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NPI-XXXXXX
UPIN-X-XX
Medicaid-XXXXXX
Tax-ID XX-XXXX

History Note

Patient: Ruby L Dixon, a 87 year old, White Female, Divorced, Methodist, residing at Autumn Breeze Health Care room

DOS: 3/19/2008 **Chart #:** 88977 **DOB:** 6/9/1920

Primary Insurance: Medicare A **Primary Policy Number:** XXXXXXXX **Secondary Insurance:**

ADVANCED DIRECTIVES: Full Code

PROGNOSIS: Good

CHIEF COMPLAINT: CAD [414.00] Sub endothelial MI,

Patient Request: test patient request

Family Request: test family request

Nursing Request: test nursing request

Diagnostic Result Request: test diagnostic

Regulatory Visit: test reg

Telephone Order: test telephone

Consultant/pharmacist Request: test consultant

HISTORY OF PRESENT ILLNESS: (Comprehensive – Location, Duration, Timing, Quality, Severity, Context, Associated signs and Symptoms, modifying factors):

Past HPI: 87 yo WF recent 3am chest pain, SOB, weakness, episode. ER eval non ST MI with elevated enzymes and chf. Patient also had Bacteremia treated with Zosyn. Hx of C-diff, Diverticulosis, was found to have UTI as source of Bacteremia. Now stable Patient is transferred to MHCR for rehabilitation / Physical Therapy and disposition probably home.

IMPRESSION/DIAGNOSIS/ASSESSMENT/PLAN/CURRENT MEDS:

CAD [414.00] (Improved) Active, 3-New Problem, w/ no addtl work planned;

Assessment: S/P Subendothelial MI c no present signs or symptoms;

Plan: Continue present therapy;

IMDUR (60mg) QD

PRAVACHOL (80) QD

LOPRESSOR (50mg) Q 8 hr

Congestive Heart Failure [428.0] (Improved) Under Control, 3-New Problem, w/ no addtl work planned;

Assessment: No signs or symptoms of CHF;

Plan: Monitor for changes, worsening;

LASIX (20mg) QD

K-DUR (20meq) BID

DVT [453.8] (Improved) Under Control, 3-New Problem, w/ no addtl work planned;

Assessment: Monitor and maintain adequate control of BP's;

Plan: Review med records/ daily nursing assessment;

LISINAPRIL (40mg) QD

NORVASC (10mg) QD

LOPRESSOR (50mg) Q 8 hr

Diabetes Type I [250.01] (Improved) Under Control, 3-New Problem, w/ no addtl work planned;

SYNTHROID (50mcg) QD

Diarrhea [787.91] (Improved) Active,
VANCOMYCIN (250mg) PO Q 8hr

GERD [530.81] (Improved) Under Control,
PRILOSEC (40mg) QD

Hyperlipidemia Other Unspecific Mixed [272.4] (Improved) Active,
PRAVACHOL (40mg) QD

Hypertension Heart Inv [402.90] (Improved) Active, 3-New Problem, w/ no addtl work planned;

Assessment: No s/s of infection;

Plan: Continue Antibiotics to completion;

FLAGYL

Backache Unspecific [724.5] (Improved) Active,

LORTAB (5/500mg) Q 4hr

Diverticulosis Colon [562.10] (Improved) Under Control,

History Note

Trigeminal Neuralgia [350.1] (Improved) Active,
PREDNISONONE (15mg) QD

Overall Risk Level: 4-One or more chronic illness(es) with severe exacerbation or progression

Diet: No special diet requirement.

Ambulation Independent: Geri/chair

ADLS: Eating: Independent **Toileting:** Independent **Dressing:** Independent **Hygiene:** Independent

FAMILY AND SOCIAL HISTORY:

Social History: No glasses, smoking, alcohol use, substance abuse, not a DFAC client.

Former Occupation:

Family History: CAD [414.00]

Chronic Air Obstruction [496]

Fatigue [780.79]

Insomnia Nos [780.52]

Nephrotic Syn In Oth Dis [581.81]

PAST MEDICAL HISTORY

Allergies: NONE

Past Medical/Past Surgical History:

REVIEW OF SYSTEMS: (Through Patient/Staff/Doctor) – Total Systems Reviewed(6), Total Bullets (16)

(3) **Constitutional/Systemic:** well-groomed, fever, insomnia, no other clinically pertinent findings.

(4) **Skin:** good turgor, good color, normal hair distribution, clear skin, no other clinically pertinent findings.

(4) **Pulmonary/Chest:** no productive spittle, no orthopnea, no palpitations, no SOB, no other clinically pertinent findings.

(3) **Neurologic:** Oriented x4, alert, lethargic, anxiety, no other clinically pertinent findings.

PHYSICAL EXAMINATION: Total Systems Reviewed: (5) Total Bullets: (15)

VITALS - Temp: 101 **P:** RR: BP: Wght: Pain: 0 - Denied

(1) **Systemic:** pleasantly confused, no other clinically pertinent findings.

(2) **Skin:** good turgor, good skin color, no other clinically pertinent findings.

(2) **ENT:** dry mouth, neck: pain, no other clinically pertinent findings.

(2) **GU:** female genitalia intact, lesion, no other clinically pertinent findings.

(3) **Extremities:** full range movement - lower, Left foot intact, From x2, no other clinically pertinent findings.

(5) **Vascular:** Pulse status: carotid (4-Normal), radial present (4-Normal), femoral (4-Normal), dorsalis pedis (4-Normal), posterior tibial (4-Normal), no other clinically pertinent findings.

MEDICAL DECISION MAKING:

Problem Points (Max 3): Diagnostic Procedures Data Points (Max 4): Risk Management (Max 4):

Signature: Dr. Joseph T. Hannan

Nurse:

Nursing Facility: Autumn Breeze Health Care

Nursing Facility Code: 99308

Physician License Number: 025759

Guarantor Information: Lloyd Dixon 1590 Longwood Dr, Marietta, GA.

PATIENT NAME: Ruby L Dixon