

River Oak Medical
277 Huntress Street
Wetumpka AL, 36092-3329
(334) 567-3309

Date: 01/14/25

PATIENT: SMITH, HOLLY **DOB:** 03/21/1981 **Gender:** FEMALE **MRN:** 40849 **AGE:** 43 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: AWV

HISTORY OF PRESENT ILLNESS: Pt is a 43 year old female here for her AWV

No complaints at this time.

VITALS: BP: 118/72 **Site:** Left Arm **Position:** Sitting **Pulse:** 78; **Temp:** 95.9; **Resp:** 16; **Ht:** 66 in.; **Wt:** 192 lbs.; **BMI:** 30.98; **Pulse Oximetry:** 99%

ALLERGIES: Bactrim; SULFA-MAX (product)

MEDICATIONS:

Flonase Allergy Relief 50 mcg/actuation nasal spray,suspension (q 4hrs)

Iron (ferrous sulfate) 325 mg (65 mg iron) tablet (po qd)

Zyrtec 10 mg tablet (po qd)

azelastine 137 mcg-fluticasone 50 mcg/spray nasal spray (daily)

hydrochlorothiazide 12.5 mg tablet (po qd)

omeprazole 20 mg capsule,delayed release (po qd)

potassium chloride ER 20 mEq tablet,extended release (1 TAB PO QD)

PAST MEDICAL HISTORY:

High cholesterol

Acid reflux

Eczema

Meniere's

PAST SURGICAL HISTORY:

Breast reduction

Cesarean section

SOCIAL HISTORY: Patient does not have an advance directive; Does not consume alcohol; Does not smoke; Counseled for nutrition. Counseled for physical activity. Patient has No Advanced Directive.

FAMILY HISTORY:

Diabetes- GP

Heart disease- GP

High cholesterol-DAD, GP

COPD-GP

High blood pressure-Mom, GP

HEALTH MX HISTORY: Last Mammogram Date: April 2024

Last Pap Smear Date: Feb 2024

REVIEW OF SYSTEMS:

CONSTITUTIONALS: The patient denies: Fatigue, chills, fever, night sweats

HEENT: The patient denies: Nasal congestion, sore throat, headaches;

3/25/25
Reviewed
J. Hinton
C. H.

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CARDIOLOGIC: The patient denies: Palpitations, chest pain, orthopnea, or peripheral edema.

RESPIRATORY: The patient denies: Shortness of breath, dyspnea on exertion;

GASTROINTESTINAL: The patient denies: Nausea, vomiting, diarrhea, constipation, reflux symptoms, abdominal pain, hematemesis, hematochezia or black tarry stools, or change in bowel habits.

GENITOURINARY: The patient denies: Dysuria, hematuria, nocturia, frequency, urgency, or flank pain.

MUSCULOSKELETAL: The patient denies: Neck pain, back pain

INTEGUMENTARY: The patient puncture wound to right lower leg

NEUROLOGIC: The patient denies: focal deficits, sensory deficits, or motor deficits.

PSYCHIATRIC: The patient denies anxiety, depression, change in mood, or change in affect.

PHYSICAL EXAMINATION:

GENERAL: Alert and oriented x 3 and in no acute distress. Well-nourished and well-developed.

HEENT: Head is normocephalic and atraumatic. Pupils are equal, round and reactive to light and accommodation. Extraocular muscles are intact. Throat is clear; External auditory canals are clear bilaterally. Tympanic membranes are clear with good light reflex bilaterally. Conjunctivae are clear bilaterally.

NECK: Supple without lymphadenopathy, thyromegaly, masses or bruit.

CARDIOVASCULAR: Regular rate and rhythm without murmurs, rubs or gallops.

RESPIRATORY: Clear to auscultation bilaterally

GASTROINTESTINAL: Abdomen is soft, nontender and nondistended with active bowel sounds. There are no masses, hepatosplenomegaly or bruit. No guarding, rebound, or abnormal pulsations.

MUSCULOSKELETAL: The spine is midline and nontender. There is full range of motion on flexion, extension, right and left lateral motion and twisting motion.

DERMATOLOGIC: Small puncture site to right lateral achilles tendon; No erythema or drainage

NEUROLOGIC: Cranial nerves II through XII are intact.

PSYCHIATRIC: Normal judgement, mood and affect. No suicidal or homicidal ideations.

ORDERS:

*Venipuncture (1 unit(s)): In-House Lab
Hemoglobin A1C (1 unit(s)): Other External
Lipid Panel (1 unit(s)): Other External
CMP (1 unit(s)): Other External
CBC w/diff (Complete Blood Count) (1 unit(s)): Other External
Preventive Medicine Services Est pt - Adult 40-64 (1 unit(s)): EM Code
Cognitive Function Assessment (1 unit(s)): HEDIS

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Functional Status assessed (1 unit(s)): HEDIS

Pain Severity quantified - No pain present (1 unit(s)): HEDIS

ASSESSMENT:

Z00.00 - ENCNT FOR GEN ADULT MEDICAL EXAM W/O AB FIND (PRIMARY)

R73.03 - PREDIABETES

E78.2 - MIXED HYPERLIPIDEMIA

K21.9 - GASTRO-ESOPHAGEAL REFLUX DIS WITHOUT ESOPHAGITIS

H81.03 - MENIERE'S DISEASE, BILATERAL

Z68.30 - BODY MASS INDEX (BMI) 30.0-30.9, ADULT.

PLAN:

Pt presents to office today for AWW and routine f/u. Pt states she is feeling well today and has no new complaints.

BP is optimal. I reviewed previous labs. Pt's A1C in Aug was 6.1 and TC was 212. We discussed dietary changes and exercise.

I will check labs today and pt will cont current regimen.

Mammo and Pap are UTD.

Follow up in 6 months.

Electronically signed by Brandy Laurenzi, CRNP on 01/14/25 8:02 AM



Reported Date/Time: 01/15/25 6:17
 MEDICAL DIRECTOR: STEVEN A. MANN, M.D.
 ELMORE COMMUNITY HOSPITAL
 500 HOSPITAL DRIVE
 WETUMPKA, AL 36092
 LABORATORY: COMPARATIVE REPORT
 PAGE: 1
 CLIA#0100680545
 LACUKV2

NAME.: SMITH HOLLY

SEX.....: F

ATTENDING: LAUREN E BRANDY E CRNP

ACCT#: 1012969

AGE.....: 43 Y

SECOND...:

ROOM.: O/P

- NO PENDING ORDERS

DOB.....: 03/21/1981

PRIM CARE,:

PAT. PHONE: 2563227556

ADMIT: 01/14/25

MR#: 148176

CHEMISTRY

Collect Dt/tm	011425 0713	011425 0713	REFERENCE	
Report Dt/tm	011425 1515	011425 1450	RANGE	UNITS
SODIUM		142.0	133 -	145 mmol/L
POTASSIUM		4.30	3.50 -	5.10 mmol/L
CHLORIDE		102.0	98.0 -	107 mmol/L
CO2		30.7	21.0 -	31.0 mmol/L
ANION GAP		9	3 -	11
GLUCOSE		126 H	74 -	106 mg/dL
BUN		16	7 -	18 mg/dL
CREATININE		0.82	0.55 -	1.02 mg/dL
BUN/CREAT		20	6 -	25
TOTAL PROTEIN		6.8	6.4 -	8.2 g/dL
ALBUMIN		3.8	3.4 -	5.0 g/dL
A/G RATIO		1.3	0.8 -	2.0
CALCIUM		9.3	8.5 -	10.1
TOTAL BILI		0.5	0.2 -	1.0 mg/dL
ALKALINE PHOS		59	46 -	116 IU/L
SGOT/AST		23	15 -	37 IU/L
SGPT/ALT		30	14 -	59 IU/L
OSMOLALITY		277	270 -	300 mOsm/K
CHOLESTEROL		263 H	0 -	240 mg/dL
TRIGLYCERIDES		130	0 -	150 mg/dL
HDL		49	40 -	60 mg/dL
LDL		188	75 -	193 mg/dL
RISK FACTOR		5.4		
LDL/HDL		4		
VLDL		26		mg/dL
HGB A1C		6.3 H	4.3 -	6.2 %
eGFR AA		92		mL/min
eGFR NON AFR		76		mL/min
RACE		UNKNOWN		

HDL INTERPRETATION

HDL levels are inversely related to the incidence of coronary heart disease (CHD).

HDL <40 mg/dL

Major risk factor for CHD

HDL ≥60 mg/dL

Negative risk factor for CHD

HGB A1C INTERPRETATION

In the normal 120 day lifespan of the red blood cell, glucose molecules react with hemoglobin, forming glycated hemoglobin. In individuals with poorly controlled diabetes, the quantities of these glycated hemoglobins are much higher than in healthy people.

Once a hemoglobin molecule is glycated, it remains that way. A buildup of glycated hemoglobin within the red cell, therefore, reflects the average level of glucose to which the cell has been exposed during its life cycle. Measuring glycated hemoglobin

REPORTED DATE/TIME: 01/15/25 06:17 SMITH HOLLY

006 Page: 1 CONTINUED

LEGEND: L=Low, H=High, C=Critical, A=Abnormal, *E=Error

Reported Date/Time: 01/15/25 6:17
 MEDICAL DIRECTOR
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ATTENDING: LAURENZI BRANDY E CRNP

SECOND...:

PRIM CARE.:

- NO PENDING ORDERS

CHEMISTRY

assesses the effectiveness of therapy by monitoring long-term serum glucose regulation. The HbA1c level is proportional to average blood glucose concentration over the previous four weeks to three months. Some researchers state that the major proportion of its value is weighted toward the most recent 2 to 4 weeks.

HEMATOLOGY

Collect Dt/tm	011425 0713	REFERENCE	UNITS
Report Dt/tm:	011425 1444	RANGE	
WBC	4.50	3.80 - 10.80	K/UL
RBC	4.91	3.99 - 5.63	M/UL
HEMOGLOBIN	13.4	11.8 - 16.3	g/dL
HEMATOCRIT	40.9	37.7 - 47.9	%
MCV	83.4	77.0 - 94.0	fL
MCH	27.4	26.3 - 32.5	pg
MCHC	32.8	32.5 - 36.0	g/dL
RDW	15.2 H	9.6 - 14.2	%
PLATELETS	334	122 - 366	K/UL
MPV	9.00	6.70 - 9.80	fL
%NEUT	61.0	47.6 - 70.2	%
%LYMPH	25.1	20.6 - 41.7	%
%MONO	7.8	3.1 - 9.9	%
%EOS	5.0 H	0.6 - 4.7	%
%BASO	1.1	0.2 - 1.2	%
%NEUT	2.8	1.9 - 6.8	K/UL
%LYMPH	1.1	1.0 - 3.4	K/UL
%MONO	0.4	0.1 - 0.7	K/UL
%EOS	0.2	0.0 - 0.3	K/UL
MANUAL DIFF	NOT INDICATED		
RBC MORPH	NOT INDICATED		

NORMAL: NONE SEEN