

Auburn Montgomery Student Health Services

7461 East Dr STE 102
Montgomery AL, 36117-8092
(334) 244-3281

Date: 07/28/22

PATIENT: DENT, PAMELA **DOB:** 08/11/1960 **Gender:** FEMALE **MRN:** 493 **AGE:** 61 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: N/V/D for 7 days

HISTORY OF PRESENT ILLNESS: Pt is a 61 YOF who comes in with c/o N/V/D that started Friday after eating a chicken sand-which and cole slaw. She reports vomiting 19 times Saturday, continues to have nausea without vomiting today. She had 4 episodes of diarrhea today. She has not ate or drank much this week. She had two pieces of toast today with very little fluids. She has history of heart palpitations. Recent heart palpitations with racing heart today. BP elevated in clinic. Reports fatigue and SOB. Denies fevers.

VITALS: BP: 152/98 **Pulse:** 130; **Temp:** 98.6; **Resp:** 20; **Ht:** 66 in.; **Wt:** 168 lbs.; **BMI:** 27.11; **Pulse Oximetry:** 97%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Inderal LA 120 mg capsule,extended release (One tablet PO daily)
Protonix 40 mg granules delayed-release packet (1 tablet PO daily)
Synthroid 100 mcg tablet (1 tablet PO daily)

PAST MEDICAL HISTORY: Migraines, infertility, hypothyroidism, GERD, postpartum CHF, tachycardia (Cardiologist Dr. Paul Moore).

PAST SURGICAL HISTORY: Right lobe of thyroid removed, c-section

SOCIAL HISTORY: Does not use alcohol; Does not exercise regularly; Does not use recreational drugs; Does not use tobacco;

FAMILY HISTORY:

Mother with history of:Lung Ca, hyperlipidemia
Father: hyperlipidemia, HTN
Grandparents: unknown

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.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI.

CARDIOVASCULAR: S1 S2; Regular rate and rhythm; No systolic ejection murmurs 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.

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

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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:

EKG (1 unit(s)): Office Procedure

ASSESSMENT:

R00.0 - TACHYCARDIA, UNSPECIFIED (PRIMARY)

R94.31 - Abnormal electrocardiogram [ECG] [EKG]

R06.02 - Shortness of breath

R11.2 - Nausea with vomiting, unspecified

R19.7 - Diarrhea, unspecified

PLAN:

HR 150 upon arrival. EKG showed HR 130 with tachycardia and abnormal ST waves in lateral leads. No previous EKG to compare. Due to recent N/V/D, likely dehydrated. BP elevated. Hx of heart palpitations and CHF. Based on abnormal HR and BP along with fatigue and SOB on exam, asked to proceed to BMCE. She agrees. Offered EMS, she would like to go POV. Hx of seeing Dr. Moore at MCA. Defer further rec's to the ER. PT agrees to go.

Electronically signed by Maranda Fain, CRNP on 07/28/22 2:23 PM

M. Fain, CRNP