

Progress Note

Patient Name: Patient ID:

Sex: Birthdate:

Referring Provider:

Male



Visit Date: Provider:

Location: **Location Address:**

November 17, 2015



Location Phone:

History Of Present Illness

is a 50 year old African American/Black male in the office today in consult for REFERRING CARE PROVIDER NAME for cardiovascular evaluation.

This pleasant 50-year-old African-American gentleman refers himself to the office today for an opinion regarding management of syncope and SVT. Recently, he had seem at the VA Hospital. The patient describes having multiple spells over the last 5-6 years of abrupt onset syncope. These are usually preceded by brief rapid palpitations associated with chest pain. He was wearing a monitor when he had another spell, and transmitted narrow complex tachycardia at approximately 180 bpm during a spell. This appears to be AV nodal reentrant tachycardia.

discussed with the patient having an ablation, and referred him for that procedure at the VA in Unfortunately, he needs to wait for January to have this done.

On talking to the patient, he continues to have spells lasting 5-10 minutes 2-3 times per week. He was placed on diltiazem without much effect. The patient currently is free of chest pain. He denies dyspnea, PND, orthopnea, and ankle swelling.

Risk factors to ischemic heart disease are not present in this patient. He denies any history of hypertension, hypercholesterolemia, diabetes, smoking, or any family history of coronary disease.

The patient is a 34 year veteran of the army. He recently was discharged for medical disabilities. His disabilities include PTSD, chronic back pain now on methadone, fibromyalgia, and advanced degenerative joint disease.

The patient is surgically is single, and has 2 sons age and years. He lives in

Past Medical History

Disease Name	Date Onset	Notes
*******HYPERTENSION******		11/17/2015 - dmt
Chest Pain	로 돌아있다. 그 사실 보호 등	
Gastritis		
Hypertension	-	
Palpitations		
Shortness of breath		11/17/2015 - dmt
SVT (supraventricular tachycardia)		2
Syncope		
Fibromyalgia		

Past Surgical History

ast Suigical Illstory		
Procedure Name	Date	Notes
Back surgery		11/17/2015 - dmt
Knee surgery		11/17/2015 - dmt

Medication List

Name	Date Started	Instructions
capsaicin topical cream 0.025 %		apply to the affected area(s) by topical route 3 times per day
cetirizine oral tablet 10 mg		take 1 tablet (10 mg) by oral route once daily
Cialis oral tablet 5 mg		

Progress Notes

Compazine oral tablet 5 mg

diclofenac sodium topical gel 3 %

diltiazem HCl oral capsule, extended release 180 mg

duloxetine oral capsule, delayed release (DR/EC) 20 mg

esomeprazole magnesium oral capsule, delayed release(DR/EC) 20 mg

fluticasone nasal spray, suspension 50 mcg/actuation

gabapentin oral tablet 600 mg

lactulose oral solution 10 gram/15 mL (15 mL)

lidocaine topical adhesive patch,medicated 5 %(700 mg/patch)

methadone oral tablet 10 mg

mirtazapine oral tablet 15 mg

oxybutynin chloride oral tablet 5 mg

Patanol ophthalmic drops 0.1 %

ranitidine HCI oral capsule 150 mg

sodium chloride nasal aerosol,spray 0.65 %

sumatriptan nasal spray,non-aerosol 20 mg/actuation

take 1 tablet (5 mg) by oral route 3 times per day

--

take 1 capsule (180 mg) by oral route once daily

take 1 capsule (20 mg) by oral route 2 times per day

take 1 capsule (20 mg) by oral route once daily at least 1 hour before a meal swallowing whole. Do not crush or chew granules.

inhale 2 sprays (100 mcg) in each nostril by intranasal route once daily

take 1 tablet (600 mg) by oral route 3 times per day

take 15 milliliters (10 gram) by oral route once daily

apply 1 patch by transdermal route once daily (May wear up to 12hours.)

take 1 tablet (10 mg) by oral route every 12 hours

take 1 tablet (15 mg) by oral route once daily before bedtime

take 1 tablet (5 mg) by oral route 2 times per day

instill 1 drop into affected eye(s) by ophthalmic route 2 times per day at an interval of 6 to 8 hours

apply 2 sprays by nasal route daily

spray 1 spray (20 mg) by intranasal route once; if headache returns, dose may be repeated once after 2 hours, not to exceed 40 mg per day

Allergy List
Allergen Name
Augmentin

Date

Reaction

Notes

causes his face to rash

Family Medical History

Disease Name Depression Relative/Age

Notes

Social History

	Finding	Status	Start/Stop	Quantity	Notes
	2 CHILDREN		/		11/17/2015 - dmt
	Alcohol	Never	/		11/17/2015 - dmt
	Caffeine	Never	/		11/17/2015 - dmt
	Denies illicit substance abuse	Never	/	_	11/17/2015 - dmt
	Living Will		/		11/17/2015 - d,mt
	Patient has an Advance Care Plan.	-	/		11/17/2015 - dmt
	Tobacco	Never	/	_	11/17/2015 - dmt

Review of Systems

Constitutional

o Denies: fatigue, fever, chills, malaise, body aches, night sweats, weight loss, weight gain, loss of appetite Cardiovascular



o * See HPI

Respiratory

o Denies: shortness of breath, wheezing, cough

Gastrointestinal

o Denies: nausea, vomiting, blood in stools

Neurologic

o Denies: muscular weakness, difficulty concentrating, speech difficulties

Musculoskeletal

o Admits : bilateral knee pain

o Denies: joint swelling, muscular weakness

Psychiatric

o Denies: anxiety, depression

All Others Negative

Vitals

BMI

2.45

Date Time BP Position Site L\R Cuff Size HR RR TEMP(°F) WT HT kg/m² BSA m² O2 Sat HC

11/17/2015 09:24 AM 130/60 Sitting 65 - R 249lbs 9oz 6' 3" 31.19

Physical Examination

Constitutional

 Appearance: overweight, well developed, alert, in no acute distress, well-tended appearance, appears about reported age

Head and Face

o Head:

Inspection : Atraumatic, normo cephalic

Eyes

o Conjunctivae: Conjunctivae normal

o Sclerae: Sclera white

o Eyelids/Ocular Adnexae: Eyelid appearance normal, no xanthelasmas present

Ears, Nose, Mouth and Throat

o Oral Cavity:

Oral Mucosa: Oral mucoas moist

Neck

o Thyroid: Gland size normal, nontender, no nodules or masses present on palpation

o Jugular Veins: 3 cm JVD at 45 degress

Respiratory

o Respiratory Effort : Breathing unlabored

o Inspection of Chest: Normal appearance, no retractions

o Auscultation of Lungs: Normal breath sounds bilaterally without rales, rhonchi, or wheezes

o Palpation of Chest : Nontender

Cardiovascular

o Heart:

Palpation of Heart : Normal PMI, no cardiac thrill present

Auscultation of Heart: Regular rate, regular rhythm, no murmurs, no rubs, no gallop

o Peripheral Vascular System:

Carotid Arteries: Normal pulses bilaterally, no bruits

Extremities : No edema present

Gastrointestinal

o Abdominal Examination: Abdomen nontender to palpation, normal bowel sounds

o Liver and Spleen: No hepatomegaly present

Musculoskeletal

o General: Muscle tone appears normal for age

Skin and Subcutaneous Tissue

o General Inspection: Skin warm and dry

Digits and Nails: No clubbing, cyanosis, or deformities present

Neurologic

o Mental Status Examination: Oriented to person, place, and time

o Cranial Nerves: Grossly intact

Psychiatric

- o Judgement and Insight: Judgement and insight intact
- o Mood and Affect : Affect appropriate

EKG

o **EKG Interpretation**: Twelve-lead EKG shows normal sinus rhythm with no abnormality. There is no evidence of preexcitation. Interference with TENS unit is noted.

Assessment

- Moderate Recurrent Syncope 780.2/R55
- Moderate Recurrent SVT (supraventricular tachycardia) 427.89/I47.1

In summary, the patient has recurrent spells of rapid narrow complex tachycardia, most likely AV nodal reentrant tachycardia associated with vasodepressive syncope. Based on his young age, and other medical problems, he should be considered for early ablation. I did discuss with him the option of having the procedure here versus Atlanta. The patient is interested in proceeding to having his procedure done here after Thanksgiving, and we will tentatively book him for November 30. In the meantime, we'll order precath labs. Patient should stop diltiazem just before Thanksgiving. I will plan to do an EPS with radiofrequency ablation, pending findings. We will plan to do mapping with ESI system.

Thank you for this consultation. I will plan to see the patient back at the completion of testing and treatment in 4 weeks. In the meantime, have also ordered an echo to exclude any structural heart disease.

Plan

Orders

- SVT Ablation (SVTAB) 780.2/R55, 427.89/I47.1 11/17/2015
 Book for EPS/RFA with ESI
- o Pre Cath Labs (PCATH) 780.2/R55, 427.89/I47.1 11/17/2015
- o Echocardiogram 780.2/R55, 427.89/I47.1 11/17/2015

Instructions

- o On behalf of my colleagues and myself at Palmetto Heart, I would like to thank you for the opportunity to participate in the ongoing cardiac care of this patient.
- The risks of EP STUDIES have been explained to the patient to include: hematoma, venous thrombosis infection and risk of cardiac emergencies
- o Discussed in details with the patient and the family the pathophysiology of atrial arrhythmia and different treatment options, including using antiarrhythmic drugs, E. CVN, and ablation. The patient opted for ablation. Risks and benefits of ablation were discussed in details with the patient and the ramily. RISKS include, but not limited to, bleeding, infection, DVT, PE, MI, CVA, pneumothorax, cardiac perforation causing tamponade needing surgery, heart block (0.1%) needing permanent pacemaker, etc. The patient understood and wanted to proceed with the procedure, which will be scheduled at next available ablation slot. The patient was advised to stop any antiarrhythmic drug 5 days prior to ablation date.
- o Book for EPS/RFA on NOV 30th ? first case
- o Needs pre cath labs
- o Book echo
- o See 4 weeks

Disposition

o Return Visit Request in/on 4 weeks +/- 2 days (116701).

Electronically Signed by: MD -Author on November 17, 2015 11:15:40 AM

BP: 130/60





Transthoracic Echocardiogram

Med Rec#: Account#:

Date: Patient: Room#:

Height:

L1/18/2015

Weight: BSA: 2.33 DOB: Sex: M Age: 50y

Type:Outpatient Loc:

Referring: Reading:

Sonographer:



Diagnosis: CPT Codes: Indication:

ICD-10-PCS Syncope and collapse (R55) Echo 2D Complete/Color Flow/Doppler (93306)

syncope

Conclusions

The left ventricular chamber size is normal.

There is no left ventricular hypertrophy observed.

There is normal left ventricular systolic function. The estimated ejection fraction is 60%

Normal left ventricular diastolic filling is observed.

There is no left ventricular segmental wall motion abnormality.

The right ventricular cavity size is normal.

7 The right ventricular global systolic function is normal.

The left atrium is normal in size.

The right atrial cavity size is mildly dilated.

0. The mitral valve leaflets are normal.

There is mild mitral regurgitation observed.

2 The aortic valve structure is normal.

There is no evidence of aortic regurgitation. 3.

4 There is no evidence of aortic stenosis.

There is trace tricuspid regurgitation present.

6. There is no pericardial effusion.

There is moderate dilatation of the ascending aorta.

No intracardiac mass, thrombi, or vegetation.

Findinge

Procedure Info:

The study quality is adequate. Patient Information: Greenway

History: Left Ventricle: Chest Pain. Hypertension. palpitations, shortness of breath. SVT

The left ventricular chamber size is normal. There is no left ventricular hypertrophy observed. There is normal left ventricular systolic function. The estimated ejection fraction is 60% Normal left ventricular diastolic filling is observed. There is no left ventricular segmental wall

motion abnormality.

Right Ventricle:

The right ventricular cavity size is normal. The right ventricular global systolic function is

normal.

Left Atrium:

The left atrium is normal in size.

Right Atrium:

The right atrial cavity size is mildly dilated.

Mitral Valve: Aortic Valve:

The mitral valve leaflets are normal. There is mild mitral regurgitation observed. There is no

evidence of mitral stenosis.

Tricuspid Valve:

The aortic valve structure is normal. There is no evidence of aortic regurgitation. There is no evidence of aortic stenosis.

The tricuspid valve leaflets are morphologically normal. There is trace tricuspid regurgitation

present. There is mild pulmonary hypertension. The pulmonic valve appears normal. There is trace pulmonic regurgitation present.

Pulmonic Valve: Pericardium:

There is no pericardial effusion.

Aorta Aortic Root: **Pulmonary Artery:**

There is moderate dilatation of the ascending aorta.

The main pulmonary artery appears normal.

The inferior vena cava is normal in size. There is a greater than 50% respiratory change in

the inferior vena cava dimension.

Mass Thrombus:

Venous:

No intracardiac mass, thrombi, or vegetation.

Measurements





Chaml	pers MM		CI	nambers 2D	
Name	Value	Normal	Name	Value	Normal Range
		Range	RVIDd (AP) 2D	2.95 cm	-
Ao root diameter (MM)	3.6 cm		RVIDd (2D) index	1.27 cm/m2	
LA dimension (AP) MM	3.8 cm	-	IVSd (2D)	0.89 cm	
_A:Ao ratio (MM)	1.06 ratio		LVPWd (2D)	0.83 cm	1
Ao root diameter (MM)	1.55		IVS:LVPW ratio (2D)	1.08 ratio	
ndex	cm/m2	a De	LVIDd (2D)	4.96 cm	-
A dimension (MM) index	1.63	100 0000	LVIDs (2D)	2.66 cm	
•	cm/m2		LVIDd (2D) index	2.13 cm/m2	
AV cusp separation (MM)	2.7 cm		LVIDs (2D) index	1.14 cm/m2	
			LV FS (2D)	46 %	
			LV FS (Teichholz) (2D)	46.4 %	The second second
			LV FS (cube) (2D)	46.4 %	
			EF Teichholz (2D)	78 %	100000000000000000000000000000000000000
			LA dimension (AP) 2D	2.8 cm	
			LA dimension (2D) inde	ex 1.2 cm/m2	

Volur	nes/Mass		Diastolio	/Systolic Fund	ction
Name	Value Normal Range		Name	Value	Normal Range
LA ESV SP 4CH (MOD)	25 ml		MV E-wave Vmax	0.74 m/sec	
LA ESV SP 2CH (MOD)	22 ml		MV A-wave Vmax	0.66 m/sec	
LA ESV BP (MOD)	26 ml	-	MV E:A ratio	1.12 ratio	
LA ESV BP (MOD) index	11.16 ml/m2		LV septal e' Vmax	0.08 m/sec	87. L. 2 L
LV mass (2D)	146.74 g	Magnetic services and the services are the services and the services and the services and the services and the services are t	LV lateral e' Vmax	0.1 m/sec	
LV mass (2D) index	62.98 g/m2		LV average e' Vmax	0.09 m/sec	
			LV E:e' septal ratio	9.26 ratio	
			LV E:e' lateral ratio	7.57 ratio	
			LV average E:e' ratio	8.22 ratio	

Aor	tic Valve			Tricuspid Valve	
Name	Value	Normal Range	Name TR Vmax	Value 2.64 m/sec	Normal Range
AV VTI	1.19 m/sec		TR peak gradient	27.88 mmHg	
AV peak gradient	5.66 mmHg		RVSP	30.88 mmHg	-
AV mean gradient	4 mmHg	4			
LVOT diameter	2.5 cm	C. Santaga			
LVOT Vmax	0.81 m/sec	-			
LVOT VTI	21.1 cm	-			
LVOT peak gradient	3 mmHg	-			
LVOT mean gradient	1 mmHg				
DOI (VTI)	0.79 ratio				
DOI (Vmax)	0.68 ratio				
SV LVOT	103.52 ml	-			
AVA (continuity Vmax)	3.34 cm2	KONNET KANTA			
AVA (continuity Vmax) index	1.43 cm2/m2	-			

Pulmonic Valve/Qp:Qs

AVA (continuity VTI)

AVA (continuity VTI) index

The second of th		
Name	Value	Normal Range
PV Vmax	0.95 m/sec	
PV peak gradient	3.61 mmHg	

Electronically signed by on 11/19/2015 08:38:59

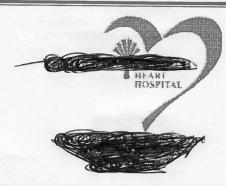


3.88 cm2 -

1.67

cm2/m2





CARDIAC CATHETERIZATION LABORATORY

PATIENT:

MR #:

ADMITTED DATE: 12/11/2015

CARDIOLOGIST: REFERRING: DOB: SEX:

PT.LOC:

CATH #:

ATTENDING PHYSICIAN:

HISTORY: Mr. is a 50-year-old male with chronic back pain referred to the lab today for further management of SVT with syncope.

PROCEDURE IN DETAIL: The patient was brought to the lab in a nonsedated, postabsorptive state. After signing a written consent form, intravenous access was secured and the patient received initial sedation with propofol. Subsequently, the right and left inguinal regions were prepped and draped in the usual fashion. A total of 20 mL of 0.5 percent bupivacaine was placed in each of the right and left femoral regions. Subsequently, a number 7-French sheath was placed in the right femoral vein and a 10-French sheath in the left femoral vein. Three number 4-French electrode catheters were placed via the left femoral vein and in the high right atrium, a second in the position of bundle of His and a third in the right ventricular apex. Satisfactory measurements were made in the atrium at 0.2 milliamps and the ventricle at 0.3 milliamps. The procedure commenced with decremental atrial and ventricular pacing to assess the site of Wenckebach. Early on, the patient had easily inducible typical AV nodal reentrant tachycardia with average heart rate at 180 beats/min with normal HV interval. The VA interval was very short at less than 50 ms. After a confirmation of the diagnosis, we then proceeded to early ablation. A 4 mm tip long curved EPT Blazer catheter was then placed via the 8-French sheath. Previous to this, coronary sinus catheter was placed in the coronary sinus. With great difficulty, a low septal burn was made which resulted in transient junctional rhythm for close to 50 seconds. A second burn was made in the same place and the procedure was subsequently completed.

Post-ablation, intermittent rapid atrial pacing at cycle lengths of 600, 500 and 400 ms was performed to assess sinus node recovery time. Atrial and ventricular stimulation was performed to check VA and AV Wenckebach. Atrial programmed stimulation was repeated to demonstrate single APCs at paced cycle lengths of 500 and 400 ms.

Isoproterenol was administered in a peak dose of 3 mcg/kg/min. Repeat atrial and ventricular program stimulation was performed during and after the isoproterenol infusion. At the completion of the study, the patient continued to

PATIENT: MR #: 6 Patient Type:

HH CARDIAC CATHETERIZATION LABORATORY Page 1 of 2



have evidence of dual AV nodal physiology, but no echos, and no further inducible arrhythmias. The procedure was completed without complication.

RESULTS:

- 1. Baseline 12-lead EKG showed normal sinus rhythm with no abnormality. Sinus cycle length was 500 ms, PR interval 149 ms, AH interval 83 ms, HV 49 ms, QRS duration 89 ms, QT was 326 ms.
- 2. Sinus node function was normal with sinus node recovery time measured at 250 ms.
- 3. AV nodal function: The patient had dual AV nodal physiology. When pacing the atrium at 400 ms, AV node ERP was measured at 270 ms post-ablation.
- 4. With programmed ventricular stimulation with single APCs at 600 and 400 ms at the right ventricular apex, there were no inducible arrhythmias.
- 5. Induced arrhythmias: The patient had multiple inductions of typical AV nodal reentrant tachycardia with a heart rate at 180 beats/min and HV interval measuring 40 ms. PVCs introduced during tachycardia failed to reset the rhythm
- 6. Ablation: With some difficulty, the ablation catheter was placed in the low septum, and a single one minute burn resulted in a prolonged episode of junctional rhythm. Second burn was made in the same location.
- 7. Isoproterenol was administered at a peak dose of 3 mcg/kg/min. Repeat atrial and ventricular program stimulation during and after the isoproterenol infusion failed to reinduce arrhythmias.

FINAL SUMMARY:

- 1. Normal sinus node function.
- 2. Normal AV nodal function with dual AV nodal physiology.
- 3. Normal His-Purkinje function.
- 4. Easily inducible typical AV nodal reentrant tachycardia.
- 5. Acutely successful radiofrequency ablation and AV nodal modification with no further induction of arrhythmia. Dual AV nodal physiology remained without echos.

COMMENTS: This was technically difficult due to some difficulties with anesthesia in this patient with a long history of narcotic addiction. Additionally, he actually required intubation in order to maintain catheter stability. The procedure was acutely successful today. We would anticipate discharge later this evening or tomorrow morning. Patient will follow up with Dr. in the clinic in 3 weeks.

D: 12/11/2015 14:23 T: 12/11/2015 14:35 TID: Job #: Doc #:





Progress Note

Patient Name:
Patient ID:
Sex:
Male
Birthdate:
Primary Care Provider
Referring Provider:

Visit Date:
Provider:
Location:
Location Address:

January 5, 2016

Location Phone:

Chief Complaint

Problem List:

- 1. AVNRT, status post RF ablation on 12/11/15
- 2. PTSD
- 3. Chronic back pain
- 4. Fibromyalgia
- 5. Advanced DJD

History Of Present Illness

is a 50 year old African American/Black male who is an established patient of

Mr. is a 50 year old African American male with a history of SVT, PTSD, chronic back pain, fibromyalgia, and advanced DJD, who returns today for a post-hospital follow up visit. He underwent acutely successful RF ablation of typical AVNRT on 12/11/15.

returns today for follow up. He still has some intermittent palpitations, but notes significant improvement since his ablation. He had no problem with his groin post-procedure. He still has some lightheadedness.

Past Medical History

Disease Name	Date Onset	Notes
Back pain		공사무리 하면 이번 이번에 되었다. 그리고 그리고 그렇게 이번 사는 이 글로 다 되었다.
Chest Pain	<u></u>	
Fibromyalgia		
Gastritis		
Hypertension		
Palpitations		(2008) (1908)
Shortness of breath	-	11/17/2015 - dmt
SVT (supraventricular tachycardia)		Status post acutely successful RF ablation of typical AVNRT on
Syncope		12/11/15
Зупсоре		

Past Surgical History

Procedure Name Ablation	Date 12/11/2015	Notes Acutely successful radiofrequency ablation and AV nodal modification with no further induction of arrhythmia. Dual AV
Back surgery Echo (Initial) Knee surgery	 11/18/2015 	nodal physiology remained without echos. 11/17/2015 - dmt EF 60%. 11/17/2015 - dmt

Medication List

Name	Date Started	Instructions
capsaicin topical cream 0.025 %		apply to the affected area(s) by topical route 3 times per day
cetirizine oral tablet 10 mg		take 1 tablet (10 mg) by oral route once daily
Cialis oral tablet 5 mg		

[Nogress Note]

Compazine oral tablet 5 mg

diclofenac sodium topical gel 3 %

diltiazem HCl oral capsule, extended release 180 mg

duloxetine oral capsule, delayed release (DR/EC) 20 mg

esomeprazole magnesium oral capsule, delayed release(DR/EC) 20 mg

fluticasone nasal spray, suspension 50 mcg/actuation

gabapentin oral tablet 600 mg

lactulose oral solution 10 gram/15 mL (15 mL)

lidocaine topical adhesive patch,medicated 5 %(700 mg/patch)

methadone oral tablet 10 mg

mirtazapine oral tablet 15 mg

oxybutynin chloride oral tablet 5 mg

Patanol ophthalmic drops 0.1 %

ranitidine HCl oral capsule 150 mg

sodium chloride nasal aerosol, spray 0.65 %

sumatriptan nasal spray,non-aerosol 20 mg/actuation

take 1 tablet (5 mg) by oral route 3 times per day

take 1 capsule (180 mg) by oral route once daily

take 1 capsule (20 mg) by oral-route 2 times per day

take 1 capsule (20 mg) by oral route once daily at least 1 hour before a meal swallowing whole. Do not crush or chew granules,

inhale 2 sprays (100 mcg) in each nostril by intranasal route once daily

take 1 tablet (600 mg) by oral route 3 times per day

take 15 milliliters (10 gram) by oral route once daily

apply 1 patch by transdermal route once daily (May wear up to 12hours.)

take 1 tablet (10 mg) by oral route every 12 hours

take 1 tablet (15 mg) by oral route once daily before bedtime.

take 1 tablet (5 mg) by oral route 2 times per day

instill 1 drop into affected eye(s) by ophthalmic route 2 times per day at an interval of 6 to 8 hours

apply 2 sprays by nasal route daily

spray 1 spray (20 mg) by intranasal route once; if headache returns, dose may be repeated once after 2 hours, not to exceed 40 mg per day

Allergy List

Allergen Name Augmentin Date

Reaction

Notes

causes his face to rash

Family Medical History

Disease Name

Depression

Relative/Age

Notes

Social History

Finding	Status	Start/Stop	Quantity	Notes
2 CHILDREN	-	/	_	11/17/2015 - dmt
Alcohol	Never	-/	4	11/17/2015 - dmt
Caffeine	Never	/	<u>-</u>	01/05/2016 - srt 11/17/2015 - dmt
Denies illicit substance abuse	Never	-/-	- -	11/17/2015 - dmt
Living Will		/		11/17/2015 - d,mt
Patient has an Advance Care Plan.		/	-	01/05/2016 - srt 11/17/2015 - dmt
Tobacco	Never	/		01/05/2016 - srt 11/17/2015 - dmt

Review of Systems Constitutional



o * See HPI

Cardiovascular

o * See HPI

Vitals

BMI

Date Time BP Position Site L\R Cuff Size HR RR TEMP(°F) WT HT kg/m² BSA m² O2 Sat HC

01/05/2016 10:54 AM 120/84 Sitting

84 - R

252lbs 4oz 6' 3"

31.53 2.46

Physical Examination

Constitutional

o Appearance: Well developed, well nourished, no acute distress

Neck

o Jugular Veins: No definite JVD

Respiratory

o Respiratory Effort: Respirations appear unlabored

o Auscultation of Lungs: Breath sounds clear bilaterally without rales, rhonchi, or wheezes

Cardiovascular

o Heart:

Auscultation of Heart: Regular rate and rhythm without murmur, rub, or gallop

o Peripheral Vascular System :

Extremities : No peripheral edema

Gastrointestinal

o Abdominal Examination: Bowel sounds active, abdomen soft

Skin and Subcutaneous Tissue

o General Inspection : Skin warm and dry

Neurologic

o Mental Status Examination : Oriented to person, place, and time

Psychiatric

o Mood and Affect: Affect appears appropriate

EKG

o EKG Interpretation: 12 lead EKG reveals sinus rhythm at 84 bpm

Assessment

• SVT (supraventricular tachycardia) 427.89/I47.1

Hypertension 401.9/I10

Mr. returns today for follow up. He underwent RF ablation of typical AVNRT on 12/11/15. He still has some palpitations, but reports significant improvement in his palpitations since ablation. His blood pressure is controlled. No changes will be made in his medical therapy today and he should return in 6 months for follow up.

Plan

Instructions

- On behalf of my colleagues and myself at Palmetto Heart, I would like to thank you for the opportunity to participate
 in the ongoing cardiac care of this patient.
- No medication changes were made today
- o Return in 6 months for follow up with Dr. Jennifer Feldman or sooner if needed

Disposition

- o Follow up with Dr. Jennifer Feldman
- o Return Visit Request in/on 6 months +/- 2 days (120615).

Referrals

 ID: 37502 Date: 11/04/2015 Type: Inbound Specialty: Cardiology