1 Patient Information

1 PATIENT DETAILS

Name
Margaret A. Holloway

Date of Service
05/06/2026

DOB / Age / Sex
07/22/1964 | 61F

Provider
Dr. James R. Patel, MD

MRN
FM-2024-3312

Encounter Type
Outpatient — Follow-up Visit

CC Chief Complaint

2 PRIMARY REASON

Patient presents for routine 3-month diabetes follow-up. She reports difficulty achieving blood glucose targets despite medication adherence, increased fatigue over the past 6 weeks, and mild bilateral foot tingling present for approximately 2 months.

HPI History of Present Illness

3 FULL HPI NARRATIVE

Ms. Holloway is a 61-year-old female with a 12-year history of type 2 diabetes mellitus currently managed on metformin 1000 mg BID and semaglutide 1 mg weekly. She reports home fasting glucose readings consistently ranging 145–185 mg/dL over the past 3 months, despite dietary efforts and adherence to medications. Her most recent HbA1c 6 months ago was 8.2%. She describes progressive fatigue beginning approximately 6 weeks ago, which she attributes partly to poor sleep quality. Over the past 2 months, she notes bilateral distal foot tingling — described as 'pins and needles' — worse in the evenings and when lying down, without associated burning or frank pain. She denies polyuria, polydipsia, or unintentional weight loss. She reports no hypoglycemic episodes. She has been attending diabetes education classes monthly and has implemented a low-carbohydrate diet with partial adherence.

H Past History, Medications & Social

4a PAST MEDICAL HISTORY

1. Type 2 diabetes mellitus — diagnosed 2012, on oral + injectable therapy. 2. Hypertension — diagnosed 2010, controlled on lisinopril. 3. Obesity (BMI 33.2) — on semaglutide for dual benefit. 4. Obstructive sleep apnea — diagnosed 2021, on CPAP therapy with inconsistent use. 5. Hypothyroidism — stable on levothyroxine.

4b PAST SURGICAL HISTORY

Laparoscopic cholecystectomy (2018). Cesarean section x2 (1989, 1992). Right carpal tunnel release (2019).

4c MEDICATIONS

1. Metformin 1000 mg PO BID with meals. 2. Semaglutide (Ozempic) 1 mg SC weekly. 3. Lisinopril 10 mg PO daily. 4. Levothyroxine 75 mcg PO daily on empty stomach. 5. Atorvastatin 40 mg PO nightly. 6. Aspirin 81 mg PO daily.

4d ALLERGIES

Sulfonamides — rash and urticaria. No known food or environmental allergies documented.

4e FAMILY & SOCIAL HISTORY

Family History

Father: T2DM, hypertension, died of MI at age 71. Mother: Alzheimer's disease, alive age 84. Maternal uncle: diabetic nephropathy requiring dialysis. Sibling: T2DM, hypertension.

Social History

ROS Review of Systems

5 SYSTEM REVIEW

Constitutional: Fatigue present x6 weeks; denies fever, chills, unintentional weight loss. Cardiovascular: Denies chest pain, palpitations, edema. Respiratory: Snoring and non-restorative sleep; no dyspnea at rest. GI: Mild nausea with semaglutide dose, manageable; denies vomiting, abdominal pain, diarrhea. GU: Denies dysuria, hematuria, frequency changes. MSK: Mild bilateral knee osteoarthritis, chronic. Neuro: Bilateral distal foot tingling x2 months, worse evenings. Endocrine: No polyuria, polydipsia; heat intolerance denied. Skin: No new lesions or foot wounds noted by patient.

V Vitals

V VITAL SIGNS

Temperature	Blood Pressure	Heart Rate
98.1°F	138/84 mmHg (left arm, seated)	78 bpm (regular)

Respiratory Rate	SpO_2	Weight
14 breaths/min	98% on room air	192 lbs / Height: 5'4" / BMI: 33.0

PE Physical Examination

6 EXAM FINDINGS

General: Well-appearing, mildly obese female, in no acute distress. HEENT: Normocephalic. No thyromegaly on palpation. Cardiovascular: RRR, S1 S2 without murmurs; no edema. Respiratory: CTA bilaterally. Abdomen: Soft, non-tender, obese habitus; no organomegaly. Skin: Mild acanthosis nigricans at posterior neck bilaterally. Feet: No open wounds or ulcerations; mild callus formation under right 2nd metatarsal head. Nails intact. Neurological: Monofilament testing — diminished sensation to 5.07 Semmes-Weinstein monofilament at bilateral plantar great toes and 2nd toes. Vibration sense reduced at bilateral first MTP joints. Ankle reflexes 1+ bilaterally and symmetric.

O Orders & Results

7a ORDERS PLACED

HbA1c (today). Comprehensive metabolic panel. Urine albumin-to-creatinine ratio. TSH. Lipid panel (fasting, scheduled for next visit). Referral to podiatry for diabetic foot care. Referral to ophthalmology for annual dilated eye exam (overdue x1 year). CPAP compliance download and sleep medicine follow-up referral.

7b RESULTS REVIEWED

HbA1c (today, point-of-care): 8.6% (up from 8.2% six months ago). CMP: BMP within normal limits; Cr 1.0, eGFR 68 mL/min/1.73m². Urine ACR (prior result, 4 months ago): 42 mg/g (microalbuminuria). TSH: 2.1 mIU/L (within normal range on current levothyroxine dose). Lipid panel (from 6 months ago): LDL 88 mg/dL (at goal on current statin), HDL 49, TG 178.

A Assessment

8 ASSESSMENT & DIAGNOSES

1. Type 2 DM, poorly controlled (HbA1c 8.6%, worsening) — intensification of therapy indicated. 2. Diabetic peripheral neuropathy — bilateral distal lower extremity sensory changes consistent with early-moderate peripheral neuropathy; podiatry referral warranted. 3. Diabetic nephropathy — microalbuminuria present, eGFR stable at 68; lisinopril continuation and ACR monitoring every 3 months. 4. Hypertension — suboptimally controlled at 138/84 on current regimen. 5. Obstructive sleep apnea — ongoing insufficient CPAP use contributing to glycemic dysregulation and fatigue; sleep medicine referral reinforced.

P Plan

9 MANAGEMENT PLAN

1. Add empagliflozin (Jardiance) 10 mg PO daily for additional glycemic control and renal/CV protection. 2. Continue semaglutide 1 mg weekly; advance to 2 mg weekly at next visit if tolerated. 3. Continue metformin 1000 mg BID. 4. Increase lisinopril to 20 mg PO daily given persistent microalbuminuria and suboptimal BP. 5. Gabapentin 300 mg PO QHS prescribed for peripheral neuropathy symptom relief. 6. Podiatry referral placed. 7. Ophthalmology referral placed — annual diabetic eye exam overdue. 8. Patient counseled extensively on foot care, glucose monitoring targets (fasting 80–130, post-meal <180), and dietary strategies. 9. Repeat HbA1c in 3 months. 10. CPAP adherence discussed; sleep medicine referral placed.

F Follow-Up

10 DISPOSITION & FOLLOW-UP

Disposition
Discharged home in stable condition. Follow-up in 3 months or sooner if glucose >300 or new symptoms arise.

Follow-Up
Return in 3 months for HbA1c recheck, medication titration, and lab review. Contact office sooner if foot wounds develop, severe nausea with new medication, or glucose persistently >300.

TIME DOCUMENTATION & BILLING

Total Time
38 minutes

E/M Level
99214

Counseling Time
15 minutes

Basis
Medical Decision Making — Moderate Complexity

Primary Dx Code
E11.65 — Type 2 DM with hyperglycemia

Secondary Dx Code(s)
E11.40 — Diabetic neuropathy; N18.32 — CKD stage 3b; I10 — Hypertension; G47.33 — OSA

PROVIDER NAME	CREDENTIALS	DATE & TIME
James R. Patel, MD — Family Medicine	MD — Family Medicine	05/06/2026