

Auburn Montgomery Student Health Services

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

Date: 03/22/18

PATIENT: RUSSELL, ANGELA **DOB:** 07/13/1989 **Gender:** FEMALE **MRN:** 326 **AGE:** 28 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Here for follow up with the CRNP

VITALS: BP: 121/82 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 78; **Wt:** 125.7 lbs.

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Celexa 40 mg tablet (TAKE 1 TABLET (40 MG) BY ORAL ROUTE ONCE DAILY)
Wellbutrin XL 150 mg 24 hr tablet, extended release (TAKE 1 TABLET (150 MG) BY ORAL ROUTE ONCE DAILY)
cholecalciferol (vitamin D3) 50,000 unit capsule (1 capsule by mouth weekly x 4 weeks)
prednisone 5 mg tablet (DISP 12 DAYS. TAKE AS DIRECTED ON PACKAGE)
triamcinolone acetonide 0.1 % topical cream (APPLY BID TO AFFECTED AREA.)

PAST MEDICAL HISTORY: Optic neuritis, anxiety, Had an eating disorder in school. Weight dropped to 83 lbs.

PAST SURGICAL HISTORY: Shoulder surgery-- rotator cuff repair, frenectomy, migraines

SOCIAL HISTORY: Consumes alcohol. socially, There are no environmental risks involved at my home/job. Has Not been exposed to someone with TB. Has Not had excessive exposure to the sun. Exercises regularly; Is Not experiencing unusual stress. Lives alone; Single; Does not use recreational drugs; Does not use tobacco; Does wear a seat belt;

FAMILY HISTORY: Sister with history of: OCD & depression, IBS, Migraine headache. Mother with history of: CREST syndrome (auto immune dz) melanoma, migraines. Father with history of: HTN, anxiety, depression, Maternal Grandmother with history of: Deceased (breast CA). Maternal Grandfather with history of: DMII, colon cancer. Paternal Grandmother with history of: hyperlipademia, HTN, depression, Paternal Grandfather with history of: CHF, CABG. deceased

REVIEW OF SYSTEMS:

CONSTITUTIONALS: Constitutional doing very well on current meds. Very few episodes of anxiety since last visit. Has been on the Wellbutrin XL 150 x 2 weeks and notices increase in libido.

PHYSICAL EXAMINATION:

GENERAL: Patient appears consistent with age, well developed/nourished, NAD, and alert and oriented x 3.

NEUROLOGIC: DTR's and +2/4 and bilaterally symmetric for upper and lower extremities. Cranial nerves grossly intact. No focal deficit.

PSYCHIATRIC: Alert and oriented x3; Mood and affect appropriate.

ASSESSMENT:

F41.9 - Anxiety disorder, unspecified (PRIMARY)
F33.0 - Major depressive disorder, recurrent, mild

PLAN:

Continue currents doses of medications.

RTC in 2 weeks and prn

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Electronically signed by Carol Stewart, NP on 03/22/18 4:20 PM