

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

WHITE, KARAN (id #198388, dob: 05/02/1966)**Encounter Date: 12/29/2021****Patient****Name**

WHITE, KARAN (55yo, F) ID# 198388

Appt. Date/Time 12/29/2021 10:30AM**DOB**

05/02/1966

Service Dept. MCA East**Provider**

SUSHANT KHAIRE, MD

Insurance

Med Primary: BCBS-AL (PPO)

Insurance # : QAU836774996

Policy/Group # : 37655

Referring Provider Name : FAIN, MARANDA, CRNP

Prescription: PRIME BCBS ALABAMA - Member is eligible. details

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Chief Complaint**Transition of Care Encounter**

Cardiac Evaluation and Management

Followup: Atypical chest pain

Followup: History of SARS-CoV-2

Followup: Body mass index 30+ - obesity

Patient's Care Team**Referring Provider (Primary Insurance):** FAIN, MARANDA, CRNP: PO BOX 244023, AUM HEALTH SERVICES, MONTGOMERY, AL 36124, Ph (334) 244-3281, Fax (334) 244-3396**Patient's Pharmacies****CVS/PHARMACY #3095 (ERX): 6891 VAUGHN ROAD, MONTGOMERY, AL 36116, Ph (334) 396-8669, Fax (334) 396-7525****Vitals****Ht:** 5 ft 7.2 in
12/29/2021 10:17
am**Wt:** 192 lbs 12/29/2021
10:21 am**BMI:** 29.9 12/29/2021
10:21 am**BP:** 116/70 sitting
12/29/2021 10:24
am
116/70 sitting
12/29/2021 10:31
am**HR:** 74 12/29/2021
10:31 am**Allergies**

Reviewed Allergies

NKDA

Medications

M. Fain CRNP
2/7/22
725am

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Reviewed Medications

Allergy Relief (cetirizine)

12/29/21 entered

Cough and Cold Mucus Relief CF
twice a day

12/29/21 entered

Iron (ferrous sulfate) 325 mg (65 mg iron) tablet
Take 1 tablet(s) every week by oral route.

12/29/21 entered

multivitamin

12/29/21 entered

phentermine 37.5 mg tablet
Take 1 tablet(s) every day by oral route.

12/29/21 entered

turmeric

12/29/21 entered

TylenoL
as needed

12/29/21 entered

Vaccines

Reviewed Vaccines

Vaccine Type	Date	Amt	Route	Site	NDC	Lot #	Mfr	Exp	VIS Date	VIS Given	Vaccinator
COVID-19											
COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose (Pfizer-BioNTech)	09/01/21										
COVID-19, mRNA, LNP-S, PF, 30 mcg/0.3 mL dose (Pfizer-BioNTech)	08/01/21										

Problems

Reviewed Problems

- Body mass index 30+ - obesity - Onset: 12/28/2021
- Fatigue - Onset: 12/29/2021
- Dyspnea on exertion - Onset: 12/29/2021
- Atypical chest pain - Onset: 12/28/2021
- History of SARS-CoV-2 - Onset: 12/28/2021

Family History

Reviewed Family History

Social History

Reviewed Social History

Diet and Exercise

What type of diet are you following?: Regular

What is your exercise level?: Occasional

Marriage and Sexuality

What is your relationship status?: Divorced

How many children do you have?: 3

Advanced Directive

Do you have an advanced directive?: No

Do you have a medical power of attorney?: No

Substance Use

Do you or have you ever smoked tobacco?: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine?: No

What was the date of your most recent tobacco screening?: 12/29/2021

MCA Cardiology

Living Will: No

Do you consume Caffeine?: Yes 3-4 beverages per day

Do you use alcohol?: Yes

Do you currently use drugs?: No

Gender Identity and LGBTQ Identity

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WHITE, KARAN (Id #198388, dob: 05/02/1966)**Surgical History**

Reviewed Surgical History

• Varicose Vein Ablation/Surgery - 2013

GYN History

None recorded.

Obstetric History

None recorded.

Past Pregnancies

None recorded.

Past Medical History

Reviewed Past Medical History

Documents for Discussion

N/A

Screening

None recorded.

HPI

Ms Karen White is a 55 year old female with history of Covid kindly referred by NP Maranda Fain for evaluation and management of chest pain. She describes the chest pain as a sharp pain that does not radiate. The first noticed the sharp discomfort following her Covid vaccines, last in September. She denies any dyspnea, nausea or cold sweats. Each episode lasts only a few seconds and last occurred two days ago. There are no specific precipitating, aggravating or relieving factors. She also has noticed fatigue and dyspnea on exertion in last 3 months which has remained stable. Otherwise today she denies any pre syncope/syncope. Denies any orthopnea, PND, LE swelling or claudication. She is a lifetime nonsmoker and denies any history of illicit drug or alcohol abuse. Her family history is limited due to being adopted.

ROS

General: General: no recent weight gain or loss; no fever, weakness, night sweats, exercise intolerance, or malaise or general aches; and **fatigue**.

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.

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: Peripheral Vascular: no lower extremity 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 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/purpura.

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 mood 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.

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Hematologic/Lymphatic: Hematologic/Lymphatic no swollen glands, excessive bleeding, or unusual bleeding tendency and **easy bruising**.

Allergic/Immunologic: Allergy/Immunologic: no itching, hives, runny nose, sinus pressure, or frequent sneezing.

Physical Exam

Patient is a 55-year-old female.

Constitutional: General Appearance: well-nourished, well-developed, and appears stated age. Level of Distress: comfortable. CSHA Clinical Frailty Assessment 2: Well appearing.

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. Ears: normal hearing. Nose: no lesions on external nose.

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

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

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

Cardiovascular: Precordial Exam: no heaves or precordial thrills. 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 or edema and normal temperature and **varicosities**.

Peripheral Pulses: Radial Pulse: normal. Posterior Tibialis Pulse normal. Dorsalis Pedis Pulse: normal. Popliteal Pulse: normal.

Abdomen: Inspection and Palpation: soft, non tender, and no masses.

Musculoskeletal: Inspection: no erythema or joint swelling.

Neurologic: Gait: normal gait. Motor: normal strength. Neurological: speech fluent.

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

Lymph Nodes: Cervical Nodes: no significant adenopathy.

Grace Cotter, LPN present during the exam

Procedure Documentation

None recorded.

Assessment / Plan

Ms. White's chest pain is not typical for angina. However, her shortness of breath and fatigue could be angina equivalent. I will check a treadmill stress test and echocardiogram to further risk stratify symptoms.

ECG: Sinus rhythm, low-voltage QRS in precordial leads. Compared to previous ECG from 12/8/21 low voltage QRS are now present.

1. Atypical chest pain

R07.89: Other chest pain

- ELECTROCARDIOGRAM

2. Dyspnea on exertion

R06.09: Other forms of dyspnea

3. Fatigue

R53.83: Other fatigue

Patient Instructions

- Advised to adhere to a low fat diet.
- Advised to limit sodium (salt) intake.
- Instructed patient on the benefits of weight loss for better health. You can download the My Fitness Pal app. Follow up with PCP for further management.
- Re-enforced importance of medication compliance as prescribed.

Discussion Notes

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- I have discussed with patient the importance of regular exercise and recommended starting or continuing a regular exercise program for good health based on the results of the stress test.

Return to Office

- to see Nuclear Medicine for Standard Stress Test at MCA East on or around 12/29/2021
- to see Echocardiogram for Echocardiogram at MCA East on or around 12/29/2021
- to see James McGough CRNP for Return MLP at MCA East on or around 12/29/2021

Encounter Sign-Off

Encounter signed-off by Sushant Khaire, MD, 12/29/2021.

Encounter performed and documented by Sushant Khaire, MD

Encounter reviewed & signed by Sushant Khaire, MD on 12/29/2021 at 10:46am