

PATIENT NAME

BD: 00/00/0000

00/00/0000

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HISTORY OF PRESENT ILLNESS: The patient is a 71-year-old white male with history of psychosis and severe COPD. He was found on February 21, 2010, with **steroid** psychosis and was admitted to the hospital. He had been up and about in his house, but was found wandering around outside the house without a coat. He was urinating in the refrigerator and had become very anxious and hostile.

PAST MEDICAL HISTORY: COPD on 3 liters oxygen usage daily, anxiety, hypertension, **steroid** usage, history of pneumonia, history of hematuria.

PAST SURGICAL HISTORY: Cholecystectomy and right inguinal herniorrhaphy.

REVIEW OF SYSTEMS: He denies any ear pain, fever or chills. He is short of breath, but this is normal for him, and he uses oxygen chronically.

SOCIAL HISTORY: He quit smoking a long time ago but was a heavy smoker at one time. No recent history of alcohol or illicit drug use.

FAMILY HISTORY: Noncontributory.

MEDICATIONS: Reviewed on the chart.

ALLERGIES: None other than the **steroids**, which caused psychosis.

PHYSICAL EXAMINATION:

Vitals: Reviewed on the chart.

General: Well-developed, well-nourished white male in no acute distress.

HEENT: Eyes, pupils are equal, round and react to light and accommodate. Ears, hearing is grossly intact. Mouth and throat, no erythema. The patient does not have dentures in.

Neck: Supple. No lymphadenopathy.

Heart: Normal S1, S2 with diminished heart sounds bilaterally.

Lungs: Diminished bilaterally with a few rhonchi.

Abdomen: Soft, positive bowel sounds. No masses. Old scar just right of midline.

GU: Normal male genitalia with circumcised penis. Testes are descended bilaterally.

Rectal: Examination not performed.

Extremities: No edema in the lower extremities. Dorsal pedis pulses bilaterally are full and equal. Radial pulses bilaterally are full and equal.

Neurologic: He does have confusion. He knows where his home is, but is not able to state where he is right now. He does move all extremities. Hand grip is equal bilaterally.

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IMPRESSION:

1. Chronic obstructive pulmonary disease.
2. Confusion secondary to steroids.
3. History of hyperlipidemia.
4. History of anxiety.

PLAN: We will continue with present care, but he is going to be discharged today.
Home healthcare and home care is arranged.

Physician's Name
DD: 00/00/00

XXX/xxx
DT: 00/00/00

SAMPLE

PATIENT NAME
00/00/00

BD: 00/00/0000

HISTORY OF PRESENT ILLNESS: This patient is an 81-year-old white female with a history of advanced dementia and cerebral palsy. She had a previous right hip fracture, unrepaired due to her medical condition. She is blind and confused. She is constantly chewing and grabbing.

REVIEW OF SYSTEMS: No recent shortness of breath or change in medical condition.

PHYSICAL EXAMINATION:

Vitals: Reviewed on the chart.

General: Well-developed, well-nourished white female in no acute distress.

Neck: Supple. No carotid bruits.

Heart: Normal S1, S2.

Lungs: Clear to auscultation.

Extremities: No edema. She is moving all extremities.

IMPRESSION:

1. Cerebral palsy.
2. Dementia.

PLAN: We will continue with supportive care.

Physician's Name
DD: 00/00/00

XXX/xxx
DT: 00/00/00

SAMPLE

PATIENT NAME
00/00/00

BD: 00/00/0000

HISTORY OF PRESENT ILLNESS: The patient is a 64-year-old white male with history of diabetes mellitus and severe peripheral vascular disease with below-knee amputation on the left side. He says he is doing okay in general. He is legally blind and gets around generally by seeing light.

REVIEW OF SYSTEMS: He has some sores on the right leg, but he does not really feel them because of the neuropathy.

PHYSICAL EXAMINATION:

General: Well-developed, well-nourished white male in no acute distress.

Neck: Supple. No lymphadenopathy.

Heart: Normal S1, S2.

Lungs: Clear to auscultation.

Extremities: Right lower leg has a few open areas that are scabbed. No tenderness in this area.

IMPRESSION:

1. Diabetes mellitus.
2. Peripheral neuropathy.
3. Open sores.

PLAN: We will use some Bactroban on the open areas.

Physician's Name
DD: 03/02/10

XXX/xxx
DT: 03/02/10

PATIENT NAME

00/00/0000

DOB: 00/00/0000

- S: Patient is present today to follow up on and discuss ADHD, as well as ongoing low back pain, right wrist pain, anxiety and bee sting allergies. This patient saw me about a month ago and has a long history of ADHD. He has been on Ritalin for many years. He states that he got to the point where he was tired of ignoring his symptoms, and he was having some job performance concerns. He works as a manager for a corporation and finally resigned himself to getting treatment. The patient was started on Strattera. He states that he was having quite a bit of fatigue from this medication. He states that he actually took it for about 14 days and then discontinued the medication because he was having trouble staying awake at work. He did try to manipulate the time he was taking the Strattera to try to make it more effective, but he states it did not work. The patient states he has had this side effect before with other medications. He was treated for anxiety and panic attacks and used Lexapro and another medication that affected his serotonin levels, and he states that he had a reaction of extreme sedation. The patient states that he continues to have ADHD symptoms, predominantly inability to focus at work with some mind racing. He is able to control his impulses. He is not actually acting out with hyperactivity, but he states that he constantly has to control himself. The patient also states that he has been having more anxiety lately. He states that it seems to start with inability to concentrate at work. He has a lot of authority at work, and when he feels as if he cannot concentrate, it makes him very anxious and sometimes he feels as if he has a panic attack over it. Patient denies suicidal or homicidal ideation. He states that at those times he does get chest tightness and shortness of breath. Patient is also requesting a refill of his EpiPen today. **He has a severe bee sting allergy** and does require refills. He usually gets a couple of pens a year. He has not had to use one for several years. Patient is also continuing followup in regard to low back pain and wrist pain. This patient has pending referrals to an orthopedist for his right wrist. He has had multiple surgeries on that wrist, and he is continuing to have problems. His appointment is set up with Dr. Keller. He is also seeing a "back doctor" for ongoing concerns with his back. The last time that I saw him, I gave him Celebrex. He states that this does help when he uses it, but he is fearful that using it routinely will make it less effective. Patient denies any new trauma, new joint pain or new joint swelling.
- O: VITAL SIGNS: Blood pressure is 130/90. Pulse is 66. Respirations are 16. Temperature is 97.9. He is 5 feet 9 inches and 213 pounds. SAO₂ is 98% on room air. GENERAL: This pleasant male patient is alert and oriented x3. HEENT: Normal TMs and normal nares and turbinates. Tonsils are nonerythematous. NECK: Supple, no lymphadenopathy. CHEST: Respirations are regular and easy. LUNGS: Clear throughout. CARDIOVASCULAR: Normal S1, S2, without clicks, murmurs or rubs. PSYCHIATRIC: Mood and affect is appropriate to the situation, not depressed. Speech is not slurred. Eye contact is good.
- A/P:
1. Attention deficit hyperactivity disorder. I did discuss our policy. Patient is to stop the Strattera, and we will start Ritalin 10 mg 1 tablet p.o. daily. Patient will have a one-month followup with Dr. Joseph. Assuming he is stable on this medication, he will follow up with Dr. Joseph yearly and any time he needs to make a medication change.
 2. Anxiety. Patient seems reluctant to be on a daily medication for this. I discussed that I do not want to combine Ritalin with any benzodiazepines. He states he is hopeful that by controlling his attention deficit hyperactivity disorder, he will not feel so anxious all the time. He is to follow up again in one month in regard to this. I did discuss using a non-serotonin medication for anxiety. He declines this at this time.
 3. Right wrist pain and low back pain. Patient may continue the Celebrex as needed. I discussed that this may have more efficacy if he uses it on a daily basis until further managed by his specialist. He may otherwise follow up here as needed.
 4. Bee sting allergy. I did refill his EpiPen to use as needed.
 5. Patient is to have a one-month followup as stated above with Dr. Joseph. This appointment is scheduled today. A release for records is also obtained today. Patient does verbalize understanding and is agreeable with this plan of care.

Physician's Name/xxx