

MCA • 273 Winton M Blount Loop, Montgomery AL 36117-3507

HIGDON, LEON (id #190214, dob: 03/20/1966)

Medical Records - CONFIDENTIAL

FROM: AL - Montgomery Cardiovascular Assoc, PC

Amanda P

273 Winton M Blount Loop, Montgomery, AL 36117-3507

Phone: (334) 280-1500

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TO: LINDSEY BARTON CRNP

7461 EAST DR, MONTGOMERY, AL 36117-8092

Phone: (334) 244-3281

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Name: HIGDON, LEON

DOB: 03/20/1966

Date Range: 01/01/2020 to 12/18/2020

This document contains the following records of the patient:

• **Admin Documents**

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MCA • 273 Winton M Blount Loop, Montgomery AL 36117-3507

HIGDON JR, LEON C (id #190214, dob: 03/20/1966)

MONTGOMERY CARDIOVASCULAR ASSOCIATES PC

273 Winton M Blount Loop

Montgomery, AL 36117-3507

Phone: (334) 280-1500

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Encounter Summary - Progress Note

Date Printed: 12/28/2020

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Patient	Higdon Jr, Leon C (54yo, M) #190214
DOB	03/20/1966

Patient Address	80 Bright Spot St Pike Road, AL 36064	Home Phone	(251) 622-1918
		Work Phone	

Encounter Reason/Date	Transition of Care Encounter Cardiac Evaluation and Management Followup: Electrocardiogram abnormal 12/28/2020 - 10:15AM - MCA East
History of Present Illness	Mr. Higdon is a 54 year old caucasian male with no known cardiac history, who is kindly referred by NP Lindsey Barton for consultation due to abnormal EKG. This scan was ordered as part of his routine physical, and was suggestive of right bundle branch block. Recent echocardiogram revealed a normal EF, borderline concentric LVH, and mild left atrial enlargement. He is scheduled for a nuclear stress test in the near future. Additional history includes former tobacco abuse and hypertension. Today Mr. Higdon states he is doing well and reports good exercise capacity. He is able to walk, bicycle, golf, and lift weights without incident. At this time, the patient denies any chest pain, palpitations, shortness of breath, PND, orthopnea, peripheral edema, syncope or near syncope. He has not had any recent cardiac-related ER visits. He has no family history of ischemic heart disease or early cardiac death.
Review of Systems	General:General: no recent weight gain or loss and no fever, weakness, fatigue, night sweats, exercise intolerance, or malaise or general achiness. Eyes:Eyes: no cataracts, double vision/diplopia, history of glaucoma, sensitivity to light/photophobia, or loss of vision. Ears/Nose/Mouth/Throat:Ears: no difficulty hearing, ear pain, or ringing in the ears/tinnitus. Nose: no nosebleeds or sinus problems. Mouth/Throat: no sore throat, bleeding gums, dry mouth, mouth ulcers, or teeth problems or dental decay. Respiratory:Respiratory: no cough, wheezing, snoring, shortness of breath, or coughing up blood. Gastrointestinal:Gastrointestinal: no vomiting, diarrhea, dyspepsia/indigestion, GERD, jaundice, constipation, nausea, abdominal pain, blood in stool or black/tarry stools, or difficulty swallowing /dysphagia and normal appetite and not vomiting blood.

MCA

Higdon Jr, Leon C (ID:190214), DOB:03/20/1966

Genitourinary: Genitourinary: no difficulty urinating or initiating urination and no incontinence, hematuria/blood in urine, increased frequency or urgency, burning sensation during urination, pain during urination/dysuria, or pelvic pain. Musculoskeletal: Musculoskeletal: no muscle weakness or aches or cramps and no arthralgias/joint pain, back pain, or joint swelling. Peripheral Vascular: right lower extremity no temperature change to right leg or right foot and no right lower leg pain with walking (no claudication), loss of hair from right lower limb, or skin discoloration or ulceration of right lower extremity. left lower extremity no temperature change to left leg or left foot and no itching/pruritis, left lower leg pain with walking (no claudication), loss of hair from left lower extremity, or skin discoloration or ulceration of left lower extremity. Integumentary: Skin: no rashes or itching/pruritis. Neurologic: Neurologic: no numbness, seizures, dizziness, headaches, tremors, loss of consciousness, focal weakness, severe headaches, memory loss, or history of falls and normal gait/no unsteadiness or walking difficulty. Psychiatric: Psych: no sleep disturbances or disturbances: excessive sleepiness during the day (daytime somnolence) and no depression, anxiety, hallucinations, or suicidal thoughts. Endocrine: Endocrine: no fatigue, unusual sweating, heat intolerance, or intolerance to cold. Hematologic/Lymphatic: Hematologic/Lymphatic no bruising, swollen glands, excessive bleeding, or unusual bleeding tendency. Allergic/Immunologic: Allergy/Immunologic: no itching, hives, runny nose, sinus pressure, or frequent sneezing.							
Vitals	<table border="1"> <tr> <td>Ht: 5 ft 11 in 12/28/2020 10:44 am</td> <td>Wt: 211 lbs 12/28/2020 10:44 am</td> <td>BMI: 29.4 12/28/2020 10:44 am</td> </tr> <tr> <td>BP: 122/80 sitting 12/28/2020 10:45 am</td> <td>HR: 63 12/28/2020 11:00 am</td> <td></td> </tr> </table>	Ht: 5 ft 11 in 12/28/2020 10:44 am	Wt: 211 lbs 12/28/2020 10:44 am	BMI: 29.4 12/28/2020 10:44 am	BP: 122/80 sitting 12/28/2020 10:45 am	HR: 63 12/28/2020 11:00 am	
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BP: 122/80 sitting 12/28/2020 10:45 am	HR: 63 12/28/2020 11:00 am						
Allergies	Reviewed Allergies PENICILLINS						
Medications	Reviewed Medications amlODIPine 10 mg tablet 12/28/20 entered Take 1 tablet(s) every day by oral route. hydroCHLORothiazide 25 mg tablet 12/28/20 entered Take 1 tablet(s) every day by oral route. 12/28/2020 Pt didn't bring meds, reviewed verbally. JG						
Family History	Reviewed Family History <table border="1"> <tr> <td>Father</td> <td>- No current problems or disability</td> </tr> <tr> <td>Mother</td> <td>- No current problems or disability</td> </tr> </table>	Father	- No current problems or disability	Mother	- No current problems or disability		
Father	- No current problems or disability						
Mother	- No current problems or disability						
Past Medical History	Reviewed Past Medical History Hypertension: Y						
Past Surgical History	Reviewed Surgical History Echocardiogram - 12/23/2020 - Dr. EC - EF 65-70%, borderline cLVH, mild LAE, trace MR						
Results/Interpretations	None recorded						
Physical Exam	Patient is a 54-year-old male. Constitutional: General Appearance: well-nourished, well-developed, and appears stated age. Level of Distress: comfortable. Psychiatric: Mental Status: normal affect, concentration, mood, and attention span and alert, cooperative, and cognition intact. Orientation:						

oriented to time, place, and person.

HEENT: Head: normocephalic and atraumatic. Mouth, Lips, Teeth: no cyanosis or deformity or lesions and normal dentition. Ears: TMs clear, TM mobility normal, and normal hearing. Nose: no lesions on external nose.

Eyes: Lids and Conjunctivae: no discharge, pallor, xanthelasma, or arcus. Pupils: PERRLA and EOM intact.

Neck: Neck: supple, trachea midline, no masses, and normal ROM. Carotid Arteries: no bruits or thrills and bilateral normal upstroke. Jugular Veins: normal jugular venous pressure. Thyroid: not enlarged, non tender, or no nodules.

Lungs: Respiratory Effort: unlabored. Chest Exam: no thoracic deformity or chest wall tenderness and normal curvature. Percussion: resonant. Auscultation: no wheezing, rales, or rhonchi and clear bilaterally.

Cardiovascular: Precordial Exam: no heaves or precordial thrills and non displaced focal PMI. Rate And Rhythm: regular rate and rhythm. Heart Sounds: no rub, gallop, or click and normal S1 and physiologically split S2. Systolic Murmur: not heard. Diastolic Murmur: not heard. Extremities: no cyanosis, edema, clubbing, or peripheral signs of emboli and normal temperature and capillary refill.

Peripheral Pulses: Pulses of Chest and Abdomen: no palpable aortic enlargement or audible aortic bruit. Brachial Pulse: normal and equal bilaterally. Radial Pulse: normal. Femoral Pulse: no bruits appreciated or radial femoral delay and normal. Posterior Tibialis Pulse normal. Dorsalis Pedis Pulse: normal. Popliteal Pulse: normal.

Abdomen: Inspection and Palpation: non distended or tender and soft and no masses. Liver: non tender or no hepatomegaly. Spleen: non tender or no splenomegaly.

Musculoskeletal: Inspection: no joint tenderness or swelling, no erythema, and normal ROM.

Neurologic: Gait: normal gait. Motor: normal strength and tone. Neurological: speech fluent and cranial nerves II-XII grossly intact.

Skin: Inspection and Palpation: skin intact and warm and dry.

Lymph Nodes: Cervical Nodes: no significant adenopathy. Axillary Nodes: no significant adenopathy. Inguinal Nodes: no significant adenopathy.

Assessment and Plan

- 1. Electrocardiogram abnormal** - RBBB/LAFB Asymptomatic/Unknown duration/Good exercise capacity
R94.31: Abnormal electrocardiogram [ECG] [EKG]
 - ELECTROCARDIOGRAM
- 2. Essential hypertension** - well controlled
I10: Essential (primary) hypertension
 - DASH DIET: CARE INSTRUCTIONS
- 3. Body mass index 25-29 - overweight**
Z68.29: Body mass index [BMI] 29.0-29.9, adult
 - LEARNING ABOUT THE MEDITERRANEAN DIET
- 4. Ex-smoker**
Z87.891: Personal history of nicotine dependence

Patient Instructions

- Keep upcoming appointment for stress test.

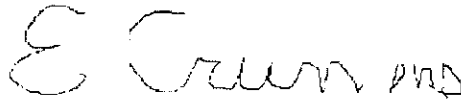
Discussion Notes

- Encouraged patient to keep any upcoming follow up appointments with PCP and specialty physicians for continuity of care.

Return to Office

- Nuclear Medicine for Nuclear Stress Test at MCA East on 02/25/2021 at 08:00 AM
- Nicholas Howell PA for Return MLP at MCA East on 03/11/2021 at 11:00 AM

Electronically Signed by: RICHARD ERIC CRUM MD



Admin Documents

AUM | **ARIZONA UNIVERSITY
AT MONTGOMERY**
WOMEN'S HEALTH SERVICES

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Reply

fragments

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**12/23 at 11:30am for Echocardiogram,
12/28 at 10:15am with Dr. Criss & 1/12
at 10:45am for Nuclear stress test

MS# 8228/2015 2-12-19 AM DATE 2/20/2 FAX 507/551

[illegible]

APPOINTMENT DATE/TIME: