Identifying Data:
Name: Mr. RS
Address: Brooklyn, NY
Date of Birth: June 11, 1947
Date & Time: February 24, 2020
Location: LTC-VA - ADHC
Religion: Christian
Source of Information: Self, unreliable due to his mild cognitive impairment
Source of Referral: Self
Mode of Transport: Virgo Taxi

Chief Complaint:
Monthly Medical Evaluation

History of Present Illness:
Pt is a 72 y/o African American veteran Male with a 35-pack year smoking history who recently quit and PMH of NSTEMI, Dementia, HFrEF, HTN, HLD, and OA of Knees b/l. Pt was last seen at ADHC in 02/03/2020 c/o n/v/SOB. Noted to be tachycardic followed by a syncopal episode, code was called, 911 arrived, found to have wide complex tachycardia/ Vtach. received shock x 1 and converted to NSR. Then taken to Jamaica Hospital ER and transferred to Manhattan VA CCU on 02/05/2020. Discharged from hospital on 02/14/2020 and received a BiV ICD on 02/10/2020.

Today he presents for readmission to ADHC program for continuation of care, he currently lives with his girlfriend and her son on the 13th floor of an apartment building and ambulates with a walker. Pt is independent with most ADLs and IADLs. However his girlfriend does the shopping, cleaning, and prepares his meals. He reports having some urinary urgency, frequency, incontinence and wears slip-on underwear. He denies any N/V/D/C, chest pain, SOB, fever, chills or any acute complaints.

Past Medical History:
NSTEMI in 20202
Dementia since 2018
HfrEF
HTN
HLD
OA of Knees b/l

Past Surgical History:
BiV ICD on 02/10/2020 at NY VA, no reported complications
Colon Resection, due to shrapnel while serving in army, unknown date/location, history unclear

Allergies:
Penicillin, Adverse reaction - rashes
No known food, or environmental allergies.

Medications:
Active and Recently Expired Outpatient Medications (including Supplies):

Active Outpatient Medications	Status
1) APIXABAN (ELIQUIS) 5MG TAB,ORAL TAKE ONE TABLET BY MOUTH TWICE A DAY	ACTIVE
2) ASPIRIN 81MG TAB,ENTERIC COATED TAKE ONE TABLET BY MOUTH DAILY AS BLOOD THINNER	ACTIVE
3) ATORVASTATIN CALCIUM 20MG TAB TAKE ONE TABLET BY MOUTH AT BED-TIME DAILY FOR CHOLESTEROL (AVOID GRAPEFRUIT PRODUCTS)	ACTIVE
4) FUROSEMIDE 40MG TAB TAKE ONE TABLET BY MOUTH DAILY TO PREVENT FLUID RETENTION	ACTIVE
5) INCONT SLIP-ON UNDERWEAR LG M#PRKAP0730 USE 1 UNDERWEAR EXTERNALLY TO AFFECTED AREAS DAILY AS DIRECTED	ACTIVE
6) METOPROLOL SUCCINATE 50MG SA TAB TAKE THREE TABLETS BY MOUTH DAILY FOR HEART	ACTIVE
7) NICOTINE 14MG/24HR TRANSDERMAL PATCH APPLY ONE (1) PATCH EXTERNALLY EVERY MORNING . ROTATE SITES OF ADMINISTRATION AND DO NOT SMOKE WHILE ON PATCH.	ACTIVE
8) PILL CUTTER USE A PILL CUTTER FOR PILL-SPLIT USE AS DIRECTED	ACTIVE
9) SACUBITRIL 49MG/VALSARTAN 51MG TAB TAKE 1 TABLET BY MOUTH TWICE A DAY FOR HEART	ACTIVE
10) SPIRONOLACTONE 25MG TAB TAKE ONE-HALF TABLET BY MOUTH DAILY FOR FLUID RETENTION OR HEART	ACTIVE
11) UNDERPAD,BED ULTRASORB 24X36IN M#2436 USE 1 LARGE UNDERPAD (23INX36IN) BE PLACED ON BED DAILY AS DIRECTED	ACTIVE

11 Total Medications

Social History:
Patient is a retired veteran, with a high school education and worked as a securtiy guard for 20 years. He lives in an apartment on the 13th fl with his girlfriend and her 30 y/o son. He states he sleeps about 7 hours per night. He has a good appetite, currently on low salt and fat diet but reports eating beef, chicken, and fish for most meals with 1-2 servings of fruit and vegetables. States he walks when it is nice out for about 2 blocks a day. Pt has a 35 pack year smoking history and quit right after his recent STEMI and also quit drinking alcohol in 2010, and denies past and current drug use. No recent travel or pets at home.

Review of Systems:
General
Admits to losing about 8lbs since recent hospitalization, denies fever, chills, fatigue, loss of

appetite, generalized weakness, and night sweats.

Skin, hair, and nails
Denies: excessive dryness or sweating, discolorations, pigmentations, moles, and changes in hair distribution, pruritus, rashes, changes in texture

Head
Denies: headaches, migraines, light-headedness, vertigo, and any instances of head trauma.

Eyes
Denies: blurring, fatigue with use of eyes, halos, lacrimation, photophobia, diplopia, and pruritus. Does not recall last eye doctor appointment.

Ears
Denies: deafness, pain, discharge, tinnitus, and congestion.

Nose/Sinuses
Denies: discharge, epistaxis, and obstruction.

Mouth/Throat
Admits to use of full dentures. Denies: any issues with dentures or difficulty chewing, no missing teeth, bleeding gums, sore tongue, sore throat, mouth ulcers, and any voice changes.

Neck
Denies: localized swelling/lumps and stiffness/decreased range of motion.

Breast
Denies: lumps, nipple discharge, and pain.

Pulmonary System
Denies: dyspnea, dyspnea on exertion, cough, sputum production, wheezing, hemoptysis, cyanosis, orthopnea, and paroxysmal nocturnal dyspnea.

Cardiovascular System
Reports receiving a BiV ICD on 02/10/2020. Denies**:** chest pain, palpitations, irregular heartbeat, edema/swelling of ankles or feet, and syncope.

Gastrointestinal System
Denies: abdominal pain, changes in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, flatulence, eructations, diarrhea, constipation, changes in bowel habits, jaundice, light clay-colored stool, hemorrhoids, rectal bleeding, and blood in stool

Genitourinary System
He reports having some urinary urgency, frequency, incontinence and wears slip-on underwear. He denies dysuria, flank pain, pyuria, hematuria, nocturia, oliguria, and any history of STIs.

Nervous system
Admits to some memory loss, which he attributes to old age. Denies: seizures, headaches, loss of consciousness, numbness, ataxia, tremors, loss of strength, change in cognition, or mental status.

Musculoskeletal system
Admits to knee pain b/l. Denies: any deformities, swelling, and redness

Peripheral Vascular system
Denies: intermittent claudication, varicose veins in legs, coldness or trophic changes, peripheral edema, and color change.

Hematologic System
Denies: anemia, lymph node enlargement, easy bruising or bleeding, and any history of DVT/PE

Endocrine System
Denies: polydipsia / polyphagia, heat or cold intolerance, goiter, excessive sweating, and hirsutism

Psychiatric
Denies: feelings of depression/sadness, anxiety, obsessive / compulsive disorder, being prescribed/taking psychiatric medications

Physical Examination

Vitals:
Height: 72inches (182.88 cm)
Weight: 180.8 lbs (82 kg)
BMI: 24.5
Pulse Oximetry: 99% - room air
RR: 16 bpm - unlabored
Pulse: 64bpm - strong regular rhythm
Temperature: 98.2 F - oral
BP: 153/94 - Seated L arm
150/92 – Standing L arm

General Survey
72 y/o male ambulates with walker is alert and oriented x 3, appears well dressed, well groomed, in no acute distress, and appears his stated age of 72.

Hair, Skin, and Nails
Hair: Unremarkable distribution and quantity.
Skin: Warm and dry, good tugor, Nonicteric, no lesions, erythema, swelling, bruises, or masses. Has a midline abdominal scar from previous surgery. BiV ICD visualized and palpated below left clavicle.
Nails: No clubbing, unremarkable shape and texture; capillary refill < 2 seconds
Head: Normocephalic, atraumatic, nontender-to-palpation throughout

Eyes:
Eyes: sclera is white; conjunctiva & cornea clear. No discharge, PERRL. IEOM B/L. Visual fields full OU. Fundoscopy – Red reflex intact OU. Cup: Disk ≤ 0.5 OU and no evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.

Ear, Nose, Throat, Sinuses:
Ears**:** Symmetrical and normal size. Mild cerumen AU. No evidence of lesions/masses / trauma on external ears. No discharge noted. Auditory acuity intact to whisper AU.

Nose - Symmetrical; No obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally. Nasal mucosa, septum, and turbinates unremarkable.

Sinuses – Non-tender to palpation over bilateral frontal, ethmoid and maxillary sinuses.

Lips - Pink, moist; no evidence of cyanosis or lesions.
Mucosa - Pink ; well hydrated. No masses; lesions noted.
Palate – Pink; well hydrated. Palate with no lesions; masses; scars.
Teeth – Has full upper and lower dentures.
Gingivae – Pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge.
Tongue – Pink; well papillated; no masses, lesions or deviation noted.
Oropharynx - Well hydrated; no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions

Neck:
Neck - Trachea midline. No masses; lesions; scars; pulsations noted. Supple; non-tender to palpation. FROM; no stridor noted. 2+ Carotid pulses, no thrills; bruits noted bilaterally, no palpable adenopathy noted.

Thyroid - Non-tender; no palpable masses; no thyromegaly; no bruits noted.

Thorax and Lungs
Chest - Symmetrical, no deformities, no evidence trauma. Respirations unlabored; no paradoxic respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation. BiV ICD visualized and palpated below left clavicle, no redness, or signs of infection.

Lungs - Clear to auscultation and percussion bilaterally. Chest expansion symmetrical. No adventitious sounds.

Cardiac:
Heart: RRR, S1 and S2 are normal. No JVD, murmur, rubs, gallop, bruits, or thrills noted**.** Carotid pulses are 2+ bilaterally without bruits.

Breasts:
Symmetric, no skin changes or lesions, no dimpling or palpable lumps.

Abdomen:
BS present in all 4 quadrants. Midline scar noted from previous surgery. No evidence of striae, caput medusae or abnormal pulsations. Soft, non-tender and non-distended abdomen**.** Tympanic to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly, hernias, or masses noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally.

Genital:
Genital and rectal deffered

Peripheral Vascular:
The extremities are normal in color, size and temperature. Pulses are 2+ bilaterally in upper and lower extremities. No bruits noted. No clubbing, cyanosis or edema noted bilaterally and No stasis changes or ulcerations noted.

	Brachial	Ulnar	Radial	Femoral	Popliteal	D.P.	P.T.
R	2+	2+	2+	2+	2+	2+	2+
L	2+	2+	2+	2+	2+	2+	2+

Neurological:
Mental Status
Orientation: Alert and Oriented to person, place, and time.
Appearance: Appears as stated age, well groomed, good eye contact
Behavior/Attitude: Calm and cooperative
Rapport: Candid and easy to establish.
Speech and Language: Soft volume, No dysarthria, dysphonia or aphasia noted. Receptive and expressive abilities intact.
Mood: Happy and willing to talk
Affect: Congruent with mood, no masked facies
Thought Processes/Associations: Logical, but would periodically be inattentive
Thought Content: Non-delusional, appropriate
Suicidal/Homicidal Ideation: No suicidal or homicidal ideation
Concentration: Follows commands and able to spell WORLD forward
Abstraction: Poor, unable to interpret proverbs, but able to find similarty between words
Serial Sevens: Poor, Unable to complete
Memory: Able to remember last meal, but unable to recall objects after 5 mins

MMSE: MOCA (19/30), last MOCA (15/30) on 09/09/19..
Insight: Good, aware of recent hospitalization and his current condition
Judgment: Good; Understood the need to leave for safety when prompted with fire in a movie theater, also to quit smoking to better his health.

Cranial Nerves
I - *Did not assess olfactory nerve.*
II- Visual fields by confrontation full. Fundoscopic exam: Red reflex intact OU. No evidence of A-V nicking, papilledema, hemorrhage, exudate, cotton wool spots, or neovascularization OU.
III-IV-VI- PERRL, EOMs intact without nystagmus.
V- Facial sensation intact.
VII- Facial movements intact.
VIII- Auditory acuity intact bilaterally to whispered voice.
IX-X-XII- Swallowing intact. Tongue movement intact. uvula midline, soft palate and pharynx rise symmetrically
XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles 5/5 b/l.
XII. No tongue atrophy, deviation upon protrusion or fasciculation noted.

Motor/Cerebellar
No soft tissue swelling, erythema, ecchymosis, atrophy, fasciculations, abnormal movements or deformities in bilateral upper and lower extremities. Upper and lower extremities are non-tender to palpation and normal muscle bulk, countour, and tone. FROM of upper and lower extremities bilaterally, and 2+ symetric reflexs. No tenderness to palpation of the lumbar spine. No evidence of spinal deformities. Rapid alternating movements and point-to-point movements intact b/l, no asterixis, gait normal, Romberg and pronator drift negative.

Sensory
Intact to light touch, point localization, and extinction testing in upper and lower extremities bilaterally. Proprioception, stereognosis, graphesthesia intact.

Geriatric Functional Assessments:

Orthostatic BP:
Sitting: 153/94
On standing: 150/92
Orthostatic Hypotension:
Absent

Hearing impairment:
Does a hearing problem cause you to feel embarrassed?
No
Does a hearing problem cause you to feel frustrated when talking to family members?
No
Do you have difficulty hearing when someone speaks in a whisper?
No

Do you feel handicapped by a hearing problem?
No
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
No
Does a hearing problem cause you to attend religious services less often than you would like?
No
Does a hearing problem cause you to have arguments with family members?
No
Does a hearing problem cause you difficulty when listening to TV or radio?
No
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
No
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
No
HHIE-S Total Score: 0
0-8: No hearing handicap

Self-rated Health:
Good

Frailty: Fried Phenotype frailty score:
1. Weight loss > 10lbs in last year
No - 0
2. Exhaustion: How often in the past week did you feel like everything you did was an effort or you could not get going? Positive if the answer is 'often'
No - 0
3. Low physical activity (<383kcal/Wk., women <270kcal/Wk.)
Yes - 1
4. Slowness (Gait speed)
Yes - 1
5. Weakness (grip strength)
No - 0
Total Frailty Score: 2
0-2: pre-frail

Depression PHQ 2 and if positive PHQ 9:
Over the past 2 weeks, how often have you been bothered by the following problems?
1-not at all
1-not at all

Depression screen:
0-2 Negative

Generalized anxiety disorder (GAD-2):
Over the last 2 weeks, how often has the Veteran been bothered by any of the following symptoms:
1. Feeling nervous, anxious or on edge
0 - not at all (0-1days)
2. Not being able to stop or control worrying
0 - not at all (0-1days)
Total score: 0/6 (>3 needs further evaluation)

Montreal Cognitive Assessment (MOCA):
Visuospatial
Trail making: 0
Copy Cube: 0
Clock: 2
Naming
Lion, Rhino, Camel: 2
Attention
Digit forward [21854]: 1
Digit backward [742]: 1
Tap hand for letter 'A'-FBACMNAAJKLBAFAKDEAAAJAMOFAAB: 1
Serial 7 subtraction starting at 100: 1pt for 1 correct
Language
I only know that John is the on eto help today: 1
The cat always hid under the couch when the dogs were in the room: 1
Name words starting with letter 'F' in one minute (N=>11): 0
Abstration
Similarity between train and bicycle: 1
Similarity between watch and ruler: 0
Delayed Recall
Face, Velvet, Church, Daisy, Red: 2
With cues [0-5]: 4 (Do not included in total)
Orientation
Date, Month, year, day, place, City: 5
Add '1' point if 12yrs or less of education: 1
19 Total Score (As Discussed)
18-25 [MILD COGNITIVE IMPAIRMENT]

DEMENTIA SEVERITY RATING SCALE (DSRS)- Dr. Christopher M Clark, Alzheimer's Disease Core Center
MEMORY
2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.
Speech and Language

1 Sometimes cannot find word, but able to carry on conversations
Recognition of Family members
0 Normal-Recognizes people and generally knows who they are
Orientation and Time
0 Normal awareness of time of day and day of week.
Orientation to Place
0 Normal awareness of where they are even in new places
Ability to make decisions
1 Only some difficulty making decisions that arise in day-day life
Social and Community activity
1 Only mild problems that are not really important, but clearly acts differently from previous years
Home activities and Responsibilities
1 Some problems with home activities. May have more trouble with paying bills, fixing things. Can stil go to store, cook, clean,watches TV,reads news paper with interest & understanding.
Personal Care-Cleanliness
0 Normal. Takes care of self as well as they used to.
Eating
0 Normal, does not need help in eating food that is served to them.
Control or Urination and Bowels
1 Rarely fails to control urination (generally less than one accident per month).
Ability to get from place to place
0 Normal, able to get around on their own. (May have physical problems that require a cane/walker)
TOTAL SCORE: 7
0-18 Mild Dementia
19-36 Moderate Dementia
37-54 Severe Dementia

Mobility: Fall Risk Assessment
a. In the last 12 months did you fall to the ground?
Yes
b. How many times:
1
c. Describe the nature of the Injury:
Hospitalized
d. Circumstances of fall (Describe): Vtach/syncope
e. Do you feel unsteady when standing or walking?
No
f. Are you afraid of or worry about falling?
No
g. Walking aids used by patient:
Walker

Get up and Go
Maximum use of arms
3. Gait speed: (meters/sec)
Time to complete 5 meters:
<0.4 Household walker

Urinary Symptoms:
wears diapers

A/P: Pt is a 72 y/o African American veteran Male with a 35-pack year smoking history who recently quit and PMH of NSTEMI, Dementia, HFrEF, HTN, HLD, and OA of Knees b/l. Pt was recently discharged from Hospital on 02/14/2020 and had a BiV ICD. Today he presents for readmission to ADHC program for continuation of care.

1. S/P NSTEMI, doing well, with no acute complaints

-Monitor BiV ICD
-f/u with cardiology and pacemaker clinic
-avoid extreme arm motion and heavy lifting x 6 weeks.
-f/u with PCP apt on 03/2/2020

2. HTN - BP 153/94 on 02/24/2020, not well controlled

-f/u with PCP appt on 03/02/2020
-c/w Metoprolol XL 150mg daily
-will continue to monitor BP
-recommended low salt diet

3. HFrEF - Stable

- c/w FUROSEMIDE 40MG TAB PO daily
- c/w SACUBITRIL 49MG/VALSARTAN 51MG TAB
- c/w ASA 81mg daily
- c/w Apixaban 5mg BID today
- c/w Atorvastatin 40mg daily
- c/w Spironolactone at 12.5mg
- f/u with cardiology and PCP

4. HLD – Stable, LDL – 102 mg/dL, total cholesterol -179 mg/dL

-c/w atorvastatin 20 mg PO
-Monitor Cholesterol and Lipids

5. OA of Knee b/l, reports intermittent pain

-Order X-Ray of knees b/l
-evaluate for Physical and Occupational therapy

6. Dementia, stable

-Evaluate for possible Neuropsychologist consult for further evaluation

7. Smoking Cessation, reports not smoking and not using Nicotine patches
-states he Quit after recent hospitalization
-prescribed NICOTINE 14MG/24HR TRANSDERMAL PATCH, however may not be nicotine dependent, evaluate for Nicotine gum prn