SAMPLE COPIES

HISTORY AND PHYSICAL

MORGAN MEMORIAL HOSPITAL
OUTPATIENT OBSERVATION HISTORY AND PHYSICAL

PATIENT: [redacted] **ROOM NO.:** 155 **HOSP. NO.:** [redacted]
ATTENDING PHYSICIAN: Eduardo M. Cossio, M.D. **DATE OF ADMISSION:** 06-23-09

HISTORY OF PRESENT ILLNESS: This 83 -year-old white female presented to my office today with a chief complaint of weakness and generalized malaise. After patient was evaluated, she was found to be dehydrated clinically. Her lab work as an outpatient showed a blood urea nitrogen of 36, creatinine of 2.5 and potassium 5.9. At this time, patient was subsequently admitted to Morgan Memorial Hospital for further workup and management and treatment. Patient's only complaint is weakness. Denies any neurological symptoms, cardiac symptoms, gastrointestinal symptoms, pulmonary symptoms, urinary symptoms, dermatological symptoms, upper respiratory symptoms or any other complaints at this time.

PAST MEDICAL HISTORY:

1. Malignant hypertension.
2. Renal insufficiency.
3. Hyperkalemia.
4. Coronary artery disease with arteriosclerotic vascular disease.
5. Vascular disease.
6. Hypothyroidism.
7. Hyperlipidemia, on Zocor.
8. Low normal B-12 level.
9. Osteoporosis.

PAST SURGICAL HISTORY: Tubal ligation.

SOCIAL HISTORY:

1. The patient is a nonsmoker.
2. The patient is a nondrinker.

FAMILY HISTORY:

1. Father died with emphysema and asthma.
2. Mother died on childbirth.

MEDICATIONS:

1. Kayexelate 30 grams daily.
2. Atenolol 20 milligrams every morning.
3. Zocor 20 milligrams at bedtime.
4. B-12 1 cubic centimeter every month.
5. Synthroid 50 micrograms daily.

DATE:_____ SIGNED:_____
DD: 06-23-09 17:58 DT: 06-24-09 10:20 EMC/oes Eduardo M. Cossio, M.D.

ALLERGIES: PENICILLIN and SULFA.

REVIEW OF SYSTEMS: As above.

GENERAL: Patient has generalized weakness.

SKIN: Poor turgor without any rash.

HEAD: The patient is normocephalic. No trauma.

EYES: Pupils equal, round, and reactive to light and accommodation. Extraocular movements are intact. Fundi show no hemorrhage or papilledema.

EARS: Tympanic membranes are clear bilaterally.

NOSE: Clear without any polyps.

THROAT: Clear. Oral mucosa is dry.

NECK: Supple without any lymphadenopathy, bruits, or goiter.

BREASTS: Deferred at this time due to the patient's cardiac and vascular disease.

HEART: S1 S2 is regular without any murmurs.

LUNGS: Clear to auscultations bilaterally.

ABDOMEN: Soft, nontender. Bowel sounds are present times four. No rebound or guarding. No costovertebral angle tenderness.

GENITALIA: Deferred at this time due to the patient's cardiac and vascular disease.

RECTAL: Deferred at this time due to the patient's cardiac and vascular disease.

EXTREMITIES: Show no edema, cyanosis, or calf tenderness.

NEUROLOGICAL: The patient is conscious, alert, and oriented times three. Cranial nerves II-XII are grossly intact. Motors and sensories are equal bilaterally. Reflexes are plus 2 bilaterally.

DATE:_____ SIGNED:_____
DD: 06-23-09 17:58 DT: 06-24-09 10:20 EMC/oes Eduardo M. Cossio, M.D.

IMPRESSION:

1. Dehydration.
2. Hyperkalemia.
3. Renal insufficiency.
4. Malignant hypertension.
5. Coronary artery disease with arteriosclerotic vascular disease.
6. Hypothyroidism.
7. Hyperlipidemia.
8. Low normal B-12 level.
9. Osteoporosis.

PLAN: Treatment and plan will consist of placing patient on a 2-gram sodium low cholesterol diet and no potassium. Get intravenous fluids of D5 half normal saline at 1,000 cubic centimeters an hour. Get basic metabolic profile in the morning. Continue current home medications. This treatment will be adjusted according to patient's response to current management.

DATE:_____ SIGNED:_____
DD: 06-23-09 17:58 DT: 06-24-09 10:20 EMC/oes Eduardo M. Cossio, M.D.

MORGAN MEMORIAL HOSPITAL
INPATIENT HISTORY AND PHYSICAL

PATIENT: [redacted] **ROOM NO.:** 155 **HOSP. NO.:** [redacted]
ATTENDING PHYSICIAN: Pamela G. Hall, M.D. **DATE OF ADMISSION:** 01-13-09

CHIEF COMPLAINT: Weakness, swelling and intermittent confusion.

HISTORY OF PRESENT ILLNESS: This is an unfortunate 64 -year-old woman who has breast cancer which has spread to the liver with diffuse metastases there and advancing ascitic fluid as well as lower extremity edema who was diagnosed approximately one week prior to admission with small deep venous thrombosis according to her oncology nurse and for which she was anticoagulated with Lovenox and Coumadin. Over the weekend, she began noticing gross hematuria and the family contacted me. I did ask her to stop her Lovenox and to followup in one day for urinalysis, urine culture and complete blood count as she had no fever or symptoms of urinary tract infection. Her oncologist called me on Monday the 12th requesting rehabilitation admission for physical therapy and strengthening as she was inappropriate at the time for any further chemotherapeutic treatment including the Zometa that she has been getting monthly. Her hematuria has somewhat resolved. She has been eating well and she has been intermittently confused according to her husband and according to her oncologist who says further that her prognosis is very poor. However, I believe he has discussed possible further chemotherapeutic options with the patient's husband.

PAST MEDICAL HISTORY: Includes nothing significant other than the metastatic breast cancer which recurred with diffuse bony metastases after five years of remission.

PAST SURGICAL HISTORY: Includes mastectomy and breast reconstruction on the left, implantation of a central venous port.

SOCIAL HISTORY: She does not drink or smoke. Lives with her husband. They have a lot of support from her sister. She has two adult children.

DATE:
DD: 01-14-09 17:31 DT: 01-15-09 10:20

SIGNED.
PGH/oes Pamela G. Hall, M.D.

FAMILY HISTORY: Negative for breast cancer.

MEDICATIONS: Include Effexor, MS Contin twice daily, Xanax as needed for anxiety, monthly Zometa, stool softener and recently Flagyl for Clostridium difficile diarrhea for which she was admitted in December and which did resolve and Macrodantin for a confirmed urinary tract infection that was fluoroquinolone resistant Escherichia coli.

ALLERGIES: CODEINE DERIVATIVES.

REVIEW OF SYSTEMS: She denies headache and reports some lower abdominal pain without dysuria or polyuria. Last bowel movement was two days prior. She denies chest pain. She has had [illegible] difficulty breathing. The nurse has noted some wheezing although the patient does not appreciate same. She denies fever or chills. She has had a weight gain of 20 pounds secondary to fluid retention. Her appetite has been good for the last two days but was very poor prior to Monday the 12th.

GENERAL: On examination, she is in no distress. However, her voice is very weak and raspy. She appears generally weak but appropriate and oriented.

HEAD: Revealed alopecia. There is no wasting.

EYES: Conjunctiva are well perfused.

EARS: Ear canals clear.

NOSE: Clear.

THROAT: There is no thrush. She has healthy dentition.

NECK: Without lymphadenopathy or masses. There is no jugular vein distension.

BREASTS: No suspicious nodules in the right breast. The left breast is surgically reconstructed. There is a Port-O-Cath in the upper left chest wall.

DATE:_____ SIGNED:_____
DD: 01-14-09 17:31 DT: 01-15-09 10:20 PGH/oes Pamela G. Hall, M.D.

HEART: Regular rate and rhythm. No gallop, murmur, or rub.

LUNGS: Decreased breath sounds in the bases without crackles.

ABDOMEN: Moderately distended and dull to percussion throughout. There is moderate tenderness in the suprapubic area without guarding or rebound. No tumor mass or hepatosplenomegaly can be palpated.

GENITALIA: Not performed

RECTAL: Not performed.

EXTREMITIES: Lower extremities revealed 1+ edema. There are no palpable cords and there is a negative Homan's sign. There is no febrile area or localized tenderness or erythema.

NEUROLOGICAL: Again, she is oriented. She is weak generally but has symmetric strength which is 4 out of 5 in the lower and upper extremities.

IMPRESSION:

1. Metastatic breast cancer with very poor prognosis and advancing edema secondary to abdominal tumor mass and probably low protein.
2. Recent urinary tract infection with Escherichia coli.
3. Recent Clostridium difficile diarrhea.
4. Recent history of reportedly small deep venous thrombosis for which she was anticoagulated with Coumadin for three days and Lovenox for the same three days. These were discontinued with the last doses on the 11th.

PLAN: Admit for Acute Care now where we can still start physical therapy. Otherwise, she will be on bedrest. She is not going to need any further Coumadin or Lovenox as her native anticoagulation status secondary to hepatic insufficiency demonstrates an international normalized ratio of 15. Will check a urinalysis and urine culture and sensitivity and restart Macrodantin to which this organism was sensitive recently. I have discussed with her husband the need for some sort of Advanced Directive or at least some clear direction as far as resuscitation efforts. Will go ahead and get a chest x-ray secondary to what appears to be advancing effusion and use Lasix gingerly and continue her MS Contin and Effexor and Xanax.

DATE:_____ SIGNED:_____
DD: 01-14-09 17:31 DT: 01-15-09 10:20 PGH/oes Pamela G. Hall, M.D.

MORGAN MEMORIAL HOSPITAL
SWING BED HISTORY AND PHYSICAL

PATIENT: [redacted] **ROOM NO.:** 106-A **HOSP. NO.:** [redacted]
ATTENDING PHYSICIAN: David T. Fletcher, M.D. **DATE OF ADMISSION:** 06-12-09

CHIEF COMPLAINT: Urosepsis, severe malnutrition, gastric outlet obstruction and chronic atrial fibrillation.

HISTORY OF PRESENT ILLNESS: Patient was seen at Landmark Hospital in Athens, Georgia, and released here for rehabilitation. She is an 83 -year-old white female who was transferred from Athens Regional to Landmark Hospital for continuation of care and then transferred here for step-down of intensity. While in the hospital she had a jejunostomy tube placed and had multi-drug resistant Klebsiella urinary tract infection and she was on antibiotics at time of transfer. There has been a discrepancy whether she came from home or if she came from the Boswell Nursing Home. However, she is here for severe malnutrition. She is currently getting a jejunostomy tube feeding as well as she is beginning to take some oral substances.

PAST MEDICAL HISTORY: Significant for gastric outlet obstruction, gastric ulcer, chronic left lower extremity thrombosis, chronic atrial fibrillation, hypertension, cerebrovascular accident, osteoarthritis and chronic kidney disease Stage 3.

PAST SURGICAL HISTORY: Includes a Billroth II done by Dr. Shirley. She has had hernia surgery, cardiac surgery and uterine fibroid surgery.

SOCIAL HISTORY: Unclear. The daughter was present at time of examination and did state that she lived with her. However, at some point she was placed in the Boswell Nursing Home so there is a discrepancy in the care and place of location. Patient has no alcohol, tobacco or drugs.

FAMILY HISTORY: Noncontributory.

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DD: 06-15-09 15:36 DT: 06-16-09 09:37 DTF/oes David T. Fletcher, M.D.

MEDICATIONS: Her medications at time of transfer include Albuterol and Atrovent per nebulizers every 4 hours as needed, Prevacid 30 milligrams by mouth every 24, Metoprolol 25 milligrams by mouth every 12, Provigil 100 milligrams by mouth every 24, Neosporin every 12 to percutaneous endoscopic gastrostomy site, and Suplena at 30 milliliters per hour.

ALLERGIES: FLEXERIL and MORPHINE, unknown reaction.

REVIEW OF SYSTEMS: Patient reports that she is doing well. She has no shortness of breath, difficulty breathing or chest pain. She does report, however, that she would like to have something to eat, that she is a bit hungry and is looking forward to being able to eat a regular diet.

GENERAL: This is an older than stated age Caucasian female in no acute distress. Alert and oriented. No respiratory distress. Her vitals at time of admission were blood pressure 130/68, pulse 72, respiration rate 20, temperature 98.4, oxygen saturation of 98 percent. Weight is 151.3 pounds.

SKIN: Clean, dry and intact.

HEAD: Normocephalic. Atraumatic.

EYES: Normal.

EARS: Normal.

NOSE: Normal.

THROAT: Normal.

NECK: Supple with no carotid bruits.

BREASTS: Deferred.

HEART: Regular rate and rhythm. S1, S2. No murmurs, clicks or rubs.

DATE:_____ SIGNED:_____
DD: 06-15-09 15:36 DT: 06-16-09 09:37 DTF/oes David T. Fletcher, M.D.

LUNGS: Clear to auscultation bilaterally. Positive breath sounds in all lung fields. No wheezes, rales or rhonchi.

ABDOMEN:

GENITALIA: Deferred.

RECTAL: Deferred.

EXTREMITIES: She had +2 pulses in all extremities.No clubbing, cyanosis or edema. No tenderness.

NEUROLOGICAL: Grossly intact. Cranial nerves II through XII intact.

LAB: She had no labs available at time of admission.

IMPRESSION/PLAN:

1. Urosepsis from urinary tract infection. Seems to be resolving. Patient is doing better. Will follow that closely.
2. Severe malnutrition. Will continue her percutaneous endoscopic gastrostomy tube feedings and have physical therapy and speech evaluation to be done as well as physical therapy to see if we can rehabilitate this patient to her normal status.
3. Gastric outlet obstruction. Of course, we will continue with the jejunostomy tube feedings and follow that closely.
4. Atrial fibrillation. Will continue Metoprolol.
5. Hypertension. Will also continue Metoprolol.

DISPOSITION: Guarded. We will follow her closely. I do not now if she will be able to make a good recovery. Just depends on the patient's attitude and desire to get better so will follow that closely.

DATE:_____ SIGNED:_____
DD: 06-15-09 15:36 DT: 06-16-09 09:37 DTF/oes David T. Fletcher, M.D.

MORGAN MEMORIAL HOSPITAL
SWING BED HISTORY AND PHYSICAL

PATIENT: [redacted] **ROOM NO.:** 109 **HOSP. NO.:** [redacted]
ATTENDING PHYSICIAN: W. Daniel Zant, M.D. **DATE OF ADMISSION:** 05-27-09

CHIEF COMPLAINT: Here for rehabilitation and strengthening after hospital admission for congestive heart failure and subendocardial myocardial infarction.

HISTORY OF PRESENT ILLNESS: This is a 90 -year-old white male who apparently had been having some increasing shortness of breath and left-sided chest pain. Was taken to Newton Medical Center and found to be in congestive heart failure as well as having an elevated creatine phosphokinase and Troponin on his cardiac enzymes. He also had an elevated B-type Natriuretic Peptide with bilateral effusions on his chest x-ray. He was admitted and started on treatment for the heart failure. An echocardiogram was obtained which showed a 20 percent ejection fraction. He was not an interventional candidate for the coronary disease. He was diuresed and started on beta blockers and doing much better for the heart failure and then transferred. As of note, his daughter that he lives with also had some heart trouble and is currently in the hospital in Athens after sustaining a myocardial infarction and being in the Intensive Care Unit for several days.

PAST MEDICAL HISTORY: Congestive heart failure.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: He does not smoke or drink. He lives with his daughter who, as above, is in the hospital with a myocardial infarction.

FAMILY HISTORY: Hypertension, heart disease and diabetes.

MEDICATIONS: Include aspirin 81 daily, Lopressor 25 twice daily, Lasix 40 milligrams twice daily, Duonebs four times daily, Lisinopril 10 milligrams daily, Aldactone 12.5 daily.

ALLERGIES: None.

DATE:_____ SIGNED:_____
DD: 05-28-09 16:24 DT: 05-29-09 09:25 WDZ/oes W. Daniel Zant, M.D.

REVIEW OF SYSTEMS: He states that he is feeling very well now. His breathing is much better. He has no more chest pain. No nausea, vomiting, shortness of breath, headache or other complaint at this time.

GENERAL: Temperature 97.3, pulse 71, respirations 20, blood pressure 109/71, oxygen saturation 98 percent on room air. Weight 177 pounds.

SKIN:

HEAD: Unremarkable.

EYES: Unremarkable.

EARS: Unremarkable.

NOSE: Unremarkable.

THROAT: Unremarkable.

NECK: Supple without jugular vein distension.

BREASTS: Normal.

HEART: Regular.

LUNGS: Show some bilateral rales.

ABDOMEN: Soft and nontender. Positive bowel sounds.

GENITALIA: Not examined.

RECTAL: Not examined.

EXTREMITIES: Trace to 1+ edema of the lower extremities on both sides.

NEUROLOGICAL: He is very hard of hearing. Otherwise, he has no focal deficits.

LAB: None.

DATE:_____ SIGNED:_____
DD: 05-28-09 16:24 DT: 05-29-09 09:25 WDZ/oes W. Daniel Zant, M.D.

IMPRESSION:

1. Congestive heart failure.
2. Subendocardial myocardial infarction.
3. Hypertension.
4. Hard of hearing.

PLAN: Admit to Swing Bed for rehabilitation.

DATE:_____ SIGNED:_____
DD: 05-28-09 16:24 DT: 05-29-09 09:25 WDZ/oes W. Daniel Zant, M.D.

MORGAN MEMORIAL HOSPITAL
TRANSITIONAL CARE UNIT HISTORY AND PHYSICAL

PATIENT: [redacted] **ROOM NO.:** 322 **HOSP. NO.:** [redacted]
ATTENDING PHYSICIAN: Miguel E. Cossio, M.D. **DATE OF ADMISSION:** 06-19-09

HISTORY OF PRESENT ILLNESS: This is a 65 -year-old white male who underwent surgery for left hip fracture up in Athens Regional. Patient comes here for rehabilitation after undergoing surgery at Athens Regional. He is in the Transitional Care Unit.

PAST MEDICAL HISTORY: Patient has multiple problems including diabetes, high blood pressure, atrial fibrillation. He has mentioned about Coumadin treatment. He has peptic ulcer disease with history of peptic ulcer bleeding. Obstructive sleep apnea, venous stasis. Past history of right femur fracture, was seen by an orthopedist in Athens.

PAST SURGICAL HISTORY:

SOCIAL HISTORY: He denies smoking and drinking at this time.

FAMILY HISTORY: Noncontributory.

MEDICATIONS: He takes multiple medications. Zithromax 250, Glucophage 850 twice a day, Benadryl 25 milligrams every 4 hours, Milk of Magnesia, Ambien 5 milligrams at bedtime, Lortab 5 one tablet every 4 hours, Protonix 40 once a day, potassium 20, Lasix 40, magnesium 800, Nadolol 20, Zoloft 100, Vasotec 5 and Tikosyn 0.25 two capsules every 12 hours.

ALLERGIES: SULFA and PRILOSEC.

GENERAL: On physical examination, he is alert, oriented. Complains of hip pain. In bed.

HEAD: Within normal limits.

EYES: Within normal limits.

EARS: Within normal limits.

NOSE: Within normal limits.

THROAT: Within normal limits.

DATE:_____ SIGNED:_____
DD: 06-23-09 15:03 DT: 06-24-09 09:48 MEC/oes Miguel E. Cossio, M.D.

NECK: Supple.

CHEST: Increased anteroposterior diameter.

HEART: S1 S2 regular rhythm. Irregularly irregular.

ABDOMEN: Benign.

EXTREMITIES: Pulses equal bilaterally. He is in bed so there is no weight to be placed on the leg at this time.

NEUROLOGICAL: No focal deficit.

IMPRESSION:
1. Status post fracture surgery.
2. History of diabetes, high blood pressure, chronic atrial fibrillation, peptic ulcer disease and sleep apnea.

PLAN: He is on multiple medications which we are going to continue which are Zithromax 250, Glucophage 850 twice a day, Benadryl 25 milligrams every 4 hours, Milk of Magnesia, Ambien 5 milligrams at bedtime, Lortab 5 one tablet every 4 hours, Protonix 40 once a day, potassium 20, Lasix 40, magnesium 800, Nadolol 20, Zoloft 100, Vasotec 5 and Tikosyn 0.25 two capsules every 12 hours. We are going to continue with that routine and adjust the treatment according to the patient's presentation. We are also going to give him insulin coverage. He has some issues with low platelets so we are avoiding Lovenox and Coumadin at this time.

DATE:_____ SIGNED:_____
DD: 06-23-09 15:03 DT: 06-24-09 09:48 MEC/oes Miguel E. Cossio, M.D.