FOLLOWUP NOTE

Name of Patient: Deane Smith
Date of Birth: 10/19/27
Medical Record No.: 4202
Date of Visit: 04/19/11

History of Present Illness:
The patient is an 83-year-old male who has cardiovascular reevaluation for valvular heart disease with chronic atrial fibrillation. Since his last evaluation, the patient has spent the winter in Arizona. He states in January, he slipped and fell and hit his head which resulted in extensive bruising. He was evaluated with a CT scan about 4 weeks after his fall and results were unremarkable. The patient states that he had an episode of being very exhausted when he was walking during an air show in San Diego. He states that his shortness of breath has increased since his last visit. He also feels slightly off balance. He has had chest pain about 3 times, the last time a couple of months ago, but states that these were unrelated to activity.

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

Social History:
The patient 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. 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 comfortable-appearing male.
Vital Signs: Weight: Stable at 189. Blood Pressure: 116/74. Pulse: 68 and regular. Respiratory Rate: 16 and unlabored.
HEENT: Normocephalic and atraumatic cranium.

Lungs: Essentially clear to auscultation. No rales, no rhonchi, no wheezing. No JVD noted. No carotid bruit auscultated.
Cardiac Examination: Reveals regular rate and rhythm. S1 and S2 are normal. 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. Bowel sounds present.
Extremities: Have a trace of pedal edema bilaterally. Pedal pulses palpable.
Neurologic Examination: The patient is alert and oriented with appropriate mood and affect.

Pacemaker Interrogation:
Permanent pacemaker interrogation was reviewed. This reveals a well-functioning Boston Scientific Insignia I pacemaker with VVIR setting. Underlying rate is 60 and maximum tracking rate is 130. The patient is 69% paced in the ventricle. Intrinsic amplitude in the right ventricle is 7.2 mV with impedance of 470 ohms. Pacing threshold is 0.6 volts at 0.4 msec. Underlying rhythm is atrial fibrillation and no repeat ventricular tachycardia has been detected. Since the patient complains of increased fatigue, the pacemaker was programmed to change sensor from 3 to 4 which may help in decreasing fatigue.

Impression and Plan:
The patient has arteriosclerotic and valvular heart disease with complaints of increased fatigue. If the program change in the pacemaker is not improving his fatigue, we will repeat echo Doppler to evaluate valvular disease. Continue on his medications as he has in the past, continue on furosemide for volume control; and have a clinical and laboratory reevaluation with a pacemaker interrogation in 3 months or sooner if necessary for deterioration in symptoms.

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