Patient #1

**Chief Complaints/ Concerns:**  Allergic Reaction

Patient broke out in hives yesterday; they continue to spread and are itchy. No dysphagia or SOB.

Finished a course of Sulfa for UTI recently.

No prior allergic history. No other known allergies.

Physical exam Respiratory: Normal to inspection. Lungs clear to auscultation. No rales or rubs.

Cardiovascular: Regular rate and rhythm. No murmurs, gallops or rubs.

Integumentary: Urticarial rash on face, bilateral arms, leg, feet, and trunk.

A/P: Severe case of hives. Injection will be provided today along with prescription for prednisone. Patient can also take OTC Benadryl 150mg Q 6 hr. Advised patient to call office if symptoms begin worsening.

Methylprednisolone (Depo-Medrol) Injection 80 mg. 80Mg 1mL IM Today

RX sent to King Sooper for: Prednisone 20 mg/1 tablet PO TID.

Patient #2

Sex: F Age: 67 years

CC: Feels well but still struggling w/weight loss. Here to discuss recent lab work and get refills on her maintance meds: of Synthroid, Simvastatin, Diovan, Lorazepam.

HPI: Still left side sinus congestion at times. Scheduled to for mammogram next week. Const: Denies chills, fatigue, fever and weight change. General health stated as good. Eyes: Denies visual disturbance. CV: Denies chest pain and palpitations. Resp: Denies cough, dyspnea and wheezing. Gl: Denies constipation. diarrhea, dyspepsia, dysphagia, hematochezia, melena, nausea and vomiting. GU: Urinary: denies dysuria, frequency, hematuria, incontinence, nocturia and urgency. Musculo: Denies arthralgias and myalgia. Skin: Denies rashes. Neuro: Denies neurologic symptoms. Psych: Denies psychiatric symptoms.

Current Meds: Reglan 10 mg. Albuterol 90 mcg/act, Prevacid 30 mg, Synthroid 75 mcg, Diovan HCT 80/12.5. Lorazepam 0.5 mg. Simvastatin 20 mg

Allergies: NKDA

PMH: UTI, Cold

Current conditions: Emphysema, Thyroid Disease, Hiatal Hernia Surgeries: Knee Surgery Assistive Devices: Wears glasses. FH: Father: Deceased due to MI. Mother: Deceased due to MI.

SH: Highest level of education completed is 12th grade. Marital status: married. Lives with spouse and 3 dogs. Occupation: Retired. The patient does not have an advance directive.

Personal Habits: Cigarette Use: Never Smoked Cigarettes but sometimes smokes marijuana. Alcohol: None. Drug Use: Denies daily use. Daily Caffeine: Occasionally. Always uses a seat belt.

Objective BP: 112/70 Pulse: 72 T: 98.2 Ht: 63.25" 5'3.25" Wt: 2141b Wt Prior: 2101b as of 06/06/08 Wt Dif: +4lb BMI: 37.6

Exam: Const: Appears obese, in no apparent distress. ENMT: Auditory canals normal. Tympanic membranes are intact. Nasal mucosa is pink and moist. Dentition is in good repair. Posterior pharynx shows no exudate, irritation or redness.

Neck: Palpation reveals no lymphadenopathy, masses or thyromegaly. No JVD.

Resp: Respiration rate is normal. No wheezing. Auscultate good airflow. Lungs are clear bilaterally.

CV: Rate is regular. Rhythm is regular. No heart murmur appreciated.

Extremities: No clubbing, cyanosis or edema.

Abdomen: Bowel sounds are normoactive. Palpation of the abdomen reveals no CVA tenderness, guarding, rebound tenderness, no masses or hepatosplenomegaly.

Musculo: Walks with a normal gait.

Skin: Skin is warm and dry.

Assessment #1: Hypothyroidism – we discussed lab and renewed meds. (Synthroid 75 mcg 1 po qd Lab: Thyroxine Free)

Assessment #2: Hypertension well controlled on current med. Refilled: Diovan HCT 80/12.5 1 po daily

 Assessment #3: Hyperlipidemia Mixed – we discussed labs and renewed med. (Simvastatin 20 mg 1 po qd Lab: Annual Labs for Females)

Assessment #4: Obesity – Continue to encourage patient efforts and explained thyroid is not to blame. No plan currently or medications.

 Assessment #5: Esophageal Reflux – no surgery patient will remain on prevacid. Will renew med - Prevacid 30 mg 1 po qd

Assessment #6: Anxiety Disorder Generalized – per patient rarely uses lorazepam and just as needed. Will renew med: Lorazepam 0.5 mg 1 po bid prn

Assessment #7: Acute Bronchospasm – renew current med: Albuterol 90 mcg/act 2 puffs q4h prn

Discussed flu shot – patient got shot in November 2019 at Walgreens Pharmacy.

Follow-up after labs in 6 months

**Patient #3**

New Patient presents with Pink eye L eye

HPI: L eye matted shut this morning, red itchy watery today

ROS: No fever, no ear pain, rhinorrhea, sore throat, Abd pain, diarrhea, constipation, dysuria, rash or edema

SH: Lives with parents and older sister

FH: Anemia, bowel disorders, htn, asthma/environmental allergies

Allergies: NKDA

Meds: none reported

Vitals: T: 97.8 Wt: 140lb; P: 80; RR:18

PE: vision right 10/10 left 10/13, PERRLA EOMI, no periorbital edema or erythema or tenderness

A/P Conjunctivitis

Advised patient to wash hands often with soap and warm water for at least 20 seconds, avoid touching or rubbing the affected eye. Clean any discharge from around the eye several times a day if needed using a clean wet washcloth or fresh cotton ball.

Rx for Polytrim drops, 3 drops affected eye 5x day for 7 days, #1 bottle