CARDIOLOGY ASSOCIATES OF TEXAS

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Patient Name: William Green
Patient DOB: 11-30-1950
Patient Sex: Male
Date of Service:03-04-2016

Chief Complaints/HPI

Patient presents with chest pain. Patient first began experiencing symptoms approximately 3 day(s) ago. It is located in the left chest. This usually ocurrs after walking up the steps. It is radiating to the left shoulder. It is described as burning. Patient rates the pain as a 7/10 (10 point scale). Aggravating factors include exercise, running and work. Alleviating factors include medication, nitrates and oxygen. Associated symptoms include dyspnea on exersion, fatigue and shortness of breath. Besides that Mr. Green comes to the office today for a routine followup evaluation for Angina. His blood pressure has not been well controlled by Benicar 20 mg and has caused his feet to be edematous and perhaps ankles, and he complains of pain in his feet especially at night and towards the evening hours. He seems to be waking up at night with leg pain as well. Other than that, he is doing quite well.

HISTORY

MEDICAL HISTORY: Patient has a history of hypertension, hyperchloesterolemia and DM type 2. Details as follows:

Coronary artery disease and unstable angina in May 2012. Cardiac catheterization on May 3, 2012 showed an occluded right coronary artery. He had percutaneous transluminal coronary angioplasty of this vessel with three ION drug-eluting stents implanted.

History of an ST elevation myocardial infarction in March 2002. He had percutaneous transluminal coronary angioplasty to the left circumflex coronary artery with a bare-metal stent implantation at Christiana Hospital.

Paroxysmal atrial fibrillation. He had laparoscopic cholecystectomy on October 30, 2012.

Dyslipidemia with low HDL levels.

Current Medications

Metformin Hydrochloride 500mg Tablet
Lasix 20mg Tablet
Benicar 20mg Tablet e
Warfarin Sodium 10mg Tablet
Coreg 25mg Tablet
Crestor 10mg Tablet One tablet BID

Problem List

Chest Pain, Unspecified (R07.9)
Cardiac Murmur, Unspecified (R01.1)
Tachycardia, Unspecified (R00.0)
Essential (Primary) Hypertension (I10)
Family History Of Diabetes Mellitus (Z83.3)
Nonrheumatic Mitral (Valve) Insufficiency (I34.0)
Nonrheumatic Aortic Valve Disorder, Unspecified (I35.9)
Pure Hypercholesterolemia (E78.0)
Type 2 Diabetes Mellitus (E11)

Allergies

No Known Drug Allergies

FAMILY HISTORY: Father has history of CAD and HTN. Mother has history of DM.

SOCIAL HISTORY: Alcohol consumption is on weekends. Patient is current some day smoker Patient works as Maintenance man, has one child and is married. .

SURGICAL HISTORY: Patient has history of coronary artery bypass grafting.

Risk Factors
HTN,
High LDL,
tobacco smoker,
Family H/O Early CAD,
obesity
sedentary lifestyle.

REVIEW OF SYSTEMS

CONSTITUTIONAL: Patient complained of no constitutional symptoms.

MUSCULOSKELETAL: Patient complained of no muscloskeletal symptoms.

HEENT: Patient complained of no HEENT symptoms.

RESPIRATORY: As above in HPI.

CVS: As above in HPI **edema**, **SOB**, **chest pain** and **swelling of the ankles**.

GU: Patient complained of no GU symptoms.

NEUROLOGIC: Patient complained of no neurological symptoms.

SKIN: Patient complained of no skin symptoms.

PSYCHIATRIC: Patient complained of no psychiatric symptoms.

VITALS

Height: 70 in.
Weight: 255 lbs.
BMI: 36.6.
Temperature: 98.6 F.
Pulse: 78.
BP Systolic Sitting: 150.
BP Diastolic Sitting: 100.

PHYSICAL EXAM

GENERAL: On examination AAO X 3 WNWD in NAD.

NECK: On neck examination normal and enlarged.

CVS: On cardiovascular examination thrills absent, on auscultation S1 normal, S2 normal, tachycardia and heart rhythm is irregular and Murmur: diastolic 3/4, Systolic: early systolic, in the right sternal border.

RESPIRATORY: On thorax and lung examination normal chest expansion, good air movement, lungs clear to

auscultation, no rales, rhonchi or wheezing, no respiratory distress.

GI: On GI examination Soft, nontender, nondistended, bowel sounds present. No organomegaly, no masses palpated.

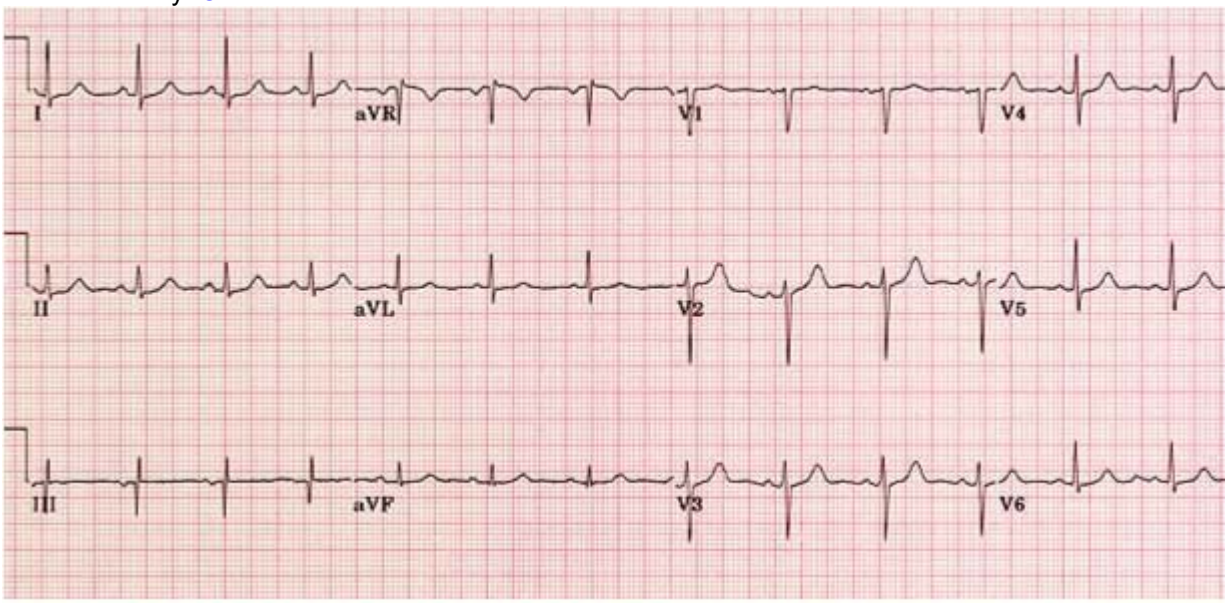
EXTREMITIES: On extremity examination Normal gait. Normal upper and lower extremities, bilaterally. Power 5/5 upper and lower extremities, bilaterally. No nail clubbing or cyanosis. No extremity edema.

REVIEW LIST

The following procedures have been reviewed today:

EKG

Date of test/procedure: 04 March, 2016
Name of doctor: Dr. Smith
Name of facility: Office



2D Echocardiogram

Date of Test/procedure: 09/11/2013
Normal left ventricular size and preserved systolic function. Mild mitral regurgitation. Mild tricuspid regurgitation with an estimated pulmonary artery systolic pressure of 34 mm hg. Normal sized right heart.

Assessment

Angina Pectoris, Unspecified (I20.9)
Essential (Primary) Hypertension (I10) Not controlled today
Nonrheumatic Mitral (Valve) Insufficiency (I34.0)
Cardiac Murmur, Unspecified (R01.1)
Type 2 Diabetes Mellitus (E11)
Unspecified Right Bundle-Branch Block (I45.10)
Pure Hypercholesterolemia (E78.0) On Atorvastatin
Sleep Apnea, Unspecified (G47.30)
Dorsalgia, Unspecified (M54.9)
Asthma (J45)
Supraventricular Tachycardia (I47.1)

History of supraventricular tachycardia after exercise stress nuclear study.
From a cardiac perspective Mr Green is doing quite well. His lipid panel is certainly quite acceptable even after stopping Niaspan.
Symptomatically he has not had any evidence of recurrent atrial fibrillation but we must remember his atrial fibrillation was largely asymptomatic in the past and was exercise induced. He has been placed on Atenolol albeit at a moderate dose. He is to have a exercise stress nuclear study before his next visit in 4 months time. We can monitor for recurrence of

atrial fibrillation with exercise.

Plan

Lab

PT WITH INR
NUCLEAR STRESS TREADMILL
CAROTID SCAN
LIPID PROFILE
CBC W/O DIFFERENTIAL
CHEM 7
LFT
TSH
CXR
URINE ANALYSIS
HB A1C
PLASMA METANEPHRINES
24 HR URINE FOR VMA AND METANEPHRINES
LIPOPROTEIN (A)
HOMOCYSTEINE

Today's Medication

Atenolol 25mg Tablet is Prescribed, Take 1 tablet BID
Januvia 100mg Tablet is Prescribed, Take 1 tablet PO BID
Celebrex 400mg Capsule is Prescribed, take 1 capsule (400mg) by oral route 2 times per day with food

Procedure

EKG 93010

Recommendation

1. Watch caffeine, alcohol, decongestants. Light exercise like walking ok. Call if you have questions. Call 911 if your symptoms worsen and you are not safe to be driven to the nearest hospital.

2. Discussed the long term detrimental health effects of hypertension. Stressed importance of restricting the use of caffeine, nicotine, salt and alcohol. Also discussed the beneficial effects of regular aerobic exercise and maintaining ideal weight. The patient will keep a blood pressure diary for review at the next visit. Patient will return to the office for re evaluation sooner if the blood pressure remains greater than 135/85.

3. We discussed adverse health effects of smoking. Patient was encouraged to quit smoking. I informed the patient about various aids to quit including patch, inhaler, gum and oral medications. The patient was encouraged to set a date to quit smoking.

4. Statin Education: Discussed the common and serious side effects of this medication and the need to follow-up with regular blood tests. Reviewed the risk of liver and/or muscle problems. Discussed need to alert me immediately if they develop any malaise or flu-like symptoms.

Patient is advised to follow up in 1 week.

Health Education

HTN EDUCATION
UNSTABLE ANGINA

The visit was electronically signed off by Steven Smith, MD on 03/08/2016 04:24:43 PM