LODI MEMORIAL HOSPITAL
ADMISSION HISTORY & PHYSICAL

DATE
05/11/2012

CHIEF COMPLAINT
Right leg pain, swelling and redness.

PRIMARY CARE PHYSICIAN
Edmund Freund, MD

CONSULTATION
Michael Ketelaar, MD

INFECTIOUS DISEASE
Manuel A. Orellana, M.D.

HISTORY OF THE PRESENT ILLNESS
This is a 69-year-old female with a history of insulin dependent diabetes, hypertension, congestive heart failure, history of coronary artery disease status post coronary artery bypass graft, came into the hospital because of increasing right lower extremity swelling, redness and pain. The patient states that redness has been going on for 2 weeks and has not seen any primary physician as an outpatient, did not use any oral antibiotics, however, the redness progressively started with the lower extremity and progressed to the middle shin area. The patient denies any fall or spider bite and does not know what is going on. She suddenly started to have redness on the right lower extremity. The patient also states that the leg swelling has been worsening in the past 2 days. The patient has been drinking a lot of water and also the patient has been using Lasix, however, the swelling is still persistent, therefore the patient was admitted to the hospital for leg swelling and right lower extremity cellulitis.

REVIEW OF SYSTEMS
Discussed with the patient. The patient does not have any fevers or chills, no chest pain, no abdominal pain, no constipation or diarrhea, no urinary symptoms. The patient complained of right lower extremity pain and swelling and redness. All other review of systems are unremarkable.

PAST MEDICAL HISTORY
1. History of congestive heart failure. Most recent echo indicating left ventricular function of 30%.
2. History of coronary artery disease status post coronary artery bypass graft.
3. History of insulin dependent diabetes.
4. History of hypertension.
5. History of cerebrovascular accident.
6. History of chronic kidney disease stage 3.
7. History of hypothyroidism.

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PARVIN,MARY JEAN
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Dict. Dr. Edward T MD-HOSP Chang

8. History of depression.
9. History of anxiety.

PAST SURGICAL HISTORY
Status post ICD placement and CABG and appendectomy.

ALLERGIES: SULFA.

SOCIAL HISTORY
Nonsmoker. No alcohol and no drug use. The patient currently lives in Lodi with her daughter.

FAMILY HISTORY
Reviewed and noncontributory.

MEDICATIONS
I have reviewed with Dr. Edmund Freund, primary care physician that the patient is taking:
1. Isosorbide 30 mg one a day.
2. Januvia 50 mg once a day.
3. Zetia 10 mg once a day.
4. Kay-Ciel 10 mg twice a day.
5. Levothyroxine 100 mcg once a day.
6. Lasix 80 mg once a day.
7. Ambien 5 mg every daily p.r.n.
8. Coreg 12.5 mg p.o. b.i.d.
9. Lexapro 20 mg one a day.
10. Famotidine 20 mg p.o. b.i.d.
11. Lovastatin 40 mg one every night.
12. Lisinopril 20 mg one a day.
13. Micardis 80 mg one a day.
14. Norco 5 mg every 6 hours p.r.n. for pain.
15. Aspirin 81 mg once a day.
16. Multivitamins 1 a day.
17. Biotene 1 a day.
18. Lantus 30 units in the morning and Lantus 25 units at night.
19. Insulin coverage scale.

VITAL SIGNS
Temperature 36.9 with a heart rate of 74 to 83, respirations 20, blood pressure initially was 220/95, pulse oximetry 99% on room air. Repeat blood pressure 163/89.

PHYSICAL EXAMINATION
NEUROLOGIC: The patient is alert, awake, oriented to person, place, time.
GENERAL APPEARANCE: In no acute distress.
HEENT: Pupils are equal, reactive to light bilaterally. Conjunctivae clear. Oral cavity, mucous membranes dry. Pharynx with no erythema. Nose with no

Patient Name: PARVIN,MARY JEAN
Unit No: M053082

EXAM#	TYPE/EXAM	RESULT
001116852	US/EXTREMITY VEINS BILATERAL LE	

History: Bilateral lower extremity swelling

Deep veins of the both lower extremities from the common femoral to the popliteal level compress and augment normally. Grayscale, duplex and color Doppler images demonstrate no apparent filling defects.

Impression:

No evidence of lower extremity deep vein thrombosis from the common femoral to the popliteal levels.

Ultrasound for deep vein thrombosis is not 100% sensitive. Calf vein thrombosis may not be demonstrated on this study. Such thrombosis can progress into the thigh veins. Alternatively, deep vein thrombosis can develop after a negative vein ultrasound study. Therefore, the patient should be followed clinically with repeat ultrasound as necessary.

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Reported By: HARTWICK, FRANK MD

CC: Freund,Edmund MD-Mills

Technologist: LINDSTROM,SHARON
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Name: PARVIN,MARY JEAN
Phys: Chang,Edward T MD-HOSP
DOB: 03/16/1943 Age: 69 Sex: F
Acct No: V023586118 Loc: 377 A
Exam Date: 05/11/2012 Status: DIS IN
Radiology No: 00003311