twelve hours

J Smith MD, Department of Internal Medicine

CC:XXXXXX Home Health 9999 S. Wherever Ave.Anytown, WI

Example 7

DOB: 01/01/1941

SUBJECTIVE: This is an office visit, physical exam, and problem-oriented visit. Patient is a 66 year old who came in for routine health maintenance physical exam, but he has several active problems that he would like to have addressed as well.

1. Episode of chest pain. This past weekend, he was seen in the Emergency Room at the XXXX Medical Center. He woke up in the middle of the night with 2 episodes of severe chest pain. He describes this as a very sharp pain that occurred just left of the left breast. The episodes would come on and last just a matter of 15 seconds or so and then would subside. They were severe enough, however, that he broke into a clammy sweat. When the second episode occurred, patient and his wife summoned an ambulance. He was transported to the ER for further evaluation. They did an extensive Emergency Room evaluation, including chest x-rays, EKGs, and labs. Troponins were negative. D-dimer was negative. Chest x-ray was negative. There were no significant EKG changes that would suggest myocardial ischemia. They ultimately made a tentative diagnosis of body wall chest pain. Patient has not had a cardiac stress test in sometime. He does have risk factors of heart disease, including very minimal elevation of blood sugar noted up at XXXX. His father died of an MI at age 63. I recommended to patient that we follow-through with the stress Sestamibi. If that is negative, then I think we can relax a bit in terms of this pain.
2. Hypertension, which has been borderline. It is not completely well controlled. He is a nonsmoker.
3. Diverticulosis. He had a recent episode of diverticulitis. This was treated in the Immediate Care Center. He was put on antibiotics, and his symptoms gradually resolved over the course of antibiotic therapy. He had a flexible sigmoidoscopy in 2004, which showed diverticulosis. No other significant abnormalities.
4. Benign prostatic hypertrophy. He has had a moderately elevated PSA. Over the last year or two, the PSA levels have actually been coming down, in spite of a fairly enlarged gland. He is followed by Dr AAAA.
5. Question of osteoporosis. He had a heel density test done in a screening program. He had a formal DEXA, which showed mild osteopenia.

PAST MEDICAL HISTORY: Significant for:

1. Hypertension.
2. He had right knee surgery in 1965.
3. Appendectomy in 1970.
4. Herniorrhaphy in the mid 1970s by Dr ????
5. He had left sided knee surgery in the early 1980s.
6. Right knee surgery in 1988.
7. He has a history of having had a pulmonary embolism in 2002 and a spinal fusion in 2005.

CURRENT MEDICATIONS:

1. Norvasc 5 mg daily.
2. Triamterene/hydrochlorothiazide one daily.
3. Ecotrin 325 mg daily.
4. Prilosec 20 mg daily for GERD.
5. Uroxatral 10 mg daily.

6. Multivitamins daily.

ALLERGIES: He has no known medication allergies.
FAMILY HISTORY: Family history is significant for the death of his father at age 63 of an MI. His mother died of a heart attack in her 80s in 1984. A sister died in childbirth in 1938. One child has a history of Hodgkin lymphoma.
PERSONAL HISTORY: He is the President of a small manufacturing company. He is married and is college educated. He has 4 children in the area.
IMMUNIZATIONS: He is overdue for a Pneumovax. We will update him today.

REVIEW OF SYSTEMS: Review of systems is, otherwise, unremarkable. A complete 12-point review of systems is documented on the Internal Medicine intake form. He has diminished hearing and wears a hearing aid in the left ear, otherwise, a fairly unremarkable review of systems.

On **physical exam**, he is well developed, well nourished, and in no acute distress. Blood pressure is 156/88. Repeat is 144/84. Pulse is 60 and regular. He is 6 feet 5 inches tall and 235 pounds. Skin is warm and dry. HEENT is atraumatic, normocephalic. PERRL. Oropharynx is unremarkable. Neck is supple. Lungs are clear. Cardiac exam: Regular rate and rhythm. S1 and S2 are normal with no murmurs or gallops. Abdomen is soft and nontender. Extremities reveal no cyanosis, clubbing, or edema. External genitalia: Normal. Rectal exam reveals brown, Hemoccult negative stool. The prostate is 1 to 2+ diffusely enlarged with no discrete nodules.

IMPRESSION:

1. Probable chest wall pain. He does have some palpation tenderness to the left of the nipple on the left chest wall. The lungs are clear. He also complains of some pain between the shoulder blades. We will check a thoracic spine x-ray to make sure that there is no evidence of an osteoporotic compression fracture or any destructive lesion in the upper thoracic spine that might cause radicular pain at that level.
2. Hypertension. He should continue current therapies for now. I will not make any real adjustment in his meds at this time.
3. Chest pain. Rule out ischemic pain. I recommended that he undergo a stress Sestamibi just to round out the workup that he had at XXXX for evaluation of chest pain. Laboratory studies done at XXXX showed a normal D-dimer, PT INR, and PTT were normal. Chemistries were normal. CBC was normal. A chest x-ray was normal. Troponins were normal. CK and CK-MB were normal. Blood sugar was minimally elevated at 124 and that is something we need to keep an eye on.
4. I will see patient back in a month to follow up on the Sestamibi stress test.
5. He should notify me if any new problems arise in the interim.

Doctor, MD Internal Medicine (MEDS AND TESTS BELOW)

Medications

	Prescriptions	Disp	Refills	Start	End
Prescriptions Ordered/Recorded this Encounter	MULTIVITAMIN OR **Sig**: 1 tablet daily **Class**: Historical Med **Route**: Oral				
	RA CALCIUM PLUS VITAMIN D 600-125 MG-UNIT OR TABS **Sig**: 2 TABLETS DAILY **Class**: Historical Med **Route**: Oral				

Orders

Lab and Imaging	Order	Order #

Orders	X-RAY THORACIC SPINE 2 VW(Order#22244100) on 6/8/07 - Lab and Imaging Orders	22244100
	Order	Order #
Other Orders	CARDIOVASCULAR STRESS TEST(Order#22243799) on 6/8/07 - Other Orders	22243799
	PNEUMOCOCCAL VACCINE(Order#22244255) on 6/8/07 - Other Orders	22244255

Result Summary for X-RAY THORACIC SPINE 2 VW (Order# 22244100)

Result Information Report Date6/8/2008 Status Final result

Result History X-RAY THORACIC SPINE 2 VW (Order#22244100) on 6/8/07 - Order Result History Report

Document Text

X-RAY REPORT

Patient DOB: 1941
DOS 06/08/2008

THORACIC SPINE, AP AND LATERAL
HISTORY: Pain.

FINDINGS: There is mild curvature of the mid- and lower thoracic spine with convexity to the left. There is moderate degenerative disk disease at the mid- and lower thoracic spine with mild loss of height of the disk spaces and lateral anterior bony spurring off the vertebral bodies. The vertebrae are intact. Vertebral alignment is normal.

CONCLUSION: MILD SCOLIOSIS. MODERATE Degenerative DISEASE.

Radiologist, MD

Follow-up and Disposition

Disposition

Return in about 4 weeks (around 7/8/2008) for fu chest pain.

Example 8

PATIENT: DATE OF BIRTH: 47 Years
DATE:06/18/2008 1:31 PM DEPT/VISIT TYPE: OBGYN

Chief Complaints/ Concerns
1. ovarain cyst 47year old G3P3003 s/p C/Sectionsx3 and TAH approx 5 years ago for fibroids. Diagnosed with ovarian cysts on CT scan done last week for bladder pain and dyspareunia by Urology (Dr. XXX)
No known allergies

Obstetric History
Past Medical/Surgical History

Med System	Disease	Year	Month	Procedure
musculoskeletal	Hernated disc L5	2004		discectomy
women's health	Fibroids	1999		total abdominal hysterectomy
musculoskeletal	Herniated disc L5	1997		discectomy
women's health	Pregnancy	1983		cesarean delivery
women's health	Undesired fertility	1983		Bilateral tubal ligation
women's health	Pregnancy	1980		cesarean delivery
women's health	Pregnancy	1977		cesarean delivery
metabolic/endocrine	Hypercholesterolemia			

Family History

*	Condition	Family Mbr	Age	Comment
	Asthma	Mother		
	Hyperlipidemia	self		
	Diabetes	Father		
	Cancer -breast	Sister		
	CAD	Father		
	Alcoholism	Father		
	Alcoholism	Sister		
	Cancer -breast	Paternal grandmother		

Social History
Advance Directives in Place: No advanced directives.
General Information: Born in chicago. Occupation: bus driver. Education: High school. Employed by Laidlaw.
Marital status is married. No children.

Patient agrees to transfusion.
Tobacco: Non-smoker.
Caffeine: Consumes caffeine. Drinks approximately 5 cups per day of soda
Activity Level: Sedentary.
Review of Systems
Constitutional:
Negative for chills, pallor, fatigue, fever, weakness, malaise, night sweats, insomnia, weight gain, weight loss, activity change, lethargy, irritability.
Genitourinary:
Negative for frequency, hesitancy, urgency, hematuria, polyuria, oliguria, decreased urine stream, passage of stones, foul odor in urine, cloudy urine, nocturia, change in urine color, back pain, flank pain, incontinence, groin mass.
Positive for dysuria,
Gynecological:

Peri-menopausal, Amenorrhea. Negative for Dysmenorrhea.. Negative for Menorrhagia.,
Details: Pt had a TAH so has no periods. Contraception Method: Tubaligation

Breasts: Nipple discharge negative, Breast lumps negative, Breast pain negative. Does not perform BSE.
Family History of Breast Cancer Positive. sister at age 42

Other Findings:
INFERTILITY: Patient has NO history of infertility
SEXUAL DYSFUNCTION:history of sexual dysfunction negative
DYSPAREUNIA: History of dyspareunia.
FIBROIDS:History of fibroids.
OVARIAN CYSTS: History of ovarian cysts.
Incontinence Negative.
History of abnormal bleeding positive.
Last PAP: 02/08/2005.
vaginal itch negative,
vaginal discharge negative,
Protein Glocoses Dip: Protein Glocoses Dip 2:
oral contraceptive use,

See Chief Complaint.
Comments: Sexually active with husband.

Vital Signs

Bp Syst.	Bp Dias.	Pulse	Temp F	Hgt In.	Wt Lb	BMI Calc
144	86				167.00	

PHYSICAL EXAMINATION

General/Constitutional:
No acute distress. alert, overweight, Apatheic,
Nose / Throat:
teeth/gums characterized by caries, poor dentition, No breath odor noted.
Neck / Thyroid:
Symmetric. Trachea midline and mobile. No cervical adenopathy. No thyromegaly or thyroid nodules.
Lymphatic:
There is no palpable
anterior cervical, posterior cervical, supraclavicular, axillary adenopathy, inguinal,
Breast:
Right Breast Symmetric, no dimpling. No masses/dominant lesions. Nipple normal, no discharge.
Left Breast Symmetric, no dimpling. No masses/dominant lesions. Nipple normal, no discharge.
Vascular:
Pulses
Carotid pulses 2+ bilaterally without bruits. Femoral pulses 2+ bilaterally without bruits. Dorsalis pedis pulses 2+ bilaterally without bruits.
Varicosities absent.
Abdomen:
soft, nontender, no organomegaly, no masses, no hernias, umibilicus normal,
Inspection has detected striae, surgical scar(s) midline and lower back.
no CVA tenderness,
Genitourinary:
External Gyn Scarce pubic hair. Labia/clitoris unremarkable. Normal glands. Perineum unremarkable. No perianal abnormalities. Introitus normal in caliber
Internal Gyn Vaginal walls are Adequate estrogen, no discharge. Cervix is absent, Uterus is absent, Ovaries are mass, R, non-palpable, L. Rectovaginal confirmatory, Fecal material is no stool in rectal vault,
No CVA tenderness. No flank mass(es). No suprapubic tenderness.
Rectal:
Peri-rectal area normal to inspection and palpation. No hemorrhoids, fissures or condylomata.
Normal sphincter tone. Fecal material no stool in rectal vault
Extremities:
No edema.

No ulceration present.
No calf tenderness. Varicosities absent.
Neurological:
Alert and oriented X 3. Grossly normal intellect.
Psychiatric:
Not anxious. Not depressed.

Assessments/ Plans

Routine General Medical Exam (V7231), Routine
OVARIAN CYST NEC/NOS (6202), Chronic.

Medications new, active or stopped this encounter:

Brand Name	Dose	Sig Codes	Start Date	Stop Date	Elseware
Flomax	0.4mg	1T PO QD	05/11/2007		N
Macrobid	100mg	1CAP PO BID	05/11/2007		N
Synthroid	100mcg	1T PO QD	03/26/2007		N
Detrol La	4mg	1T PO QD AM	03/05/2007		N
Zyrtec	10mg		02/19/2007		N
Lipitor	20mg	1T PO QD	01/22/2007		N
Hyzaar	50-12.5mg	1T PO QD	01/09/2007		N
Estrace	0.01%	1CR TOP BID	01/05/2006		N
Flonase	50mcg		12/05/2005		N
Triamcinolone Acetonide	0.1%	1CR TOP Q12H	03/01/2005		N
Albuterol	90mcg		10/22/2004		N

Status	Order	Timeframe	Reason/comment
completed	Breast Cancer education		Print-out available
completed	Complete Physical - Women education		Print-out available
completed	Diagnosis Explained education		Print-out available
completed	Self breast exam education		Print-out available

Plan comments:
Pt was due for annual pelvic exam. That was completed and pt informed that she did not need a Pap as she has had a hysterectomy for non cancer reasons. Pt verbalizes understanding. Mammogram also scheduled in this week and pt advised to stay current with both. Discussed the utility of CT scan as a diagnostic tool for pelvic pathology. I advised pt to have a TVS so that it can be compared to prior studies. Pt verbalizes understanding. and will schedule that.
This patient was instructed to return for recheck scheduled in 1 Month on 07/18/2008

Example #9

Chief Complaint Patient presents with Elbow Problem, Fall

HPI Comments: The patient is a 95-year-old gentleman with a past medical history significant for congestive heart failure, MI status post CABG in 1995 and Alzheimer dementia presenting to the emergency department after sustaining a fall yesterday. He is accompanied by his family, who report that about 10 days ago, the patient had some episodes of clamminess, dizziness, and hypotension. At that time, his home health nurse thought that he might be dehydrated and instructed that the patient stop taking his hydrochlorothiazide. Some of his symptoms resolved, though the patient then fell yesterday. He does not remember the fall, and does not report any problems with chest pain, shortness of breath, dizziness, or unsteady gait. His family brings him into the emergency department for evaluation because they are concerned he might have an organic reason for his fall. The patient currently reports right elbow pain, he says that he is able to move the elbow, but that it hurts. He has no numbness or tingling distal to the injury.

Past Medical History : Diagnosis Unspecified Cardiac Dysrhythmia,

- Congestive Heart Failure, Unspecified
- Dementia of the Alzheimer Type
- Aortic Aneurysm, Abdominal
- COPD
- CAD (Coronary Artery Disease)
- Atrial Fibrillation, *transisant*
- High Cholesterol
- Chronic Kidney Disease
- Depression
- Chronic Rhinitis
- renal cancer
- S/P Nephrectomy - left
- turp
- BPH
- Inguinal Hernia
- Bowen Disease
- S/P Appendectomy
- Rotator Cuff Injury
- Empyema

No Known Allergies.

No family history on file.

Social History Marital Status, Widowed

- Tobacco Use: Quit *quit 40 years ago*
- Alcohol Use: No
- Drug Use: No
- Sexually Active: Not Currently

Review of Systems Unable to perform ROS: Dementia

Filed Vitals:

	06/23/2008 1:21 PM	06/23/2008 1:51 PM
BP:	109/55	110/59
Pulse:	62	57
Temp:	95.4 °F (35.2 °C) Source: Oral	
Resp:	24	12
Weight:		150 lb (68.04 kg)
SpO2:	96%	98%

Physical Exam

Nursing note and vitals reviewed.

Constitutional: He appears well-developed and well-nourished. He appears not diaphoretic. No distress.

Head: Normocephalic and atraumatic.
Right Ear: External ear normal.
Left Ear: External ear normal.

Mouth/Throat: No oropharyngeal exudate.

Eyes: Conjunctivae and extraocular motions are normal. Pupils are equal, round, and reactive to light. Right eye exhibits no discharge. Left eye exhibits no discharge.

Neck: Normal range of motion. Neck supple. No tracheal deviation present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal. No respiratory distress. He has no wheezes. He has rales.

Abdominal: Bowel sounds are normal. He exhibits no distension. Soft. No tenderness. He has no rebound and no guarding.
Musculoskeletal: He exhibits tenderness. He exhibits no edema.
Right shoulder: Normal.
Right elbow: He exhibits decreased range of motion. He exhibits no deformity and no laceration. Medial epicondyle tenderness noted.
Left elbow: Normal.
Right wrist: Normal.
Neurological: He is alert. No cranial nerve deficit.

Skin: Skin is warm and dry. No rash noted. He is not diaphoretic. No erythema.

Labs with values returned at the time of this note: **Results for orders placed during the hospital encounter of 06/23/2008**

CBC WITH DIFFERENTIAL

Component	Value	Range
• White Cell Count.	6.5	3.8-10.5 (K/uL)
• Red Cell Count	3.8 (*)	4.4-5.8 (M/uL)
• Hemoglobin	11.5 (*)	13.6-17.2 (g/dL)
• Hematocrit	33 (*)	40-52 (%)
• MCV	88	80-97 (fL)
• MCHC	35	32-36 (g/dL RBC)
• RDW CV	13.8	11.7-14.7 (%)
• RDW SD	43.7	36.0-46.0 (fL)
• Platelet	201	160-370 (K/uL)
• % Neuts	64	40-75 (% WBC)
• % Lymphs	27	20-45 (% WBC)
• % Monos	7	2-12 (% WBC)
• % Eos	2	0-7 (% WBC)
• %Basos	0	0-2 (% WBC)
• Neutrophils	4170	1700-7500 (/uL)
• Lymphocytes	1770	1000-3500 (/uL)
• Monocytes	440	200-900 (/uL)
• Eosinophils	130	0-500 (/uL)
• Basophils	10	0-200 (/uL)

BASIC METABOLIC PANEL

Component	Value	Range
• Sodium	138	135-144 (mmol/L)
• Potassium	4.4	3.5-4.8 (mmol/L)
• Chloride	106	97-106 (mmol/L)
• Carbon Dioxide Content	23	22-32 (mmol/L)
• Anion Gap	9	7-14 (mmol/L)
• Glucose	100 (*)	70-99 (mg/dL)
• BUN	28 (*)	7-20 (mg/dL)

• Creatinine	1.9 (*)	0.6-1.3 (mg/dL)
• e-GFR	35 (*)	60-120 (mL/min/1.73sqm)
• Calcium	9.4	8.5-10.2 (mg/dL)

TROPONIN

Component	Value	Range
• Troponin-I	0.0	0.0-0.3 (ng/mL)

The ECG show sinus rhythm with a ventricular rate of 58. The QRS complex indicates a RBBB pattern.

ST segment depression is present 1 mm ST depression is noted in leads V1, V2 and V3.

ST segment elevation is not present.

LVH is not present.

T waves are inverted in III, aVF, V1, V2 and V3 leads.

Medical Decision Making:

1400: given the patient's dementia, as well as his history of heart disease, will check for other causes of his fall, including MI, UTI, or arrhythmia. At this time, the patient is stable. X-ray of his right elbow is pending. The patient does not report any pain at this time.

1450: patient status remains unchanged.

1530: XR shows no fx.

1730: CT negative for bleed. Patient's family would like to take him home with F/U in PCP clinic. Explained fall risk, they will watch patient closely.

Diagnosis: Fall.

Question, Example #10

Patient seen for ear pain. Diagnosis- otitis. Antibiotic given. MDM comes out to moderate due to med given and new problem. I have argued that the medical necessity is not there for 99214. If a simple otitis can be charged as 99214, how does this compare to asthma exacerbation which would also be 99214? There’s quite a difference.

Question, Example #11

I have a question on physician's documentation. When the physician documents the time spent with a patient, does it have to be seperated out by; -Total time -Face to face with patient -Time spent on unit or can the physican just use one total time?

Question, Example #12

We are wondering if the following note should include an E/M level in addition to the PHE

Reason for Visit:Newborn Physical
Vitals - Last Recorded

Pulse	Temp (Src)	Resp	Wt
136	97.4 °F (36.3 °C) (Axillary)	40	7 lb 13 oz (3.544 kg)

Vitals History Recorded
Default Flowsheet Data (all recorded)
Diagnoses: Routine Child Health Exam [V20.2A] **Jaundice of Newborn** [774.6W]
Visit Notes
********** **CMA(AAMA)** Tue *** **, 2008 3:16 PM
Pt is here today with mom for newborn phe.
Progress Notes
******** **MD** Tue *** **, 2008 5:38 PM Signed
SUBJECTIVE
********* is here with her mother and cousin for 4 day old well child check.
Concerns: Slight jaundice. Milk came in yesterday.
Will be moving to milwaukee sometime soon for help with baby
Pregnancy/Delivery History:
Full term, NSVD.
No complications with pregnancy or delivery.
Passed hearing screen.
Hepatitis B given in hospital.
.
Diet: Breastfeeding see above.
Output: Only 2 voids last 2 days and 2 voids today
Regular, soft stools.
Sleep: on back and SIDS safety reviewed
Development History- has reached these milestones (the ages after the milestones indicate average ages at which the milestone is reached):
Social: fixes and follows with eyes briefly- 0-2 weeks
Language: cries as main vocalization- 0-2 weeks
Gross Motor: moves all extremities equally- 0-2 weeks
Sensory: responds to sound and bright light- 0-2 weeks
History:none
Social history: Lives with: mother, father and siblings . Pets: dog.

OBJECTIVE
EXAM: Pulse 136 | Temp (Src) 97.4 °F (36.3 °C) (Axillary) | Resp 40 | Wt 7 lb 13 oz (3.544 kg)
GENERAL: appears vigorous, no apparent distress, no dysmorphic features.
HEAD: atraumatic, normocephalic, anterior fontanelle soft and flat.
EYES: sclerae and conjuctivae clear, red reflex normal and symmetric.
EARS: tympanic membranes normal. External auditory canals, and pinnae normal bilaterally.
NOSE: patent.
MOUTH: normal teeth, palate and pharynx, moist mucous membranes.
NECK: supple, full range of motion, no significant lymphadenopathy, no masses or thyromegaly.
LUNGS: clear to auscultation, no wheezes or crackles noted.
HEART: regular rate. No murmur. Femoral pulses 2+ bilaterally.
ABDOMEN: soft, nontender, nondistended, no masses, no umbilical abnormalities.

GU: Tanner 1. Normal female genitalia. Normal vaginal introitus and vulva. Normal anus.
SKIN: no significant rashes or bruises.
M/S: spine without deformity, symmetric leg length.
NEURO: normal tone and reflexes.
ASSESSMENT
Well 4 day old female infant.
Growth and development age appropriate. Not back to birth weight will check bili today
Other Issues: bili

Lab Results	Test	Value	Date/Time
	NBILI	14.9*	6/10/08
	BC	0.0	6/10/08
	BU	14.9*	6/10/08

PLAN:
Reviewed growth chart with guardian.
Anticipatory guidance: SID safety.
Follow up at 2 weeks of age for next well child visit, sooner as needed.
See patient instructions below.
Handouts provided as needed.

Follow-up and Disposition
Return in 2 weeks (on 6/24/2008).
Level Of Service
PREVENTIVE VISIT,EST,INFANT [99391]
Orders
BILIRUBIN, NEONATAL PANEL [NBIL]
Results are available for this encounter