

Auburn Montgomery Warhawk Health Services

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

Date: 03/17/26

PATIENT: JUDY, REBECCA **DOB:** 03/30/1968 **Gender:** FEMALE **MRN:** 5433 **AGE:** 57 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: left upper arm pain since Saturday with tingling feeling to hand

HISTORY OF PRESENT ILLNESS: 57 YO F PTC with c/o left upper arm pain, beginning saturday, denies chest pain or SOB but is noted to be tachycardic which pt states is not normal for her. Pt denies any med changes, new meds, energy drinks etc.

VITALS: BP: 153/82 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 120; **Temp:** 97.4; **Resp:** 18; **Ht:** 67 in.; **Wt:** 171.8 lbs.; **BMI:** 26.9; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Lipitor 20 mg tablet (TAKE ONE PO QHS)
Protonix 40 mg tablet, delayed release (TAKE ON PO QD)
Vyvanse 60 mg capsule (daily)
Wellbutrin XL 300 mg 24 hr tablet, extended release (TAKE ONE PO QD)
hydrochlorothiazide 25 mg tablet (TAKE ONE PO QD)
levothyroxine 25 mcg tablet (daily)
meloxicam 15 mg tablet (daily)

PAST MEDICAL HISTORY: HTN, HLD, Hypothyroidism, ADD, Anxiety, GERD

PAST SURGICAL HISTORY: BTL, Uterine Ablation

SOCIAL HISTORY: Does not use tobacco; Does not use recreational drugs; Consumes alcohol. Frequency: Rarely

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; TACHYCARDIC 120'S 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. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

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:

R00.0 - TACHYCARDIA, UNSPECIFIED (PRIMARY)

R94.31 - Abnormal electrocardiogram [ECG] [EKG]

PLAN:

ABNORMAL EKG-INFERIOR MYOCARDIAL INFARCTION(40+ MS Q WAVE AND OR ST/T ABNORMALITY IN II/AVF) PROBABLY OLD WITH POSTERIOR EXTENSION

VENT RATE 120

PR INT 169

QRS DURATION 94 MS

RESULTS DISCUSSED WITH PT, EMS CALLED FOR TRANSPORT TO ED. PT DOES NOT WISH TO TAKE AMBULANCE TO ED, DISCUSSED WITH PT RISKS OF POV, SUCH AS LOSS OF CONSCIOUSNESS, SUDDEN DEATH. PT AGREEABLE TO EMS COMING TO EVALUATE HER.

EMS EVALUATED IN OFFICE, RECOMMEND ER BUT STATE SHE DOES NOT HAVE TO TAKE AMBULANCE IF SOMEONE CAN DRIVE HER. PT AGREEABLE. PT RELEASED WITH DR BLAKE TO TRANSPORT HER TO THE ED. COPY OF EKG AND MED LIST SENT WITH PT.

Electronically signed by Breena Till, CRNP on 03/17/26 2:09 PM

