



FAMILY MEDICINE CENTER OF TEXAS

6860 North Dallas Pkwy, Ste 200, Plano, TX 75024

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Patient Name: WILLIAM GREEN
Patient DOB : 1/15/1962
Patient's Sex: MALE
Date of Service: 3/4/2016

HPI

Asthma

Patient is here due to **Asthma** Exacerbation. Patient's condition **is same** as prior visit. Nasal symptoms are **present** today including nasal congestion and rhinorrhea. Night time symptoms are present as well including **shortness of breath, cough and wheezing**. Inhaler is used **>2 x week**. **Patient has a history of smoking**. It gets aggravated by **exposure to cold air, mild to moderate exertion and smoking**. It gets alleviated by **inhaler and lying down**.

History

MEDICAL HISTORY: Patient has history of **diabetes** and **HTN**.

SURGICAL HISTORY: Patient has history of **cholecystectomy** in 2001.

FAMILY HISTORY: **Patient has no significant family history**.

SOCIAL HISTORY: Smoking status: **current every day smoker**. Alcohol consumption is **2-3 beers on weekend only**. **No illicit IV drug abuse**.

PSYCHIATRIC HISTORY: Patient has **no psychiatric history**.

HEALTH MAINTENANCE:

Last PSA: **29 February, 2016**.

Last EKG: **29 February, 2016**.

Current Medications

Allegra 30mg Tablet, take 2 tablets (60mg) by oral route 2 times per day

Augmentin 875mg Tablet, One tablet once daily

Allegra 180mg Tablet, take 1 tablet (180mg) by oral route once daily

Allergies

Patient is allergic to **Penicillin**.

Patient is allergic to **Pollen Extracts**.

Problem List

Type 2 Diabetes Mellitus Without Complications (E11.9)

Mild Persistent Asthma With (Acute) Exacerbation (J45.31)

Essential (Primary) Hypertension (I10)

ROS

CONSTITUTIONAL: Patient complained of **weakness** and **fatigue**.

EYES: Patient complained of **no eye symptoms**.

EARS: Patient complained of **no ear symptoms**.

NOSE: Patient complained of **no nasal symptoms**.

SINUSES: Patient complained of **no sinus symptoms**.

THROAT: Patient complained of **no throat symptoms**.

RESPIRATORY: Patient complained of **cough, shortness of breath** and **wheezing**.

CV: Patient complained of **no CV symptoms**.

GI: Patient complained of **no GI symptoms**.

GU: Patient complained of **no GU symptoms**.

NEUROLOGICAL: Patient complained of **no neurological symptoms**.

SKIN: Patient complained of **no skin symptoms**.

ENDOCRINE: Patient complained of **no endocrine symptoms**.

PSYCHIATRIC: Patient complained of **no psychiatric symptoms**.

MUSCULOSKELETAL: Patient complained of **no musculoskeletal symptoms**.

Vital Signs

The Systolic BP is **120**.

The Diastolic BP is **80**.

Height is **72** in.

Weight is **250** lbs.

BMI is **34**.

Respiratory Rate is **19**.

Smoking Status: **current every day smoker**.

Physical Exam

GENERAL: On examination height is **72** in and weight is **250** lbs.

HEENT: Normocephalic. Atraumatic. No gross facial abnormalities, edema, facial or sinus tenderness. Sclerae and conjunctivae are clear and normal. PERRLA. EOMI. Oropharynx clear and normal. Tonsils are grossly normal. Mucous membranes moist. Rt ear canal and TM grossly normal. Lt ear canal and TM grossly normal.

NECK: On neck examination supple. No gross abnormalities, edema or thyromegaly. No tenderness. No mass. No JVD. No bruits. No C-spine tenderness.

LYMPH NODE: On lymph node examination no lymphadenopathy.

CV: On cardiovascular examination S1, S2, regular rate and rhythm, no murmurs, rubs, clicks or gallops.

RESPIRATORY: On examination **normal breath sounds**, **positive chest tenderness**, **decreased air movement**, **mild respiratory distress**, percussion of chest is **lung resonance is present**, palpation of chest reveals **tenderness is present** and auscultation of lungs revealed **wheezing**.

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

SKIN: On skin examination no gross abnormalities. No grossly abnormal appearing lesions or rash.

NEUROLOGICAL: On neurological examination normal gait. CN II-XII grossly normal. No sensory-motor deficits. No tremors. No nystagmus. DTR 2+ upper and lower extremities.

PSYCHIATRIC: On psychiatric examination well groomed. Appropriately dressed. Normal speech pattern. Normal thought pattern. No gross evidence of depression or abuse.

EXTREMITIES: On extremities 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.

MUSCULOSKELETAL: On musculoskeletal examination normal gait. No nail clubbing or cyanosis. No edema.

HEALTH MAINTENANCE COUNSELING

Tobacco cessation.

Cholesterol lowering diet.

diabetes counseling.

stress reduction counseling.

Assessment

Mild Persistent Asthma With (Acute) Exacerbation (J45.31)

Plan

Lab

XRAY CHEST PA/LAT

Today's Medication

Advair Diskus 100mcg-50mcg/actuation Powder for Inhalation is Ordered, inhale 1 puff by inhalation route 2 times per day morning and evening approximately 12 hours apart

Montelukast Sodium 4mg Chewable Tablet is Prescribed, One tablet once day

Flovent 110mcg/actuation Inhalation Aerosol is Prescribed, 2-3 puffs twice a day

Cromolyn Sodium 20mg/2ml Solution for Inhalation is Prescribed, 2-3 puffs once day as needed

Procedure

Pulse oximetry 94760

Peak Flow 94200

Spirometry, Pre and Post 94060

Follow Up

Patient is advised to follow up in one month.

Health Education

ASTHMA

This visit was electronically signed off by Daid Newman, MD on 03/08/2016 04:01:19 PM