

Auburn Montgomery Warhawk Health Services

7461 East Dr STE 102
Montgomery AL, 36117-8092
(334) 244-3281

Date: 01/26/24

PATIENT: TANEJA, AYUSH **DOB:** 03/28/1989 **Gender:** MALE **MRN:** 1274 **AGE:** 34 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: PATIENT PRESENTS TO CLINIC WITH C/O SINUS PRESSURE AND CONGESTION. REPORTS PRODUCTIVE COUGH WITH GREEN SPUTUM. REPORTS PRESSURE TO FRONTAL AND MAXILLARY SINUS CAVITIES. DENIES FEVER. REPORTS HE WAS OUT OF THE COUNTRY AND RETURNED ON 1/22, AND IS MOST BOTHERED BY COUGH.

VITALS: BP: 117/83 **Site:** RIGHT ARM **Position:** SITTING **Pulse:** 102; **Temp:** 97.7; **Resp:** 18; **Ht:** 71 in.; **Wt:** 218 lbs.;
BMI: 30.4; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Fish Oil 1,000 mg (120 mg-180 mg) capsule

PAST MEDICAL HISTORY: Asthma when he was younger, no issues in last 10-15 years. and high cholesterol

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Male, heterosexual. Exercises on a regular basis. Drinks a limited amount of alcohol, occasionally.

FAMILY HISTORY: Father has diabetes

REVIEW OF SYSTEMS:

CONSTITUTIONALS: All 14 point review of systems negative except those listed in HPI.

PHYSICAL EXAMINATION:

GENERAL: No apparent distress noted; Well developed; Pleasant.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. Nose - with nasal congestion - septum - midline; Positive for maxillary or frontal sinus tenderness, worse on right than left. Throat - pink without exudates. No anterior or posterior cervical nodes palpated; No palpable thyroid abnormality or enlargement.

CARDIOVASCULAR: S1 S2; Regular rate and rhythm; No systolic ejection murmurs noted; No carotid bruits noted. No peripheral edema bilateral lower extremities.

RESPIRATORY: Breath sounds equal and unlabored. Clear to auscultation bilaterally without wheezes, rales, or rhonchi.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

MUSCULOSKELETAL: Normal range of movement x 4 extremities; 2+ DP and PT pulses bilaterally

INTEGUMENTARY: Warm, dry, intact. No lesions or rash noted.

NEUROLOGIC: Alert and Oriented X3. CN II-XII intact. Sensation intact. Speech clear. Ambulates with steady gait.

PSYCHIATRIC: Appropriate mood and affect.

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ASSESSMENT:

J01.90 - Acute sinusitis, unspecified (PRIMARY)

R05.1 - Acute cough

PLAN:

Patient was offered steroids along with the antibiotics. Patient declined steroids, shot and pills, and will notify clinic if no improvement in condition by Monday.

Patient has been ill for a full 6-7 days. No hx fever, therefore, at this time I do not feel it is prudent to test for covid and/or flu, as he would be past additional interventions for either, and it would not affect my treatment plan. Patient is in agreement.

amoxicillin 875 mg tablet

Refills: 0 Qty: 20 TABLET(S)

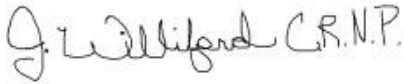
Instructions: TAKE 1 TABLET (875 MG) BY ORAL ROUTE EVERY 12 HOURS X 7 DAYS

Bromfed DM 2 mg-30 mg-10 mg/5 mL oral syrup

Refills: 0 Qty: 120 ML(S)

Instructions: TAKE 10 MILLILITERS BY ORAL ROUTE EVERY 6 HOURS AS NEEDED FOR COUGH AND CONGESTION

Electronically signed by Joyce Williford, CRNP on 01/26/24 9:00 AM

Handwritten signature of J. Williford CRNP in black ink.