INTERNAL MEDICINE ASSOCIATES OF TEXAS

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Patient Name: Christine Bell
Patient DOB: 07-19-1959
Patient Sex: Female
Date of Service: 03-04-2016

Chief Complaints/HPI

The patient is a 56 year(s) old female who is here for Thyroid and Diabetes workup.

She feels back to self. She ran 45 minutes along the water in long beach.
She had severe external ear infections . Treated with antibiotics and given drops to ears. All finally healed. She went to ER in Florida and I spoke to ER doctor and ENT physician about this. I had just started Tapazole and then this happened. She had been on it only 2 days but got the ear infection. I sent her to ER to get WBC.

TSH was suppressed. She was on Tapzole 5mg 1/2 tablet daily for at least 19-20 days. She had itching the first 7 days. On January 3rd, she called me with ear concerns and I sent her to hospitla and coordinated care with ENT phsycian and ER doctor. TSH had normalized to 0.6. I had lowered to 2.5mg every other day but we decided to wait until she came home to decide next step. TSH now done last week is again low at 0.17 but not suppressed. She feels back to her normal.

I explained that with her age 83, the overactive thyroid is dangerous with Atrial fibrillation and stroke.
She doesn't want to do the RAI therapy. Now that she is home, I am fine with trying tapazole again. She has the meds.
Start 1/2 tablet every other day.
Followup 1 month. If any itching, stop immediately. Will do RAI if allergic to this.
BP last week high for her 140 systolic.
She is back to self even with lowish TSH of 0.17. I want it normal.
Nuclear scan reviewed.
She has had an autonomous multinodular goiter for years. TSH has been running 0.19-0.3 for years. Now TSH finally hyperthyroid range. She moved in May and was under alot of stress.

History

MEDICAL HISTORY: Patient has history of diabetes, graves disease and HTN.

SURGICAL HISTORY: Patient has history of cholecystectomy in 2010.

FAMILY HISTORY: Patient has no significant family history.

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

HEALTH MAINTENANCE:
Last Mammogram: 28 February, 2016.
Last DEXA: 29 February, 2016.
Last Pap: 3/1/2016 12:00:00 AM.
Last TSH: 01 March, 2016.

Allergies

Patient is allergic to Penicillin.

CURRENT MEDICATIONS
Amlodipine Besylate 10 mg Tablet
Benicar 20 mg Tablet
Humalog 100 unit/ml
Metformin 500 mg Tablet
Januvia 50 mg Tablet
Glipizide 10 mg Tablet
Atenolol 25 mg Tablet
Atorvastatin 40 mg Tablet
Aspirin 81 mg Tablet

Problem List
Type 2 Diabetes Mellitus With Unspecified Complications (E11.8)
Pure Hypercholesterolemia (E78.0)
Obesity, Unspecified (E66.9)
Essential (Primary) Hypertension (I10)
Migraine, Unspecified, Not Intractable, Without Status Migrainosus (G43.909)
Other Polyuria (R35.8)

ROS
CONSTITUTIONAL: Patient complained of **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 **polydipsia**, **polyphagia**, **polyuria** and **cold intolerance**.
PSYCHIATRIC: Patient complained of no psychiatric symptoms.
MUSCULOSKELETAL: Patient complained of no musculoskeletal symptoms.

Vital Signs
The Systolic BP is 140.
The Diastolic BP is 90.
Sitting Pulse is 75.
Height is 66 in.
Weight is 180 lbs.
BMI is 29

Physical Exam
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.

HEALTH MAINTENANCE COUNSELING
Annual pap.
Tobacco cessation.
Cholesterol lowering diet.
Exercise plan.
Low salt diet.
Diabetes counseling.

Assessment
Type 2 Diabetes Mellitus With Unspecified Complications (E11.8)
Pure Hypercholesterolemia (E78.0)
Essential (Primary) Hypertension (I10)

Plan
Lab
CBC
COMPREHENSIVE METABOLIC PANEL
LIPID PANEL
TSH
DEXA BONE DENSITOMETRY

Today's Medication
Metformin Hydrochloride 500mg Tablet is Prescribed, take 1 tablet (500mg) by oral route 2 times per day with morning and evening meals
Humalog 100unit/ml Solution for Injection is Prescribed, inject by subcutaneous route per insulin sliding scale protocol
Benicar 20mg Tablet is Prescribed, take 1 tablet (20mg) by oral route once daily
Amlodipine Besylate 10mg Tablet is Prescribed, Take 1 table BID

Procedure
HgA1C 83036
Influenza Vaccine 90658
Pneumococal Vaccination 90732

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

Lifestyle modifications were discussed with patient including a healthy, low sodium diet, exercise and weight loss towards an ideal BMI.
Medications and laboratory / radiology studies reviewed with patient.

Follow Up
Patient is advised to follow up in 1 month.

Health Education
DIABETES OVERVIEW
HTN EDUCATION

Patient is referred to Dr. Friedman for Endocrinology Consultation. Appointment has been confirmed for 10:00 AM.

The visit was electronically signed off by Peter Klein, MD on 03/08/2016 12:43:21 AM