1 Patient Information

Name:	Margaret A. Thornton
DOB / Age:	03/14/1966 / 58 years
MRN:	MRN-2847651
Date of Visit:	April 27, 2025
Provider:	Dr. Sandra K. Reeves, MD
Specialty / Dept:	Internal Medicine

2 Constitutional

Fever:	Denies fever. No documented temperature elevations. No night sweats reported.
Chills:	Occasional chills associated with recent upper respiratory infection 3 weeks ago, now resolved.
Weight loss:	Unintentional weight loss of approximately 8 lbs over the past 3 months, noted with concern.
Weight gain:	No weight gain reported. BMI trending downward from 29.1 to 27.8.
Fatigue:	Moderate to severe fatigue present daily, worse in the afternoons, limiting ability to complete household tasks.

3 HEENT

Vision changes:	Reports intermittent blurry vision, right eye greater than left, particularly after prolonged reading. Last ophthalmology visit 18 months ago.
Hearing changes:	Mild bilateral high-frequency hearing loss per last audiogram (2023). No acute changes.
Nasal symptoms:	Chronic nasal congestion, worse in spring. Uses fluticasone nasal spray as needed. No epistaxis.
Throat symptoms:	Mild sore throat during recent URI, now resolved. No dysphagia or odynophagia.

4 Cardiovascular

Chest pain:	Denies chest pain, pressure, or tightness. No radiation to arm or jaw.
Palpitations:	

	Reports occasional palpitations lasting seconds, not associated with exertion or syncope. Occurred twice in past month.
Syncope:	No syncope or near-syncope episodes. No presyncope reported.
Edema:	Mild bilateral ankle edema at end of day, present for 6 months. Worse with prolonged standing.

5 Respiratory

Shortness of breath:	Mild dyspnea on exertion with two flights of stairs. No orthopnea or paroxysmal nocturnal dyspnea.
Cough:	Dry persistent cough for 8 weeks, worse at night. Currently on lisinopril — ACE inhibitor cough suspected.
Wheezing:	No wheezing reported. No prior asthma diagnosis. No bronchodilator use.

6 Gastrointestinal

Nausea:	Intermittent nausea, especially in the morning, not associated with vomiting. Attributed to metformin.
Vomiting:	Denies vomiting. Last episode was during URI three weeks ago.
Abdominal pain:	Mild epigastric discomfort after meals, present for 2 months. No radiation. Improves with antacids.
Diarrhea:	Loose stools 2–3 times per week since metformin dose increase 4 months ago.
Constipation:	No constipation. Bowel movements daily to every other day.

7 Genitourinary

Dysuria:	No burning, pain, or discomfort with urination.
Frequency:	Reports urinary frequency — voiding 8–10 times per day with urgency. Nocturia x2 per night.
Hematuria:	Denies gross hematuria. No prior history of kidney stones or UTI in past 2 years.
Incontinence:	Mild stress urinary incontinence with coughing or sneezing, present for approximately 1 year.

8 Reproductive

Menstrual history:	Postmenopausal since age 52. No postmenopausal bleeding. Was on HRT from age 52–55, discontinued.
Sexual function:	

	Reports decreased libido since menopause. Denies dyspareunia. Not currently sexually active.
Pregnancy status:	Not pregnant. G3P3. Last delivery in 1998. No complications during pregnancies.

9 Musculoskeletal

Joint pain:	Bilateral knee pain, right greater than left, worsened with stair climbing and prolonged standing. Consistent with OA.
Muscle pain:	Reports diffuse myalgias, particularly in thighs and calves. On statin therapy — myopathy being evaluated.
Stiffness:	Morning stiffness in hands and knees lasting approximately 20 minutes. Improves with activity.

10 Skin

Rash:	No active rash. History of contact dermatitis to nickel. No eczema or psoriasis flares currently.
Lesions:	Two seborrheic keratoses on upper back, stable. No new or changing lesions.
Pruritus:	Mild generalized pruritus, worsened in dry winter months. Uses moisturizer daily.

11 Neurologic

Headache:	Tension-type headaches 2–3 times per month, bifrontal, mild to moderate severity. Responds to ibuprofen.
Weakness:	Reports mild proximal lower extremity weakness. Difficulty rising from low chairs without use of arms.
Numbness:	Tingling in bilateral feet, symmetrical, consistent with diabetic peripheral neuropathy. Present for 2 years.
Seizures:	No seizures. No history of epilepsy or loss of consciousness.
Dizziness:	Occasional lightheadedness with position changes, particularly on rising from seated position. No vertigo.

12 Psychiatric

Depression:	PHQ-9 score 8 at last visit (mild depression). Reports low mood, loss of interest in hobbies. On sertraline 50mg.
Anxiety:	GAD-7 score 6. Reports worry about health and finances. Coping with mindfulness techniques.
Mood changes:	

	Mood generally low, some irritability in the evenings. No suicidal ideation. Sees therapist bimonthly.
Sleep disturbance:	Difficulty maintaining sleep, awakens 2–3 times per night. Average 5.5 hours per night. Fatigue is prominent.

13 Endocrine

Heat intolerance:	Reports heat intolerance with excessive sweating during summer months. TSH within normal limits at last check.
Cold intolerance:	Mild cold intolerance reported. Feels cold more easily than others. Thyroid function to be rechecked.
Polyuria:	Reports increased urinary frequency and volume, especially after meals. A1c 8.4% at last check.
Polydipsia:	Increased thirst present, drinking approximately 3 liters of fluids daily. Consistent with suboptimal glycemic control.

14 Hematologic / Lymphatic

Easy bruising:	Reports easy bruising on forearms and shins. On daily aspirin 81mg. No spontaneous bruising.
Bleeding:	No abnormal bleeding. No gingival bleeding. No prolonged bleeding after cuts.
Lymphadenopathy:	No palpable lymphadenopathy reported by patient. No tender nodal swelling.

15 Allergic / Immunologic

Allergies:	Seasonal allergic rhinitis. Environmental: dust mites, tree pollen. Drug: penicillin (rash). Nickel contact allergy.
Recurrent infections:	Reports 3 UTIs in past 18 months, all treated successfully with antibiotics. No other recurrent infections.

16 Additional

All other systems reviewed and negative unless otherwise noted:	Hematologic, cardiovascular, and pulmonary systems reviewed. Patient denies hemoptysis, chest tightness at rest, or palpable masses.

Patient presents today for annual wellness visit with multiple active chronic conditions. Primary concerns are suboptimal diabetes control (A1c 8.4%), persistent dry cough likely secondary to ACE inhibitor, and new unintentional weight loss requiring further evaluation. Potential statin-induced myopathy under investigation.

Referred to endocrinology for diabetes management optimization. Thyroid panel, CBC, CMP, and urine microalbumin ordered today.

Provider name & credentials:	Dr. Sandra K. Reeves, MD, FACP
Signature:	S.K. Reeves, MD
NPI:	1234567890
Date / Time:	April 27, 2025 — 10:45 AM
Facility:	Oakwood Internal Medicine Associates, Chicago, IL
Visit type:	Office Visit — Annual Wellness Exam (99396)