

Auburn Montgomery Warhawk Health Services

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

Date: 04/18/24

PATIENT: BRAY, STEPHEN **DOB:** 08/02/1983 **Gender:** MALE **MRN:** 1321 **AGE:** 40 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: nausea, dizziness, fatigue

HISTORY OF PRESENT ILLNESS: 40 year old male presents to clinic due to "not feeling like himself". Upon arrival he complains of nausea, fatigue, dizziness, heart palpitations, and an overall feeling of being "spacey". He reports it started about 20 mins ago while he was sitting in his office. He reports he was off-balance walking over here and walked into a wall. He has a history of TBI from being overseas in the military and has not felt himself in general the last few days/weeks. He has a history of having one panic attack before and has xanax to take as needed. He sees his PCP every 3 months and has an appt coming soon.

VITALS: BP: 137/84 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 95; **Temp:** 98; **Resp:** 18; **Ht:** 70 in.; **Wt:** 209 lbs.;
BMI: 29.98; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Adderall 10 mg tablet (daily)

PAST MEDICAL HISTORY: Concussion (TBI in 2004), B12 deficiency, reactive airway disease- PCP is Dr. Dailey

PAST SURGICAL HISTORY: (R) ulnar nerve

SOCIAL HISTORY: Denies smoking, drinking and drug use

FAMILY HISTORY: Denies

REVIEW OF SYSTEMS:

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

PHYSICAL EXAMINATION:

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

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; No maxillary or frontal sinus tenderness. 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

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

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

PSYCHIATRIC: Appropriate mood and affect.

ORDERS:

UA (1 unit(s)): In-House Lab
Glucose (1 unit(s)): In-House Lab
EKG (1 unit(s)): Office Procedure

RESULTS:

UA:
 Appearance: clear
 Color: amber
 Glucose: Negative
 Bill: Negative
 Ketones: Positive
 Sp: 1.015
 Blood: Negative
 pH: 7
 Protein: Negative
 Urobilinogen: Negative
 Nitrites: Negative
 Leukocytes: Positive
 Comments: Leuk: 25 Leu/uL

Ketones: 15 mg/dL

Glucose:
 Value: 100

ASSESSMENT:

R42 - DIZZINESS AND GIDDINESS (PRIMARY)
R00.2 - PALPITATIONS
F41.0 - Panic disorder [episodic paroxysmal anxiety]

PLAN:

EKG- NSR at 89 bpm w/ short PRI at 114 ms. No ischemic changes. His glucose and UA are normal. I offered to check basic labs but he declined today. After about 20 min in the office he reports feeling back to normal. Most likely a panic attack related to recent stress. I recommended he take his prn xanax at the onset of symptoms for panic attack. Given ER precautions if the symptoms return. He verbalized understanding.

Electronically signed by Lindsey Barton, CRNP on 04/19/24 2:30 PM

L Barton, CRNP

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