

Auburn Montgomery Student Health Services

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

Date: 01/24/22

PATIENT: BANKS, DEREK **DOB:** 04/21/1977 **Gender:** MALE **MRN:** 5187 **AGE:** 44 Years

VISIT TYPE: Office Visit New

CHIEF COMPLAINT: SOB, Fatigue, CP

HISTORY OF PRESENT ILLNESS: Pt is a 44 YOM with a PMH of HTN and HLD. He comes in today with c/o increased SOB and fatigue with ADLs and climbing stairs for 2 weeks now. He is on Norvasc for BP, but he does not check BP at home. He denies syncope, near syncope, edema, orthopnea. He has had CP that is upon wakening in the AM, with radiation to his left shoulder. He feels he can feel his pulse in his arm when he wakes up with the CP. It is usually a 6/10 pain in the AM. No CP currently. It does not last long.

VITALS: BP: 146/95 **Pulse:** 82; **Temp:** 96; **Resp:** 17; **Ht:** 72 in.; **Wt:** 205 lbs.; **BMI:** 27.8; **Pulse Oximetry:** 99%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

amlodipine 5 mg tablet (one tab PO daily)

PAST MEDICAL HISTORY: HTN, HLD

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Denies tobacco, ETOH, illicit drug abuse. Works on campus.

FAMILY HISTORY: Father-stroke, still living, currently age 75. No other CV history reported.

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, EOML.

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.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended.

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.

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ORDERS:

EKG (1 unit(s)): Office Procedure

ASSESSMENT:

R07.9 - CHEST PAIN, UNSPECIFIED (PRIMARY)
R06.00 - DYSPNEA, UNSPECIFIED
R53.83 - OTHER FATIGUE
I10 - ESSENTIAL (PRIMARY) HYPERTENSION
E78.5 - Hyperlipidemia, unspecified

PLAN:

Pt here with CP, SOB, fatigue. EKG showed NSR, normal rate. No history of CV disease, but he has RF that include: HTN, HLD, over weight. Will increase Norvasc to 10 mg, he will call if he develops any LE edema. Will refer to Cardiology. He agrees.

Referral: Khaire, Sushant (Cardiology)

Instructions: CP, SOB, fatigue, Hx of HTN and HLD. EKG normal.

amlodipine 10 mg tablet

Refills: 6 Qty: 30 TABLET(S)

Instructions: TAKE 1 TABLET (10 MG) BY ORAL ROUTE ONCE DAILY

Electronically signed by Maranda Fain, CRNP on 01/24/22 10:24 AM

M. Fain, CRNP