

Auburn Montgomery Student Health Services

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

Date: 10/21/21

PATIENT: KHAN, FAHAD **DOB:** 06/02/1994 **Gender:** MALE **MRN:** 4926 **AGE:** 27 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: left flank pain

HISTORY OF PRESENT ILLNESS: Pt is a 27 YOM who comes in with c/o left flank pain. He feels it does not expand the same when he takes a deep breath. He feels it is not as muscular as his other side. He feels his ribs are too low. He also c/o worsening pain with coffee, sodas, spicy foods. He hears a gurgling noise when he makes his stomach move in and out. He feels weird when he bends to the side. He reports history of normal work up in India. He denies being sexual active.

VITALS: BP: 119/82 **Pulse:** 72; **Temp:** 97.2; **Resp:** 19; **Ht:** 68 in.; **Wt:** 138 lbs.; **BMI:** 20.98; **Pulse Oximetry:** 99%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

No Known Medications

PAST MEDICAL HISTORY: Denies

PAST SURGICAL HISTORY: denies

SOCIAL HISTORY: Pt lives off campus. Denies ETOH, Tobacco, recreational drug abuse.

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.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI.

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.

GASTROINTESTINAL: Abdomen is soft; Nontender; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

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: anxious.

ORDERS:

UA (1 unit(s)): In-House Lab

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RESULTS:

UA:

Appearance: clear
Color: yellow
Glucose: Negative
Bill: Negative
Ketones: Negative
Sp: 1.010
Blood: Negative
pH: 5
Protein: Negative
Urobilinogen: Negative
Nitrites: Negative
Leukocytes: Negative

ASSESSMENT:

R10.9 - UNSPECIFIED ABDOMINAL PAIN (PRIMARY)
R07.81 - PLEURODYNIA
K21.9 - GASTRO-ESOPHAGEAL REFLUX DIS WITHOUT ESOPHAGITIS
R35.0 - FREQUENCY OF MICTURITION

PLAN:

Pt presents with left rib and flank pain with some GI symptoms suggestive of GERD. He is very concerned with his left side and pain. He feels it is not anatomically normal. Will get XR of left ribs and Complete ABD US. He agrees. I do not feel he needs a CT at this time. His of normal EEG reported as well as normal CT. UA normal. No blood in urine. Will start on Omeprazole for GERD, he agrees. F/U 6 weeks to assess GERD symptoms. Follow up based on other tests pending. Education provided on foods to avoid with GERD.

omeprazole 20 mg capsule, delayed release

Refills: 2 Qty: 30 CAPSULE(S)

Instructions: TAKE 1 CAPSULE (20 MG) BY ORAL ROUTE ONCE DAILY 30 MINUTES TO 1 HOUR BEFORE A MEAL

Electronically signed by Maranda Fain, CRNP on 10/21/21 1:49 PM

