

Auburn Montgomery Warhawk Health Services

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

Date: 09/08/22

PATIENT: ESSEX, LEANDREW **DOB:** 03/07/2002 **Gender:** FEMALE **MRN:** 5180 **AGE:** 20 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: 1 week blood pressure follow up

HISTORY OF PRESENT ILLNESS: Mr. Essex is a 20 yo male here today for HTN follow up. He was prescribed amlodipine 2 weeks ago. He states he did not pick it up. He reported that he had a BP cuff but today states its at his parent's home, so he hasn't been checking his BP. He denies headaches, dizziness, chest pain, palpitations, SOB, or lower extremity swelling. He does not exercise and reports eating a lot of high sodium foods. Both his parents have HTN.

VITALS: BP: 150/98 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 94; **Temp:** 97; **Resp:** 16; **Ht:** 74 in.; **Wt:** 304.1 lbs.;
BMI: 39.04; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

amlodipine 5 mg tablet (TAKE 1 TABLET (5 MG) BY ORAL ROUTE ONCE DAILY for high blood pressure)

PAST MEDICAL HISTORY: HTN

PAST SURGICAL HISTORY: Bil. hip surgery as teenager.

SOCIAL HISTORY: Denies smoking, drinking, or illicit drug use.

FAMILY HISTORY: Mother- HTN; 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.

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.

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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COMP METABOLIC PANEL (QUEST) (1 unit(s)): Quest Diagnostics
CBC W/ DIFF (QUEST) (1 unit(s)): Quest Diagnostics
TSH (QUEST) (1 unit(s)): Quest Diagnostics
LIPID PANEL (QUEST) (1 unit(s)): Quest Diagnostics
EKG (1 unit(s)): Office Procedure

ASSESSMENT:

I10 - ESSENTIAL (PRIMARY) HYPERTENSION (PRIMARY)

PLAN:

EKG- NSR at 93 BPM w/ no ischemic changes.

Recommended he pick up the amlodipine and take as prescribed. Requested he get a BP cuff and check his BP twice daily. He was given a BP log. He was also given the option to stop by the clinic to have his BP checked a few times each week until his follow up. Given guidelines on low sodium diet (DASH diet instruction sheet given). Recommended he start an exercise program and encouraged weight loss. He verbalized understanding. Follow up in 2-3 weeks for recheck.

Electronically signed by Lindsey Barton, CRNP on 09/08/22 3:13 PM

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