

Auburn Montgomery Student Health Services

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

Date: 05/25/22

PATIENT: MORRIS, KENDRA **DOB:** 08/02/1978 **Gender:** FEMALE **MRN:** 1412 **AGE:** 43 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Hit head on safe at work

HISTORY OF PRESENT ILLNESS: Mrs. Morris is a 43 yo female here today for work related injury. She hit her head on the safe while she was getting something out of it. She c/o headache now and a bump on her head. She has applied ice to the site. She is able to recall the incident. No nausea, vomiting, blurred vision, or loss of consciousness.

VITALS: BP: 115/80 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 100; **Temp:** 98.3; **Resp:** 17; **Ht:** 69 in.; **Wt:** 154.1 lbs.; **BMI:** 22.75; **Pulse Oximetry:** 100%

ALLERGIES: Biaxin; Cefzil; amoxicillin

MEDICATIONS:

Flonase Allergy Relief 50 mcg/actuation nasal spray,suspension (1 puff each nostril daily)
Nurtec ODT 75 mg disintegrating tablet (once every other day)
Plaquenil 200 mg tablet (daily)
Simponi 50 mg/0.5 mL subcutaneous syringe (monthly)
Vitamin C 500 mg tablet (daily)
Vitamin D3 25 mcg (1,000 unit) capsule (daily)
Zyrtec 10 mg tablet (daily)
folic acid 1 mg tablet (daily)
gabapentin 300 mg capsule (BID)
meloxicam 7.5 mg tablet (daily)
methotrexate 2.5 mg tablet (weekly on Thursday)
prednisone 2.5 mg tablet (1 tablet daily)
prednisone 5 mg tablet (1 tablet daily)
risedronate 150 mg tablet (once monthly)
rizatriptan 10 mg tablet (as needed)
topiramate 50 mg tablet (daily)
tramadol 50 mg tablet (Q4Hours PRN)

PAST MEDICAL HISTORY: RA, migraines and allergies. Takes prednisone for management of RA.

SOCIAL HISTORY: Married. AUM employee. 2 children. Denies smoking, drinking, or illicit drug use.

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. No nystagmus. 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.

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

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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. Small 2 cm round contusion to middle of scalp.

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

PSYCHIATRIC: Appropriate mood and affect.

ASSESSMENT:

S00.03XA - CONTUSION OF SCALP, INITIAL ENCOUNTER (PRIMARY)

PLAN:

Given ibuprofen 400mg in office to take for headache. She was given instructions for symptoms of concussion to monitor for and instructions to go to nearest ER if symptoms occur. She verbalized understanding. Ibuprofen or tylenol as needed for headache. Application of ice as needed for pain/swelling. Follow up as needed.

Electronically signed by Lindsey Barton, CRNP on 05/25/22 1:00 PM

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