

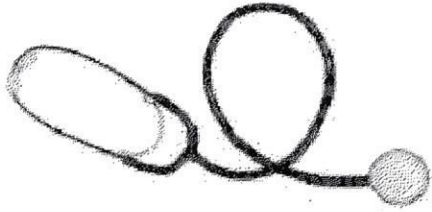


F A X S H E E T

Date: Jun-15-2023 05:38:09
To:
Subject: Faxing Multiple Encounters
Fax Number: 3342443396
To Company:
From Name: Metz,Alyssa
From Company: Valley Internal Med And Pediatrics
From Facility: Valley Internal Med And Pediatrics
Support Contact: 256-325-7425
Number of Pages(s): 10

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6/16/23
Reviewed +
Requested labs
to be faxed w/ee
J. Branton, MD



WALKER, DAVID M

61 Y old Male, DOB: 05/28/1960

Account Number: 62927

13501 WISTERIA PL, ATHENS, AL-35613-8224

Home: 251-366-0029

Guarantor: WALKER, DAVID M Insurance: BCBS

ALABAMA Payer ID: 00510

PCP: Akram Haggag

Appointment Facility: Valley Internal Med And Pediatrics

05/04/2022

Appointment Provider: Jared connor, NP

Supervising Provider: Akram Haggag, MD

Current Medications

Taking

- Gabapentin 300 MG Capsule 1 capsule Orally three times a day
 - Pepcid
 - IBU 800 MG Tablet 1 tablet with food or milk as needed Orally BID
 - Lisinopril-hydroCHLORothiazide 20-12.5 MG Tablet 1 tablet Orally Once a day
 - Glimepiride 2 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day
 - metFORMIN HCl ER 500 MG Tablet Extended Release 24 Hour 1 tablet with meal Orally TID / 1500 mg daily total
 - Ozempic (0.25 or 0.5 MG/DOSE) 2 MG/1.5ML Solution Pen-injector 0.5 mg Subcutaneous once weekly as directed , stop date 10/03/2022
 - NovoFine 32G X 6 MM Miscellaneous as directed with ozempic SQ once weekly
- Medication List reviewed and reconciled with the patient

Past Medical History

Eye- 2020.
Flu- 01/2020.
Colon- Due.
Tdap-unknown.

Surgical History

No Surgical History documented.

Family History

Father: alive
Mother: alive
Friend(s): diagnosed with DM, HTN
1 brother(s) , 2 sister(s) - healthy.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems

10 point review of system completed as noted above in HPI, otherwise negative.

Reason for Appointment

1. Sick Visit

History of Present Illness

Constitutional:

pleasant male presenting for FU after aspiration during attempt at CESI.

happened yesterday. aspirated on table before steroid injection complete. started on augmentin.

still having some cough and mild hemoptysis as well with this.

Vital Signs

Wt: 184 lbs, Ht: 67 in, BMI: 28.82 Index, HR: 95 /min, BP: 116/70 mm Hg, Oxygen sat %: 95 %, Ht-cm: 170.18 cm, Wt-kg: 83.46 kg.

Examination

General Examination:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

HEAD: normocephalic, atraumatic.

EYES: pupils equal, round, reactive to light and accommodation.

EARS: normal.

ORAL CAVITY: mucosa moist.

THROAT: clear.

NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.

SKIN: no suspicious lesions, warm and dry.

HEART: no murmurs, regular rate and rhythm, S1, S2 normal.

LUNGS: clear to auscultation bilaterally.

ABDOMEN: normal, bowel sounds present, soft, nontender, nondistended.

FEMALE GENITOURINARY: normal.

EXTREMITIES: no clubbing, cyanosis, or edema.

NEUROLOGIC: nonfocal, motor strength normal upper and lower extremities, sensory exam intact.

Assessments

1. Follow-up exam - Z09 (Primary)

2. Aspiration pneumonitis - J69.0

3. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin - E11.65

Treatment

1. Aspiration pneumonitis

Start Albuterol Sulfate HFA Aerosol Solution, 108 (90 Base)

MCG/ACT. 1-2 puffs as needed for SOb/wheeze. Inhalation. q 4-6

metformin, 12 pens as needed for GERD/acid, initiating q 12 hours, 30 days, 1, Refills 1

Notes: suspect ozempic/metformin contributing to delayed gastric emptying prior to procedure the night before despite NPO status after midnight.

continue augmentin. add albuterol. if no improvement check CXR, and consider change abx to clindamycin for better coverage of aspirate.

plan on stop ozempic and cut down on metformin dosing prior to next planned procedure.

2. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin

Notes: CCM, but hold ozempic prior to next procedure. titrate back up at 0.25 mg dosing for 1-2 weeks prior to going back to 0.5 mg dosing. recommend cut down total metformin dosing to 1000 mg daily (whether AM/lunch BID dosing vs 1000mg with early AM dosing) and hopefully cutting out evening dosing will help prevent reflux etc at night as well.

FU labs etc when due again, but will likely have moved to montgomery area by that time. FU with myself or new PCP depending on if established yet or not.

Visit Codes

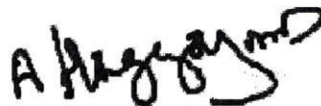
99214 Office Visit, Est Pt., Level 4.

Follow Up

1 Week (Reason: if no improvement)



Appointment Provider: Jared connor, NP



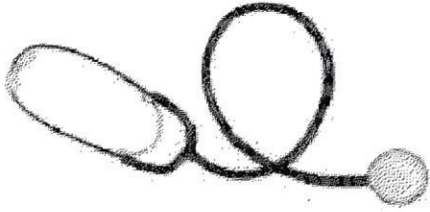
Electronically signed by Akram Haggag , MD on 06/15/2023 at 05:37 PM EDT

Sign off status: Pending

Valley Internal Med And Pediatrics
708 WILL HALSEY WAY
STE A
MADISON, AL 35758-2566
Tel: 256-325-7425
Fax: 256-325-2765

Progress Note: Jared connor, NP 05/04/2022

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)



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Home: 251-366-0029

Guarantor: WALKER, DAVID M Insurance: BCBS

ALABAMA Payer ID: 00510

PCP: Akram Haggag

Appointment Facility: Valley Internal Med And Pediatrics

04/06/2022

Appointment Provider: Jared connor, NP

Supervising Provider: Akram Haggag, MD

Current Medications

Taking

- Pepcid
 - IBU 800 MG Tablet 1 tablet with food or milk as needed Orally BID
 - Lisinopril-hydroCHLORothiazide 20-12.5 MG Tablet 1 tablet Orally Once a day
 - NovoFine 32G X 6 MM Miscellaneous as directed with ozempic SQ once weekly
 - metFORMIN HCl ER 500 MG Tablet Extended Release 24 Hour 1 tablet with meal Orally TID / 1500 mg daily total
 - Ozempic (0.25 or 0.5 MG/DOSE) 2 MG/1.5ML Solution Pen-injector 0.5 mg Subcutaneous once weekly as directed , stop date 04/30/2022
 - Glimepiride 2 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Eye- 2020.
Flu- 01/2020.
Colon- Due.
Tdap-unknown.

Surgical History

No Surgical History documented.

Family History

Father: alive
Mother: alive
Friend(s): diagnosed with DM, HTN
1 brother(s) , 2 sister(s) - healthy.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

No Hospitalization History.

Review of Systems

10 point review of system completed as noted above in HPI, otherwise negative.

Reason for Appointment

1. Lab review

History of Present Illness

Interim History:

This is a pleasant male with diabetes much improved, hypertension not optimal control today and cervicgia with paresthesia to the left upper extremity. He is presenting for lab review and refills today. He is following with TOC. Currently they have him on ibuprofen 800 mg twice daily with Pepcid. This does help to some degree he follows with chiropractor, and has done some therapy. They are probably planning on injection at some point, but he is trying to postpone surgical intervention if possible.

Diabetes much improved with addition of Ozempic. A1c 10.2 down to 7.5. He will continue working on lifestyle endeavors. Labs reviewed in detail, copy given to the patient.

Vital Signs

Wt: 184 lbs, Ht: 67 in, BMI: 28.82 Index, HR: 93 /min, BP: 156/90 mm Hg, Oxygen sat %: 97 %, Ht-cm: 170.18 cm, Wt-kg: 83.46 kg.

Examination

General Examination:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

HEAD: normocephalic, atraumatic.

EYES: pupils equal, round, reactive to light and accommodation.

EARS: normal.

ORAL CAVITY: mucosa moist.

THROAT: clear.

NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.

SKIN: no suspicious lesions, warm and dry.

HEART: no murmurs, regular rate and rhythm, S1, S2 normal.

LUNGS: clear to auscultation bilaterally.

ABDOMEN: normal, bowel sounds present, soft, nontender, nondistended.

FEMALE GENITOURINARY: normal.

EXTREMITIES: no clubbing, cyanosis, or edema.

NEUROLOGIC: nonfocal, motor strength normal upper and lower extremities, sensory exam intact.

Assessments

1. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin - E11.65 (Primary)

2. Essential hypertension - I10
3. DDD (degenerative disc disease), cervical - M50.30

Treatment

1. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin

Refill Glimepiride Tablet, 2 MG, 1 tablet with breakfast or the first main meal of the day, Orally, Once a day, 90 days, 90 Tablet, Refills 1

Refill metFORMIN HCl ER Tablet Extended Release 24 Hour, 500 MG, 1 tablet with meal, Orally, TID / 1500 mg daily total, 90 days, 270, Refills 1

Refill Ozempic (0.25 or 0.5 MG/DOSE) Solution Pen-injector, 2 MG/1.5ML, 0.5 mg, Subcutaneous, once weekly as directed, 90 days, 4.5 mL, Refills 1

Refill NovoFine Miscellaneous, 32G X 6 MM, as directed with ozempic, SQ, once weekly, 90 days, 30, Refills 1

2. Essential hypertension

Refill Lisinopril-hydroCHLORothiazide Tablet, 20-12.5 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 1

3. Others

Notes: Diabetes much improved. Continue current management consider increasing Ozempic to 1 mg weekly, but he would like to continue current management and work on lifestyle changes initially.

Degenerative disc disease of the cervical spine with radiculopathy symptoms. Continue follow-up with orthopedics as directed. Continue current management as otherwise mentioned.

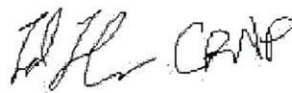
Hypertension. Grossly stable, reports he did not take his blood pressure medication yet this morning and due to traffic and missing exit, running late, he suspects this is somewhat contributing as well. He will continue to monitor closely. Recommend low-sodium diet regular exercise, weight reduction etc.

Visit Codes

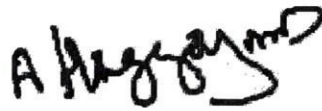
99214 Office Visit, Est Pt., Level 4.

Follow Up

4 Months (Reason: cbc cmp lipid panel a1c thyroid panel PSA prior)



Appointment Provider: Jared connor, NP



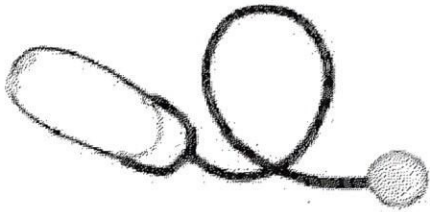
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Progress Note: Jared connor, NP 04/06/2022

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ALABAMA Payer ID: 00510

PCP: Akram Haggag

Appointment Facility: Valley Internal Med And Pediatrics

02/14/2022

Appointment Provider: Jared connor, NP

Supervising Provider: Akram Haggag, MD

Current Medications

Taking

- Pepcid
 - IBU 800 MG Tablet 1 tablet with food or milk as needed Orally BID
 - Lisinopril-hydroCHLORothiazide 20-12.5 MG Tablet 1 tablet Orally Once a day
 - NovoFine 32G X 6 MM Miscellaneous as directed with ozempic SQ once weekly
 - metFORMIN HCl ER 500 MG Tablet Extended Release 24 Hour 1 tablet with meal Orally TID / 1500 mg daily total
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 - Glimepiride 2 MG Tablet 1 tablet with breakfast or the first main meal of the day Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

Eye- 2020.
Flu- 01/2020.
Colon- Due.
Tdap-unknown.

Surgical History

Denies Past Surgical History

Family History

Father: alive
Mother: alive
Friend(s): diagnosed with DM, HTN
1 brother(s) , 2 sister(s) - healthy.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

Denies Past Hospitalization

Review of Systems

10 point ROS completed and as noted above in HPI, otherwise negative.

Reason for Appointment

1. 2 month

History of Present Illness

Constitutional:

pleasant male with HTN which is exacerbated recently, and DM, which appears to be improved based on am glucose readings.

presenting for FU.

saw TOC Dr. boyett in interim. discussed options for DDD. going to chiropractor currently. started on IBU 800 mg BID which helps but has noticed BP up, also having more GERD/reflux symptoms. taking pepcid 20 mg with this to make a generic Duexis prescribed initially by Dr. Boyette.

had COVID jan 23rd, but doing ok now from that standpoint. will return for fasting labs in near future.

Vital Signs

Wt: 180 lbs, Ht: 67 in, BMI: 28.19 Index, HR: 77 /min, BP: 152/102 mm Hg, Oxygen sat %: 98 %, Ht-cm: 170.18 cm, Wt-kg: 81.65 kg.

Examination

Genitourinary:

GENERAL APPEARANCE: in no acute distress, well developed, well nourished.

HEAD: normocephalic, atraumatic.

EYES: pupils equal, round, reactive to light and accommodation.

EARS: normal.

ORAL CAVITY: mucosa moist.

THROAT: clear.

NECK/THYROID: neck supple, full range of motion, no cervical lymphadenopathy.

SKIN: no suspicious lesions, warm and dry.

HEART: no murmurs, regular rate and rhythm, S1, S2 normal.

LUNGS: clear to auscultation bilaterally.

ABDOMEN: normal, bowel sounds present, soft, nontender, nondistended.

EXTREMITIES: no clubbing, cyanosis, or edema.

NEUROLOGIC: nonfocal, motor strength normal upper and lower extremities, sensory exam intact.

Assessments

1. Essential hypertension - I10 (Primary)

2. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin - E11.65

- 3. DDD (degenerative disc disease), cervical - M50.30
- 4. Follow up - Z09

Treatment

1. Essential hypertension

Notes: not optimal control currently.

HH diet recommended, weight loss, regular exercise and hopefully try to decrease NSAID intake which is probably contributing.

we did discuss diet, recommend book "why we get sick" to get more info on insulin resistance which is contributing to HTN and DM, etc.

2. Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin

Notes: CCM and will FU labs in near future. etc.

discussed ALA 1200 mg daily may help with gluc control as well as paresthesia symptoms to some degree.

3. DDD (degenerative disc disease), cervical

Notes: recommend try cutting IBU down to once daily to limit some of its effect on BP and reflux symptoms/side effects.

recommend try CBD oil 25-50 mg dosing probably at night to help with pain overall.

continue FU with TOC otherwise as directed and chiro as already doing.

Visit Codes

99214 Office Visit, Est Pt., Level

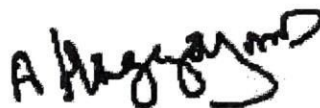
4.

Follow Up

2 Weeks (Reason: cbc cmp a1c prior)



Appointment Provider: Jared connor, NP



Electronically signed by Akram Haggag , MD on 06/15/2023 at 05:37 PM EDT

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