

Auburn Montgomery Student Health Services

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

Date: 03/05/18

PATIENT: SHETA, HENILKUMAR **DOB:** 06/17/1999 **Gender:** **MRN:** 410 **AGE:** 18 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Cough

Symptoms: Cough since Saturday. Nonproductive. No fever or night sweats. No HA.
ModFact: Pt is an insulin-dependent diabetic.

COMPLAINT 2: Diabetes

Symptoms: IDDM
Context: Patient reports that he only eats 2 meals per day.
ModFact: Takes Actrapid 6 units every afternoon
Allstar 18 units at night and 25 units in the morning.

Also takes oral hypoglycemic agent but unsure of name of medication

VITALS: BP: 107/70 **Pulse:** 82; **Temp:** 97.7

ALLERGIES: No Known Drug Allergies

PAST MEDICAL HISTORY: type 1 diabetes Diagnosed at age 15. Has had poor management. Was hospitalized in India with DKA about 6 weeks ago. After discharge, came to the US two days later with 6 months Rx of insulin and oral medication. Has no plan for medical follow-up to manage health issues,

PAST SURGICAL HISTORY: Denies any surgeries

SOCIAL HISTORY: Denies use of alcohol or recreational drugs. Denies exercising regularly. Smokes 2 cigarettes/day.

FAMILY HISTORY: Denies any family health history.

REVIEW OF SYSTEMS:

CONSTITUTIONALS: Patient denies: Fever, Chills,

RESPIRATORY: Patient is positive for: Cough,

PHYSICAL EXAMINATION:

GENERAL: Well/Developed/Nourished; Appears Consistent with Age; NAD;

HEENT: Normocephalic; EOMI; Sclera White; Conjunctiva Clear; No cyanosis of lips or mucosa; Airways patent; Membranes moist; Good Dentation;

EARS: TM's intact and reflect NCL; External Auditory Canal clear;

NOSE: Nasal mucosa moist and pink; mild nasal congestion Sinus nontender; No Turbinate Hypertrophy;

THROAT: Throat red; Posterior Nasal Drainage; No Tonsillar Hypertrophy; No exudates;

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

CARDIOVASCULAR: HRRR , no extra heart sounds, no murmur

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RESPIRATORY: Lungs CTA; no rhonchi wheeze or rales; breath sounds symmetric; no chest wall tenderness.

NEUROLOGIC: No Focal Deficit; Gait and Station Normal;

PSYCHIATRIC: Mood and Affect Appropriate; Alert and Oriented x3;

ASSESSMENT:

J06.9 - ACUTE UPPER RESPIRATORY INFECTION, UNSPECIFIED (PRIMARY)

E10.9 - TYPE 1 DIABETES MELLITUS WITHOUT COMPLICATIONS

F17.200 - NICOTINE DEPENDENCE, UNSPECIFIED, UNCOMPLICATED

PLAN:

Discussed diet with patient and gave examples of meals appropriate for patient with IDDM.

URI information sheet provided to patient.

Advised patient to stop smoking.

loratadine 10 mg tablet

Refills: 1 Qty: 30 TABLET(S)

Instructions: TAKE 1 TABLET (10 MG) BY ORAL ROUTE ONCE DAILY

RTC 2 weeks for recheck (lab work) or for worsening symptoms. Advised to RTC for fever greater than 101.

Electronically signed by Melodye Harvey, CRNP on 03/05/18 10:16 AM