

Auburn Montgomery Student Health Services

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

Date: 02/15/18

PATIENT: DESAI, SHRADDHA **DOB:** 03/03/1998 **Gender:** **MRN:** 435 **AGE:** 19 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Pt in for follow up with CRNP

Symptoms: States she is feeling better. Brough medications from.

ModFact: Also takes Flunarizine-propranolol combination.

VITALS: BP: 84/60 **Pulse:** 66 **BP2:** 103/76 **Site2:** RIGHT ARM **Position2:** SITTING **Pulse2:** 80

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

amitriptyline-chlordiazepoxide 12.5 mg-5 mg tablet

domperidone maleate 10 mg tablet

naproxen sodium 550 mg tablet

PAST MEDICAL HISTORY: No past illnesses reported

PAST SURGICAL HISTORY: None

SOCIAL HISTORY: Denies alcohol use, tobacco use, or illicit drug use. Is not currently sexually active.

FAMILY HISTORY: No pertinent family history

REVIEW OF SYSTEMS:

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

HEENT: All negative for cough, runny nose, congestion, sinus pain, earache, sore throat.

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, diarrhea, nausea, vomiting

NEUROLOGIC: All negative for headache, difficulty with vision, numbness in hands and feet, hot flashes, and night sweats. Patient reports not having any headaches since following recommendations from previous visit. She states that she has increased her water intake, eaten home-cooked food and avoided junk food, and attempted to organize her studies to reduce stress.

PHYSICAL EXAMINATION:

GENERAL: Patient appears consistent with age, well developed/nourished, NAD, and alert and oriented x3. cooperative

HEAD: Normocephalic, EOMI, PERRLA, lids and conjunctivae appear normal, sclera white, visual fields normal, light reflex present.

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

NECK: Neck is supple, no tracheal deviation, no JVD, no lymphadenopathy.

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CARDIOVASCULAR: HRRR without murmur. no clicks, gallops or rubs. Heart sounds of normal intensity.

RESPIRATORY: Lungs CTA; no rhonci wheeze or rales, breath sounds symmetric, no intercostals retractions, no nasal flaring, no chest wall tenderness, no dullness to percussion. No supra clavicular lymphadenopathy

MUSCULOSKELETAL: Good Range of Motion of upper and lower extremities; pulses equal and bilaterally symmetric; gait normal; no muscle tenderness; No clubbing, cyanosis, or edema. No cutaneous temperature difference bilaterally

DERMATOLOGIC: Temperature: warm, dry. No rash. No jaundice. No cyanosis.

LYMPHATIC: No adenopathy.

NEUROLOGIC: CN II - XII grossly intact. Good grip. Strength note bilateral sensation intact to pain & slight touch cerebella fx intact with finger to finger, heel to shin. Normal Gait.

PSYCHIATRIC: Alert and oriented x3, memory intact, mood and affect appropriate.

ASSESSMENT:

G44.201 - TENSION-TYPE HEADACHE, UNSPECIFIED, INTRACTABLE (PRIMARY)

PLAN:

Patient to discontinue current meds being used for headaches and should return to clinic if headaches return for possible neurology referral.

Electronically signed by Carol Stewart, NP on 02/16/18 2:37 PM