DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	7-11-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 060060	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR Cleared 7/18/06, letter attached ✓	[X] Prepare reply for appropriate signature DATE DUE 7-20-06
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Carl A. Smart, M.D.
Pulmonary and Critical Care Medicine

MECKLENBURG PULMONARY SPECIALISTS, P.A.

2711 Randolph Road, Suite 208
Charlotte NC 28207

Tel: 704/926/5433
Fax: 704/926/5460

July 7, 2006

Medical Director
PO Box 8206
Columbia, SC 27622

Re: pt.- Melony McNeil
Id #- 1780079324

To Whom it May Concern:
We received a denial for the patient for date of service 4/19/06 stating that the patient has exceeded her allowed office visits for the fiscal year. Please review the attached letter from Dr. Carl Smart explaining the necessity for the office visits with our practice for the year and the medical records. If any questions arise, please call me at 704-926-5466.

Thank you,

Kisha Stewart
Billing Supervisor

CARL A SMART M.D.
201 PROVIDENCE RD STE 103
CHARLOTTE, NC 28207

June 21, 2006

Medical Director
P.O. Box 8206
Columbia, SC 29202-8206

RE: MELONY MCNEIL
OFFICE NUMBER: 3843

Dear Sir or Madame,

Ms. McNeil has been a patient of mine for quite some time. She actually suffers from an underlying lung disease that required at one point open lung biopsy. To that end, we have followed her since then. She has required at least a couple or three admissions to the hospital as it pertains to this underlying lung disease. She unfortunately will continue to require ongoing pulmonary management and care and to that end will likely need monthly visits for ongoing followup and treatment.

Your attention in this matter is greatly appreciated.

Sincerely,

Carl A. Smart, M.D.

CAS:MG22 3094

Chief complaint

The Chief Complaint is: Sob, difficulty breathing is happening more frequent, loose cough, wheezing, excessive sweating, yellowish nasal discharge, postnasal drip, chest pains, tightness, and pressure.

History of present illness

MELONY MCNEIL is a 34 year old female.
She reported a fever and a recent weight gain.
She reported blurry vision.
She reported no earache. She reported a yellow nasal discharge and down the throat from above but which is not watery which is not blood-tinged. She reported no epistaxis, no nasal passage blockage, no snoring, and no sneezing.
She reported chest pain or discomfort.
She reported no new onset dyspnea which is not sudden onset. She reported chronic dyspnea, at rest, while walking on level ground, a loose cough, and wheezing.
She reported excessive sweating.
She reported pain localized to one or more joints.
She reported no nausea and no vomiting.

Past medical/surgical history

Diagnosis History:
Hypertension.
Asthma.
Diabetes mellitus.
Osteoarthritis.
Migraine headache.
Psychiatric disorders

Personal history

Behavioral history: Smoking.
Alcohol: No alcohol use.
Drug use: No drug use.
Work: Work history.
Marital: Marital history.

Family history

A loss of hearing
Cardiac problems
Hypertension
Diabetes mellitus
Cancer.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms:A yellow nasal discharge and down the throat from above but no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest tightness or heavy pressure.
Pulmonary symptoms: Shortness of breath, which is chronic, a loose cough wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.

Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	103 bpm	50 - 100
Blood pressure while sitting	124/80 mmHg	94-140/60-90
Weight	158 lbs	98 - 183
Height	62.0 in	60.236 - 68.504

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:

	Value	Normal Range
Oxygen saturation	96%	

Assessment

* Normal examination ASSESSMENT AND PLAN: The patient is a young lady who reports that she has been doing well until some time in 2002. At that time, she came down with what sound like a sore throat and then subsequently a bronchitis and then sinus disease. Since that time, she has actually had a bronchoscopy and told that she had:

1. Rheumatoid lungs.
2. Told that she had bilateral pneumonia.~She was treated with such and was also told that she had asthma. She has been on multiple courses of steroids during this period of time and subsequently resulted in her being hyperglycemic. Each time that she is able to get down on the prednisone within a relatively short period of time, she has to go back on because of her symptoms worsened. It does not help given the fact that she smokes and continues to smoke. Looking the CT scan she does have evidence of ground glass changes throughout the lungs. Certainly, her differential diagnoses includes:

1. An interstitial lung process.
2. Inflammatory noninfectious process sarcoidosis, as a possibility Wagner's and doubt Goodpasture's.~She is could have allergic bronchopulmonary aspergillosis but I see no real evidence of any significant bronchiectasis. I would like to see what her IgE level looks like. Although, she states that she had studies done before in terms of blood test that were reported as normal. To this is related rheumatoid arthritis from the standpoint of an interstitial process certainly, but other collagen vascular process needs to be entertained. I believe that moving forward what we are probably going to end up need to do is to:

1. Get her wheezing under control first, hence steroids and bronchodilators. Sinusitis: She is going to need some chronic antibiotics for about a month or so to clear all this up.
2. She is probably going to need a follow-up bronchoscopy or possibly an open lung biopsy to get to the bottom of this.~~Carl A. Smart, M.D.~CAS:MG15 0714

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 11/30/2004 15:17

Chief complaint

The Chief Complaint is: Sob is better, coughing but can't bring up the phlegm. and wheezing.

History of present illness

MELONY MCNEIL is a 34 year old female.
She reported dyspnea at rest, while walking on level ground, a cough but can't bring up the phlegm, and wheezing.
She reported vomiting.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Shortness of breath, a cough, and wheezing.
Gastrointestinal symptoms: Vomiting.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs

	Value	Normal Range
Pulse rate	111 bpm	50 - 100
Blood pressure while sitting	120/80 mmHg	94-140/60-90
Weight	161 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:

The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	96%	

Assessment

* Normal examination ASSESSMENT AND PLAN: The patient is here for follow-up. She is actually feeling somewhat better but still having bouts of shortness of breath and dyspnea on exertion. She has been on the prednisone and prednisone seems to have kept things at bay, and I would certainly like to continue that for the time being. Her blood studies did not show any evidence of any Wegner's, which is good but I wonder if she has some degree of pulmonary hypertension because she does describe plethora of this syndrome of essentially having bouts of dyspnea on exertion with any type of exercise. This is the point where she actually has to stop and rest. So could she have exercise-induced pulmonary hypertension? Let us continue the steroids and antibiotics for the time being. She did have little bit of rhonchi and rales at the bases and I wonder if bronchiectasis is playing a role here as well.~~Carl A. Smart, M.D.~CAS:MG15
1026

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 12/29/2004 08:49

Chief complaint

The Chief Complaint is: Wheezing and chest congestion.

History of present illness

MELONY MCNEIL is a 34 year old female.
She reported wheezing.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	98 bpm	50 - 100
Blood pressure while sitting	130/70 mmHg	94-140/60-90
Weight	163 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	96%	

Assessment

ASSESSMENT AND PLAN: Melony is here for follow-up, really getting kind of depressed about the whole process here. Specifically having no resolution in about two or so years. From my standpoint, I think that she is definitely improved. There is no wheezing. She still has some shortness of breath and she actually states that this is the best she has felt in a while. What I may ultimately end up needing to do are the following:

1. Taper her prednisone. She is going to go to 10 mg every day.
2. Continue the clindamycin.
3. Continue the bronchodilators.~In terms of her stress test, not back yet.~~Carl A. Smart, M.D.~CAS:MG15 1441

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 02/07/2005 16:24

Chief complaint

The Chief Complaint is: Face feels sunburn, eyes are burning, dry cough, and wheezing when lying down.

History of present illness

MELONY MCNEIL is a 34 year old female.
She reported wheezing when lying down.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms:A nonproductive cough and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	97 bpm	50 - 100
Blood pressure while sitting	110/70 mmHg	94-140/60-90
Weight	164 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	98%	

Assessment

ASSESSMENT AND PLAN: The patient is here for follow-up. One of the concerns that I have is the fact that she is relating this to where apparently at work they have had some issues with possible exposures. These exposures are likely related to molds in the phone, etc. This is of incredibly high concern given the fact that she could be having some 'allergic reaction' or process to this. This has led to shortness of breath and bronchospasm. This obviously needs to be resolved ASAP.~I am going to start to taper her off of prednisone as well and she is definitely going to need to have a bronchoscopy to evaluate such. This process has been going on for too long now with the cough, etc., that we need to have a much better look or better sense as to exactly whether or not there is any endobronchial process that could be causing or doing this.~~Carl A. Smart, M.D.~CAS:MG15 2688-2689

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 02/18/2005 13:48

Chief complaint

The Chief Complaint is: Coughing with yellowish phlegm, postnasal drip, and chest pains.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a postnasal drip.
She reported yellow sputum.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms:A postnasal drip but no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest pain in the left precordium.
Pulmonary symptoms: Yellow sputum.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	102 bpm	50 - 100
Blood pressure while sitting	134/82 mmHg	94-140/60-90
Weight	164 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal

and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	97%	

Assessment

ASSESSMENT AND PLAN: The patient is here for follow-up. As you know, she recently had open lung biopsy. It subsequently came back consistent with respiratory bronchiolitis/interstitial lung disease. To that end:

1. She needs to quit smoking.
2. We will keep her on some prednisone. ~However, she is complaining of ongoing discomfort and pain near or around the surgical site. Clearly there is some evidence of some swelling, no erythema, no pus but definitely some swelling there. I am going to get a chest x-ray just to evaluate such. No need for any antibiotics at this time but she is clearly not ready for any kind of work yet.~~Carl A. Smart, M.D.~CAS:MG15 3118

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Entered data sealed by: AUDREY Date: 04/27/2005 13:42

Chief complaint

The Chief Complaint is: Postnasal drip and sob.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a postnasal drip.
She reported dyspnea at rest and while walking on level ground.
She reported no gastrointestinal symptoms. She reported no genitourinary symptoms. She reported no endocrine symptoms. She reported no skin symptoms. She reported no hematologic symptoms. She reported no musculoskeletal symptoms. She reported no neurological symptoms. She reported no psychological symptoms.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms:A postnasal drip but no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Shortness of breath.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	96 bpm	50 - 100
Blood pressure while sitting	120/80 mmHg	94-140/60-90
Weight	167 lbs	98 - 183

General appearance:

The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:

The head showed no abnormality of appearance.

Eyes:

General/bilateral:

Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:

General/bilateral:

Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:

No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:

The general condition of the oral cavity was not fair.

Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:

Pharynx: normal.

Neck:

The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	93%	

Assessment

The patient is here for follow-up. Actually, mostly has been doing okay. She still has some bouts of shortness of breath and dyspnea on exertion. What is of concern to me however is the fact that she recently went back to work to visit someone and while there was noted to have, where her work area is there has been a fair amount of construction around there. That concerns me re the possibility of her being exposed to fungi that could make things worse. Secondly, she is just not quite ready yet and to that end, let uskeep her out of work and keep her on the prednisone, but I am going to actually drop it.

~

Carl A. Smart, M.D.~CAS:MG15 3437

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 05/11/2005 10:30

Chief complaint

The Chief Complaint is: Sob when moving around, hurting in chest tube area, and wheezing when lying down at night.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported dyspnea while walking on level ground and wheezing at night.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Pulmonary symptoms: Dyspnea during exertion and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	95 bpm	50 - 100
Blood pressure while sitting	110/70 mmHg	94-140/60-90
Weight	167 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	95%	

Assessment

ASSESSMENT AND PLAN: The patient is here for follow-up. Overall, actually she has been doing much better. She is still having bouts of shortness of breath and dyspnea on exertion on and off, but certainly has moved in the right direction. I would like to start tapering her off of her 10 mg of prednisone now, go down to essentially 5 mg a day. Usually, we have done that in the past when she has had a flare-up, but I think we have no choice given that we want to eliminate the possibility of the complications associated with such, so 5 mg of prednisone per day.~~.

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 06/15/2005 11:50

Chief complaint

The Chief Complaint is: None.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	101 bpm	50 - 100
Blood pressure while sitting	120/80 mmHg	94-140/60-90
Weight	167 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed

no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	94%	

Assessment

The patient is here for follow-up. Actually, it is the best I have actually seen her look since I have started to take care of her. She has much more energy. She has minimal to no shortness of breath. She denies any current wheezing, any coughing, and any chest pain. She has been on prednisone, and today actually or yesterday was her last day of taking it. I think we will keep her off of it for an indefinite period of time. Hopefully, this process will not come back. She does intermittently still smoke but to a limited degree. Her lungs are currently clear. From my standpoint, she can actually go back to work.~~Carl A. Smart, M.D.~CAS:MG15 3966

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CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 08/30/2005 14:24

Chief complaint

The Chief Complaint is: Sweating, difficulty breathing, sob, coughing, and wheezing.

Review of systems

Systemic symptoms: No systemic symptoms. Feeling poorly (malaise) but pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Dyspnea expressed as feeling short of breath, a cough, and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	113 bpm	50 - 100
Blood pressure while sitting	100/60 mmHg	94-140/60-90
Weight	163 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed

no abnormalities.

Lungs:

A paroxysmal cough was observed but the chest was not overinflated. Wheezing was heard but no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	93%	

Assessment

The patient is here for follow-up. She is sick. Actually she had called yesterday with more shortness of breath and dyspnea on exertion. She actually went and started cutting her yard and then after that started to have worsening shortness of breath, dyspnea on exertion, and wheezing. She is wheezing up a storm here today. Actually we need to put her in the hospital but she said that she has to pick her children. Her father is in the hospital and she really has not any help and hence cannot. To accommodate such:

1. I will give her a shot of Solu-Medrol I have already done that. She is going to go on Levaquin, go to DuoNeb q.4h. p.r.n., if get any worse advised to go to the Emergency Room.~~Carl A. Smart, M.D.~CAS:MG15 4770

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 09/07/2005 13:18

Chief complaint

The Chief Complaint is: Sob upon exertion, coughing, wheezing, watery nasal discharege, and larygnitis.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported dyspnea while walking on level ground, a cough, and wheezing.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms:A watery nasal discharge and hoarseness but no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: Dyspnea during exertion, a cough, and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	99 bpm	50 - 100
Blood pressure while sitting	100/70 mmHg	94-140/60-90
Weight	159 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated and no paroxysmal cough was observed. Wheezing was heard but no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	93%	

Assessment

* Oral thrush

Melony is here for follow-up. Actually I had spoken to her on Friday, not doing so well, and told her to go to the emergency room. For whatever reason opted not to go, still complaining of shortness of breath, coughing, and definitely is hoarse and is also wheezing. At this point, I would like to put her in the hospital but she is reluctant to do so.

1. I am going to bump her prednisone back up.
2. Continue inhalers.
3. Question as to whether or not she has some thrush and I will put her on some Diflucan for such.~~Carl A. Smart, M.D.~CAS:MG15 4852

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 09/14/2005 13:41

Chief complaint

The Chief Complaint is: Brreathing much better, dry cough, and wheezing.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a cough and wheezing.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms:A cough and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	92 bpm	50 - 100
Blood pressure while sitting	110/64 mmHg	94-140/60-90
Weight	155 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.
Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.
Lungs:
A paroxysmal cough was observed but the chest was not overinflated, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.
Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.
Back:
Back: normal.
Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.
Hair:
Hair: normal.
Nails:
Nails: normal.
Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.
Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	97%	

Assessment

Here we are. She is actually doing somewhat better. Her hoarseness has gone. She is moving air. She is less short of breath. I think we can start tapering her off the prednisone. She is now on 20 mg, just give her 10 mg for about three days and then 5 mg for another week and then be totally off.Continue her inhalers, however, for now. No need for any further antibiotic.~~Carl A. Smart, M.D.~CAS:MG15 4935

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CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 11/09/2005 10:40

Chief complaint

The Chief Complaint is: Sob and difficulty breathing are better than last week. coughing nonproductive, wheezing, chest pains, tightness and pressure.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported chronic dyspnea is better than last week, at rest, while walking on level ground, a cough, and wheezing.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest tightness or heavy pressure.
Pulmonary symptoms: Dyspnea expressed as feeling short of breath, a cough, and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	98 bpm	50 - 100
Blood pressure while sitting	120/80 mmHg	94-140/60-90
Weight	156 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:

The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

A paroxysmal cough was observed but the chest was not overinflated. Wheezing was heard but no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	91%	

Assessment

Here is where we are with Melony, clearly worse. Over the last week or so she has had progressive shortness of breath and dyspnea on exertion. She has felt fairly ill. As an outpatient, we put her on prednisone. She has been using her inhalers every four hours to no avail. She clearly is wheezing up a storm and worse overall. I hence do not feel comfortable sending her home and to that end needs to be in the hospital. She is going to need:

1. IV steroids.
2. Bronchodilators.
3. Antibiotics.
4. Pulmicort nebulizer.
5. While she is there, get a followup CT scan to make sure the previous interstitial process has now resolved altogether.
6. O2 support as needed.~~

Carl A. Smart, M.D.~CAS:MG22 5578

Chief complaint

The Chief Complaint is: Cough, tightness in chest, postnasal drip.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a postnasal drip.
She reported a cough.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest pain or discomfort.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	97 bpm	50 - 100
Blood pressure while sitting	120/78 mmHg	94-140/60-90
Weight	163 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
A paroxysmal cough was observed but the chest was not overinflated, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	97%	

Assessment

Melony was just recently discharged from the hospital. Unfortunately, she continues to smoke. I had a long talk about that and the importance and need for her to quit smoking. However, more importantly is she does have some rales on her exam today and, on top of that, she has also had some progressive shortness of breath and dyspnea on exertion. She has been on the prednisone, but the prednisone is causing her sugars to go up. As you know, we are treating this incidental process. She already had an open lung biopsy for such. I am inclined to put her back on the prednisone versus trying the methotrexate, which is where we may ultimately be headed, but I am going to try her on the prednisone at a relatively low dose once again and see if she improves with such here.~~
Carl A. Smart, M.D.~CAS:MG22 0778

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 12/27/2005 15:58

Chief complaint

The Chief Complaint is: DOB:03-08-70
SOB, WHEEZING, CHEST TIGHTNESS, PAINS IN UPPER BACK, RUNNY NOSE.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a watery nasal discharge.
She reported chronic dyspnea and wheezing.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms: No otolaryngeal symptoms and no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest tightness or heavy pressure.
Pulmonary symptoms: Dyspnea expressed as feeling short of breath and wheezing.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	115 bpm	50 - 100
Blood pressure while sitting	140/64 mmHg	94-140/60-90
Weight	162 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:

The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.

Murmurs: No murmurs were heard.

Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.

Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.

Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.

Hepatic Findings: The liver was normal to palpation.

Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	98%	

Assessment

Melony is here for followup. Here is where we are: She is smoking and back on a fair amount of cigarettes. I have expressed to her the importance of quitting smoking. She is more short of breath and coughing despite being on antibiotics and prednisone. I am going to put her back on the methotrexate. Also of note is that she is going to need ultimately to get a followup CT scan to relook at this process primarily because we are approaching where we were about a year or so ago.~~
Carl A. Smart, M.D.~CAS:MG22 1195

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 02/20/2006 10:16

Chief complaint

The Chief Complaint is: DOB: 3-8-70
cough, sinus drainage, postnasal drip, and left side chest discomfort.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a postnasal drip.
She reported chest pain or discomfort.
She reported a cough.

Review of systems

Systemic symptoms: No systemic symptoms and pain cannot be controlled.
Head symptoms: No head symptoms.
Eye symptoms: No eye symptoms.
Otolaryngeal symptoms:A postnasal drip but no neck symptoms.
Breast symptoms: No breast symptoms.
Cardiovascular symptoms: Chest pain in the left precordium.
Pulmonary symptoms:A cough.
Gastrointestinal symptoms: No gastrointestinal symptoms.
Genitourinary symptoms: No genitourinary symptoms.
Endocrine symptoms: No endocrine symptoms.
Skin symptoms: No skin symptoms.
Hematologic symptoms: No hematologic symptoms.
Musculoskeletal symptoms: No musculoskeletal symptoms.
Neurological symptoms: No neurological symptoms.
Psychological symptoms: No psychological symptoms.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	98 bpm	50 - 100
Blood pressure while sitting	130/80 mmHg	94-140/60-90
Weight	164 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
A nasal discharge was seen but the nasal turbinate was not erythematous and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
A paroxysmal cough was observed but the chest was not overinflated, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:
Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	98%	

Assessment

Melony is here for followup, doing a little bit better. As you know, she recently had some bouts of shortness of breath and some dyspnea on exertion. Moving forward, a couple of things:

1. She is on methotrexate.
2. Prednisone. We will taper her off of the prednisone.
3. She needs to quit smoking.
4. Her CT scan showed small airway disease, but no interstitial process in terms of alveolitis. ~~

Carl A. Smart, M.D.~CAS:MG22 1302

Entered data sealed by: AUDREY Date: 02/20/2006 10:16

Chief complaint

The Chief Complaint is: DOB: 3-8-70
coughing , postnasal drip, and chest pains and pressure.

History of present illness

MELONY MCNEIL is a 35 year old female.
She reported a postnasal drip.
She reported a cough.

Review of systems

Otolaryngeal symptoms:A postnasal drip.
Cardiovascular symptoms: Chest tightness or heavy pressure.
Pulmonary symptoms:A cough.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	112 bpm	50 - 100
Blood pressure while sitting	112/70 mmHg	94-140/60-90
Weight	168 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:

Back: normal.

Abdomen:

Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:

Hair: normal.

Nails:

Nails: normal.

Musculoskeletal system:

General/bilateral: Musculoskeletal system: normal.

Neurological:

Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	96%	

Assessment

Melony is here for followup. Overall, she has been doing okay. As you know, she has a history of:
1. Asthma and bronchospasm.
2. Interstitial lung disease and had an open lung biopsy.~In any event, she is doing some better. She is still having some bouts of postnasal drip, but at this point, her shortness of breath is improved, but still present. She is still having a cough. Moving forward, I would like to actually get her off of the methotrexate and I have made recommendations to that end. Also, we will need to give her some nasal sprays in the form of Astelin to help as well.~~
Carl A. Smart, M.D.~CAS:MG22 1729

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CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 04/19/2006 10:56

Chief complaint

The Chief Complaint is: DOB: 3-8-70
sob is better, dry cough, wheezing when lying down, watery nasal discharge, and postnasal drip.

History of present illness

MELONY MCNEIL is a 36 year old female.
She reported a watery nasal discharge and down the throat from above.
She reported dyspnea at rest, while walking on level ground, a cough, and wheezing when lying down.

Review of systems

Otolaryngeal symptoms: A watery nasal discharge and down the throat from above.
Pulmonary symptoms: Shortness of breath, a cough, and wheezing.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	87 bpm	50 - 100
Blood pressure while sitting	118/72 mmHg	94-140/60-90
Weight	163 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	96%	

Assessment

The patient is here for followup. Actually, she has been doing okay. Unfortunately, she continues to have ongoing issues with smoking. This is obviously playing a tremendous role on or with how she is progressing. She recently had some rheumatologic evaluation and needed some steroids and at this point she does not want to have such. I do suspect that allergies are playing a tremendous role here. To that end, we are going to get an ImmunoCAP region 2 evaluation on her to evaluate such.~~
Carl A. Smart, M.D.~CAS:MG22 2398

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 05/30/2006 12:12

Chief complaint

The Chief Complaint is: DOB: 3-8-70
sob,difficulty breathing, chest tightness and pressure, coughing, wheezing,and nasal passage blockage.

History of present illness

MELONY MCNEIL is a 36 year old female.
She reported nasal passage blockage.
She reported chronic dyspnea, at rest, while walking on level ground, a cough, and wheezing.

Review of systems

Otolaryngeal symptoms: Nasal passage blockage.
Cardiovascular symptoms: Chest tightness or heavy pressure.
Pulmonary symptoms: Dyspnea expressed as feeling short of breath, a cough, and wheezing.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	106 bpm	50 - 100
Blood pressure while sitting	134/80 mmHg	94-140/60-90
Weight	157 lbs	98 - 183

General appearance:
The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:
The head showed no abnormality of appearance.

Eyes:
General/bilateral:
Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:
General/bilateral:
Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:
No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:
The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:
Pharynx: normal.

Neck:
The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:
There was no adenopathy and the lymph nodes were not tender.

Chest:
No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:
The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	93%	

Assessment

Melony is here for followup, not doing all that great. She has had progressive shortness of breath, dyspnea on exertion, and wheezing to a fair degree. She has been on prednisone of 40 mg q.d. for the last couple of days and still does not feel like things are budging. She said that things have gotten so bad that on Saturday she felt like she was at 'ground zero' given the degree of wheezing that she has had. To that end:

1. She is going to be admitted to the hospital.
2. IV steroids.
3. Bronchodilators.
4. O2 support.
5. Check her labs.
6. We are hopeful that she will be able to get over this in relatively short order, but I suspect that this may have been brought on by the fact that her son recently had a pneumonia and just got recent care for such.
7. Put her on antibiotics.~~

Carl A. Smart, M.D.~CAS:MG22 2842

CARL A SMART M.D.

Entered data sealed by: AUDREY Date: 06/22/2006 10:28

Chief complaint

The Chief Complaint is: Dob: 3-8-70
wheezing mostly at night.

History of present illness

MELONY MCNEIL is a 36 year old female.
She reported wheezing mostly at night.

Review of systems

Pulmonary symptoms: Wheezing worse at night.

Physical findings

Vital signs:

Vital Signs	Value	Normal Range
Pulse rate	99 bpm	50 - 100
Blood pressure while sitting	130/84 mmHg	94-140/60-90
Weight	159 lbs	98 - 183

General appearance:

The patient was awake, alert, oriented to time, place, and person, well developed, well nourished, healthy appearing, in no acute distress, not chronically ill, and not acutely exhausted.

Head:

The head showed no abnormality of appearance.

Eyes:

General/bilateral:

Pupils: The pupils were equal in size, round, reactive to light, with normal accommodation.
External Eye: The external eye showed no abnormalities.
Sclera: The sclera was normal.

Ears:

General/bilateral:

Outer Ear: The pinna was normal, the lobule had no abnormalities, the tragus had no abnormalities, and the concha had no abnormalities.

Nose:

No nasal discharge was seen, the nasal turbinate was not erythematous, and the nasal turbinate was not swollen and hypertrophied.

Oral cavity:

The general condition of the oral cavity was not fair.
Salivary Gland Abnormalities: Examination of the salivary glands showed no abnormalities.

Pharynx:

Pharynx: normal.

Neck:

The neck was not swollen and there was no tenderness of the neck. The carotid arteries were normal and the trachea was not deviated. The thyroid showed no abnormalities.

Lymph Nodes:

There was no adenopathy and the lymph nodes were not tender.

Chest:

No surgical/traumatic scar was seen on the chest, no thoracic deformity was seen, and the ribs showed no abnormalities.

Lungs:

The chest was not overinflated, no paroxysmal cough was observed, no wheezing was heard, no rhonchi were heard, no decreased breath sounds were heard, and a prolonged expiratory time was not observed.

Cardiovascular system:

Heart Rate And Rhythm: Heart rate and rhythm were normal.
Murmurs: No murmurs were heard.
Jugular Vein: The jugular vein did not have a sustained hepatojugular reflux and was not swollen and

tender.
Edema: Pitting edema was not seen.

Back:
Back: normal.

Abdomen:
Auscultation: The bowel sounds were normal and a bruit was not heard in the abdomen.
Percussion: The abdomen was not tympanitic on percussion and demonstrated no succussion splash.
Hepatic Findings: The liver was normal to palpation.
Splenic Findings: The spleen was normal to palpation.

Hair:
Hair: normal.

Nails:
Nails: normal.

Musculoskeletal system:
General/bilateral: Musculoskeletal system: normal.

Neurological:
Neurological system: normal.

Tests

Pulmonary Function Tests:	Value	Normal Range
Oxygen saturation	98%	

Assessment

Melony is here for followup. As you know, she was recently in the hospital. In any event, she said that her wheezing is mostly at nighttime and overall has been relatively stable. On examination today, her lungs are noted to be completely clear. I would like for her to continue on her nebulizers, however, and continue on the prednisone of 5 mg. We will see how she does over the next short period of time defined as the next six weeks. ~~

Carl A. Smart, M.D.~CAS:MG22 3119

klenburg Pulmonary Specialists
711 Randolph
Charlotte, ...

MEDICAL DIRECTOR
MEDICAID - S.C.
P.O. BOX 8206
COLUMBIA, S.C. 29202

Log #60

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

July 18, 2006

Carl A. Smart, MD
Pulmonary and Critical Care Medicine
201 Providence Road, Suite 103
Charlotte, North Carolina 28207

Re: Melony McNeil

Dear Dr. Smart:

Thank you for corresponding regarding this patient. The South Carolina Department of Health and Human Services (DHHS) can support two (2) additional physician office visits for this fiscal year ending June 30, 2006. Please attach a copy of this correspondence to any physician office visit claim you have that will exceed the twelve-visit limit. This will alert our staff to override the automatic system payment rejection edit and reimburse you for this care. Please assist the patient and the S.C. Medicaid program to make optimal use of these visits for medically necessary care. Additional visits should, in general, be physician directed as opposed to patient directed. Also, the 99211 code can accommodate brief encounters and does not count against the allotted number of office visits.

If you would like to discuss this further, please call me 803-898-2500 or 803-255-3400. Thank you for your advocacy regarding this patient and for caring for South Carolina Medicaid beneficiaries.

Sincerely,

O. Marion Burton, MD
Medical Director

OMB/bk

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2500 • Fax (803) 898-4515

bc: Melanie Giese
Val Williams