FOLLOWUP NOTE

Name of Patient: Deane Smith
Date of Birth: 10/19/27
Medical Record No.: 4202
Date of Visit: 06/03/11

History of Present Illness:
The patient is an 83-year-old male who has cardiovascular reevaluation for complaints of feeling very short of breath with exertion, as well as very fatigued. He was seen on April 19. At that time, pacemaker was programmed to change sensor from 3 to 4 to help decrease fatigue. The patient states that he has had no improvement in his symptoms. As a matter of fact, he feels more short of breath. He had an echo Doppler today to evaluate his valvular structures, as well as left ventricular size and function.

Past Medical History:
The patient has history of atrial fibrillation, severe tricuspid regurgitation, mitral valve prolapse and mitral regurgitation, and history of nonsustained ventricular tachycardia status post pacemaker insertion in 2007.

Social History:
The patient lives with his wife. He does not use tobacco products.

Medications:
Medications were reviewed with this patient and are listed in the medical record.

Review of Systems:
Review of systems reveals no fever, chills, or sweats. The patient states he has had no changes in GI, GU, or ENT function to suggest bleeding. He continues on warfarin anticoagulation therapy without apparent side effects. He has known coronary artery disease with previous cardiac catheterization in 2002 with 50% LAD, 40% circumflex, and 25% RCA stenosis.

Physical Examination:
General: On physical examination, this is a currently ill-appearing patient.
Vital Signs: Weight: Decreased by 8 pounds to 181. Blood Pressure: 120/62.
Pulse: 68 and irregular. Respiratory Rate: 16 and unlabored.
HEENT: Normocephalic and atraumatic cranium.
Lungs: Lung sounds are very decreased on his left base to mid-lobe. They are clear on the right side. There is no JVD noted. No carotid bruit auscultated.

Cardiac Examination: Reveals an irregularly irregular rate. There is a 2/6 holosystolic murmur present at the left ventricular apex and a 2/6 systolic ejection murmur present at the lower left sternal border.
Abdomen: Soft, nontender.
Extremities: Free of edema. Pedal pulses palpable bilaterally.
Neurologic Examination: The patient is alert and oriented with appropriate mood and affect.

Diagnostic Data:
Preliminary findings from echocardiogram today reveal normal left ventricular size and systolic function with an ejection fraction estimated at 52%, dilated left and right atrium, mild mitral regurgitation, and severe tricuspid regurgitation. Tracing is similar to previous findings on an echocardiogram from August 2010.

EKG today reveals atrial fibrillation with left axis deviation with a heart rate of 86.

Impression and Plan:
The patient has coronary artery disease and valvular disease with complaints of increased fatigue and shortness of breath. His lung sounds are abnormal, and in consultation with Dr. Kures, we have recommended a chest x-ray to assess for possible pleural effusion and/or pneumonia. We have recommended a laboratory evaluation of BNP, CRP and CBC, as well as TSH and renal function panel. Further treatment will depend on results of chest x-ray and lab findings. If the patient has deterioration in symptoms, he is to activate the emergency system. Otherwise, we will see him again in the beginning of next week.

ILSE-MARIE REICHERT, ARNP

IMR/ktl