History

Identifying Data:
Full Name: JAVR
Address: Jamaica, NY
Date & Time: August 31, 2020 at 10:15 AM
Location: Amazing Medical Services PC
Religion: Christian
Source of Information: Self and son, Reliability Good
Source of Referral: Self

IF TRANSLATED DOCUMENT HERE...
SHOULD NOT BE FAMILY TRANSLATING

Chief Complaint: "Diabetes follow-up"

History of Present Illness:
48 year old male recently diagnosed with type 2 diabetes. ~~He comes to the office with his son, who assists with interpretation for a one week diabetes follow up~~. He had presented to the office last week, for the first time to establish care and he reported the last time he saw a doctor was about 2 years ago. During his last visit he had complained of unintentional weight loss of almost 20 pounds over the past year. He stated his diet has not changed, he's not taking any medications and denies any active exercising. Last weeks in office finger stick glucose was 486, for which he was diagnosed with diabetes, and started on Metformin 500 mg and Glyburide 2.5 mg, and prescribed a glucometer to measure daily sugar. Patient reports that he did not start his medications because he was unable to pick up his medications. He also brings in his glucometer for instruction on its use. He denies any fever, night sweats, HA, CP, SOB, abdominal pain, N/V/D, cough, hemoptysis, muscle loss, or urinary symptoms.

Depression Screening:
PHQ-2 (2015 Edition) Little interest or pleasure in doing things? Not at all, Feeling down, depressed, or hopeless? Not at all, Total Score 0. ?

Past Medical History:
None
Childhood illnesses – Denies
Immunizations – Up to date; flu vaccine yearly.
Screening tests and results: Denies PPD recently

Past Surgical History:
Denies any past Surgical History

Medications:
Metformin 500 mg PO bid, Not started taking
Glyburide 2.5 mg PO daily, Not stated taking
Atorvastatin 40 mg PO daily, Not stated taking
Denies past/ present herbal or vitamin use.

Allergies:
Denies any known drug, environmental or food allergies.

Family History:
Father – Deceased at age 60, diagnosed with Unspecified nonpsychotic mental disorder following organic brain damage
Mother – Alive, has history of DM and HTN.
Brother – alive, healthy
Spouse – alive, healthy
Sons – 3, alive and healthy

Social History:
Mr. JAVR is an El Salvadorian, married male, who lives with his wife and three sons. He works in a restaurant as a line chef.
Habits –He has a cup of coffee daily. He denies smoking cigarettes, past or present and denies any past/present alcohol or illicit drug use.

Tobacco Use:

Smoking Are you a: Never smoker, Additional Findings: Tobacco Non-User, Non-smoker for personal reasons.

Drug/Alcohol

DAST-10 DAST 10 Screening 08/31/2020.
Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.

Travel – Denies any recent travel or COVID contacts.
Diet - He states he eats a lot of rice, bread, beans, and meat.
Exercise - He denies any formal exercise, and sleeps about 7 hours each night.
Safety measures - Admits to wearing a seat belt while driving and has smoke detectors at home.
Sexual Hx – Heterosexual who has sex with his wife only and denies history of sexually transmitted infections.

Review of Systems:
General – Denies any weakness, or fatigue.

Skin, hair, nails – Denies dry skin, changes in texture, oiliness, or sweating, discolorations, pigmentations, moles/rashes, pruritus, lesions, easy bruising, or changes in hair distribution.

Head – Denies headache, vertigo, head trauma, loss of consciousness, coma, and fainting.

Eyes – Denies any blurry vision, diplopia, scotoma, halos, infection, pain, discharge, injury, lacrimation, photophobia, or pruritus. Denies use of glasses/contacts and last eye exam 2017.

Ears – Denies any deafness, decrease hearing, pain, discharge, tinnitus, infection, and use of hearing aids.

Nose/sinuses – Denies any discharge, epistaxis, obstruction, unusual odors, sinus infections, pain, injury, frequent sneezing, or loss of smell.

Mouth/throat –Denies bleeding gums, sore throat, excessive salivation or dryness, discharge, lesions, change in taste or texture, sore tongue, mouth ulcers, dysphagia, voice changes, loss of/trouble speaking or use of dentures. Last dental exam about 2018, unremarkable.

Neck – Denies localized swelling/lumps, goiter and stiffness/decreased range of motion. or pain..

Chest – Denies any lumps, tenderness, masses, deformity, changes in nipple or skin, or pain..

Pulmonary system – Denies dyspnea, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Cardiovascular system – Denies palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur.

Gastrointestinal system – He has good appetite and ~~regular~~ FORMED BROWN bowel movements daily. Denies intolerance to specific foods, heartburn/reflux, nausea, vomiting, hemoptysis, pyrosis, unusual flatulence or eructation's, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system – Denies urinary frequency or urgency, nocturia, oliguria, polyuria, dysuria, incontinence, kidney stones, or lumbar/flank pain. no hernias, no discharge or sores on penis.

Nervous system – Denies any loss of sensation/numbness/tingling in extremities, seizures, sensory disturbances, ataxia, loss of strength, tremors, involuntary movements, change in cognition / mental status / memory/insight/judgment.

Musculoskeletal system – Denies joint pain, muscle weakness, any deformities, swelling, and redness of joints.

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

Hematological system – Denies anemia, lymph node enlargement, easy bruising or bleeding, and any history of DVT/PE.

Endocrine system – Denies tremors, polydipsia, polyphagia, polyuria, heat or cold intolerance, excessive sweating, or goiter.

Psychiatric – Denies insomnia, excessive sleep or sleep disturbances, disorientation, mood extremes, hallucinations, delusions, depression/sadness, anxiety, OCD, being prescribed/taking psychiatric medications or seeing a mental health professional.

Physical

Vital Signs:
Height: 5 ft 0 in
Weight: 124 lbs
BMI: 24.21
Pulse Oximetry: 98% - room air
RR: 16 bpm - unlabored
Pulse: 86bpm - strong regular rhythm
Temperature: 98.1 F - oral
BP: 109/68 - seated L arm
Pain Scale: 0

General: 48 year old El Salvadorian male, slim, neatly groomed, appropriately-dressed, good hygiene, seated in no apparent distress. Alert and cooperative, looks younger than his stated age of 48.

Skin: warm & moist, good turgor. Nonicteric, no lesions noted, no scars, tattoos, erythema, swelling, bruises, or masses.
Hair: average quantity and distribution.
Nails: no clubbing noted, capillary refill <2 seconds throughout.
Head: normocephalic, atraumatic, non tender to palpation throughout

Eyes: symmetrical OU; no evidence of strabismus, exophthalmos or ptosis; sclera white; conjunctiva pink & cornea clear.
Visual acuity (Uncorrected - 20/30 OS, 20/20 OD, 20/20 OU).
Visual fields full OU. PERRLA, EOMs full with no nystagmus.
Fundoscopy – Red Reflex intact OU, Cup: Disk <= 0.5 OU, no evidence of copper wiring, A-V nicking, cotton wool spots, papilledema, hemorrhage, exudate, or neovascularization.

Ears: Symmetrical and unremarkable size. No evidence of lesions/masses/trauma on external ear. No discharge/foreign bodies/cerumen in external auditory canals AU. TM's pearly white/ intact with light reflex in normal position AU. Auditory acuity intact to whisper test AU.

Nose: Nose symmetrical, no obvious masses, lesions, deformities, trauma, discharge. Nares patent bilaterally, nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. Septum midline without lesions, deformities, injection, or perforation. No evidence of foreign bodies.

Sinuses: Non tender to palpation over bilateral frontal and maxillary sinuses.

Mouth: Lips were pink, moist; no evidence of cyanosis or lesions. Mucosa - Pink ; well hydrated. No masses; lesions noted. No evidence of leukoplakia or candidiasis. Teeth – Good

dentition / no obvious dental caries noted, unable to recall last dental visit. Gingivae – pink; moist. No evidence of hyperplasia; masses; lesions; erythema or discharge. Tongue – Pink; well papillated; no masses, lesions or deviation noted. Oropharynx - no evidence of injection; exudate; masses; lesions; foreign bodies. Tonsils present with no evidence of injection or exudate. Uvula pink, no edema, lesions, or deviation. ✓

<u>Neck:</u> Trachea midline. No masses, lesions, scars, pulsations noted. Supple, non-tender to palpation. FROM, no stridor noted. No thrills, bruits noted bilaterally, no palpable adenopathy noted. ✓

<u>Thyroid:</u> Non-tender, no palpable masses, no thyromegaly, no bruits noted. ✓

<u>Chest</u>: Symmetrical, no deformities, no evidence trauma. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. Lat to AP diameter 2:1. Non-tender to palpation. ✓

<u>Lungs:</u> Clear to auscultation bilaterally. Chest expansion and diaphragmatic excursion symmetrical. Tactile fremitus ~~intact~~ SYMMETRIC throughout. No adventitious sounds. ✓

<u>Heart:</u> Regular rate and rhythm (RRR); S1 and S2 are normal. There are no JVD, no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds. Carotid pulses are 2+ bilaterally without bruits. ✓

<u>Breasts:</u> symmetric, no lumps/masses, or lesions. ✓

<u>Abdomen:</u> Flat / symmetrical / no evidence of scars, striae, caput medusae or abnormal pulsations. BS present in all 4 quadrants. No bruits noted over aortic/renal/iliac/femoral arteries. Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly. No masses or hernias noted. No evidence of guarding or rebound tenderness. No CVAT noted bilaterally. ✓

<u>Male Genital:</u> Genital and rectal deffered ✓

<u>Anus, Rectum, and Prostate:</u> Exam deferred ✓

<u>Musculoskeletal System – Upper/Lower Extremity:</u>
No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of all upper and lower extremities bilaterally. No evidence of spinal deformities. ✓

<u>Peripheral Vascular:</u> D/P AND RADIAL PULSES +2 B/L
The extremities are normal in color, size and temperature. ~~Pulses are 2+ bilaterally in upper/lower extremities~~. No bruits noted. No clubbing, cyanosis or edema noted bilaterally. No stasis changes or ulcerations noted. ✓

Neurological: Alert and Oriented: To person, place and time. Mood/Affect Normal. Sensory: normal sensation. Motor: normal strength b/l. Normal Gait. CN II – XII ~~intact~~. GROSSLY INTACT

Motor/Cerebellar:
Full passive ROM of all extremities. Normal muscle bulk and tone. No pill-rolling movements noted. No atrophy or fasciculations. Normal strength noted on upper and lower extremity (5/5). No Pronator Drift. Coordination by Rapidly Alternating Movement and point to point intact bilaterally, Romberg and pronator drift negative.

Sensory: Intact to light touch, point localization, and extinction testing bilaterally.

LAB WORK:

Lab: LIPID PANEL, STANDARD (7600) Abnormal

	Value		Reference Range
TRIGLYCERIDES	**405**	**H**	**<150 - mg/dL**
CHOLESTEROL, TOTAL	169		<200 - mg/dL
HDL CHOLESTEROL	**37**	**L**	**> OR = 40 - mg/dL**
LDL-CHOLESTEROL	SEE COMMENT		- mg/dL (calc)
CHOL/HDLC RATIO	4.6		<5.0 - (calc)
NON HDL CHOLESTEROL	**132**	**H**	**<130 - mg/dL (calc)**

Lab: COMPREHENSIVE METABOLIC PANEL (10231) Abnormal

	Value		Reference Range
GLUCOSE	**527**	**HH**	**65-99 - mg/dL**
UREA NITROGEN (BUN)	13		7-25 - mg/dL
CREATININE	0.67		0.60-1.35 - mg/dL

Test	Result	Flag	Reference Range
eGFR NON-AFR. AMERICAN	114		> OR = 60 - mL/min/1.73m2
eGFR AFRICAN AMERICAN	132		> OR = 60 - mL/min/1.73m2
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 - (calc)
SODIUM	135		135-146 - mmol/L
POTASSIUM	4.2		3.5-5.3 - mmol/L
CHLORIDE	100		98-110 - mmol/L
CARBON DIOXIDE	22		20-32 - mmol/L
CALCIUM	9.4		8.6-10.3 - mg/dL
PROTEIN, TOTAL	6.6		6.1-8.1 - g/dL
ALBUMIN	4.3		3.6-5.1 - g/dL
GLOBULIN	2.3		1.9-3.7 - g/dL (calc)
ALBUMIN/GLOBULIN RATIO	1.9		1.0-2.5 - (calc)
BILIRUBIN, TOTAL	0.6		0.2-1.2 - mg/dL
ALKALINE PHOSPHATASE	**198**	**H**	**36-130 - U/L**
AST	21		10-40 - U/L
ALT	22		9-46 - U/L

Lab: CBC (INCLUDES DIFF/PLT) (6399) Abnormal

	Value		Reference Range
WHITE BLOOD CELL COUNT	7.4		3.8-10.8 - Thousand/uL
RED BLOOD CELL COUNT	4.68		4.20-5.80 - Million/uL
HEMOGLOBIN	15.1		13.2-17.1 - g/dL
HEMATOCRIT	46.9		38.5-50.0 - %
MCV	**100.2**	**H**	**80.0-100.0 - fL**
MCH	32.3		27.0-33.0 - pg
MCHC	32.2		32.0-36.0 - g/dL
RDW	12.9		11.0-15.0 - %
PLATELET COUNT	178		140-400 - Thousand/uL
NEUTROPHILS	53.9		38-80 - %
ABSOLUTE NEUTROPHILS	3989		1500-7800 - cells/uL
LYMPHOCYTES	38.7		15-49 - %
ABSOLUTE LYMPHOCYTES	2864		850-3900 - cells/uL
MONOCYTES	6.5		0-13 - %
ABSOLUTE MONOCYTES	481		200-950 - cells/uL
EOSINOPHILS	0.8		0-8 - %
ABSOLUTE EOSINOPHILS	59		15-500 - cells/uL

BASOPHILS	0.1	0-2 - %
ABSOLUTE BASOPHILS	7	0-200 - cells/uL
MPV	10.8	7.5-12.5 - fL

Lab: URINALYSIS, COMPLETE (5463) Abnormal

	Value		Reference Range
COLOR	YELLOW		YELLOW -
APPEARANCE	CLEAR		CLEAR -
BILIRUBIN	NEGATIVE		NEGATIVE -
KETONES	NEGATIVE		NEGATIVE -
SPECIFIC GRAVITY	**1.040**	**H**	**1.001-1.035 -**
OCCULT BLOOD	NEGATIVE		NEGATIVE -
PH	7.5		5.0-8.0 -
PROTEIN	NEGATIVE		NEGATIVE -
NITRITE	NEGATIVE		NEGATIVE -
LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE -
WBC	0-5		< OR = 5 - /HPF
RBC	NONE SEEN		< OR = 2 - /HPF
SQUAMOUS EPITHELIAL CELLS	NONE SEEN		< OR = 5 - /HPF

TRANSITIONAL EPITHELIAL		
RENAL EPITHELIAL CELLS		
AMORPHOUS SEDIMENT		
YEAST		
BACTERIA	**FEW**	**A NONE SEEN - /HPF**
COMMENTS		
CRYSTALS		
CALCIUM OXALATE CRYSTALS		
TRIPLE PHOSPHATE CRYSTALS		
URIC ACID CRYSTALS		
HYALINE CAST	NONE SEEN	NONE SEEN - /LPF
GRANULAR CAST		
CASTS		
NOTE		
GLUCOSE	**3+**	**A NEGATIVE -**

Lab: HEPATITIS C AB W/REFL TO HCV RNA, QN, PCR (8472) Negative

	Value	Reference Range
HEPATITIS C ANTIBODY	NON-REACTIVE	NON-REACTIVE -
SIGNAL TO CUT-OFF	0.01	<1.00 -

Lab: HIV 1/2 ANTIGEN/ANTIBODY,FOURTH GENERATION W/RFL (91431) Negative

	Value	Reference Range
HIV AG/AB, 4TH GEN	NON-REACTIVE	NON-REACTIVE -

Lab: QUANTIFERON(R)-TB GOLD PLUS, 1 TUBE (36970) **REACTIVE**

Lab: PSA (FREE AND TOTAL) (31348) Normal

	Value	Reference Range
PSA, FREE	0.2	- ng/mL
PSA, TOTAL	0.4	< OR = 4.0 - ng/mL
PSA, % FREE	50	>25 - % (calc)

Lab: ALBUMIN, RANDOM URINE W/CREATININE (6517) Negative

	Value		Reference Range
CREATININE, RANDOM URINE	**19**	**L**	**20-320 - mg/dL**
ALBUMIN, URINE	<0.2		See Note: - mg/dL
ALBUMIN/CREATININE RATIO, RANDOM URINE	NOTE		<30 - mcg/mg creat

Lab: COMPREHENSIVE METABOLIC PANEL (10231) Abnormal

	Value	Reference Range

GLUCOSE	**527**	**HH**	**65-99 - mg/dL**
UREA NITROGEN (BUN)	13		7-25 - mg/dL
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eGFR NON-AFR. AMERICAN	114		> OR = 60 - mL/min/1.73m2
eGFR AFRICAN AMERICAN	132		> OR = 60 - mL/min/1.73m2
BUN/CREATININE RATIO	NOT APPLICABLE		6-22 - (calc)
SODIUM	135		135-146 - mmol/L
POTASSIUM	4.2		3.5-5.3 - mmol/L
CHLORIDE	100		98-110 - mmol/L
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CALCIUM	9.4		8.6-10.3 - mg/dL
PROTEIN, TOTAL	6.6		6.1-8.1 - g/dL
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ALBUMIN/GLOBULIN RATIO	1.9		1.0-2.5 - (calc)
BILIRUBIN, TOTAL	0.6		0.2-1.2 - mg/dL

ALKALINE PHOSPHATASE	**198**	**H**	**36-130 - U/L**
AST	21		10-40 - U/L
ALT	22		9-46 - U/L

Lab: HEMOGLOBIN A1c (496) High

	Value		Reference Range
HEMOGLOBIN A1c	**>14.0**	**H**	**<5.7 - % of total Hgb**

Lab: TSH (899) Normal

	Value	Reference Range
TSH	2.72	0.40-4.50 - mIU/L

<u>Assessment</u>:
48 year old male recently diagnosed with type 2 diabetes. He comes to the office with his son, who assists with interpretation for a one week diabetes follow up. His last week in office finger stick glucose was 486, for which he was diagnosed with diabetes, and started on Metformin 500 mg and Glyburide 2.5 mg, and prescribed a glucometer to measure daily sugar. Patient reports that he did not start his medications because he was unable to pick up his medications. He also brings in his glucometer for instruction on its use.

Type 2 diabetes mellitus without complications - E11.9
Mixed hyperlipidemia – E78.2
Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis - R76.12
Abnormal results of liver function studies - R94.5
Abnormal finding of blood chemistry, unspecified – R79.9
Dietary counseling and surveillance - Z71.3
Exercise counseling - Z71.82

<u>Plan</u>:

<u>Type 2 diabetes mellitus without complications</u>
-Procedure –_Finger stick Glucose – 361, high
-Uncontrolled, Last A1c - >14.0.
-To start Metformin 500 mg BID and Glyburide 2.5 mg daily.

-Compliance issues reviewed, Educated patient on importance of adherence and need to avoid concentrated sugars.

-Educated on use of glucometer and target ranges as well as tracking glucose levels. Patient will bring log to office on next visit.
-Diet and exercise reviewed with patient and information sent to MyPortal.
-Follow up in one month, to review home blood sugar and medication compliance and side effects.

Mixed hyperlipidemia
-Start Atorvastatin 40 mg daily. ✓
-diet & exercise reviewed

Nonspecific reaction to cell mediated immunity measurement of gamma interferon antigen response without active tuberculosis
-Requires further evaluation, patient educated ✓
-Referred for Chest X-Ray

Abnormal results of liver function studies
-Reviewed results with patient and verbalized need for further testing ✓
-Referred for US of Abdomen

WOULD PROBABLY WAIT UNTIL THIS IS WORKED UP BEFORE STARTING STATIN

Abnormal finding of blood chemistry, unspecified
-Reviewed results with patient
-Lab: Vitamin B12 and Folate ✓

Dietary counseling and surveillance
-Notes: diet & exercise reviewed with patient. ✓

Exercise counseling
-Notes: exercise - graduated plan reviewed, increase as tolerated.

Preventive Medicine:

Counseling: Depression Intervention Depression Screening Findings Negative. Social: diet: Discussed the importance of eating a nutritious healthy food on a regular basis, exercise: Discussed the benefits of at least a few hours each week of moderate aerobic exercise, Discussed the benefits of any exercise for overall health and well-being.

Goals: Education provided: daily exercise, increase vegetables intake. Literature provided: daily exercise. ✓

Care Plan: ACP Diabetic Care Plan Why Does Diabetes Occur? Diabetes is not a disease to be taken lightly. It can be life threatening if uncontrolled. Unfortunately, as a person ages, insulin resistance can increase while the pancreatic islet cell function decreases. This can put an older person at a greater risk for Type 2 diabetes. When the body is unable to control its insulin levels, diabetes occurs. Type 2 diabetes: occurs when a person's body pushes blood glucose or sugar to above normal levels. When this happens, the pancreas compensates by making additional insulin

to offset the higher glucose level. This works for a while, but a point comes when the pancreas can no longer make enough insulin to keep blood glucose levels at normal. This is when a doctor may prescribe medications and insulin. A. Prevention & Care Plan Type 2 diabetes can be prevented. There are many factors that contribute to preventing the onset of diabetes. To help keep the disease at bay: Monitor your blood sugar, Blood pressure, and Cholesterol levels Adopting a healthy diet, Staying active and maintaining healthy weight for your age and height may also help stave off a diabetes diagnosis. Many of the factors that can help prevent diabetes are also instrumental in managing diabetes if you do have it. Starting to adopt healthier practices sooner rather than later may help prevent development of the disease to begin with.