

Auburn Montgomery Warhawk Health Services

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

Date: 12/02/22

PATIENT: GREEN, LATARCHIA **DOB:** 08/21/1975 **Gender:** FEMALE **MRN:** 5245 **AGE:** 47 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: BP follow up

HISTORY OF PRESENT ILLNESS: Ms. Green is a 47 yo female here today for BP follow up. See BP log scanned in. BP ranges from 139-150s systolic. Denies chest pain, SOB, or swelling in legs. She reports she has never had a problem with her BP in the past. She does not exercise as she has 3 jobs and just doesn't have the time.

VITALS: BP: 155/77 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 82; **Temp:** 97.8; **Resp:** 16; **Wt:** 256.8 lbs.; **Pulse Oximetry:** 97%

ALLERGIES: adhesive tape

MEDICATIONS:

Bromfed DM 2 mg-30 mg-10 mg/5 mL oral syrup (TAKE 10 MILLILITERS BY ORAL ROUTE EVERY 8 hrs as needed for cough/congestion)
multivitamin tablet

PAST MEDICAL HISTORY: Endometriosis, uterine fibroids, anemia.

PAST SURGICAL HISTORY: partial hysterectomy (still has ovaries) 2014. Left breast biopsy (benign) 2020. Lipoma right axilla removed in 1994. C-section 1996. Left femur surgery in 2011.

SOCIAL HISTORY: Works in the cafe on campus. Denies smoking, drinking, or illicit drug use.

FAMILY HISTORY: Mother- HTN.

HEALTH MX HISTORY:

Former PCP was Dr. Chamnong until her insurance changed. Now she does not have a PCP.

GYN- Dr. Waller.

Mammogram- 2020.

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.

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

MUSCULOSKELETAL: Normal range of movement x 4 extremities

INTEGUMENTARY: Warm, dry, intact. No lesions or rash noted.

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NEUROLOGIC: Alert and Oriented X3. CN II-XII intact. Sensation intact. Speech clear. Ambulates with steady gait.

PSYCHIATRIC: Appropriate mood and affect.

ORDERS:

EKG (1 unit(s)): Office Procedure

ASSESSMENT:

I10 - ESSENTIAL (PRIMARY) HYPERTENSION (PRIMARY)

PLAN:

Follow up with lab results. Start norvasc 5 mg once daily for HTN. Discussed weight loss, start exercise program, and low sodium diet 2gm per day. Follow up in 2 weeks with BP log for review.

Norvasc 5 mg tablet

Refills: 1 Qty: 30 TABLET(S)

Instructions: TAKE 1 TABLET (5 MG) BY ORAL ROUTE ONCE DAILY FOR HTN

Electronically signed by Lindsey Barton, CRNP on 12/02/22 3:26 PM

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