Visit Summary (by El Bow MD, MD)

Patient: Demo Don

DOS: 4/15/22

Office Visit - Rheumatoid Arthritis

El Bow MD, MD (AAOMCP Rheumatology)

**Type**

Progress Note

**Category**

Unspecified

**Encounter Note:**

Routine treatment for rheumatoid arthritis.

Medical History:
Rheumatoid Arthritis diagnosed in 2018.
Seasonal Allergies.

Medications:
Methotrexate 15 mg weekly
Folic Acid 1 mg daily
Ibuprofen as needed for pain
Allergies: No known drug allergies.

Social History:
Non-smoker
Occasional alcohol consumption
Works as a software engineer
Married with two children

Review of Systems:
Joint pain and stiffness, especially in the morning or after periods of inactivity.
No recent fever, rash, or gastrointestinal symptoms.

**Treatment Administered:**

Benadryl 25mg IV Push: Administered as pre-medication to prevent potential allergic reactions to Remicade. The patient showed no immediate adverse reactions.
Solu-Medrol 1gm IV: Infusion began at 10:14completed at 10:46. This corticosteroid was given to reduce inflammation and alleviate acute symptoms of rheumatoid arthritis. The patient was monitored and did not exhibit any adverse reactions.
Remicade 400mg IV: Infusion began at 10:14 and concluded at 12;45. This is part of the patient's biologic treatment regimen for rheumatoid arthritis. The patient tolerated the infusion well, with vital signs remaining stable throughout the procedure.

**Physical Examination:**
Vital Signs: BP 120/80, HR 70, Temp 98.6°F, RR 14.
General Appearance: Well-nourished, well-developed male in no acute distress.
Musculoskeletal: Mild swelling and tenderness noted in the metacarpophalangeal joints.
Skin: No rashes or lesions noted.

**Assessment/Plan:**

Rheumatoid arthritis: Patient is currently on a stable regimen of Methotrexate and biologic therapy with Remicade. Today's infusion was well-tolerated without immediate complications.
Continue current medication regimen. Monitor for any side effects of Remicade, including signs of infection.
Follow-up in 8 weeks for the next scheduled infusion, unless symptoms worsen before then.

Counseling/Education Provided: Discussed the importance of adherence to medication regimen, regular exercise, and a balanced diet to manage rheumatoid arthritis symptoms. Instructed to report any signs of infection, allergic reactions, or other concerning symptoms immediately.

El Bow, M.D.

Patient: Demo Don

DOS: 5/22/22

Reason for Visit hives dizziness ear infection sores in mouth

Vitals:

BMI 25.0 BP 118/72 Height 5' 5" Pulse 96 RR 16 Temp. 98. 2 °F Weight 150 lb O OZ

Subjective: Demo comes to clinic today with cc: ear pain. he said that he went to another doctor for the ear pain and said that he hurt his ear worse. he said that the pain has been there for months. also he has dizziness. he said that this has been going on x 14 days. also he is here for sores in his mouth. he said that he has had the sores in his mouth x 6 months. also he is here for hives. he is said that he has hives off/on x2 mon

CC: cc

sores in mouth - is to see dentist

dizziness

ear infections

HPI: has been to several er's and to his primary provider is upset that no one has found anything wrong with his ear. he states sometimes when he lays on it he is dissy. states has had hives (does not have any now). had sores in his mouth "for a long time" nnw today.

ear pain.

Timing: Gradual

Duration: Intermittent

Severity: Burning ear pain

Hearing loss? No Quality: Sharp pain

Course: Worsening

Location: Right ear REVIEW OF SYSTEMS:

General: Fatigue: Absent Weight gain: Absent Anorexia: Absent Weight Loss: Absent Syncope: Absent Diaphoresis: Absent Fever: Absent

Dermatologic: Rash: Absent Ulcers/Lesions on arms or legs: Absent Changes in moles: Absent

ENT: Diplopia: Absent Blurred vision: Absent Tinnitus: Absent Cold: Absent Swollen glands: Absent Allergies:

Absent

Respiratory: Dyspnea: Absent Cough: Absent Orthopnea: Absent

Cardiovascular: Chest pain: Absent Chest pain at rest: Absent

Chest tightness: Absent Palpitations: Absent OBJECTIVE:

General: Well appearing, well nourished in no distress. Oriented x 3, normal mood and affect.

Skin: good turgor, no rash or prominent lesions

Mouth: Mucous membranes moist, no mucosal lesions.

Eyes: PERLA -- pupils equal, react to light and accommodation.

Conjunctiva is normal, color white, non-injected.

Ears: External ear normal, tympanic membranes dull red and bulging, no light reflex, no mobility on pneumatic otoscopy.

Pharynx: mucosa non-inflamrned, no tonsillar hypertrophy or exudate Neck: supple, without lesions, bruits, or adenopathy, thyroid non-enlarged and non-tender

Heart: no cardiomegaly or thrills; regular rate and rhythm, no murmur or gallop

Lungs: clear to auscultation and percussion, breathing sounds normal

ASSESSMENT: ear pain

PLAN:

have discussed that he needs to f/u with his primary provider - that I did not see anything in his ear or any infection. he may need to see an ent.

Patient: Demo Don

DOS: 06/15/22

Reason for Visit back pian

Vitals:

BMI 24.5 BP 130/70 Height 5' 5" Pulse 88 RR 18 Temp. 98.2 °F Weight 147 lb O OZ

Subjective: Demo comes to clinic with c/o back pain, he says iot has been hurting alot more lately, also has anxiety and would like meds refilled for that.

Objective: lower back pain is increased. he does lift his wife from chair to bed. there have been several deaths in their family and he is having a hard time with it. they like the apt they have found and will move this month.

GENERAL APPEARANCE:

_x_ _w ell developed, well nourished RESPIRATORY:

__ x_ascultation, effort, percussion CARDIOVASCULAR:

_x_rrr w/o murmur,

---x no edema/varicosities GI/ABDOMEN:

_x __ soft, nt, w/o mass, bs normal SKIN:

_x_good color, warm/dry

---x no rash/lesion/mass MUSCULOSKELETAL:

NECK:

_x __ strength/tone/rom BACK/SPINE

_x_strength/tone/rom EXTREMITIES:

_x __ strength/tone/rom _x_no tenderness/swelling OTHER:

_x __ digits/nails

_x __ gait

_x __ reflexes are all 2+/equal bilateral

_x __ sensation nl throughout

---x sensation nl bilat in all extremities Assessment: Problem List:

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia

Plan: xray t &l spine

Rx: Lortab 10/500 500 mg-10 mg 1 tab(s) TIO #90 OR discuss exercises that may help back

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia

Patient: Demo Don

DOS: 7/12/22

Reason for Visit chronic back pain

Vitals:

BMI 24.8 BP 122/70 Height 5' 5" Pulse 104 RR 16 Temp. 98.6 °F Weight 149 lb O OZ

Subjective: Demo comes to clinic today with c/o chronic pain, also c/o left sided abdominal/side pain. He is also depressed, his sister just passed away on New years day, and his daughter Laurie was held hostage in her home on Christmas eve, it make s him sad.

Objective: daughters house was broken into. she was held hostage. and his sister died of heart failure and sister in law die over the weekend. pain in right lower abd. is either constant diarrhea or constipation. states that drinking coke helps. states that the cold weather made his and his wifes pain much worse. his shoulder is hurting again because of moving and lifting. lower back is more painful then before because of moving. abd is soft, non-tender no pain with palpitation.

GENERAL APPEARANCE:

_x_ _ well developed, well nourished RESPIRATORY:

_x_ _ ascultation, effort, percussion CARDIOVASCULAR:

_x_ _r rr w/o murmur, carotid, pedal, and radial pulses wnl x no edema/varicosities

---

GI/ABDOMEN:

_x_ _ soft, nt, w/o mass, bs normal -states has had right bowel pain - not today SKIN:

_x_ _ good color, warm/dry

---x no rash/lesion/mass MUSCULOSKELETAL:

NECK:

__x _strength/tone/rom BACK/SPINE

__x _strength/tone/rom EXTREMITIES:

__x _strength/tone/rom

__ x_no tenderness/swelling

\

PSYCHIATIC: very concerned about his daughter, his wife.      states the moving was hard for him.   both emotionally and physically.

Assessment: Problem List:

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia abd pain right lower

Plan:  lortab 10 1 tid

discuss right lower side pain,.     s/s to watch for and call us

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia

Patient: Demo Don

DOS: 09/14/22

Chief Complaints: ROUTINE PHYSICAL

HPI: The patient comes for Physical Feeling well had high blood pressure today BP 180/110 because didn't take BP pills today. Took Clonidine 0.1 mg after 140/80

Medical History: - Diabetes: - Hypertension: - Heart Disease: - Hyperlipidemia: - GASTRITIS

Hospitalizations: (1) REGIONAL HOSPITAL 2017 CARDIAC SURGERY

Family History: Name Relation DOB Live/Deceased Current Deceased Age Cause

Condition Comment

(1) MARGARITA Mother Deceased 90 RESPIRATORY FAILURE

(2) EMILIO Father Deceased 56 HEART ATTACK

Relative Disease: - Diabetes: MOTHER - High Boold Pressure: FATHER

Allergy: (1) nkda:

**Active Medications:**

Truetest Test Strips (strip , OTC) 1 strip twice a day via meter

simvastatin (tablet 80 mg) 1 tablet every night by mouth

Albuterol Sulfate (Nebu Soln 0.083%) Inhale 1 vial four times a day using nebulizer as needed

losartan (tablet 50 mg) Take 1 tablet once a day by mouth as directed

ranitidine HCl (capsule 150 mg) 1 capsule every night by mouth as directed

metformin (tablet 1,000 mg) 1 tablet twice a day by mouth as directed

metoprolol tartrate (tablet 25 mg) Take 1 tablet once a day by mouth as directed

lisinopril (tablet 2.5 mg) Take 1 tablet once a day by mouth as directed

glipizide (tablet 10 mg) Take 1 tablet twice a day by mouth as directed

Januvia (tablet 25 mg) 1 tablet once a day by mouth

aspirin (tablet,delayed release (DR/EC) 81 mg, OTC) Take 1 tablet once a day by mouth as directed

gabapentin (capsule 300 mg) Take 1 capsule twice a day by mouth as directed

latanoprost (drops 0.005%) Instill 1 drop every night in both eyes as directed

Lancets,Thin (misc , OTC) Use 1 lancet twice a day to skin as directed

strips for glucometer ( ) 1 strip twice a day to skin

Prilosec OTC (tablet,delayed release (DR/EC) 20 mg, OTC) 1 tablet twice a day by mouth

**Surgical History:**

(1) CARDIAC SURGERY 2012 CORONARY BYPASS

(2) LEFT EYE SURGERY 2010 CATARACT

Social History: - Smoking/Use Tobacco: Current every day smoker - Use Alcohol: Yes

SOCIAL - Substance Abuse/Use Drug: No

- Violence or abuse in the home: (including physical, psychological or sexual abuse) No - Sexually Active: Yes
- Occupation: Disabled
- Marital Status: Married
- Live With: With Spouse
- Children: 7

Vaccinations: No significant vaccinations information on file.

Infection History: N/A

Screening Tests: No significant screening test information on file.

X-RAY History: No significant x-ray history information on file.

REVIEW OF SYSTEM RESULTS

General / Constitutional: Negative (Fever, Pain, Anxiousness, Forgetfullness, Chills, Sweating, Loss of sleep, Weight loss, Fatigue, Weight gain, Anorexia, Headache, General malaise, Poor energy, Polydipsia)

Eyes: Abnormal (Vision change (blurriness, decrease ) , Eye glasses. Glaucoma R eye)

Head, Ear, Nose and Throat: Negative (Nasal secretions, Ear discharge, Loss of hearing, Tm perforation or surgery tube, Head trauma, Ulcers in mouth/lips, Bleeding gums, Ringing in the ears, Nasal congestion, Nose bleeding, Nasal polyps, Sinus pain (frontal , maxillar), Sore throat, Aphonia, Dysphagia, Earache)

Cardiovascular: Abnormal (High blood pressure , CABG 2012. Hyperlipidemia.)

Respiratory: Negative (Shortness of breath, Wheezing, Hemoptysis, Cough (dry), Pain with inspiration, Cough (productive))

Gastrointestinal: Negative (Constipation, Gastric reflux, Rectal pain, Poor appetite, Bowel changes, Hemorrhoids, Diarrhea, Flatulence, Bloody

Stool, Abdominal Pain, Nausea/Vomiting/Indigestion, Fecal Incontinence, Epigastric burning, Black stool)

Genitourinary (Male): Negative (Frequency, Incontinence, Post-void dribbling, Nocturia, Genital ulcer/ lesion, Polyuria, Erection difficulties, Dyspareunia, Penile discharge, Lump in testicle, Blood in the urine, Incomplete emptying of urine, Painful urination, Urgency)

Musculoskeletal: Negative (Myalgia, Neck pain, Hip pain, Shoulder pain, Foot pain, Hand pain, Numbness (face), Numbness (extremeties), Knee pain, Heel pain, Muscle weakness, Arthralgia, Muscular Atrophy, Muscle weakness (upper extre), Hemiplegia ( R ), Hemiplegia (L ), Back pain)

Skin: Negative (Dry skin, Change of lesion character (color, size,and borders ), Redness and inflamation, Tinea pedis, Hives, Scars, Sores that won't heal, Mass or induration, Rash, Pigmented lesions, Ulcers, Bruise easily, Tinea corporis, Hematomas, Tinea cruris, Toe nail fungus)

Neurologic: Negative (Trouble walking, Syncope, Seizures, Numbness, Severe memory problems, Burning pain (neuralgia), Headaches, Double vision) Psychiatric: Negative (Anxiety, Depression, Crying, Hallucinations, Suicidal ideation, Homicidal ideation, Sad mood) Endocrine: Abnormal (DM II uncontrolled better)

Hematology/Lymphatic: Negative (Bleeding, Bruises, Adenopathy)

VITAL SIGNS

Temperature: 97.4 Pulse: 78 Respiration: 20 02 Sat: % Blood Pressure: (1) 180/110 (2) 150/80 (60 mins later) (3) 140/80

Weight: 229 lbs. Height: 6 '' 5' BMI = 36.96 (Obese)

**PHYSICAL EXAMINATION RESULTS**

Constitutional: Abnormalities: General Apperance - Body build: Obese; General Apperance - Body build: short;

(Aside from above listed abnormalities, any other examined area appears normal)

Neurological: Mini-mental status exam unremarkable. Cranial nerves II-XII grossly intact by direct confrontation. Motor 5/5 strength throughout with good tone. Sensory intact throughout to pain, light touch, vibratory. Gait is symmetrical and balanced. Romberg is negative. Reflexes 2+ symmetrical with negative Babinski. No asterixis.

Psychiatric: Alert and oriented to person, place, time, and condition. Normal affect and mood. Responds to questions appropriately. No suicidal thoughts or ideation. Lymphatic: No lymph nodes palpated.

H.E.E.N.T. and Neck: Examination of the HEAD is normocephalic and atraumatic. EYES- PEERL, EOMI. TM's-Intact, nl light reflex and landmark. NOSE- no discharge noted. MOUTH- lips, mucosa, and gingiva-moist and pink.NECK- full range of motion, supple, no lymphadenopathy, no carotid bruits. TRACHEA- is midline. THYROID- smooth without nodules. No jugular venous distension or hepatojugular reflux. NECK: Supple

Thorax and Lungs: Chest symmetrical. Clear to auscultation bilaterally, no wheezing, no crackles, no rhonchi. Percussion: no dullness.

Heart, Pressures, and Pulses: CARDIOVASCULAR-Normal S1 and S2. Absent of S3 and S4. Regular rate without murmurs, rubs, heaves, or thrills. Peripheral pulses symmetrical and 2+ throughout.

Breasts and Axillae: BREASTS: Symmetrical, no tenderness, no masses, no nipple discharge or skin retraction noted. Areolar-no abnormal discoloration noted.

AXILLAE: no lymph nodes palpated.

Abdomen: Abnormalities: PROTUBERANT ABDOMENS - obese/ increase adipose tissue;

(Aside from above listed abnormalities, any other examined area appears normal) Back: Straight and symmetrical. No abnormal spinal curvatures noted. No costovertebral angle tenderness.

Anus and Rectum : Deferred

Extremities: No clubbing, cynosis or edema. Pulses 2+ bilaterally.

Male Genitalia, Hernias and Prostate: Deferred

Skin: Intact, without rashes, no erythema, no scaliness, no dyspigmentations nor suspicious lesions noted. Good turgor. No petechiae.

Musculoskeletal: Upper and lower extremities symmetrical, full range of motion noted without joint tenderness, swelling or deformities noted.

ASSESSMENT FORMS

(1) Care of Older Adults Assessment

(2) Geriatric Depression Scale (5 - Mild Depression)

(3) Instrumental Activities of Daily Living Assessment

(4) Mini-Mental State Exam (Score: 28, Normal)

DISCUSSED WITH PATIENT THE FOLLOWING TEST RESULT(S) / REFERRAL EVALUATION(S)/ MEDICAL CORRESPONDENCE

(1) Lab: 85025 - CBC, w/ differential

**PROBLEM LIST**

DERMATOPHYTOSIS OF NAIL

OBESITY UNSPECIFIED

DIABETES EYE MANIF TYPE II

GLAUCOMA W SYSTEMIC SYNDROMES

DIABETES RENAL MANIF TYPE II

Diabetes w/ Chronic Kidney Disease, Stage II

Stricture of artery

Chr airway obstruct

PROTEINURIA

AORTOCORONARY BYPASS STATUS

ATHEROSCLER NATIVE CORONARY ART

OTHER AND UNSPECIFIED HYPERLIPIDEMIA

TOBACCO USE DISORDER

UNSPECIFIED CIRCULATORY SYSTEM DISORDER

DIABETES NEUR MANIF TYPE II

DIABETES CIRC DIS TYPE II

DIABETES W MANIF OT TYPE II

Neuropathy in diabetes

MORBID OBESITY

HYPERTEN HEART DIS W HT FAILURE

CONGESTIVE HEART FAILURE UNSPEC

**TODAY'S ASSESSMENT**

ROUTINE MEDICAL EXAM Treatment Plan: z Comprehen metabolic panel z Lipid panel

Urinalysis, nonauto w/sco

PSA total

TSH - Thryoid stimulating hormone z CBC, w/ differential z Electrocardiogram

CONGESTIVE HEART FAILURE

HYPERTEN HEART DIS W HT FAIL

MORBID OBESITY

NEUROPATHY IN DIABETES (Chronic Disease)

DIAB W MANIF OT TYPE II (Chronic Disease)

DIAB CIRC DIS TYPE II UNCONT (Chronic Disease)

DIAB NEUR MANIF TYPE II UNCN (Chronic Disease)

HYPERLIPIDEMIA OT/UNSPEC (Chronic Disease)

CIRCULATORY DISEASE UNSPEC (Chronic Disease)

OBACCO USE DISORDER (Chronic Disease)

AORTOCORONARY BYPASS (Chronic Disease)

ATHEROSCLER NATIVE COR ART (Chronic Disease)

PROTEINURIA (Chronic Disease)

CHR AIRWAY OBSTRUCT OT (Chronic Disease)

STRICTURE OF ARTERY (Chronic Disease)

CHRONIC KIDNEY DIS STG II (Chronic Disease)

DIAB RENAL MANIF TYPE II UNC (Chronic Disease)

GLAUCOMA W SYSTEMIC SYND (Chronic Disease)

DIAB EYE MANIF TYPE II UNCN (Chronic Disease)

OBESITY UNSPECIFIED (Chronic Disease)

SCREENING FOR DEPRESSION

BMI BET 36.0-36.9 ADULT

(BMI:36.96,Obese)

**TREATMENT PLAN**

Lab Works: (1) B-12:

CBC, W/ DIFFERENTIAL:

COMPREHEN METABOLIC PANEL:

FECAL OCCULT BLOOD TEST (FIT):

FOLATE

HBA1C GLYCOHEMOGLOBIN, TOTAL:

LIPID PANEL:

MICROALBUMIN, RANDOM URINE:

PSA TOTAL:

THYROXINE (T4)

TSH - THRYOID STIMULATING HORMONE:

URINALYSIS, NONAUTO W/SCO:

VITAMIN D, 25-HYDROXY

Diagnostic Procedures:

ELECTROCARDIOGRAM:

Procedures/Surgeries N/A /Instructions:

Medications:

amoxicillin (amoxicillin) - capsule 500 mg 30 capsule for 10 Days; Take 1 capsule three times a day by mouth

**Treatment Plan and Comments:**

The diagnosis and prognosis were discussed, as well as expectations. Specific instructions for treatments were given. Lifestyle modifications were discussed at length with the patient that include 1.5 mg sodium daily diet, daily exercise, smoking cessation, balanced diet. If symptoms worsens to return for further evaluation. The current problems and medications list were reviewed with patient. Discussed w/Patient: RISK & BENEFITS of medication(s)

**REFERRAL**

(1) DERMATOLOGY: Patient is being referred to your office/facility for the above mentioned condition(s). Kindly report to us your finding(s) and treatment suggestion(s). Thanks! Eval & treat

Patient: Demo Don

DOS: 8/4/22

Reason for Visit f u and refills mg

Vitals:

BP 100/70 Pulse 76 RR 16 Temp. 98.2 °F Weight 147 lb O oz

Here today for med refills and personal problems.

Objective: problems having erection. stomach has been bothering

him. gerd is again a problem. he eats lots of "hot'' food and peppers. shoulder has been worse with the cold weather. right knee is tender as he fell on it. depression is worse because of erection problems.

Assessment: Problem List:

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia

erection dysfunction

GENERAL APPEARANCE: x well developed, well nourished

EYES:x_perrl, lids, sclerae, conj wnl NECK;x_no jvd

RESPIRATORY:x_ascultation, effort, percussion

CARDIOVASCULAR:x_rrr w/o murmur, carotid, pedal, and radial pulses wnlx_no edema/varicosities

GI/ABDOMEN:x_soft, nt, w/o mass, bs normal xx no hemorrhoids

SKIN:x_good color, warm/dry no rash/lesion/mass - neck mole

X

MUSCULOSKELETAL:

NECK:x_strength/tone/rom

BACK/SPINE-xstrength/tone/rom

EXTREMITIES:x_strength/tone/rom

x_no tenderness/swelling

OTHER:x_digits/nails-xgait/station

NEUROLOGIC:x_reflexes are all 2+/equal bilateral x sensation nl throughoutxsensation nl bilat in all extremities PSYCHIATIC: does not want to see the councilors at this time.

Assessment:

Plan: Rx: Prilosec 20 mg 1 cap(s) QD #30 6R

apt with uro. for erections

Rx: Lortab 10/500 500 mg-10 mg 1 tab(s) TIO #90 OR will make derm with dr Spock.

Joint pain, shoulder

Depression with anxiety

Back pain

Hypercholesterolemia