DATE OF SERVICE: August 31, 2006
PATIENT NAME: DEANE SMITH
MRN#: 6759

HISTORY OF PRESENT ILLNESS: This 78-year-old male has cardiovascular reevaluation for atrial fibrillation, chronic Coumadin anticoagulation, hypertension and hyperlipidemia. Since the previous assessment, the patient has had no recurrence of chest, throat, arm or jaw pain. He has had previous coronary angiography that has revealed non-critically obstructive coronary atherosclerotic disease with 50% LAD, 40% circumflex and 25% RCA at the time of cardiac catheterization in 2002. He has had previous pacemaker management for bradycardia and chronic atrial fibrillation. LV ejection fraction was calculated at 52% by exercise nuclear stress scan in 2005.

SOCIAL HISTORY: The patient does not use tobacco or ethanol products.

FAMILY HISTORY: Family history is significant for no premature coronary artery disease or cardiac death.

MEDICATIONS: Medications include Coumadin 2.5 mg p.o. q.d., Toprol 25 mg p.o. q.d. and Lipitor 5 mg Monday, Wednesday and Friday.

PHYSICAL EXAMINATION: Physical examination reveals a currently comfortable, well-appearing male. His blood pressure is 150/90, pulse is 70 and irregularly irregular, and respiratory rate is 16. HEENT reveals a normocephalic, atraumatic cranium. Jugular venous pressure is normal with normal contour. Carotid upstroke is +2 bilaterally without bruits. Sclerae are anicteric. Thyroid is midline. Lungs are clear. Cardiac examination reveals an irregularly irregular rhythm. S1 and S2 are normal. A 2/6 holosystolic murmur is heard at the apex. Abdominal examination reveals a soft and nontender abdomen. Extremities reveal no edema. On neurological examination, the patient is alert and oriented with appropriate mood and affect.

DIAGNOSTIC STUDIES: EKG reveals atrial fibrillation, marked left axis deviation and right bundle-branch block with intermittent V-paced rhythm.

IMPRESSION AND PLAN: The patient has atherosclerotic cardiovascular disease with non-critically obstructive coronary artery disease and chronic atrial fibrillation with permanent pacemaker for bradycardia. He has tolerated Coumadin anticoagulation without evidence of GI, GU or ENT bleeding or evidence of thromboembolic phenomenon. Laboratory evaluation reveals highly favorable LDL at 64 mg/dL with hematocrit 23% and normal BUN, creatinine, glucose and SGOT.

I recommend continuation of the current medical regimen with cardiovascular reevaluation in six months or sooner if necessary for symptomatic deterioration.

Peter Kures, M.D.