Medical History

Patient Data

Name: Henry Williams
Gender: Male
Age: 69
Weight: 88 kg (194 lbs)
Allergies: Penicillin
Attending physician: Dr. Nelson

Race: African American
Religion: Baptist
Height: 183 cm (72 in)
Major support: Ertha (wife) and Betty (daughter-in-law)
Immunizations: Up to date

Vital Signs

Values are stable throughout the scenario:

HR	BP	RR	Temp.	SpO_2
84/min	126/86 mmHg	14/min	37.3°C	98%

Past Medical History

Chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), asthma, hearing loss (wears hearing aids).

History of Present Illness

COPD. Henry has spent 15 days in the rehabilitation facility having therapy and education for managing his COPD and increasing his activity tolerance. He has improved greatly and uses his oxygen at night and only as needed. He has shown that he knows how to do his breathing treatments and manage his medications. Now he and his wife Ertha are going to an assisted living apartment for the first time.

Social History

Retired.

Primary Medical Diagnosis

COPD, cardiovascular disease.

Surgeries/Procedures & Dates

Appendectomy at age 15.

Laboratory Data

None

Physician's Orders

Discharge orders:

- Fluticasone proprionate 250 every 12 hours
- Albuterol 2 puffs as needed for acute onset of shortness of breath
- Respiratory treatment: Albuterol 2.5 mg & Ipratropium bromide 0.5 mg in 3 mL normal saline every night and PRN as needed for breathing changes/shortness of breath
- Rosuvastatin calcium 20 mg PO every evening
- Lisinopril 12.5 mg PO daily
- Metoprolol tartrate 50 mg PO daily
- Acetylsalicylic acid 81 mg PO daily
- Montelukast 10 mg PO every evening
- Prednisone 10 mg PO daily
- Schedule clinic appointment for evaluation in 10 days