SUBJECTIVE DATA:

Established Patient Visit

October 15, 2014

KS is a 54 year old married white female

Informant: KS

Chief Complaint (CC):

Patient states, “I am here for my yearly exam and refills on my hormones and Diflucan.”

History of Present Illness (HPI):

KS presents to the clinic for her yearly well visit and medication refills. She has been taking Estrace for 2 years without difficulty. She has also been taking prophylactic Diflucan for recurrent vaginal yeast infections and is very pleased. She denies any other issues or concerns at this time.

Past Medical History (PMH):

KS has no food or drug allergies. Her primary care physician is Dr. Free. She was diagnosed with hypothyroidism and hypercholesterolemia 3 years ago. She began having recurrent yeast infections about 6 months ago. She was diagnosed with menopause 2 years ago. Menarche at 11 years old. LMP 3 ½ years ago. Gravida 1 Para 1 Living 1. Vaginal delivery August 6, 1994. Last mammogram 2013. Last Pap Smear 2013. Negative STDs. She first had sex when she was 20 years old with her current husband. He is her only partner. Chicken pox when she was 9 years old. Flu vaccination 10/4/2014. Last tetanus 3 years ago. Last TB skin test 6 months ago was negative.

Current Medications include:

Diflucan 150 mg PO once monthly

Estrace 1 mg PO daily

Synthroid 75 mcg PO daily

Lipitor 10 mg PO daily

Surgical/Hospitalizations:

Abdominoplasty

Family History:

Father is 76 years old and has HTN and DM. Mother is 74 years old and has DM. She has no siblings. She has 1 son who is 20 years old with no significant medical history.

Social History (SH):

KS has been married for 26 years. She and her husband own their home. The home has smoke alarms and she wears his seatbelt on a regular basis. The home has firearms that are in a locked safe. She bikes with her husband about 3 times per week. She has a college education and works as a nurse at a local hospital. She and her husband are of Baptist faith. She denies the use of tobacco, alcohol, or illicit drugs. She is not exposed to second hand smoke. She has health, dental, and vision insurance and denies any concerns related to food, supplies, or medications.

Review of Systems (ROS):

1. Constitutional Symptoms: She denies any weight loss or weight gain. Denies fever or repeated infections. Denies feeling more tired. Denies any difficulty in performing activities of daily living independently.
2. Eyes: She has glasses for reading. Denies blurred or double vision. She denies using any medications for her eyes. Denies redness, excessive tearing, pain, or trauma to the eyes. She cannot recall her last eye exam.
3. Ears, nose, mouth, throat: Ears: Denies any difficulty hearing or being exposed to high noise levels. Denies tinnitus, infection, pain, vertigo, or the use of assistive devices. Nose: Denies difficulty smelling. Denies discharge, obstruction, epistaxis, or sinus problems. Mouth and teeth: Denies the use of tobacco. Last dental exam was approximately 6 months ago. She had no cavities at that time. She does not have dentures. She brushes her teeth with fluoride toothpaste twice a day and flosses each night. Denies bleeding of gums, changes in sense of taste, mouth odor, ulcers, or sores on tongue. Throat: Denies sore throat, hoarseness, or difficulty swallowing.
4. Cardiovascular: Exercises on a regular basis. Denies history of abnormal heart sounds or murmurs. Denies chest pain, palpitations, dyspnea, activity intolerance, high blood pressure, or irregular heart rate or rhythm. Has a history of high cholesterol and currently takes medication to treat. Denies edema, claudication, or the presence of varicose veins.
5. Respiratory: Denies smoking or being exposed to second hand smoke. Denies any significant respiratory infections or usual self treatments. Denies cough. Denies being exposed to TB. Last TB skin test was negative. Denies difficulty breathing, wheezing, hemoptysis, or night sweats.
6. Gastrointestinal: Eats a diet low in fat. Denies use of nutritional supplements, heartburn, epigastric pain, nausea, vomiting, food intolerance, flatulence, or diarrhea. Usual bowel movements every day. Denies hemorrhoids or jaundice.
7. Genitourinary: Denies nocturia, dysuria, incontinence, or a history of stones. Denies burning, itching, or discharge. Complains of some vaginal dryness. She is monogamously sexually active with her husband. Denies a history of venereal diseases. Menarche at 11 years old. LMP 3 ½ years ago. Gravida 1 Para 1 Living 1. Vaginal delivery August 6, 1994. Last Pap Smear 2013. She first had sex when she was 20 years old with her current husband. He is her only partner. Vaginal sex only.
8. Musculoskeletal: Exercises on a regular basis. Always uses seatbelt and wears helmet when riding bicycle. Denies neck pain or stiffness, joint pain or swelling, incapacitating back pain, paralysis, deformities, or changes in range of motion. Reports knowledge of back injury/pain prevention through proper mechanics.
9. Integumentary: Reports using sunscreen when outside in the sun as well as examining the skin for rashes or ticks. Routinely assessing the skin for general condition. Denies any changes in the skin, rashes, itching, nail deformities, hair loss, moles, open areas, or bruising. Performs breast-self exams. Denies noticing any lumps, pain, discharge, or dimpling. Last mammogram in 2013 was negative
10. Neurologic: Denies muscle weakness, syncope, stroke, seizures, paresthesias, involuntary movements, lightheadedness, tremors, or loss of memory.
11. Psychiatric: Denies nightmares, mood changes, depression, anxiety, nervousness, insomnia, suicidal thoughts, or potential for exposure to violence.
12. Endocrine: Has a history of hypothyroidism controlled with medication. Denies heat or cold intolerance, polydipsia, polyphagia, polyuria. Denies any changes in the skin, nails, or hair. Denies any unexplained weight changes. Denies any facial or body hair changes, changes in glove or hat size. Has been taking Estrace for 2 years.
13. Hematologic/lymphatic- Denies bruising, unusual bleeding, fatigue, or a history of anemia. Denies ever having a blood transfusion. Denies presence of swollen or tender glands.
14. Allergic/Immunologic: Denies ever having any allergy testing but does have an occasional runny nose and sneezing in the Fall and Spring. Has been immunized for Hep B. Denies immunosuppression in self or family members. Denies the use of steroids.

OBJECTIVE DATA:

1. Constitutional: KS is a normal weight, well-developed 54 year old female. She appears her stated age. She is in no acute distress.

a. VS: temp 98.8, BP 119/53, Pulse 74, O2 Sat 98% on RA, Height 5’3”, Weight 139 lbs, BMI 24.6

1. Eyes: Pupils are equal, round, reactive to light and accommodating at 4mm bilaterally. No redness or drainage from the eyes.
2. ENT/Mouth: Hearing is adequate. No drainage from the ears. Tympanic membranes clear. No redness or drainage, wax present. Nose: Mucosa pink, septum midline. No nasal drainage or congestion. No tenderness of the frontal or maxillary sinuses. Throat: Oral mucosa moist and pink. Oropharynx clear, no redness. Tonsils present. No evidence of bleeding gums or foul odor. No ulcers or sores.
3. Cardiovascular: Normal S1, S2. No S3, S4. Regular rate and rhythm. No clicks, gallops, or murmurs. No carotid bruits. No varicose veins. No BLE edema
4. Respiratory: RR even and unlabored. Clear to auscultation bilaterally. No evidence of clubbing.
5. Gastrointestinal: Bowel sounds normal in all four quadrants. Soft, non-distended, non-tender.
6. Genitourinary: No costovertebral tenderness present. EGBUS normal. Speculum exam WNL. Pap done. BME reveals no evidence of adnexal mass or tenderness.
7. Musculoskeletal: No tenderness or swelling to the joints. No abnormal curvature of the spine. Bilateral upper and lower extremities strong and equal.
8. Integument/Lymphatic: No cyanosis, ecchymosis, or petechiae. No swollen or tender glands or lymph nodes. No discolored or uneven moles. Fibrocystic changes noted in the breasts with no masses, nipple discharge or skin changes noted.
9. Neurologic: No tremors or involuntary movements. Alert and oriented to person, place, time, and situation. Able to answer all questions appropriately.
10. Psychiatric: Patient calm and cooperative. No anxiety or nervousness. Normal affect.
11. Hematologic/Immunologic: No evidence of bruising or bleeding. No swollen or tender glands or lymph nodes.

 No diagnostic tests available for this visit.

ASSESSMENT:

CPT code: 99211

Differential Diagnoses:

1. Menopause 627.2 – well-controlled
2. Hypothyroidism 244.9 – well-controlled
3. Hypercholesterolemia 272.0 – well-controlled
4. Recurrent yeast infections 112.2 – well-controlled
5. Atrophic Vaginitis 627.3 – normal in menopause, thinning, drying, and inflammation of the vaginal walls

PLAN:

The following plan has been discussed and agreed on by KS for the diagnoses including:

1. Menopause 672.2
2. Continue Estrace (Estradiol
3. Indicated for KS for the treatment of vasomotor symptoms, vulvar and vaginal atrophy, and hypoestrogenism associated with menopause
4. Estrace is estrogen which is one of the major female hormones. Estrace replaces the naturally occurring estrogen that menopausal women lack.
5. Tablets 0.5mg, 1mg, 2mg
6. Available as name brand: Estrace, and generic: estradiol
7. Cost
8. Wal-Mart $4 = 30 day supply, $10 = 90 day supply
9. Walgreen’s $5 = 30 day supply, $10 = 90 day supply
10. Target $4 = 30 day supply, $10 = 90 day supply
11. Provide Education on Estrace
12. Schedule mammogram 77057
13. Pap Smear 87621
14. Follow-up in one year – will call with mammogram and Pap results
15. Recurrent Yeast Infections 112.2
16. Continue Diflucan for 6 more months and then reevaluate
17. Education on Diflucan
18. Advise her to call with any problems
19. Atrophic Vaginitis 627.3
20. Continue Estrace but inform the patient if she is unable to manage symptoms with alternative methods, the Estrace dosage can be adjusted
21. Education on methods to prevent vaginal dryness and irritation
22. Other
23. Refer to her PCP for continued management of hypothyroidism and hypercholesterolemia