

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Rodrigo A. Villanueva

DOB

06/17/1972

AGE / SEX

54 yrs / Male

MRN / PATIENT ID

PC-0093412

DATE OF SERVICE

08/13/2026

PROVIDER

Naomi C. Fitzgerald, DO

CREDENTIALS

DO, ABFM

PRIMARY CARE PROVIDER

This provider — established since 2018

VISIT TYPE

Chronic Disease Management Follow-Up — 6-month diabetes and hypertension review

CARE SETTING

Outpatient primary care clinic, in person

REFERRAL SOURCE

Not applicable

INTERPRETER USED

No — patient bilingual, declined

CC CHIEF COMPLAINT

2 PRIMARY REASON FOR VISIT

"My sugars are running high again and my feet have started burning at night. I also missed my eye appointment twice because of my shifts."

S SUBJECTIVE

3 INTERVAL HISTORY & PATIENT-REPORTED STATUS

3a PRESENTING CONCERN

Reason for visit

Scheduled 6-month chronic disease follow-up for type 2 diabetes and hypertension, with review of labs drawn 08/06/2026. Patient additionally raises new bilateral foot symptoms and repeated missed retinal screening.

History of present illness

Home fingerstick glucose has drifted upward over roughly 4 months — fasting values 160–210 mg/dL, previously 120–140. Post-dinner readings often above 250 when he eats at the depot. Reports 3–4 months of bilateral burning and tingling in both feet, worse at night, occasionally waking him, rated 4/10, symmetric, no ulcers or wounds noted. Denies polyuria beyond his baseline nocturia of twice nightly, denies visual change, chest pain and dyspnea. Attributes the deterioration to a shift change in April to rotating nights, which disrupted both his meal timing and his exercise routine. Has not missed metformin doses but concedes he “forgets the evening one maybe twice a week” when working nights.

3b CHRONIC CONDITIONS, MEDICATIONS & ALLERGIES

Chronic medical conditions

Type 2 diabetes mellitus since 2016 — now uncontrolled, HbA1c 9.1% (was 7.4% in 02/2026). Essential hypertension since 2014 — suboptimally controlled. Mixed hyperlipidemia. Obesity, class I. Non-alcoholic fatty liver disease on 2023 ultrasound. Obstructive sleep apnea diagnosed 2021, CPAP prescribed, adherence poor (reports 2–3 nights weekly).

Medication history and adherence

Metformin ER 1000 mg BID — evening dose missed roughly twice weekly. Lisinopril 20 mg daily. Amlodipine 5 mg daily. Atorvastatin 40 mg nightly. Aspirin 81 mg daily. No OTC medications; takes a store-brand multivitamin. No affordability barrier — employer insurance with a \$10 generic tier. Uses a single pharmacy with 90-day fills.

Allergies

Sulfamethoxazole-trimethoprim — diffuse maculopapular rash, 2011. No other known allergies.

3c PREVENTIVE, BEHAVIORAL & SOCIAL HISTORY

Preventive care and screening history

Colonoscopy 2023, normal, repeat due 2033. Diabetic retinal screening last completed 07/2024 — overdue, two appointments missed. Foot examination last documented 02/2026. Urine albumin-creatinine last 02/2026. Lipids current. Hepatitis C screening negative 2021. No prostate screening discussion documented since 2024.

Immunization history

Influenza 10/2025. COVID-19 booster 11/2025. Tdap 2019. Pneumococcal vaccination not yet given — indicated on the basis of diabetes. Shingles vaccine not started. No hesitancy expressed.

Lifestyle and health behaviors

Diet worsened since the shift change — two meals daily from the depot vending and a late high-carbohydrate dinner. Regular sugary soda, 2–3 cans daily, resumed in April. Exercise dropped from three weekly gym sessions to none. Sleeps 5–6 hours in fragmented blocks. Never smoked. Alcohol 2–3 beers on weekends. No substance use. Wears a seatbelt. No sun exposure concerns.

Mental health

Reports stress and irritability related to the schedule change; denies anhedonia and hopelessness. Sleep disruption is shift-related rather than mood-related. No prior psychiatric history, no medications, no therapy. Denies suicidal ideation and self-harm thoughts.

Functional status

Fully independent in ADLs and IADLs. Works full time, lifting up to 50 lb. No falls. Exercise tolerance limited by deconditioning rather than by dyspnea. No assistive devices.

Social history / social determinants

Lives with his wife and a 19-year-old son. Warehouse shift supervisor, 12-hour rotating shifts since April. Owns his home, no housing or food insecurity, reliable transportation. Health literacy good. Screens negative for intimate partner violence. Strong family support; wife attends most visits and did so today.

Family history

Father — type 2 diabetes, myocardial infarction at 61, deceased at 68. Mother — hypertension, alive at 79. Brother — type 2 diabetes at 45. No known cancer, kidney disease or sudden cardiac death.

Recent care and hospitalizations

No emergency visits, urgent care visits, hospitalizations or surgeries since the last visit. No specialist visits. Labs drawn 08/06/2026 in anticipation of today.

Pertinent negatives

Denies chest pain, exertional dyspnea, orthopnea, syncope, focal weakness, vision change, severe abdominal pain, blood in stool, uncontrolled bleeding, fever, and suicidal or homicidal ideation. No foot wounds, no discharge, no erythema.

ROS PRIMARY CARE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Constitutional — fever, chills, fatigue, appetite or weight change	Positive for fatigue and 9 lb weight gain since February. No fever.
HEENT — headache, vision or hearing change, congestion, dental	Negative. Specifically denies blurred vision.
Cardiovascular — chest pain, palpitations, edema, dizziness, syncope	Negative throughout.
Respiratory — cough, wheezing, dyspnea, sleep apnea symptoms	Positive for witnessed apneas and snoring; CPAP underused. No dyspnea.
Gastrointestinal — pain, nausea, diarrhea, constipation, reflux, blood	Positive for occasional reflux. No blood in stool.
Genitourinary — dysuria, frequency, hematuria, sexual concerns	Positive — nocturia twice nightly (baseline) and new erectile difficulty.
Musculoskeletal — joint, back or muscle pain, swelling, injury	Positive for intermittent low back ache with lifting. No swelling.
Skin — rash, lesions, wounds, itching, changing moles	Negative. No foot wounds or ulceration.
Neurologic — weakness, numbness, tingling, headache, tremor, dizziness	Positive — bilateral foot burning and tingling. No weakness.
Psychiatric — depression, anxiety, sleep disturbance, stress, SI	Positive for shift-related stress and sleep disruption. PHQ-9 negative.
Endocrine / metabolic — heat/cold intolerance, polyuria, polydipsia	Positive for hyperglycemia. No polydipsia beyond usual.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE 98.4 °F	BLOOD PRESSURE 148/92 → repeat 144/88 mmHg
HEART RATE 78 bpm	RESPIRATORY RATE 16 /min

OXYGEN SATURATION

97% RA

HEIGHT

5 ft 9 in

WEIGHT

221 lb (was 212 lb, 02/2026)

BMI

32.6

PAIN SCORE

4/10 — bilateral foot burning at night

General appearance

Well-appearing, alert, cooperative, no acute distress. Central adiposity. Good hygiene. Ambulates without difficulty.

HEENT

Conjunctiva pink, sclera anicteric, pupils equal and reactive, extraocular movements intact. Tympanic membranes clear bilaterally. Oral mucosa moist, dentition in good repair. Pharynx without erythema. No sinus tenderness. Fundoscopic exam limited without dilation — formal retinal screening required.

Neck

Supple, full range of motion. No lymphadenopathy. Thyroid non-enlarged, no nodules. No carotid bruits. Acanthosis nigricans present at the posterior neck.

Cardiovascular

Regular rate and rhythm. No murmur, rub or gallop. Radial and dorsalis pedis pulses 2+ and symmetric. Capillary refill under 2 seconds. No peripheral edema.

Pulmonary

Normal effort. Clear to auscultation bilaterally. No wheezes, crackles or rhonchi. No cough. No oxygen requirement.

Abdomen

Soft, obese, non-tender. Bowel sounds normal. No organomegaly, mass, hernia or surgical scar. No guarding or rebound.

Musculoskeletal

Full range of motion of the spine and major joints. Mild lumbar paraspinal tenderness without spasm. Strength 5/5 throughout. Normal gait.

Skin

No rash or suspicious lesion. Acanthosis nigricans at the neck and axillae. **Diabetic foot examination performed:** skin intact bilaterally, no ulceration, callus or fissure; nails well trimmed; no interdigital maceration; no erythema or warmth. Pedal pulses palpable.

Neurologic

Alert and fully oriented. Cranial nerves II–XII intact. Strength 5/5 in all extremities. **Monofilament testing: absent sensation at 3 of 10 plantar sites bilaterally.** Vibration reduced at both great toes. Ankle reflexes diminished bilaterally, knee reflexes 2+. Gait and coordination normal. No focal deficit, no tremor.

Psychiatric

Mood “tired but okay,” affect appropriate and reactive. Speech normal. Thought process linear. Insight and judgment intact. No safety concerns.

PC

PREVENTIVE CARE / HEALTH MAINTENANCE

6

NEEDS & COMPLETED ITEMS

CANCER SCREENING

Colonoscopy 2023 normal — due 2033. Prostate screening discussion held today, deferred by patient.

DIABETES MONITORING

HbA1c 9.1% — uncontrolled; CGM to be started

DEPRESSION & ANXIETY SCREENING

PHQ-2 negative, PHQ-9 3, GAD-7 5

INFECTIOUS DISEASE SCREENING

HIV 2021 negative; hepatitis C 2021 negative

DENTAL AND VISION

Dental current; diabetic retinal screening overdue since 07/2024

URINE ALBUMIN-CREATININE

142 mg/g on 08/06/2026 — new moderately increased albuminuria

LIFESTYLE COUNSELING PROVIDED

Nutrition (shift-work meal planning), physical activity restart, sleep and CPAP adherence, sugary beverage elimination, foot care — 14 minutes

BLOOD PRESSURE SCREENING

Elevated today; home monitoring initiated

LIPID SCREENING

Completed 08/06/2026 — LDL 118 mg/dL

TOBACCO, ALCOHOL & SUBSTANCE USE

Never smoker; AUDIT-C 2; no substance use

IMMUNIZATIONS

Pneumococcal PCV20 administered today; shingles series ordered

DIABETIC FOOT EXAM

Completed today — loss of protective sensation identified

ADVANCE CARE PLANNING

Not indicated at this visit

ST

SCREENING / ASSESSMENT TOOLS

7 SCORES, INTERPRETATION & COMPARISON

PHQ-2 / PHQ-9

0 / 3 — negative for depression

AUDIT-C

2 — low risk

STOP-BANG

6 — high risk; known OSA, CPAP underused

PAIN SCALE

4/10 neuropathic foot pain, nocturnal

MICHIGAN NEUROPATHY SCREENING INSTRUMENT

5/8 — consistent with diabetic peripheral neuropathy

INTIMATE PARTNER VIOLENCE SCREENING

Negative

DIABETES DISTRESS / SELF-EFFICACY

Patient identifies shift work and vending access as his two main barriers

GAD-7

5 — mild anxiety, no treatment indicated

DAST / CAGE-AID

0 / 0

FALL RISK SCREENING

Negative — no falls in 12 months

ASCVD 10-YEAR RISK

18.4% — intermediate-high (was 14.1% in 02/2026)

SOCIAL DETERMINANTS SCREENING

Negative in all domains

8 REVIEWED OR ORDERED

Routine labs (08/06/2026)

HbA1c 9.1% (02/2026: 7.4%). Fasting glucose 186 mg/dL. CMP — creatinine 1.05 mg/dL, eGFR 82, sodium 139, potassium 4.3, ALT 58 (mildly elevated, stable), AST 44. CBC normal. TSH 2.1. Lipid panel — total cholesterol 204, LDL 118, HDL 38, triglycerides 242. Urine albumin-creatinine ratio 142 mg/g (02/2026: 21 mg/g) — new moderately increased albuminuria. Vitamin B12 388 pg/mL — adequate, argues against metformin-related deficiency as the cause of the neuropathy.

Infectious disease testing

None indicated this visit.

Imaging

None this visit. Hepatic steatosis on 2023 ultrasound; FIB-4 calculated today at 1.12, low risk for advanced fibrosis, no imaging required.

Cardiac / pulmonary testing

EKG performed today — normal sinus rhythm at 78, no ischemic changes, no LVH by voltage criteria. Prior sleep study 2021 confirmed moderate OSA, AHI 21. CPAP download requested from the DME supplier.

Preventive screening results

Colonoscopy 2023 normal. Retinal screening outstanding — ordered with same-day scheduling assistance today.

Prior records reviewed

Endocrinology consultation note 2019, sleep medicine note 2021, prior lab trends 2016–2026, immunization registry, and pharmacy fill history confirming consistent refills.

9 PRIMARY CARE CLINICAL INTERPRETATION

- **Type 2 diabetes mellitus, uncontrolled, with new diabetic peripheral neuropathy and new albuminuria (E11.42, E11.21).** HbA1c has risen 1.7 points in 6 months. The deterioration is temporally and behaviourally explained by the April shift change — disrupted meal timing, depot vending access, resumed sugary beverages, cessation of exercise, and intermittent evening metformin doses. B12 is adequate, so the neuropathy is attributable to glycemic exposure rather than to metformin.
- **Essential hypertension, uncontrolled (I10).** 144/88 on repeat, above the <130/80 target for diabetes with albuminuria. The new albuminuria raises both the cardiovascular and renal stakes of this reading.
- **Moderately increased albuminuria (R80.9), new.** ACR has risen from 21 to 142 mg/g with a preserved eGFR of 82. Requires confirmation on a repeat sample and changes the medication strategy independent of glycemic control.
- **Mixed hyperlipidemia with intermediate-high ASCVD risk (E78.2).** LDL 118 on atorvastatin 40 mg, above the <70 mg/dL goal appropriate to this risk profile. Triglycerides 242.
- **Obesity, class I (E66.9), 9 lb interval gain** — contributing to glycemic, blood pressure and OSA control.
- **Obstructive sleep apnea, non-adherent to CPAP (G47.33, Z91.19).** Underuse is plausibly worsening both blood pressure and insulin resistance and warrants direct attention.
- **Preventive care gaps:** diabetic retinal screening 2 years overdue with two missed appointments — a scheduling and shift-access problem, not a motivation problem; pneumococcal and zoster vaccination outstanding.

- No red flags. No evidence of foot ulceration, infection, or acute coronary or cerebrovascular disease. Mental health screening negative; stress is situational and shift-related.

P PLAN

10 PRIMARY CARE MANAGEMENT BY PROBLEM

- **Diabetes:** add semaglutide 0.25 mg subcutaneously weekly, titrating to 0.5 mg after 4 weeks — chosen for glycemic effect, weight benefit and cardiovascular risk reduction. Continue metformin ER 1000 mg BID, with the evening dose moved to the start of his shift to fit the rotating schedule. Prescribe a continuous glucose monitor. Repeat HbA1c in 3 months.
- **Albuminuria and renal protection:** add empagliflozin 10 mg daily for its renal and cardiovascular benefit at this ACR. Confirm albuminuria with a repeat ACR in 4 weeks. Counselling on genital mycotic infection risk, euglycemic ketoacidosis, and sick-day rules for both empagliflozin and metformin — written instructions given.
- **Hypertension:** increase lisinopril to 40 mg daily. Continue amlodipine 5 mg. Home blood pressure cuff issued with a log; target <130/80. Basic metabolic panel in 2 weeks to check creatinine and potassium after the ACE inhibitor increase and the SGLT2 initiation.
- **Lipids:** increase atorvastatin to 80 mg nightly. Repeat lipid panel in 8 weeks. Continue aspirin 81 mg for secondary risk given the ASCVD estimate and family history.
- **Neuropathy:** start duloxetine 30 mg nightly for 1 week then 60 mg. Daily foot inspection taught to the patient and his wife, with a mirror provided. Podiatry referral placed for loss of protective sensation, with annual comprehensive foot care.
- **Retinal screening:** booked before the patient left the clinic for 08/22/2026 at 7:00 AM, a slot that fits his shift pattern. Clinic staff to send a reminder 48 hours ahead. This is a logistics fix, not a counselling one.
- **Sleep apnea:** CPAP download requested; re-education visit with respiratory therapy scheduled. Mask refitting arranged — patient reports the current mask leaks, which is the actual barrier.
- **Lifestyle:** shift-specific meal plan agreed — three prepared meals brought from home per shift, sugary beverages eliminated with a substitution plan, and a 20-minute walk before each shift as the restart step rather than a return to the gym. Dietitian referral placed. Weight target 5% over 6 months.
- **Immunizations:** PCV20 administered today. Recombinant zoster vaccine dose 1 scheduled with dose 2 at 2–6 months. Influenza vaccine to be given in October.
- **Education and precautions:** hypoglycemia recognition, sick-day rules, foot care, blood pressure logging, and explicit instructions to seek urgent care for chest pain, sudden vision change, a new foot wound or a non-healing lesion, or symptoms of ketoacidosis.

F FOLLOW-UP

11 REASSESSMENT PLAN

Follow-up

Nurse visit in 2 weeks for a basic metabolic panel and blood pressure recheck after the lisinopril increase and empagliflozin start. Repeat ACR in 4 weeks. Provider follow-up in 6 weeks (09/24/2026) to review the CGM download, semaglutide tolerance and titration, blood pressure log, and duloxetine response. HbA1c and lipid panel at 3 months. Retinal screening 08/22/2026, podiatry and dietitian within 6 weeks. Urgent return for chest pain, sudden vision change, a new foot wound, persistent vomiting, or symptoms of hypoglycemia or ketoacidosis.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

40 minutes

COUNSELING / PREVENTIVE COUNSELING TIME

14 minutes

CARE COORDINATION TIME

6 minutes

RECORDS REVIEW TIME

5 minutes

MEDICATION MANAGEMENT TIME

9 minutes

INTERPRETER TIME

Not applicable

E/M LEVEL

99214 — established patient, moderate MDM

PREVENTIVE VISIT CODE

Not applicable — problem-focused visit

SCREENING CODE(S),

G0245 diabetic foot exam with LOPS; 99401 preventive counselling

IMMUNIZATION ADMINISTRATION

90677 PCV20 · 90471 administration

PROCEDURE CODE(S)

93000 — EKG with interpretation and report

CHRONIC CARE MANAGEMENT

Not billed this month

BASIS FOR BILLING

Medical decision making of moderate complexity — two chronic illnesses with exacerbation, prescription drug management, and independent interpretation of the EKG

PRIMARY ICD-10

E11.42 — Type 2 diabetes mellitus with diabetic polyneuropathy

SECONDARY ICD-10

E11.65 with hyperglycemia · E11.21 with diabetic nephropathy · I10 essential hypertension · E78.2 mixed hyperlipidemia · E66.9 obesity · G47.33 obstructive sleep apnea · Z23 encounter for immunization

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Naomi C. Fitzgerald

CREDENTIALS

DO, ABFM

SPECIALTY

Primary Care

DATE

08/13/2026

TIME

2:05 PM