

Auburn Montgomery Student Health Services

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

Date: 04/29/22

PATIENT: FREDERICKS, SARAH **DOB:** 07/19/1986 **Gender:** FEMALE **MRN:** 1344 **AGE:** 35 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Cough

HISTORY OF PRESENT ILLNESS: Pt comes in with c/o cough for almost a month. She was given medrol dose pack and Biaxin after her last OV. She reports it has not improved. She notes post nasal gtt, has hx of asthma. Not being treated for asthma at this time. No recent PFTs. She coughs mostly with exertional activity and laying down to sleep at night. OTC cough medications have not helped.

VITALS: BP: 147/96 **Pulse:** 107; **Temp:** 97.2; **Ht:** 68 in.; **Wt:** 287.4 lbs.; **BMI:** 43.69; **Pulse Oximetry:** 98%; **FDLMP:** 04/13/22

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Singulair 10 mg tablet (TAKE 1 TABLET (10 MG) BY ORAL ROUTE ONCE DAILY IN THE EVENING)
Wellbutrin XL 300 mg 24 hr tablet, extended release (1 tab PO daily)
Xulane 150 mcg-35 mcg/24 hr transdermal patch (APPLY 1 PATCH BY TRANSDERMAL ROUTE ONCE WEEKLY)
hydroxyzine HCl 25 mg tablet (PRN)
triamterene 37.5 mg-hydrochlorothiazide 25 mg capsule (1 CAPSULE PO DAILY)

PAST MEDICAL HISTORY: Allergies, anxiety, asthma, depression, hearing loss, heart murmur, pneumonia, chicken pox

PAST SURGICAL HISTORY: (L) Shattered ankle

SOCIAL HISTORY: denies drinking, drugs and smoking

FAMILY HISTORY: Mother: diabetes, hypertension Father: diabetes, hypertension

HEALTH MX HISTORY:

Pap smear- 2019

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. Obese.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. 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. Expiratory Wheeze.

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:

Chest XRAY (1 unit(s)): Outside Diagnostic

NEBULIZER BREATHING TREATMENT (1 unit(s)): Office Procedure

ASSESSMENT:

R05.9 - COUGH, UNSPECIFIED (PRIMARY)

J45.909 - UNSPECIFIED ASTHMA, UNCOMPLICATED

PLAN:

Cough with recent tx for bronchitis. Hx of asthma. Needs PFTs, but she will not have insurance until August. Will postpone. CXR today. Breathing tx in office. Rescue inhaler to pharmacy with instructions for when to use. Pt verbalized understanding. Continue Singulair daily. Pt agrees.

albuterol sulfate HFA 90 mcg/actuation aerosol inhaler

Refills: 3 Qty: 1 INHALER(S)

Instructions: INHALE 2 PUFFS (180 MCG) BY INHALATION ROUTE EVERY 4-6 HOURS AS NEEDED

promethazine-DM 6.25 mg-15 mg/5 mL oral syrup

Refills: 0 Qty: 100 ML(S)

Instructions: TAKE 5 MILLILITERS BY ORAL ROUTE EVERY 4-6 HOURS AS NEEDED, NOT TO EXCEED 30 ML IN 24 HOURS

Electronically signed by Maranda Fain, CRNP on 04/29/22 3:54 PM

M. Fain, CRNP