Mrs. Jensen
Allergies: NKDA

Age: 55 years
DOB: 8/2/1960

Sex: Female
Portal:

Weight: 167 lbs
Language: English

MRN:
FN#:

LOC:
Outpatient: Part 2/1

Vitals and Measurements

Last 2 years for all visits

	Most Recent	Previous
BP	150/90	144/82
HR	70	76
Temp (°F)	98.0	98.4
Respiratory Rate	20	20
Weight (kg)	80.29	82.55
Weight (lb)	177	182
Height (in)	65	65
Body Mass Index (in)	29.5	30.3
Waist Circ. (in.)	37.75	38

APRN Notes:

Presenting Complaint:
Here for two-week follow-up visit regarding medical treatment of HTN
"I am doing well and I think my blood pressure readings are looking better."

Family History:

Mother: Hip fractured (possible osteoporosis); decreased x 8 mo.
Father: High blood pressure
Maternal and Paternal Grandparents: Heart Disease; HTN
Maternal grandfather, mother, sister: Obesity; Type 2 DM
Father: Colon Cancer

Social History:
Married

Common Labs

Last 2 years for all visits

	Most Recent	Previous
WBC		4,5
Hemoglobin		14.3
Hematocrit		43
Platelet		248
Sodium Level		143
Potassium Level		4.2
Chloride Level		98
Glucose Level		110
HDL		48
LDL		178
Triglycerides		139
Total		254
TSH		1.1
FBS		110
Hgb A1(c)		5.9

Past Medical History:
Postmenopausal (at 52 yrs)
HRT – none
DXA screen – annually last 2 years
Recent mammogram - normal
Colonoscopy 8 years ago

Past Surgical History:
T & A (age 5)

Non-drinker Non-smoker **Medications:** Calcium Multivitamin	**Review of systems:** General: Negative for fever, chills, malaise CV: Negative for chest pain, edema or palpitations GI: a little nausea; negative for heartburn or reflux Lungs: Negative for cough; problems breathing MS: Negative for arthralgias or myalgias **Exam:** Gen: Well-nourished female in no acute distress PUL: Lungs CTA and ant/post bilaterally CV: RRR, S1 and S2 auscultated, PMI WNL GI: ABD soft non-tender with BS X 4 quads. Negative for tenderness or hepatosplenomegaly. MS: Motor strength and gait normal with full ROM X 4 extremities
	Plan: 1. Continue HTN medication as prescribed 2. Continue exercise routine 3. Decrease salt intake 4. Add five fruits and vegetables to diet daily 5. Eat five ounces of meat protein each day (lean baked or broiled beef, salmon and/or tuna three times each week) 6. Increase fluid intake to eight 8oz amount/daily 7. Monitor blood pressure daily and record 8. Return to clinic in 3 months with blood pressure log.

Mrs. Jensen Allergies: NKDA	Age: 56 years DOB: 8/2/1960	Sex: Female Portal:	Weight: 167 lbs Language: English	MRN: FN#:	LOC: Outpatient: Part 2/2

Last 2 years for all visits

	Most Recent	Previous
BP	128/78	150/90
HR	72	70
Temp (ºF)	98.0	98.0
Respiratory Rate	20	20
Weight (kg)	75.75	80.29
Weight (lb)	167	177
Height (in)	65	65
Body Mass Index (in)	27.8	29.5
Waist Cir. (in)	36.5	37.75

Common Labs

Last 2 years for all visits

	Most Recent	Previous
WBC		4.5
Hemoglobin		14.3
Hematocrit		43
Platelet		248
Sodium Level		143
Potassium Level	4.0	4.2
Chloride Level		98
Glucose Level		110
HDL	50	48
LDL	170	178
Triglycerides	130	139
Total	246	254
TSH		1.1
FBS		110
Hgb A1(c)	5.7	

APRN Notes:

Presenting Complaint:

Here for a three-month follow-up visit regarding medical treatment of HTN. "I am walking 5 times a week and we have really changed the way we eat at our hours! I have even been able to lose some weight. The best part is I really do feel better."

Family History:

Mother: Hip fractured (possible osteoporosis); decreased x 8 mo.
Father: High blood pressure
Maternal and Paternal Grandparents: Heart Disease; HTN
Maternal grandfather, mother, sister: Obesity; Type 2 DM
Father: Colon Cancer

Social History:

Married
Non-drinker

Past Medical History:

Postmenopausal (at 52 yrs)
HRT – none
DXA screen – annually last 2 years
Recent mammogram - normal
Colonoscopy 8 years ago

Past Surgical History:

T & A (age 5)

Non-smoker

Medications:
Calcium
Multi-vitamin
HCTZ 12.5 mg. daily
Simvastatin 40 mg. every evening

Review of systems:
General: Negative for fever, chills, malaise
CV: Negative for chest pain, edema or palpitations
GI: a little nausea; negative for heartburn or reflux
Lungs: Negative for cough; problems breathing
MS: Negative for arthralgias or myalgias

Exam: Gen: Well-nourished female in no acute distress
PUL: Lungs CTA and ant/post bilaterally
CV: RRR, S1 and S2 auscultated, PMI WNL
GI: ABD soft non-tender with BS X 4 quads. Negative for tenderness or hepatosplenomegaly.
MS: Motor strength and gait normal with full ROM X 4 extremities

Pharmacist Note:

Pharmacy was asked to participate during Mrs. Jenson's next visit to provide any potential recommendations for her care. Today, she is here for her three month follow up after starting hydrochlorothiazide. She states that she has been "walking 5 times a week", "really changed the way she eats", and she "feels that she lost some weight."

Past Medical History/Past Surgical History
Postmenopausal (at 52 years)
HRT – none
DXA screen – annually last 2 years
Recent mammogram - normal
Colonoscopy 8 years ago

Past Surgical History:
T & A (age 5)

Family History:

Medications:
Calcium supplement daily
Multivitamin daily
Hydrochlorothiazide 12.5 mg. daily
Review of Systems: (performed by Nurse Practitioner)
Non-significant except:

- General: Negative for fever, chills, malaise
- CV: Negative for chest pain, edema or palpitations
- GI: a little nausea; negative for heartburn or reflux
- Lungs: Negative for cough; problems breathing
- MS: Negative for arthralgias or myalgias

Assessment:

1) ASCVD risk: Improving with recent lifestyle modifications, however, with ASCVD risk >7.5% patient does qualify for a moderate-intensity statin. As patient is only on hydrochlorothiazide as a prescription agent, and with low-likelihood for drug-drug interactions with the OTC multivitamin and calcium supplement,

Mother: Hip fractured (possible osteoporosis); decreased x 8 mo.
Father: High blood pressure
Maternal and Paternal Grandparents: Heart Disease; HTN
Maternal grandfather, mother, sister: Obesity; Type 2 DM
Father: Colon Cancer

Social History:
Married
Non-drinker

Physical Examination:
(performed by Nurse Practitioner during today's visit)
Gen: Well-nourished female in no acute distress
PUL: Lungs CTA and ant/post bilaterally
CV: RRR, S1 and S2 auscultated, PMI WNL
GI: ABD soft non-tender with BS X 4 quads. Negative for tenderness or hepatosplenomegaly.
MS: Motor strength and gait normal with full ROM X 4 extremities

Additional Assessments:
10-Year ASCVD risk = 7.8%

consider starting simvastatin in this patient as it is on $4 list at area pharmacies. Only 20 and 40 mg doses of simvastatin are considered moderate-intensity. With patient actively changing lifestyle, would like to still stay aggressive with statin therapy to optimize benefit and decrease ASCVD risk. Initiate simvastatin 40 mg PO every evening. Check baseline liver function tests (LFTs) to have a starting point if patient does report any myopathies or myalgias.

2) Hypertension: at goal (BP < 130/80 mmHg per ACC/AHA Guidelines) with recent initiation of hydrochlorothiazide. Potassium level within normal limits at this time. If blood pressure begins to increase over next few visits, can consider increasing the dose of hydrochlorothiazide at that time. Currently, can continue hydrochlorothiazide 12.5 mg PO daily and follow up in 3 months regarding patient's blood pressure.

3) Health Maintenance: Improving overall risk for future cardiovascular events. Patient did have a 10-lb weight loss since last visit with implementing these lifestyle changes of diet and exercise. Continue encouraging patient to lose weight, exercise on a regular basis, and stay on the diet plan.

Plan:

1) Initiate simvastatin 40 mg PO every evening
2) Check baseline LFTs to monitor levels prior to statin therapy
3) Continue hydrochlorothiazide 12.5 mg PO daily
4) Continue lifestyle modifications of diet and exercise

	5) Patient to RTC in 3 months for specific follow up of blood pressure, changes in medication Also explained to patient that if she experiences any side effects to please contact the office to potentially come in sooner to make any medication adjustments.

Mrs. Jensen
Allergies: NKDA

Age: 56 years
DOB: 8/2/1960

Sex: Female
Portal:

Weight: 157 lbs
Language: English

MRN:
FN#:

LOC:
Outpatient: Part 2/3

Vitals and Measurements

Last 2 years for all visits

	Most Recent	Previous
BP	122/74	128/78
HR	70	72
Temp (°F)	98.4	98.0
Respiratory Rate	18	20
Weight (kg)	71.214	75.75
Weight (lb)	157	167
Height (in)	65	65
Body Mass Index(in)	26.1	27.8
Waist Cir. (in)	34.5	36.5

Common Labs

Last 2 years for all visits

	Most Recent	Previous
WBC		4.5
Hemoglobin		14.3
Hematocrit		43
Platelet		248
Sodium Level		143
Potassium Level		4.0
Chloride Level		98
Glucose Level		110
HDL		50
LDL		170
Triglycerides		130
Total		246
Hgb A1(c)		5.7

APRN Notes:

Presenting Complaint:
Here for second three-month follow-up visit regarding medical treatment of HTN. "I started water aerobics about 3 months ago and have recently increased my walking to about 30 minutes every day."

Family History:
Mother: Hip fractured (possible osteoporosis); decreased x 8 mo.
Father: High blood pressure
Maternal and Paternal Grandparents: Heart Disease; HTN
Maternal grandfather, mother, sister: Obesity; Type 2 DM
Father: Colon Cancer

Social History:
Married
Non-drinker
Non-smoker

Past Medical History:
Postmenopausal (at 52 yrs)
HRT – none
DXA screen – annually last 2 years
Recent mammogram - normal
Colonoscopy 8 years ago

Past Surgical History:
T & A (age 5)

Review of systems:
General: Negative for fever, chills, malaise

Medications:
Calcium
Multivitamin
Hydrochlorothiazide 12.5 mg. po daily
Simvastatin 40 mg. each evening

Physician Notes:

I have seen and evaluated the patient and agree with the documentation provided by Kellie Bruce NP. For the patient's Hypertension I agree with continuing the HCTZ. For the patient's Hyperlipidemia I agree with starting simvastatin. ******Pharmacy note states continue simvastatin********

Pharmacist Notes:

Pharmacy attending interdisciplinary appointment for follow up with Mrs. Jensen regarding blood pressure and recent addition of simvastatin at last visit. Patient states that she has recently started water aerobics and increased her walking to 30 minutes every day. No other complaints mentioned by the patient.

ROS: Performed by Nurse Practitioner – non-significant
Gen: no complaints
GU: no complaints
Ext: Neg muscle aches/pain reported
Objective:

CV: Negative for chest pain, edema or palpitations
GI: a little nausea; negative for heartburn or reflux
Lungs: Negative for cough; problems breathing
MS: Negative for arthralgias or myalgias

Exam: Gen: Well-nourished female in no acute distress
PUL: Lungs CTA and ant/post bilaterally
CV: RRR, S1 and S2 auscultated, PMI WNL
GI: ABD soft non-tender with BS X 4 quads. Negative for tenderness or hepatosplenomegaly.
MS: Motor strength and gait normal with full ROM X 4 extremities

Plan:

1. Continue meds (HCTZ 12.5 mg. daily and Simvastatin 40 mg. in the evening)
2. Continue water aerobics and walking at least 30 minutes daily
3. Continue daily B/P monitoring and record
4. RTC in three months with B/P log

Assessment:

1) ASCVD risk: still at risk based on risk calculation performed at the last appointment. Patient recently started on simvastatin therapy and is not having issues at this time. No muscle aches/pains, or changes in urine color. Patient has also started additional exercises which will help lose weight and prevent future ASCVD events from potentially occurring in the future. Continue simvastatin 40 mg PO every evening at this time. Continue current lifestyle modifications.

Physical Exam: Performed by Nurse Practitioner
Gen: WDWN female, NAD
PUL: Lungs CTA and ant/post bilaterally
CV: RRR, S1 and S2 auscultated, PMI WNL
GI: ABD soft non-tender with BS X 4 quads. Negative for tenderness or hepatosplenomegaly.
MS: Motor strength and gait normal with full ROM X 4 extremities

2) Hypertension: controlled at goal (BP < 130/80 mmHg per ACC/AHA Guidelines) with hydrochlorothiazide and lifestyle modifications. No new labs were drawn today, but with patient not experiencing any side effects at this time. Will defer labs until prior to next appointment. Continue hydrochlorothiazide 12.5 mg PO daily. Continue to monitor blood pressure at home and have patient bring in results to next appointment. Check BMP prior to next appointment to evaluate hydrochlorothiazide therapy.

Plan:

1) Continue simvastatin 40 mg PO every evening
2) Continue hydrochlorothiazide 12.5 mg PO daily
3) Check BMP prior to next appointment
4) Continue current lifestyle modifications

Patient has also been instructed to contact the office if she experiences any side effects to make any adjustments to medications if necessary.