Medical Student Note #1

HPI:
Mr. X is a 53-year-old male who is at the clinic today to discuss blood pressure. He is currently taking medication to control his blood pressure and has no side effects. He says he has a headache today. Otherwise, he has no problems. He spent a lot of time talking about his pet cat.

Review of systems not completed

PMHx: hypertension

Surgical Hx: cholecystectomy at age 45

Social Hx: smokes cigarettes

Medications: antihypertensive

Physical Exam:
Vital signs per nursing note
General: appeared appropriate
Cardiovascular: heart sounds present
Pulmonary: breath sounds present
Extremities: legs appear swollen
Neuro: alert
Psych: good mood

Assessment & Plan:
Mr. X is a 53-year-old male with hypertension.

1. Hypertension
   -Continue medication

Medical Student Note #2

HPI:
Ms. Y is a 27-year-old female presenting for vaginal discharge. The symptoms have been present for 3 days. She describes the discharge as "white and clumpy." She endorses vaginal itching. Her last menstrual period was 1 week ago, and she states her menses is regular. She is not sexually active. She denies dysuria and urinary frequency. However, she reports she was treated for a urinary tract infection last week; she is unsure of the name of the antibiotic she took.

Review of systems:
General: denies fever, fatigue
Cardiovascular: denies chest pain, edema
Pulmonary: denies shortness of breath, cough
Gastrointestinal: denies abdominal pain, nausea, vomiting
Genitourinary: denies flank pain
Neuro: denies headache, lightheadedness
Derm: denies rash
Psych: denies depression, anxiety

PMHx: asthma

Surgical Hx: tonsillectomy at age 5

Social history: lives alone, works as a high school teacher; denies substance use

Medications: albuterol as needed

Physical Exam:
Vitals: HR 78 RR 14 BP 118/80 Temp 98.6F
General: well-appearing, no acute distress
Cardiovascular: heart sounds dual, no murmur
Pulmonary: bilateral lung fields clear to auscultation
Gastrointestinal: abdomen soft, non-tender, non-distended
Genitourinary: No CVA tenderness. Pelvic exam was performed by attending physician with the following findings: normal external genitalia, vagina, and cervix; white discharge noted in vaginal vault.
Derm: skin warm and dry

Assessment & Plan
Ms. Y is a 27-year-old female presenting for 3 days of white vaginal discharge. Attending physician collected sample during physical exam and determined her symptoms are consistent with a yeast infection.

1. Vaginal yeast infection
   -Prescribed intravaginal miconazole 2% cream for 7 days per attending physician

Medical Student Note #3

HPI:
Mr. Z is a 67-year-old male with a PMHx of COPD (not on oxygen) presenting for 2 days of shortness of breath and cough. He reports that he feels short of breath at rest, and it is worsened with activity. He has been using his albuterol inhaler 4 times a day; at baseline, he only uses this inhaler once per week. He reports he is still taking his other inhalers as prescribed. He states the cough is productive with white to yellow phlegm; he usually only has a dry cough. He denies any sick contacts and he is up to date on his immunizations. He denies chest pain and edema. He is a current smoker of 1-pack-per-day. He has been smoking since age 18. He has thought about quitting in the past, but he is not interested in quitting today. He states he wants to "focus on getting better first." He has not been on any recent long trips.

Review of systems:
General: denies fever, fatigue
HEENT: denies sore throat, congestion, rhinorrhea, ear pain
Gastrointestinal: denies abdominal pain, nausea, vomiting
Neuro: denies headache, lightheadedness
Derm: denies rash
Psych: denies depression, anxiety

PMHx: COPD, HFpEF, HTN, T2DM

Surgical Hx: Appendectomy at age 17

Social Hx: 49 pack-year smoking history, denies further substance use. Lives at home with his partner.

Medications:
Spiriva (18mcg) daily
Dulera (mometasone 100mcg/formoterol 5mcg) 2 inhalations twice daily
Lisinopril 20mg daily
Metformin 1000mg daily
Furosemide 20mg daily as needed for weight gain/lower extremity edema

Physical Exam:
Vitals: HR 86 RR 16 BP 146/90 Temp 98.6F SpO2 94% Weight 290lb
General: well-appearing, no acute distress
Cardiovascular: heart sounds dual, no murmur. No appreciable edema in lower extremities.
Pulmonary: bilateral lung fields with scattered end-expiratory wheezes, no crackles. Good air entry bilaterally.
Gastrointestinal: abdomen soft, non-tender, non-distended
Derm: skin warm and dry
Neuro: alert and oriented x3
Psych: behavior appropriate for clinical setting

Assessment & Plan

Mr. Z is a 67-year-old male with PMHx of COPD, HFpEF, HTN, and T2DM presenting with 2 days of shortness of breath and cough. Differential diagnosis includes viral URI, pulmonary embolism, COPD exacerbation, and heart failure exacerbation. Given patient has shortness of breath, as well as increased sputum production and purulence, COPD exacerbation is most likely. This is further supported by wheezing noted on physical exam. Heart failure exacerbation is less likely as there were no crackles or edema; his weight is also stable from his last visit. Patient does not have any further symptoms (i.e., fever, congestion) to suggest viral URI. Pulmonary embolism less likely as patient is without tachycardia, hemoptysis, and recent long trips.

1. COPD Exacerbation
   -Continue inhalers
   -Treat with steroids and antibiotics

2. HTN
3. T2DM
4. HFpEF
   -continue current medications

Medical Student Note #4

HPI:
Ms. W is a 52-year-old female presenting for T2DM and HTN follow-up.

T2DM: Her last A1c was 8.5% 4 months ago. Patient reports that she is exercising for 30 minutes three times a week and trying to adjust her eating habits. She admits that she has trouble resisting sweet foods, such as cake and ice cream. She drinks 2 glasses of sweet tea a day. Her current medications include metformin and Jardiance (empagliflozin); she reports taking these medications daily without any side effects. She has a home glucometer, but she does not regularly check her blood sugars. She reports having symptoms of polyuria. Denies numbness/tingling in extremities, visual changes, and lightheadedness. She follows regularly with an ophthalmologist and her retinal exam is up to date. She had a diabetic foot exam at her last visit. Her immunizations are up to date.

HTN: She has a home blood pressure cuff, and she reports her daily readings have been 130s/80s. She is currently on amlodipine and tolerating this medication well. Denies excess salt or caffeine intake. Denies headaches. Her last BMP was over 1 year ago.

Review of systems negative except for those as noted in HPI.

PMHx: HTN, T2DM

Surgical Hx: C-section x2

Social Hx: Denies substance use. Lives at home with her partner. Works as a librarian.

Health Maintenance: Up to date on age-appropriate cancer screenings, due for COVID-19 booster and flu vaccine.

Medications:
Metformin 2000mg daily
Jardiance 10mg daily
Amlodipine 5mg daily

Physical Exam:
Vitals: HR 82 RR 14 BP 138/84 Temp 98.6F SpO2 96% BMI 42.0
General: well-appearing, no acute distress
Cardiovascular: heart sounds dual, no murmur. No appreciable edema in lower extremities.
Pulmonary: bilateral lung fields clear to auscultation. Good air entry bilaterally.
Gastrointestinal: abdomen soft, non-tender, non-distended
Derm: skin warm and dry
Neuro: alert and oriented x3
Psych: behavior appropriate for clinical setting

Assessment & Plan
Ms. W is a 52-year-old female presenting for T2DM and HTN follow-up.

1. T2DM
   -Last A1c was above patient's goal of 7% and patient currently experiencing polyuria, indicating patient would benefit from additional glycemic control. However, will recheck A1c today prior to initiating new medications. If A1c remains elevated, would recommend starting Ozempic (semaglutide), as patient also has elevated BMI and this would help with weight loss. If A1c results >10% would consider starting basal-bolus insulin regimen.
   -Patient currently not on statin therapy; discussed with patient and she is agreeable to start atorvastatin 20mg daily. Will check lipid panel to determine if further intensification of statin therapy is warranted.
   -Check urine microalbumin/creatinine ratio. If signs of microalbuminuria, would change anti-hypertensive medication to ACEi/ARB
   -Remainder of diabetes care items up to date
   -Continue metformin and Jardiance

2. HTN
   -BP at goal of <140/90
   -Repeat BMP today to monitor renal function, especially given patient may be switched to ACEi/ARB therapy as noted above
   -Continue amlodipine

   Follow-up in 3 months. Will call patient beforehand to discuss lab results.

3. Health Maintenance
   -Patient agrees to receive COVID-19 booster and flu vaccine today.