

Auburn Montgomery Student Health Services

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

Date: 04/04/18

PATIENT: CONNER, JACOB **DOB:** 10/15/1988 **Gender:** **MRN:** 355 **AGE:** 29 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Here for follow up with CRNP

Symptoms: States he feels better after speaking with Mrs. Stewart.

VITALS: BP: 151/83 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 84

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: anxiety and depression

PAST SURGICAL HISTORY: Appendectomy age 19, hand surgery 2009

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. Does not exercise regularly; Is experiencing unusual stress. Does not live alone; Does not use recreational drugs; Does not use tobacco; Does wear a seat belt;

FAMILY HISTORY: Brother with history of: None Father with history of: Mother with history of: anxiety and depression, Maternal Grandmother with history of: unknown; Paternal Grandfather with history of: DMII Obesity, Paternal Grandmother with h1story of: unknown Father with history of: DMII, obesity.

REVIEW OF SYSTEMS:

CONSTITUTIONALS: Constitutional All negative for fever, chills, nausea, vomiting, dizziness, fatigue, infertility, & malaise.

CARDIOLOGIC: All negative for: pain, murmur, palpitations, numbness, cardiovascular, dizziness, diaphoresis, exertional SOB, syncope.

RESPIRATORY: All negative for cough, hemoptosis, orthopnea, shortness of breath, sputum, and wheeze.

GASTROINTESTINAL: All negative for abdominal pain, appetite loss, anorexia, belching, constipation, diarrhea, flatulence, heartburn, hematchezia, hematemesis, indigestion, mass, swelling and ulcers.

NEUROLOGIC: All negative for headache, difficulty with vision, numbness in hands and feet, hot flashes, and night sweats.

PSYCHOLOGICAL: Has an fulfilling job. has been exercising everyday. Has been building platonic and romantic relationships and overall, feels well. Continues to have episodes of anxiety but feels he is managing well.

PHYSICAL EXAMINATION:

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

HEENT: EOMI, PERRLA, lids and conjunctivae appear normal, sclera white.

EARS: Ears appear normal. TM's intact and reflect NL. External auditory canal clear.

THROAT: Throat is clear, no tonsillar hypertrophy, and no exudates.

NECK: Neck is supple, FROM, no JVD, no lymphadenopathy.

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CARDIOVASCULAR: HRRR;

RESPIRATORY: Lungs CTA; No rhonchi wheeze or rales;

MUSCULOSKELETAL: Gait Normal; No clubbing, cyanosis, or edema of lower extremities;

DERMATOLOGIC: Skin Temperature: Warm Dry;

NEUROLOGIC: Cranial Nerves Intact; No Focal Deficit;

PSYCHIATRIC: Mood and Affect Appropriate;

ASSESSMENT:

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

PLAN:

Continue current activities and RTC pm.

Electronically signed by Carol Stewart, NP on 04/04/18 4:33 PM