SUBJECTIVE DATA:

New Patient Visit

September 29, 2014

HB is a 37 year old married white male.

Informants: Patient

Chief Complaint (CC):

Patient states, “I was moving a rug yesterday and fell on my elbow.”

History of Present Illness (HPI):

HB complains of right elbow pain. The pain is constant and throbbing. On a scale of 1-10 he rates the pain a 7. The pain began after he fell on his arm yesterday at his home while moving a rug. Aggravating factors include movement and palpation. Alleviating factors are none. Associated factors include edema and erythema.

Past Medical History (PMH):

HB has no food or drug allergies. He was diagnosed with HTN about 5 years ago. He uses the Quality of Life as his PCP. His last TB skin test was 3 years ago. He had his flu and pneumonia vaccinations last week at a free clinic. His last tetanus was 2 years ago. He had chicken pox when he was 10 years old but denies any major childhood illnesses.

Current Medications Include: (HB has not taken medications in at least 1 month)

Clonidine 0.2 mg PO BID

HCTZ 25 mg PO daily

Lisinopril 10 mg PO daily

Surgical / Hospitalizations:

HB has no past surgical or hospitalization history.

Family History (FH):

Father is 60 years old and has DM and HTN. Mother is 58 years old and has DM. He has 1 sister who is 33 years old with no past medical history. HB has one son who is 14 years old with no past medical history.

Social History (SH):

HB has been married for 16 years. He and his wife rent a mobile home near their family. The home has smoke alarms and he always wears his seatbelt. The home does have firearms that are not in a locked safe. HB does not exercise on a regular basis. He has a high school education and works for his brother-in-law’s small tree trimming business. He enjoys hunting and fishing in his spare time. He and his wife are of the Baptist faith. He denies the use of alcohol or illicit drugs. He has smoked 1½ packs of cigarettes per day for the past 25 years. HB does not have health insurance at the current time and has not purchased his blood pressure medications in over a month now.

Review of Systems (ROS):

1. Constitutional Symptoms: Denies any weight loss or weight gain. Denies fever or repeated infections. Denies feeling more tired recently. Denies any difficulty in performing activities of daily living independently.
2. Eyes: He does not wear glasses and denies any difficulty seeing. Denies blurred or double vision. Denies using any medications for his eyes. Denies redness, excessive tearing, pain, or trauma to the eyes. Last eye exam is unknown.
3. Ears, Nose, Mouth, and Throat: Ears: Denies any difficulty hearing. Is exposed to high noise levels when working. 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 oral tobacco. Smokes 1½ packs of cigarettes for the past 25 years. His last dental exam was approximately 1 year ago. He had no cavities at that time. He does not have dentures. He brushes his teeth with fluoride toothpaste twice a day and flosses occasionally. 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: Does not exercise on a regular basis. Denies history of abnormal heart sounds or murmurs. Denies chest pain, palpitations, dyspnea, activity intolerance, or irregular heart rate or rhythm. Was diagnosed with HTN 5 years ago. Last EKG and cholesterol level are unknown. Denies edema, claudication, or the presence of varicose veins.
5. Respiratory: He is a smoker and is exposed to second hand smoke from his wife and coworkers. Denies any significant respiratory infections or usual self treatments. Reports having an occasional productive cough usually worse in the morning with nickel size amounts of thick, tan sputum. Last chest x-ray is unknown. Denies being exposed to TB. Denies difficulty breathing, wheezing, hemoptysis, or night sweats.
6. Gastrointestinal: He reports an unrestricted diet filled with a lot of fried foods and very little attention given to nutritional value. Denies using any nutritional supplements such as vitamins or herbs. Denies epigastric pain, abdominal pain, or food intolerance. Denies flatulence, diarrhea or constipation, changes in stools, hemorrhoids, or jaundice. Usually has 1 bowel movements per day and the last one was this morning. It was brown and formed.
7. Genitourinary: Denies nocturia, dysuria, incontinence, or a history of stones. He is monogamously sexually active with his wife. Denies a history of venereal diseases.
8. Musculoskeletal: Reports right elbow pain and swelling with limited range of motion. Denies exercising on a regular basis. Always uses seatbelt. Does not play sports. Denies neck pain or stiffness, incapacitating back pain, paralysis, or deformities. Reports knowledge of back injury/pain prevention through proper mechanics.
9. Integumentary (skin and/or/breast): Reports wearing a hat when outside in the sun as well as examining the skin for rashes or ticks. Denies routinely assessing the skin for general condition. Denies any changes in the skin, rashes, itching, nail deformities, hair loss, moles, open areas, or bruising.
10. Neurologic: Denies muscle weakness, syncope, stroke, seizures, paresthesias, involuntary movements, 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: Denies any history of thyroid problems. 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, or the use of hormonal therapy.
13. Hematologic/Lymphatic: Denies unusual bruising, unusual bleeding, fatigue, or a history of anemia. Last hemoglobin and hematocrit results are unknown. Denies ever having a blood transfusion. Denies presence of swollen or tender glands.
14. Allergic/Immunologic: Denies ever having any allergy testing. Has never been immunized for Hepatitis B and denies the potential for exposure to blood and body fluids. Denies immunosuppression in self or family members. Denies the use of steroids.

OBJECTIVE DATA:

1. Constitutional: HB is an overweight, well-developed 37 year old male. He appears his stated age. He is in no acute distress.

a. VS: temp 97.4, BP 179/117, Pulse 70, O2 Sat 98% on RA, Height 5’10”, Weight 200 lbs, BMI 28.69

1. Eyes: Pupils are equal, round, reactive to light and accommodating at 6mm 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 edema
4. Respiratory: RR even and unlabored. Bilateral breath sounds clear. Clubbing of the nails on bilateral upper extremities.
5. Gastrointestinal: Bowel sounds normal in all four quadrants. Soft, non-distended, non-tender.
6. Genitourinary: No costovertebral tenderness present.
7. Musculoskeletal: Right elbow with erythema, edema, and tenderness. No weakness of left arm. No abnormal curvature of the spine. Bilateral 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.
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.
11. Hematologic/Immunologic: No evidence of unusual bruising or bleeding. No swollen or tender glands or lymph nodes.

2 view elbow x-ray: Within normal limits. No evidence of fracture or dislocation.

ASSESSMENT:

CPT Code:

99213

Differential Diagnoses:

1. Elbow Pain 729.5 – determined by subjective data, he c/o elbow pain 7/10
2. Elbow Fracture 813.01 – determined by X-ray. No evidence of fracture.
3. Elbow Sprain or Strain 841.9 – he fell on his arm and hit his elbow. The area is read and swollen with limited range of motion. X-ray is within normal limits.
4. Closed Dislocation of the Elbow 832 – determined by x-ray. No evidence of dislocation.
5. Overweight 278.02 – BMI = 25 – 29.9 (28.69)
6. Other Benign Secondary Hypertension 405.19 – inadequately controlled
7. Tobacco Dependence 305.1 – inadequately controlled

PLAN:

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

1. Elbow Pain 729.5
2. Norco 7.5/325 mg PO once now (to help control his pain and lower his blood pressure which could be increased by the pain)
3. Prescription for Ibuprofen 800 mg PO TID for 5 days (15 pills)
4. Education on using ice on the affected joint for pain relief
5. Elbow Sprain or Strain 841.9
6. Place arm in a sling for 1 week
7. Education on no heavy lifting or pulling for 1 week
8. Referral to orthopedic if symptoms have not resolved after 1 week
9. Overweight 278.02
10. Education on diet and exercise
11. Education on weight loss, disease prevention, and health promotion.
12. Send him to have a CBC, CMP, and cholesterol level drawn
13. Follow up in 1 week to review lab results.
14. Other Benign Secondary Hypertension 405.19
15. Clonidine 0.2 mg PO once now
16. Prescription for Clonidine 0.2 mg PO BID
17. Prescription for HCTZ 25 mg PO daily
18. Prescription for Lisinopril 10 mg PO daily
19. Indicated for this patient for the treatment of hypertension
20. Lisinopril is an Angiotensin-Converting Enzyme (ACE) Inhibitor. It prevents the conversion of angiotensin I to angiotensin II, a potent vasoconstrictor. As a result the blood vessels dilate and blood pressure is reduced.
21. Usual doses include: 2.5 mg, 5 mg, 10 mg, 20 mg, 30 mg, 40 mg
22. Available as name brand: Prinivil and Zestril, Generic: Lisinopril
23. Costs
24. Walmart

$4 = 30 day supply, $10 = 90 day supply

1. Target

$4 = 30 day supply, $10 = 90 day supply

1. Walgreens

$5 = 30 day supply, $10 = 90 day supply

1. Follow up in 1 week to evaluate the effectiveness of taking BP meds
2. Tobacco Dependence 305.1
3. Education on smoking cessation
4. Education for patient and his wife on the effects of second hand smoke.
5. Other
6. Referral to medication assistance programs and free health care clinics
7. Etowah Baptists Mission Center (256)546-2980
8. Etowah Free Community Clinic (256)546-3456
9. The Salvation Army (256)547-6621