N703 SOAP Chronic
Problem List

Date Active Problems	Date Resolved/Inactive Problems
2002 Hypertension	1984 Uterine CA (TAH & BSO)
2004 Hyperlipidemia	1987 Left Nephrectomy d/t renal mass (unknown etiology)
2004 Diabetes Type II	2006 Retinal Hemorrhage
	2007 Right eye cyst
	2007 Right eye cataract
	Childhood Diseases: Chicken pox, measles

Risk Factors	Problems at Risk For
Family hx CVA, CHF	CVA
Hypertension	CAD, CHF, CVA, MI
Hyperlipidemia	CAD, CVA, MI, PVD
Diabetes Type II	Retinopathy, renal disease, neuropathy, PVD, MI

CC: 2/3/09 66 year old female presents to the office for follow-up care and management for Diabetes Type II and ongoing medical problems of chronic nature.

S: HPI

S.S is currently feeling well and has no complaints.

HTN: Reports her blood pressure has been "120's to 130's over 80's" when she checks it at the local pharmacy every month. Has been taking her meds every day. Denies chest pain, shortness of breath, palpitations.

DM: Fasting blood glucose this morning was 130, yesterday it was 75. Checks blood sugar fasting and before evening meal. Did not bring meter or readings with her to appointment today. Reports blood sugars normally between 100-175 with a reading of 200-220 before evening meal as often as once per week. Takes lantus every morning as well as using sliding scale humalog before evening meals. Has lost 5 pounds this year. Reports "watching what I eat" and "eating less sweets". Denies numbness or tingling in hands and feet. Denies changes in her vision and saw ophthalmologist last week with no abnormal findings. Checks feet daily for breakdown.

Health Maintenance: Reports annual dental visits. LMP: 1984 . Last pap and mammogram: 10/08. Denies fever, chills, fatigue, and night-sweats. Last lab test drawn 06/08. Flu shot 11/08. Pneumovax 2006. Last chest x-ray 01/2008. Last EKG 01/2008.

Relevant Family history: Mother had HTN, CHF, died at age 82. Maternal grandmother had CVA died around age 75.

Personal/Social Profile: Denies smoking. Denies ETOH/Street drugs. Sleeps "about 7 hours every night". Eats 3 meals per day with 2 snacks. Walks 30 minutes every day on treadmill. Married with 2 children and 5 grandchildren. Retired factory worker.

Medications: ASA 81 mg PO QD
Metoprolol 100 mg, ½ tab PO BID
Lantus 28 unit SQ q AM
Zocor 20 mg PO daily
Humalog SQ per sliding scale
BG 150-200 1 unit
201-250 2 units
251-300 3 units
301-350 4 units
Furosemide 20 mg PO every other day
KDur 20 mEq PO every day
Cozaar 100 mg PO daily
Citrical 1 tab PO daily

A**llergies:** No known drug allergies

Review of Systems

General: Good appetite. Sleeps well.

Skin: No rashes, lumps, sores, itching, dryness or other changes. No changes in hair or nails. No moles.

HEENT: Head: Denies dizziness or lightheadedness. *Eyes:* Vision good. No glasses or contacts. Denies pain, redness, blurred or double vision. *Ears:* Hearing good. Denies ringing, earaches, or discharge. *Nose, sinuses:* Denies problems with runny or stuffy nose, bleeding or sinus trouble. *Throat:* Denies bleeding of gums. Denies dry mouth, frequent sore throats or hoarseness.

Neck: Denies lumps or pain.

Respiratory: Denies cough, wheezing, night sweats, or shortness of breath.

Cardiovascular: Denies dyspnea, orthopnea, chest pain, palpitations, edema.

Gastrointestinal: Appetite good; denies nausea, vomiting, indigestion, constipation, diarrhea.

Urinary: Denies frequency, urgency, dysuria, hematuria, nocturia, or recent flank pain.

Peripheral Vascular: Denies leg cramps, varicose veins, clots, edema, pain with exercise or redness.

Musculoskeletal: Denies muscle or joint pain, stiffness, tingling.

Neurologic: Memory good. Denies weakness, paralysis, numbness or decreased sensation. Denies tingling, tremors, cognitive changes.

Endocrine: Denies heat or cold intolerance, excess sweating. Denies excess thirst or hunger.

O:

Vitals: BP = 138//76 R arm sitting P = 72 regular RR: 18 regular
Wt: 190 Ht: 5"10" BMI: 27
S.S is a 66 year old woman in no acute distress.

Skin: Color pink. Skin warm and moist. Feet without breakdown or redness bilaterally.

HEENT: Head-The head is normocephalic/atraumatic. Temporal arteries palpable, no thrills or heaves bilaterally. *Eyes*- Symmetric, no erythema or exudate. Peripheral vision normal. Corneas clear bilaterally. Sclera white, conjunctiva pink. Pupils equally round and reactive to light and accommodation. Corneal light reflex symmetric. Extraoccular movements conjugate. Disc margins sharp; no hemorrhages or exudates. Red reflex present bilaterally. *Ears:* External ears symmetric without erythema, masses or edema. External ear canal without erythema. No erythema, edema or exudates appreciated. Tympanic membranes with good cone of light, pearly grey, bony structures visible bilaterally. *Nose:* External nose symmetric, without erythema, edema. Nasal mucosa pink, septum midline. *Mouth and throat:* Oral mucosa pink and moist, pharynx without exudates. Gums pink. Tongue midline and pink.
Neck: Trachea midline. Neck symmetric, supple. No visible lumps or pulsations. Carotid pulses strong, regular rate and rhythm, equal bilaterally. No bruits. No adenopathy. Full ROM.

Chest: Thorax is symmetric with good expansion. Respirations even and unlabored. Clear to auscultation bilaterally anterior and posterior. Breath sounds equal.

Cardiovascular: No jugular venous distention. No carotid bruit. Apical pulse with regular rate and rhythm. Good S1, S2; no S3 or S4. No murmurs appreciated. Radial pulses palpable, strong and regular bilaterally.

Peripheral Vascular System: Extremities are warm and without edema. No varicosities or stasis changes. Calves are supple and nontender. No femoral or abdominal bruits. Bilateral pedal pulses are 2+ and symmetric.

Gastrointestinal: Abdomen is flat, soft, non-distended and non-tender. Active bowel sounds in all 4 quadrants. No pulsations appreciated. No aortic, renal, iliac or femoral bruits noted.

Neurologic: Mental Status: Alert and cooperative. *Motor:* Good muscle bulk and tone. Strength 5/5 throughout. *Sensory:* Pinprick, light touch sense intact to bilateral feet.

A:
1. Diabetes Mellitus Type II
2. Hypertension
3. Hyperlipidemia

P:
1. Monitor blood sugar regularly.
   Follow good foot care.
   Labs: HgbA1C, CBC, CMP, Urine Microalbumin
   Follow dietary guidelines.
   Follow up with ophthalmologist yearly.
   Refill: Lantus 28 units every a.m. x 3 refills
   Will wait for lab results to determine if med adjustment needed.
2. Check BP every month.
   Labs: as above
   CXR, EKG
   Refill: Furosemide 20 mg PO every other day #45, 5RF
   K-dur 20 mEq PO daily #90, 3 RF
3. Labs: Fasting Lipid Profile, AST, ALT
4. F/U in 3 months with meter and blood sugar diary.

Patient Education:
Inspect feet daily including between toes and soles of feet.
Importance of diet and exercise.
Signs and symptoms of hypoglycemia/hyperglycemia.
Signs and symptoms of high blood pressure.
Medication information.