**GERIATRICS ASSOCIATES OF TEXAS**

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Patient Name: Helen Schneider
Patient DOB: 02-01-1949
Patient Sex: Female
Visit Date: 03-07-2016

## HPI

### diabetes follow up

Patient is here for diabetes follow up.

I am seeing Helen Schneider today who is here for followup for type 2 diabetes on insulin for meals. I started Januvia 100mg and was able to stop am levemir and lower insulin. She is still having high bg generally up to 200 after meals because she is not taking insulin for snacks. She is afraid to take 1 unit for cake and continually has high bg going into dinner.

In good mood today. She is complaining of pimple on back and rash for one month. She has scratched it. She lowered her pm levemir to 12 units. Her insurance is changing to humalog from Novolog. Since bg so high it doens't really matter for her. i will make switch and erx new med. Plan is to stop levemir in am and keep all the same. It still low. fax next week. BG, food records reviewed.

She has mild hyperparathyroidism. She still hasn't done wrist bone density. She cancelled it. Calcium stable 10.2. Must reschedule this.She said she did it but again told her she hasn't done it.
She is on 400 units Vit D and the level is good.
She is on Synthroid 0.075mg for hypothyroidism. TSH is 3.21. 12/2015 labs.
Urine microalbumin is normal 12/2015.
She saw eye doctor. She is having rejection for eye tranplant. She is on steroid eye drops. She sees Dr. Udel.
She is on Simvastatin 10mg 4 times per week and lipids are good on current labs.

## History

**MEDICAL HISTORY:** Patient has history of diabetes, hyperlipidemia, hypothyroidism, hypertension and atrial fibrillation.

**SURGICAL HISTORY:** Patient has history of cholecystectomy in 2004.

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

**SOCIAL HISTORY:** Patient is current every day smoker, smoking 2 pack/day, alcohol consumption is social and no illicit iv drug abuse.

**OB/GYN HISTORY:** Patient has no significant Ob/Gyn history.

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

**HEALTH MAINTENANCE:**
Last Mammogram: 29 February, 2016.
Last DEXA: 28 February, 2016.
Last FOBT: 28 February, 2016.
Last Colonoscopy: 01 March, 2016.
Last Ophtho: 02 March, 2016.

Last Dental: 03 March, 2016.
Last EKG: 28 February, 2016.
Last TSH: 28 February, 2016.
Last Cholesterol: 28 February, 2016.

## Allergies
Patient is allergic to Penicillin.
Patient is allergic to Sulfacetamide.

## Current Medications
Metformin Hydrochloride 1000mg Extended-Release Tablet
Benicar 20mg Tablet
Simvastatin 10mg Tablet
Humalog 100unit/ml Solution for Injection
Novolog 100unit/ml Solution for Injection inject by subcutaneous route per insulin sliding scale protocol
Synthroid 75mcg Tablet take 1 tablet (75mcg) by oral route once daily
Vitamin D 400units Tablet
Levemir 100units/ml Solution for Injection inject by subcutaneous route per insulin sliding scale protocol

## Problem List
Type 2 Diabetes Mellitus Without Complications (E11.9)
Essential (Primary) Hypertension (I10)
Hyperlipidemia, Unspecified (E78.5)
Chronic Atrial Fibrillation (I48.2)
Chronic Fatigue, Unspecified (R53.82)
Hypothyroidism, Unspecified (E03.9)

## ROS
**CONSTITUTIONAL:** Patient complained of no chills, no fever, no weakness, **weight gain** 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 no respiratory symptoms.
**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
Height: 65 in.
Weight: 190 lbs.
BMI: **32**.
BP Systolic: **165** mm Hg.
BP Diastolic: **110** mm Hg.

## Physical Exam
**GENERAL:** On examination WNWD, in no absolute distress.

**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 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.

**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 extremeties.

**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.

## Assessment

Type 2 Diabetes Mellitus Without Complications (E11.9)
Essential (Primary) Hypertension (I10)
Hyperlipidemia, Unspecified (E78.5)
Hypothyroidism, Unspecified (E03.9)
Hyperparathyroidism, Unspecified (E21.3)
Chronic Fatigue, Unspecified (R53.82)
Chronic Atrial Fibrillation (I48.2)

## Plan

### Lab

CBC
COMPREHENSIVE METABOLIC PANEL
LIPID PANEL
PHOSPHORUS, SERUM
IRON & TIBC

### Today's Medication

Januvia 100mg Tablet is Prescribed, Take 1 tablet qid
Colchicine 0.6mg Tablet is Prescribed, Take 1 tablet qd
Singulair 4mg Granules is Prescribed, As directed
Seroquel 100mg Tablet is Prescribed, Take 1 tablet po od
Glipizide 10mg Extended-Release Tablet is Prescribed, take 1 tablet (10mg) by oral route once daily with breakfast

### Procedure

Urine Spot Creatinine (QW) 82570
Microalbumin 82044
UA-Automated W/O Micro (QW) 81003
Influenza Vaccine 90658

Pneumococal Vaccination 90732

## Recommendation
Lifestyle modifications were discussed with patient including a healthy, low sodium diet, exercise and weight loss towards an ideal BMI.

Adherence to medication regimen was discussed and encouraged.

Meds/Labs/Rads Reviewed

Home blood pressure monitoring was discussed. Patient agreed upon home BP monitor with appropriate sized arm cuff and track BP readings for review at next visit. Patient will call if BP is either higher or lower than goal and/or any possible blood pressure related symptoms arise.

The patient was instructed to limit sodium intake to 2000mg per day.

A high pretest probability of obstructive sleep apnea was found. Screening for sleep apnea was discussed and recommended.

## Follow Up
Patient is advised to follow up in 4 weeks.

## Health Education
HTN EDUCATION

The visit was electronically signed off by Edward Hoffman, MD on 03/07/2016 11:24:30 AM