

Auburn Montgomery Student Health Services

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

Date: 04/21/22

PATIENT: GRAY, DEVONNA **DOB:** 03/25/1961 **Gender:** FEMALE **MRN:** 4959 **AGE:** 61 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: BP follow up

HISTORY OF PRESENT ILLNESS: Mrs. Gray is a 61 yo female here today for BP follow up. Her BP in Feb was 160/73 in clinic and 140/78 in Oct. in clinic. She is currently on HCTZ once daily. She has been monitoring her BP at home and has brought in her BP log for review. Avg. BP is between 120s/60s- 130s/70s.

She also c/o right foot pain for the past 2-3 days. She has been trying to walk more for exercise and using sole inserts in her shoes. She has also used a roller to roll out the bottom of her foot for pain relief and this does help. Denies injury.

VITALS: BP: 157/80 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 76; **Temp:** 97.6; **Resp:** 16; **Ht:** 64 in.; **Wt:** 206.4 lbs.;
BMI: 35.42; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

cyclobenzaprine 5 mg tablet (TAKE 1 TABLET (5 MG) BY ORAL ROUTE 3 TIMES PER DAY as needed for muscle spasms.)

hydrochlorothiazide 25 mg tablet (1 TABLET DAILY)

ibuprofen 800 mg tablet (1 tablet every 8 hrs as needed for pain.)

omeprazole 40 mg capsule, delayed release (1 TABLET DAILY)

valacyclovir 1 gram tablet (1 TABLET DAILY)

PAST MEDICAL HISTORY: HTN, GERD; COVID August 2021. LLE DVT Sept. 2021. Chronic low back pain with left sciatica.

PAST SURGICAL HISTORY: Cholecystectomy

SOCIAL HISTORY: Recently moved here from New York with family. Works at AUM. Denies tobacco and illicit drug use. Admits to occasional alcohol intake.

FAMILY HISTORY:

HEALTH MX HISTORY:

Colonoscopy 2012 reportedly normal. Hemocult cards normal in 2019.

Mammogram- 2019- reportedly normal.

Pap smear- 2020- reportedly normal.

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.

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

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

MUSCULOSKELETAL: Normal range of movement x 4 extremities; 2+ DP and PT pulses bilaterally. + able to bear full weight on right foot. + TTP to right volar mid foot.

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.

ASSESSMENT:

I10 - Essential (primary) hypertension (PRIMARY)

M79.671 - Pain in right foot

PLAN:

Continue HCTZ as prescribed. BP is stable at home. Recommended otc ibuprofen as needed for foot pain, rest, and continue to use sole inserts. Follow up if no improvement or worsening symptoms. She was given copies of her recent mammogram and US reports. She was given instructions to call CCG to schedule her colonoscopy.

Electronically signed by Lindsey Barton, CRNP on 04/21/22 3:42 PM

A handwritten signature in blue ink that reads "J. Barton, CRNP". The signature is written in a cursive, flowing style.