Digestive & Liver Disease Consultants, P.A.
Diplomate Certified in Internal Medicine and Gastroenterology

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SAMPLE CONSULTATION REPORT

PATIENT NAME : LEONORE F.*
PATIENT ID : 555-55-5555
DATE OF BIRTH : 11/11/1933 **AGE :** 69 **SEX :** FEMALE

ATTENDED BY : Guru N. Reddy, M.D.
REFERRED BY : Dr. Peter Williams*
EXAM DATE : 08/18/03

CHIEF COMPLAINT / PRESENT ILLNESS :

Pt. c/o heartburn with severe chest pain 2 weeks ago. Seen in ER with neg cardiac and gb w/u.Pt. is taking Nexium 40 mg qd for relief. Normal bm's with no blood in stool. FS 4 years ago. SRJ/CMA

Noted to have stool filled bowel on abd films in hosp.

Had heartburn last yr and placed on Nexium with good control of sx. No sx til day 2 wks ago when had "horrible indigestion" and got very nervous and had elev BP. NO N/V. Diaphoretic. Admitted to Conroe with MI ruled out. Stress test OK.

MEDICAL HISTORY : Patient has history of colon polyps, hemorrhoids, high blood pressure.

HOSPITALIZATION OR SURGERY :

1. The patient was admitted for Appendectomy. Surgery was performed.
2. The patient was admitted for knee surgery.
3. The patient was admitted for back surgery.
4. The patient was admitted for a Bunionectomy. Surgery was performed.
5. The patient was admitted in 1987 for Hemorrhoidectomy. Surgery was performed.
6. The patient was admitted in 1995 for Colonoscopy. Procedure was performed.

FAMILY HISTORY :

Father - Heart Disease
Mother - Heart Disease, Diabetes, Lung Cancer
Denies family hx of colon polyps or cancer

MEDICATIONS : Cozaar 50 mg

ALLERGIES : PCN

SOCIAL HISTORY : Denies tobacco or ethanol use.

SYSTEMS REVIEW

GENERAL : No history of weakness. No history of fever or chills. No history of weight gain or loss.

SKIN : No history of skin rash. No history of skin infection. No history of nail problem.

CARDIAC / RESPIRATORY : No history of pain in chest. No claudication. No history of cough. No dyspnea. No hemoptysis. No history of murmurs. No nocturia. No orthopnea. No palpitation. No pleuritic pain. No sputum. No wheezing.

GASTROINTESTINAL : No history of abdominal pain. No history of loss of appetite. No history of bloating. No history of blood in stools. No history of constipation. No history of diarrhea. No dysphagia No history of heartburn. No history of hemorrhoids. No history of jaundice. No history of nausea. No history of regurgitation. No history of vomiting.

NEUROLOGICAL : No headache. No tremors. No seizures. No dizziness or fainting. No numbness. No weakness or paralysis. No depression. No anxiety.

PHYSICAL EXAMINATION

BP : 120/90 **Weight :** 140 lbs **Height :** 5'3"

GENERAL : Well developed, well nourished patient. Alert and oriented.

LUNGS : Equal breath sounds. No evidence of any dullness or tenderness on the chest. Antero-posterior diameter of the chest seems normal. No evidence of Rales. Movements with respiration appear bilaterally symmetrically and normal. Trachea seems in midline. No visible veins. No wheezing.

CARDIOVASCULAR : S1 and S2 appear normal. No S3, S4 or murmur. JVP not increased.

ABDOMEN : Does not appear distended. No evidence of Ascites. Bowel sounds present. Liver and spleen not palpable. No evidence of inguinal hernia. No masses palpable. No surgical scars. No tenderness on palpation. The umbilicus appears normal in position.

NEUROLOGICAL : Cranial nerves normal. No evidence of motor weakness Deep tendon reflexes normal. sensory deficit. Gait normal.

RADIOLOGY : CT SCAN **:** Patient had CT scan of abdomen and pelvis. CT scan report came out negative.

IMPRESSIONS :

1. Change in bowel habits (564.81)
   Rule out colon cancer.
2. Rectal pain (569.42)
   Consider hemorrhoids, anal fissure, peri-rectal infection.
3. Colon Polyp history (personal) (V12.72)
   Need repeat surveillance colonoscopy
4. Rectal bleeding (569.3)

PLAN :

Tests:
Colonoscopy
ANA
Bilirubin Direct
H. Pylori Ab(IgA)
Lactose tolerance
Stool Occult Blood * 3
Ultrasound of Abdomen

Medications:
Citrucel 2 tbsp with water/day

Diet:
High fiber diet

General:
Further recommendations will be made after completion of diagnostic work.

FOLLOW UP : Follow up in 6 months

Signature : _____ (Guru N. Reddy, M.D.)

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