



CONFIDENTIAL Fax

FROM:

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[ID:8449458-H-11015]

*Reviewed
Ophelia Luther*

GRIGGS, Kendra (id #375200, dob: 03/09/1997)



 A BAPTIST MEDICAL CENTER EAST FACILITY

ENCOUNTER REASON/DATE

Transition of Care Encounter

Cardiac Evaluation and Management

09/30/2025 - 09:00AM - BH MCA East

This is a summary of today's visit. Full record of visit is available upon request.

HISTORY OF PRESENT ILLNESS

Ms. Kendra Griggs is a 28 yr old female referred by Lindsey Barton, NP for cardiac evaluation and management of multiple sx including fatigue, dizziness, palpitations, and intermittent CP. She also has h/o colitis, HLD, and admits to snoring. Today patient feels well but admits to some anxiety about the appointment. She states that her average BP is ~125/85. Her symptoms are very random and she describes a feeling of chest "squeezing" and pressure and SOB that lasts about 2 minutes. Her fatigue is also random and admits to 6-7 hours of interrupted sleep nightly due to having young children. Her recent sleep study was negative for OSA. Family history positive for HLD. She had some issues with elevated BP at the end of her second pregnancy but did not require treatment.

PROBLEMS

Reviewed Problems

- ✖ Mixed hyperlipidemia
- ✖ Palpitations
- ✖ Chest pain
- ✖ Electrocardiogram abnormal
- ✖ Fatigue
- ✖ Snoring
- ✖ Near syncope

6/18/25 Chol 179, TG 148, HDL 37, LDL 116, TSH 0.921, FT4 1.15, Mg 2.2, Cr 0.69, eGFR 121, normal CBC

ADDITIONAL PAST MEDICAL HISTORY

Reviewed Past Medical History

Anxiety: Y

Depression: Y

Gastrointestinal Disease: Y - hx of colitis

Hyperlipidemia: Y

SURGICAL AND PROCEDURAL HISTORY

Reviewed Surgical & Procedure History

- ✖ Colonoscopy and biopsy of colon - 08/30/2025 - benign polyp

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MEDICATIONS

Reviewed Medications

Stool Softener

09/30/25 entered

Vitamin D

09/30/25 entered

9/30/25 no meds taken AR

ALLERGIES

Reviewed Allergies

NKDA

VITALS

Ht: 5 ft 4 in

Wt: 159 lbs

BMI: 27.3 09/30/2025

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09/30/2025 08:43
am

09/30/2025 08:43
am

08:43 am

BP: 111/75 sitting
09/30/2025 08:49
am

HR: 64 09/30/2025
08:53 am

PHYSICAL EXAM

Constitutional: General Appearance: well-nourished, well-developed, and appears stated age. Level of Distress: comfortable.

Psychiatric: Mental Status: normal affect, concentration, mood, and attention span and alert, cooperative, and cognition intact. Orientation: oriented to time, place, and person.

HEENT: Head: normocephalic and atraumatic. Mouth, Lips, Teeth: no cyanosis or deformity or lesions and normal dentition. Ears: TMs clear, TM mobility normal, and normal hearing. Nose: no lesions on external nose.

Eyes: Lids and Conjunctivae: no discharge, pallor, xanthelasma, or arcus. Pupils: PERRLA and EOM intact.

Neck: Neck: supple, trachea midline, no masses, and normal ROM. Carotid Arteries: no bruits or thrills and bilateral normal upstroke. Jugular Veins: normal jugular venous pressure. Thyroid: not enlarged, non tender, or no nodules.

Lungs: Respiratory Effort: unlabored. Chest Exam: no thoracic deformity or chest wall tenderness and normal curvature. Percussion: resonant. Auscultation: no wheezing, rales, or rhonchi and clear bilaterally.

Cardiovascular: Precordial Exam: no heaves or precordial thrills and non displaced focal PMI. Rate And Rhythm: regular rate and rhythm. Heart Sounds: no rub, gallop, or click and normal S1 and physiologically split S2. Systolic Murmur: not heard. Diastolic Murmur: not heard. Extremities: no cyanosis, edema, clubbing, or peripheral signs of emboli and normal temperature and capillary refill.

Peripheral Pulses: Pulses of Chest and Abdomen: no palpable aortic enlargement or audible aortic bruit. Brachial Pulse: normal and equal bilaterally. Radial Pulse: normal. Femoral Pulse: no bruits appreciated or radial femoral delay and normal. Posterior Tibialis Pulse normal. Dorsalis Pedis Pulse: normal. Popliteal Pulse: normal.

Abdomen: Inspection and Palpation: non distended or tender and soft and no masses. Liver: non tender or no hepatomegaly. Spleen: non tender or no splenomegaly.

Musculoskeletal: Inspection: no joint tenderness or swelling, no erythema, and normal ROM.

Neurologic: Gait: normal gait. Motor: normal strength and tone. Neurological: speech fluent and cranial nerves II-XII grossly intact.

Skin: Inspection and Palpation: skin intact and warm and dry.

Lymph Nodes: Cervical Nodes: no significant adenopathy. Axillary Nodes: no significant adenopathy. Inguinal Nodes: no significant adenopathy.

ASSESSMENT AND PLAN

1. Fatigue, unspecified type

check echo and 14 day monitor, nonspec ST abn noted on EKG
R53.83: Other fatigue

2. Palpitations

no high risk features by history, exam or EKG to suggest a malignant arrhythmia, but will check echo and 2 week monitor as above

R00.2: Palpitations

- * US, ECHOCARDIOGRAM, TRANSTHORACIC, COMPLETE, W/ COLOR FLOW
Contrast: With and Without

Procedure code: 93306

- * HOLTER MONITOR

3. Near syncope

R55: Syncope and collapse

- * ELECTROCARDIOGRAM

4. Mixed hyperlipidemia

urged dietary changes for now, discussed eating more fiber and less meat

E78.2: Mixed hyperlipidemia

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5. Snoring

tested for OSA with negative study

R06.83: Snoring

Patient Instructions

Schedule Echocardiogram, Wearable monitor

Discussion Notes

Patient has agreed to further testing.

Return to Office

- Monitors for 14 day MCOT at BH MCA East on 10/17/2025 at 09:00 AM
- Echocardiogram for Echocardiogram2 at BH MCA East on 11/11/2025 at 01:00 PM

Electronically Signed by: AMY COOPER, MD

