

11-Apr-07 00:00 Heart Failure Resource Center  
PIEDMONT HOSPITAL  
FUQUA HEART FAILURE RESOURCE CENTER  
Follow Up Clinic Visit  
4/11/2007

PATIENT NAME: **Sample Follow-up Patient**

DOB: 00-00-1900

REASON FOR CONSULTATION: Heart Failure

CHIEF COMPLAINT: Heart failure.

cc: xxxx., MD, xxx., MD, xxx., MD

HISTORY OF PRESENT ILLNESS: Mr. Sample Patient returns today for follow up evaluation for heart failure. He has continued to do well over the past few months. He remains very active and ambulates without complaint of dyspnea. He does experience slight dyspnea with maximal exertion such as walking briskly up steep inclines, which resolves quickly with rest. He continues to weigh daily and reports a stable weight. He is taking all heart failure medications as instructed. He reports seeing Dr. in follow up last month with lab work. No medication changes were made and he was instructed to continue his Glipizide. He also believes he might be started on a cholesterol medication after Dr. consults with Dr.

SOCIAL HISTORY: The patient is single. He is retired. He is a former smoker. He smoked 1 packs per day for 10 years, quitting in 1965. He rarely drinks alcohol. Patient exercises regularly. Participates in PH Cardiac Rehab regularly. He drinks 3 cups of caffeine daily.

ADVANCED DIRECTIVES: Durable Power of Attorney for Health Care - JSample.

ALLERGIES: NKDA.

CURRENT MEDICATIONS:

Enalapril 10mg BID  
Coreg 25mg BID  
Bumex 1mg BID  
Aspirin 81mg Daily  
Glipizide 2.5mg Daily  
Doxazosin 4mg Daily  
Lorazepam 0.5mg PRN anxiety  
Multivitamin 1 Daily  
Calcium 1 Daily  
Vitamin C 1 Daily

#### REVIEW OF SYSTEMS:

GENERAL: Denies weight gain, weight loss, weakness, fatigue, fevers.

INTEGUMENTARY: Skin Intact. Denies lesions, leg swelling, rashes, ulcers.

CARDIOVASCULAR: Sleeps on 1 pillow. Denies chest pain or discomfort, waking up at night with SOB, palpitations.

RESPIRATORY: Denies cough, shortness of breath.

NEUROLOGIC: Denies seizures, dizziness, numbness, fainting spells.

#### PHYSICAL EXAMINATION:

GENERAL: Patient is alert, oriented. In no acute distress Motor response is grossly intact.

VITAL SIGNS: BP 105/59 right arm sitting. Pulse 61. Resp 18. O2 sat 95% room air. Weight 146 lbs at home. Weight 151 lbs in clinic. Weight loss of 5 lbs over 1 months.

EYES: Conjunctivae and sclera clear.

SKIN: Skin is warm, dry.

NECK: Jugular venous pressure of less than 5cm noted. No carotid bruits.

LUNGS: Respirations non-labored and regular. Lung sounds are clear.

CARDIAC: S1, S2, distant, regular rate and rhythm. No murmur, rub or gallop. No carotid bruits. Peripheral pulses: Left radial 2+ Right radial 2+

ABDOMEN: Non-tender, obese, soft. Bowel sounds present in 4 quadrants. Large umbilical hernia present that is being treated medically.

EXTREMITIES: No clubbing or cyanosis. Capillary refill is quick. No edema noted in lower extremities.

PAIN: Patient not complaining of pain at this time.

#### IMPRESSION:

1. Compensated heart failure, NYHA Class II, stage C without worsening heart failure symptoms.
2. Ischemic cardiomyopathy, EF 25%.
3. Status post ICD, 11/2005.
4. Multiple comorbidities as previously reported.

#### PLAN:

Optimization of heart failure medications to improve heart failure symptoms per Fuqua HFRC protocols. Medication names, indications and dosages reviewed. Educational written material reviewed and sent home with patient. Continue current medication regimen.

Comprehensive heart failure patient education continued including daily weight monitoring, medications, dietary guidelines and restrictions, smoking cessation, signs and symptoms of worsening heart failure and benefits of exercise. Written education material and medication list reviewed and sent home with patient.

Will monitor his compliance and fluid volume status and be available to intervene with outpatient diuretic therapy if needed.

Return to clinic for follow up in 3-4 months or earlier if necessary.

Documented by: , APRN, MN  
Signed by: , APRN, MN  
Date of Service: 4/11/2007

SAMPLE