

XLEMR

Dr. XLEMR

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NAME: Walter L Weeks
DATE: 3/19/2008
CHART: L-11150

HISTORY SUMMARY

AGE: 45 **MARITAL STATUS:** Married **CHILDREN:** 0 **OCCUPATION:** Software Consulting

CHIEF COMPLAINT:

This patient has trouble breathing is asthmatic and has suffered from a fever since the age of three

PRESENT ILLNESS:

IMPRESSION/DIAGNOSIS:

(Under Control)
HYDROCHLOROTHIAZIDE (25mg) BID
ACTIQ (200mcg) QD
(Under Control)
ADVIL (200mg) Q6H PRN
(Under Control)
ALEVE (220mg) BID
ESTRATEST QD
(Resolved By Surgery)
ALPRAZOLAM (1mg) TID
ACYCLOVIR (200mg) QD
(Request Consultation)
ADVAIR (250mcg/50mcg) BID
(New/Pending)
AMBIEN (10mg) HS
(New/Pending)
ALLEGRA D QD
NORVASC (5mg) QD
(Psychiatric Consult)
ADVIL (600mg) Q4H
(Consultation Pending)
ALEVE (220mg) PRN
(Under Control)
ALEVE (220mg) PRN
(Under Control)
AGGRENOX (1 cap) BID
ALDACTAZIDE PRN
ASACOL (400mg) TID

CURRENT MEDICATIONS:

ACTIQ (200mcg) QD
ACYCLOVIR (200mg) QD
ADVAIR (250mcg/50mcg) BID
ADVIL (200mg) Q6H PRN
ADVIL (600mg) Q4H
AGGRENOX (1 cap) BID
ALDACTAZIDE PRN
ALEVE (220mg) PRN
ALEVE (220mg) BID
ALEVE (220mg) BID

ALEVE (220mg) PRN
ALLEGRA D QD
ALLEGRA D (xx) QD
ALPRAZOLAM (1mg) TID
AMBIEN (10mg) HS
ASACOL (400mg) TID
ESTRATEST (xx) QD
ESTRATEST QD
HYDROCHLOROTHIAZIDE (25mg) BID
NORVASC (5mg) QD

PAST MEDICATIONS:

ACCUPRIL (40mg) QD
ADIPEX (37.5mg) QD
ADVIL (200mg) 3 TID
ALDACTAZIDE (xx) PRN
ALLEGRA D (xx) QD
ALPRAZOLAM (1mg) TID
AMBIEN (10mg) HS
ENBREL (50mg) 2Q/WEEKLY
ESTRATEST (xx) QD
xx (xx)

MEDICINAL ALLERGIES:

PREDNISONE
ACTONEL

ergy

ST MEDICAL/PAST SURGICAL HISTORY:

Reviewed and nothing significant was found.

FAMILY HISTORY:

FAMILY PHYSICIAN EXAMINATION:

Sore Throat:

Complaints: No complaints of pain on swallowing, neck pain or fever

Physical Examination: Throat: **Not examined** and **Tender**

Neck: **Not examined**

Thyroid: **Not examined**

Tonsils: **Not examined**

Diagnosis:

URI:

Complaints: No complaints of fever, cough, chest congestion, or sore throat

Duration:

Physical Examination: Throat: **Not examined**

Neck: **Not examined**

Lungs: **Not examined**

Ears: **Not examined**

Diagnosis:

Cough:

Complaints: No complaints of cough

Duration:

Physical Examination: Lungs: **Not examined**

Throat: **Not examined**

Neck: **Not examined**

Diagnosis:

Asthma:

Complaints: No complaints of shortness of breath, history of asthma, wheezing, or cough

Physical Examination: Lungs:
Throat: **Not examined**

Diagnosis:

Sinusitis:

Complaints: No complaints of nasal pain, stuffiness or tooth pain

Duration:

Physical Examination: Nose:
Face: **Not examined**
Throat: **Not examined**

Diagnosis:

Allergies:

Complaints: No complaints of itchy eyes, runny nose or sneezing

Physical Examination: Eyes: **Not examined**
Nose: **Not examined**
Throat: **Not examined**
Lungs: **Not examined**

Diagnosis:

Eyes:

Complaints: No complaints of redness, itchiness, pain, photophobia, foreign body, diplopia or excessive tearing

Duration:

Physical Examination: Vision: **Not examined**
Lids: **Not examined**
Conjunctiva: **Not examined**
Lens: **Not examined**
Vitreous: **Not examined**
Fundus: **Not examined**

Diagnosis:

Headache:

Complaints: No complaints of headache, fever, vomiting, or nausea

Duration:

Physical Examination: Scalp: **Not examined**
Neurological: **Not examined**

Vital Signs: **Not examined**

Diagnosis:

Earache:

Complaints: No complaints of pain in ears **Duration:**

Physical Examination: Throat: **Not examined**
Neck: **Not examined**
Ears: **Not examined**

Diagnosis:

UTI:

Complaints: No complaints of urgency, frequency, dysuria, hematuria, flank or abdominal pain

Physical Examination: Abdomen: **Not examined**

Diagnosis:

GERD:

Complaints: No complaints of post prandial burning, fullness or nausea

Physical Examination: Abdominal: **Not examined**

Diagnosis:

Dysphagia:

Complaints: No complaints of difficulty swallowing

Duration:

Physical Examination: Throat:

Neck: **Not examined**

Diagnosis:

Abdominal Pain:

Complaints: **Duration:**

Physical Examination: Abdomen: **Not examined**

Diagnosis:

Hypertension:

Complaints: No complaints of increased blood pressure or headache

Physical Examination: **Not examined**

Diagnosis:

Chest Pain:

Complaints: No complaints of chest pain or history of CHD

Physical Examination: Lungs: **Not examined**

Heart: **Not examined**

Chest Wall: **Not examined**

Diagnosis:

Hyperlipidemia:

Complaints: No complaints of history of hyperlipidemia

Physical Examination: Heart: **Not examined**

Neck: **Not examined**

Diagnosis:

Diabetes Mellitus:

Complaints: No complaints of fatigue, polyuria, polydipsia, diplopia, or nocturia

Physical Examination: Vital signs: **Not examined**

Fundi: **Not examined**

Diagnosis:

Low Back Pain:

Complaints: No complaints of low back pain

Duration:

Physical Examination: Low Back: **Not examined**

Straight Leg Raises: **Not examined**

Reflexes: **Not examined**

Diagnosis:

Foot Pain:

Complaints: No complaints of pain in foot

Duration:

No complaints of pain in metatarsal area **Duration:**

Physical Examination: **Not examined**

Diagnosis:

Joint Pain:

Complaints: No complaints of joint pain

Duration:

Physical Examination:

Diagnosis:

Rash:

Complaints: No complaints of a rash
Duration:
Physical Examination: Not examined
Diagnosis:

Vaginitis:

Complaints:
Duration:
Physical Examination: Pelvic: **Not examined**
Abdomen: **Not examined**
Diagnosis:

Thyroid:

Complaints: No complaints of hair loss, lethargy, weight loss or gain or history of thyroid disease
Physical Examination: Skin: **Not examined**
Neck: **Not examined**
Diagnosis:

PHYSICAL EXAMINATION: T-98.6, P-82, R-12, BP-120/80, Ht.-70 in., Wt.-211 lbs.

General: The patient is well-developed, well-nourished, alert and oriented, answers appropriately, pleasant and in no acute distress.
Skin: No psoriasis, discoid lesions, malar rash, macular rash, telangiectasias, sclerodactyly, nail pitting, digital ulcers, petechiae, or rosacea.
HEENT: PERRLA, EOMS, temporal arteries are palpable and nontender. Pharynx shows no ulcers or exudates.
Neck: Supple, without lymphadenopathy, thyromegaly, salivary gland enlargement or bruits.
Chest: Clear to auscultation and percussion without rhonchi, wheezes or rales.
Heart: Regular rate and rhythm without murmurs, rubs or gallops.
Abdomen: Soft, nontender No hepatosplenomegaly. Normal bowel sounds.
Extremities: No clubbing, cyanosis or edema. Pulses are palpable.
Vascular: Carotid 4+, radial 4+, ulnar 4+, femoral 4+, popliteal 4+, dorsalis pedis 4+, posterior tibial 4+ bilaterally.
Neuro Exam: Intact to light touch and pinprick. Toes are downgoing, strength is 5/5; DTRs are +1 and symmetrical. Cranial nerves II-VII are intact.
Lymph Nodes: No lymph nodes are noted.

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