

Auburn Montgomery Student Health Services

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

Date: 07/14/21

PATIENT: SMITH, ANTONIO **DOB:** 06/26/1974 **Gender:** MALE **MRN:** 4765 **AGE:** 47 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Headache

HISTORY OF PRESENT ILLNESS: History of HTN in past. Does not take any meds for it now and has not seen a PCP in several years. Woke up this morning with headache in back of head and all over. Took tylenol with no relief. Denies chest pain, SOB, palpitations, dizziness, or blurred vision. He thinks most likely because BP is high.

VITALS: BP: 167/100 Site: LEFT ARM Position: SITTING Pulse: 103 BP2: 156/107 Site2: LEFT ARM Position2: SITTING Pulse2: 91 BP3: 151/103 Site3: LEFT ARM Position3: SITTING; Temp: 98.9; Resp: 18; Ht: 67 in.; Pulse Oximetry: 96%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

No Known Medications

PAST MEDICAL HISTORY: HTN

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Drinks alcohol socially. Smokes 1 pack of cigarettes every 3 days for past 2 years. Denies illicit drug use. Employed on campus. Smokes tobacco daily .5 packs per day for 2 years (1 Pack Years). Counseled for smoking cessation.

FAMILY HISTORY: HTN in parents and grandparents. Mother- Stroke.

HEALTH MX HISTORY:

PCP- none

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.

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

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.

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

PSYCHIATRIC: Appropriate mood and affect.

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ASSESSMENT:

I10 - Essential (primary) hypertension (PRIMARY)
R51.9 - Headache, unspecified

PLAN:

Given 0.1mg Clonidine PO x 1 dose at 08:45 am. Recheck BP at 0910 was 156/107, 91. Laid in a dark, quiet room. Recheck at 0930- 151/103. He states his headache went from a 6 to 0. He declines labs or EKG. He has a BP cuff at home. He will check twice daily and return on Monday for review of BP log. He was given an excuse for today. He reports going to go home and rest. Risk and benefits of lowering BP vs. high BP discussed to include strokes. He verbalized understanding.

He recently is employed at AUM. He does not have insurance at this time and is unable to pay a copay for today's office visit.

Electronically signed by Lindsey Barton, CRNP on 07/14/21 2:44 PM

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