

Auburn Montgomery Student Health Services

7461 East Dr
Montgomery AL, 36117-8092
(334) 244-3281

Date: 05/28/21

PATIENT: WASHINGTON, MARCUS **DOB:** 08/15/1984 **Gender:** MALE **MRN:** 1680 **AGE:** 36 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Physical

HISTORY OF PRESENT ILLNESS: Mr. Washington presents today for a physical. He reports he has not been seen by a physician in a long time and just found out that they are expecting a child. He reports a history of sleep apnea and uses a CPAP nightly. He also has hypertension and possibly hyperlipidemia but is not on any medications. He would like to learn more about a healthy diet.

VITALS: BP: 165/89 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 76; **Temp:** 97.3; **Resp:** 18; **Ht:** 70 in.; **Wt:** 423.6 lbs.;
BMI: 60.78; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: Seasonal allergies, hypertension, heart murmur, hemorrhoids, migraines, sleep apnea

PAST SURGICAL HISTORY: wisdom teeth extraction

SOCIAL HISTORY: Drinks occasionally, denies smoking and illicit drug use

FAMILY HISTORY: Mother: Diabetes, HTN; stomach cancer; Father: HTN

REVIEW OF SYSTEMS:

CONSTITUTIONALS: All 14 point review of systems negative except those listed in HPI.

PHYSICAL EXAMINATION:

GENERAL: GENERAL: No apparent distress noted; Well developed; Pleasant. Obese.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; No maxillary or frontal sinus tenderness. Throat- pink without exudates. No anterior or posterior cervical nodes palpated; No palpable thyroid abnormality or enlargement.

CARDIOVASCULAR: S1 S2; Regular rate and rhythm; No systolic ejection murmurs noted; No carotid bruits noted. No peripheral edema bilateral lower extremities.

RESPIRATORY: Breath sounds equal and unlabored. Clear to auscultation bilaterally without wheezes, rales, or rhonchi.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

MUSCULOSKELETAL: Normal range of movement x 4 extremities; 2+ DP and PT pulses bilaterally

INTEGUMENTARY: Warm, dry, intact. No lesions or rash noted.

NEUROLOGIC: Alert and Oriented X3. CN II-XII intact. Sensation intact. Speech clear. Ambulates with steady gait.

PSYCHIATRIC: Appropriate mood and affect.

ORDERS:

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TSH (QUEST) (1 unit(s)): Quest Diagnostics

COMP METABOLIC PANEL (QUEST) (1 unit(s)): Quest Diagnostics

LIPID PANEL (QUEST) (1 unit(s)): Quest Diagnostics

CBC W/ DIFF (QUEST) (1 unit(s)): Quest Diagnostics

EKG (1 unit(s)): Office Procedure

HEMOGLOBIN A1c (1 unit(s)): Quest Diagnostics

ASSESSMENT:

Z00.00 - Encounter for general adult medical examination without abnormal findings (PRIMARY)

I10 - ESSENTIAL (PRIMARY) HYPERTENSION

E66.01 - MORBID (SEVERE) OBESITY DUE TO EXCESS CALORIES

G47.33 - Obstructive sleep apnea (adult) (pediatric)

Z83.3 - FAMILY HISTORY OF DIABETES MELLITUS

PLAN:

EKG- NSR at 71 BPM with no ischemic changes.

Start amlodipine for HTN. Follow up with labs. Given BP log to return at follow up in 2 weeks. Information given on DASH diet for weight loss and low sodium diet as well. Recommended exercises program. He declined echo for HTN eval at this time.

amlodipine 10 mg tablet

Refills: 1 Qty: 30 TABLET(S)

Instructions: TAKE 1 TABLET (10 MG) BY ORAL ROUTE ONCE DAILY for High blood pressure.

Electronically signed by Lindsey Barton, CRNP on 05/28/21 10:28 AM



J. Barton, CRNP