

Auburn Montgomery Student Health Services

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

Date: 10/07/20

PATIENT: BRAY, STEPHEN **DOB:** 08/02/1983 **Gender:** MALE **MRN:** 1321 **AGE:** 37 Years

VISIT TYPE: Office Visit New

CHIEF COMPLAINT: Cough

HISTORY OF PRESENT ILLNESS: Mr. Bray presents today for a visit for a persistent, hacking cough. He reports this has been going on for the last 2-3 days . Associated with diarrhea, congestion, sinus drainage, and fatigue. Denies fever, sob, loss of taste/smell, nausea or vomiting.

He also c/o fatigue for the past few months. He is a patient at Montgomery Primary Medicine. He was told he had B12 deficiency. He is on shots and orals for this but it is not helping. He denies snoring at night or periods of apnea but he is not 100% sure about this. He sleeps from 8:30 most nights to 7 am and still wakes up with fatigue. He has a child that is less than 6 months old but he sleeps through the night so this is not a contributing factor. He has an appt today at his PCP office but would like to cancel if we can recheck his labs today.

VITALS: BP: 122/84 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 86; **Temp:** 98.3; **Resp:** 16; **Ht:** 69.2 in.; **Wt:** 210.8 lbs.; **BMI:** 30.95; **Pulse Oximetry:** 97%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Wellbutrin SR 200 mg tablet, 12 hr sustained-release (BID)

PAST MEDICAL HISTORY: Concussion, B12 deficiency

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.

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

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:

TSH W/REFLEX T4, FREE (QUEST) (1 unit(s)): Quest Diagnostics
EPSTEIN-BARR VIRUS ANTIBODY PANEL (QUEST) (1 unit(s)): Quest Diagnostics
Rocephin 1G (1 unit(s)): Injection
Decadron 4mg/ml (1 unit(s)): Injection
Depo-Medrol 40mg/ml (1 unit(s)): Injection
COMP METABOLIC PANEL (QUEST) (1 unit(s)): Quest Diagnostics
CBC W/ DIFF (QUEST) (1 unit(s)): Quest Diagnostics
IRON, TIBC, %SAT (QUEST) (1 unit(s)): Quest Diagnostics
VITAMIN B12 (QUEST) (1 unit(s)): Quest Diagnostics
VITAMIN D 25 - HYDROXY, TOTAL (QUEST) (1 unit(s)): Quest Diagnostics
THERAPEUTIC INJECTION ADMIN (2 unit(s)): Injection
COVID Rapid Testing (1 unit(s)): In-House Lab

RESULTS:

COVID Rapid Testing:
Value: Negative

ASSESSMENT:

Z20.828 - CONTACT W AND EXPO TO OTH VIRAL COMMUNICABLE DIS (PRIMARY)
J01.90 - ACUTE SINUSITIS, UNSPECIFIED
R05 - COUGH
E55.9 - VITAMIN D DEFICIENCY, UNSPECIFIED
E53.8 - DEFICIENCY OF OTHER SPECIFIED B GROUP VITAMINS
R53.83 - OTHER FATIGUE

PLAN:

Rapid COVID negative.
Rx for bactrim and bromfed.
Check labs. Discussed referral for sleep study pending lab results.
Follow up if no improvement or worsening symptoms.

Electronically signed by Lindsey Barton, CRNP on 10/07/20 1:53 PM

A handwritten signature in blue ink that reads "J. Barton, CRNP". The signature is written in a cursive, flowing style.

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