1 Patient Information

Name:	Linda S. Beaumont
DOB:	September 22, 1961
Age / Sex:	63 years / Female
Date of Service:	April 27, 2025
Provider:	Dr. Christine K. Yoo, MD, FACE — Endocrinology
Visit Type (e.g., Follow-up, Acute, Telehealth):	Follow-up — Established Patient, In-person

2 Chief Complaint

Quarterly diabetes management follow-up. Review of glycemic control following semaglutide initiation 3 months ago. Also reports new bilateral foot tingling and burning worsening over past 6 weeks.

3 History of Present Illness

INTERVAL CHANGES

Progression since last visit (improving / worsening / stable): Overall glycemic control improving — better post-meal glucose readings per home monitoring log. New neuropathic foot symptoms represent active concern requiring evaluation. BP well-controlled. Weight loss 11 lbs since semaglutide initiation 3 months ago.

SYMPTOM STATUS

Current symptoms, severity, and frequency: Bilateral foot burning and tingling — symmetric, balls of feet to toes bilaterally, constant, rated 5/10, worsened at night. Sleep interrupted 3-4 nights/week due to foot discomfort. Moderate fatigue from sleep disruption.

RESPONSE TO TREATMENT

Effectiveness of prior interventions, adherence, and side effects: Semaglutide 0.5mg SQ weekly — good adherence. Initial nausea first 3 weeks, now resolved. Home glucose log: fasting 98-138 mg/dL (improved from 140-185). Post-prandial 140-175 mg/dL (improved from 210-260).

NEW SYMPTOMS OR CONCERNS

Any newly developed issues since last evaluation: Bilateral foot tingling and burning — progressive, now daily, consistent with diabetic peripheral neuropathy. No foot wounds or skin breakdown. Mild constipation (possible GLP-1 side effect).

PERTINENT NEGATIVES

Explicit denial of key symptoms relevant to condition:	Denies severe hypoglycemia (lowest home glucose 82 mg/dL, asymptomatic). Denies chest pain, syncope, polyuria, polydipsia, or weight gain.

4 Review of Systems

Constitutional:	11 lb intentional weight loss on semaglutide. Fatigue from sleep disruption by neuropathic pain. Decreased appetite per GLP-1 effect. No fever.
Cardiovascular:	Denies chest pain, palpitations, or exertional dyspnea. No lower extremity edema. BP well-controlled.
Respiratory:	Denies dyspnea, cough, or wheezing.
Gastrointestinal:	Mild constipation — BM every 3 days, straining. Nausea fully resolved. No abdominal pain or vomiting.
Neurological:	Bilateral symmetric foot burning and tingling — constant, worse at night. No weakness, gait instability, or headache.
Psychiatric:	Mood good — motivated by weight loss progress. PHQ-2 negative. No depression or anxiety.
Other systems as clinically indicated:	Ophthalmology: dilated exam November 2024 — mild NPDR, stable. Renal: urine microalbumin 45 mg/g (microalbuminuria) 3 months ago.

5 Vitals

Temperature:	98.2°F (36.8°C)	**Heart Rate:**	72 bpm, regular	**Oxygen Saturation:**	97% on room air
Blood Pressure:	124/78 mmHg (right arm, seated, 5 minutes rest — excellent)	**Respiratory Rate:**	14 breaths/minute	**Weight (if relevant):**	167 lbs — down 11 lbs from 178 lbs at last visit. BMI 27.4 kg/m² (down from 29.2)

6 Physical Examination

General Appearance:	Well-appearing female appearing stated age. Alert and oriented x4. No distress. Pleased with weight loss progress.
HEENT:	Normocephalic. PERRLA. No icterus. Oral mucosa moist. No thyromegaly.
Neck:	Supple. No lymphadenopathy. No carotid bruits. Thyroid non-tender, no nodules.
Cardiovascular exam:	RRR. S1 and S2 normal. No murmurs, rubs, or gallops. No JVD. No peripheral edema.

Respiratory exam:	Clear to auscultation bilaterally. No wheezes or crackles.
Abdomen:	Soft, non-tender, non-distended. No organomegaly. Bowel sounds present. Semaglutide injection sites: no lipohypertrophy, bruising, or infection.
Musculoskeletal exam:	Full ROM bilateral lower extremities. No joint swelling or erythema.
Neurologic exam:	CN II-XII intact. Lower extremity: decreased vibratory sense bilateral great toes (5 sec, normal >10 sec). Decreased monofilament sensation at 3/10 sites bilaterally. Absent ankle reflexes bilaterally. Decreased pin-prick distal to mid-foot bilaterally. Slightly wide-based gait, stable without assistive device.
Skin:	Warm and dry. No ulcers or wounds on bilateral feet. Toenails slightly thickened bilaterally — podiatry referral appropriate. No acanthosis nigricans. No injection site complications.
Psychiatric exam:	Alert, cooperative, appropriate affect. PHQ-2 negative. Good insight. Positive engagement with lifestyle modifications.

7 Lab & Diagnostic Results

Laboratory findings:	Today's labs (fasting): - HbA1c: 7.1% (DOWN from 9.4% — significant improvement) - Fasting glucose: 104 mg/dL - BMP: Na 138, K 4.2, Cr 0.9, eGFR 74 (stable) - LDL: 88 mg/dL (at goal on statin) - Urine ACR: 38 mg/g (improved from 45 mg/g) - TSH: 2.1 mIU/L (normal) - CBC: WBC 6.4, Hgb 13.2, Plt 218 — normal
Imaging studies:	No imaging ordered or reviewed. Right foot X-ray not indicated — no concern for Charcot joint or osteomyelitis.
Other diagnostics (ECG, POC testing):	POC HbA1c confirmed 7.1% (consistent with lab). No ECG performed today.

8 Assessment

1. Type 2 Diabetes Mellitus — IMPROVING. HbA1c decreased from 9.4% to 7.1% over 3 months — excellent response to semaglutide. Target HbA1c <7.0% nearly achieved.

2. Diabetic Peripheral Neuropathy (DPN) — NEW, ACTIVE. Length-dependent sensory neuropathy confirmed: decreased monofilament, absent ankle reflexes, reduced vibratory sense. Neuropathic pain interfering with sleep.

3. Hypertension — STABLE. BP 124/78 at target.

4. Microalbuminuria — IMPROVING. ACR 38 mg/g (down from 45 mg/g).

5. Overweight — IMPROVING. 11 lb loss in 3 months. BMI 27.4, declining.

6. Constipation — NEW. Likely GLP-1 receptor agonist related.

9 Plan

1. DIABETES: UPTITRATE semaglutide 0.5mg to 1.0mg SQ weekly. Continue metformin 1000mg BID, lisinopril 10mg daily, atorvastatin 40mg nightly. Repeat HbA1c 3 months.

2. DPN: Initiate gabapentin 300mg PO nightly x2 weeks, then 300mg BID if tolerated. Counsel on fall risk. Foot care education: daily inspection, moisturizer, appropriate footwear. REFERRAL: Podiatry within 4 weeks.

3. CONSTIPATION: MiraLax 17g daily PRN. Increase water and fiber.

4. OPHTHALMOLOGY: Annual exam due November 2025 — reminder provided.

5. LABS IN 3 MONTHS: HbA1c, BMP, urine ACR, fasting lipids.

6. LIFESTYLE: Mediterranean diet reinforced. 150 min/week moderate aerobic exercise — swimming or cycling preferred over running for neuropathic feet.

10 Follow-Up

Next visit timeframe and purpose:	Return in 3 months (July 27, 2025) for quarterly diabetes management — HbA1c after semaglutide uptitration, neuropathy symptom response to gabapentin, weight, and labs.
Return earlier if:	Worsening neuropathic pain, hypoglycemia, foot wound, severe GI intolerance to semaglutide uptitration, or new vision changes.

11 Time & Billing

Total Time Spent:	40 minutes
Counseling / Coordination of Care Time:	18 minutes — foot care education, gabapentin counseling, semaglutide uptitration, dietary guidance, fall risk

E/M CODING

E/M Level (e.g., 99213 / 99214 / 99215):	99214 (Established patient, moderate complexity MDM)
Basis for Billing (Time-based / MDM):	Medical Decision Making — moderate complexity: new problem (DPN), prescription drug management, chronic conditions with worsening

ICD-10 CODES

Primary Diagnosis Code + Description:	E11.65 — Type 2 diabetes mellitus with hyperglycemia
Secondary Diagnosis Code(s):	E11.40 — T2DM with diabetic neuropathy unspecified; I10 — Hypertension; N18.3 — CKD Stage 3

Physician Name, MD:	Dr. Christine K. Yoo, MD, FACE
Specialty:	Endocrinology
Date:	

	April 27, 2025
Time:	9:30 AM CST