

Auburn Montgomery Student Health Services

7461 East Dr STE 102
Montgomery AL, 36117-8092
(334) 244-3281

Date: 03/29/22

PATIENT: BRONSON, DARRIN **DOB:** 05/25/2005 **Gender:** MALE **MRN:** 4962 **AGE:** 16 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: headache, abdominal pain, and elevated BP.

HISTORY OF PRESENT ILLNESS: Mr. Bronson is a 16 yo male here today with elevated BP and headache. He was sent to see his PCP after being evaluated by the school nurse. He has a history of headaches since he was around 6 yrs old. He gets them at least 1-2 times per week. Located above both his eyes. He does c/o nausea but no vomiting. Denies dizziness. He wears glasses and had an eye exam last summer that was normal w/ his corrective lenses. He has seen a neurologist in NY about 2 years ago before they moved here. He had a MRI that was reportedly normal. He typically takes 400mg ibuprofen and lays down for a nap. When he wakes up they are usually gone. He has not taken any meds for his headache today.

He also c/o nausea and abdominal pain located around his umbilicus that started today. Pain is intermittent and he describes it as "aching" with decreased appetite today. Denies vomiting. Denies diarrhea, constipation, or urinary symptoms. His last BM was yesterday and was reportedly normal.

He has a history of asthma. He has not had to use his inhaler in about 2 years. He c/o sob since this morning. He states it is "slight" sob. Denies wheezing, runny nose, congestion, sore throat, or fever. His school is requiring a COVID test before returning back to class.

VITALS: BP: 137/88 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 98; **Temp:** 97.4; **Resp:** 16; **Ht:** 69.5 in.; **Wt:** 285.3 lbs.; **BMI:** 41.52; **Pulse Oximetry:** 100%

GROWTH PERCENTILES:

Weight/Age: >97

Height/Age: 57

Weight/Height: N/A

BMI/Age: >97

Head Circumference/Age: N/A

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

ProAir HFA 90 mcg/actuation aerosol inhaler (INHALE 2 PUFFS (180 MCG) BY INHALATION ROUTE EVERY 4-6 HOURS AS NEEDED for sob/wheezing)

albuterol sulfate 2.5 mg/3 mL (0.083 %) solution for nebulization (INHALE 3 MILLILITERS (2.5 MG) BY NEBULIZATION ROUTE 3 TIMES PER DAY as needed for sob/wheezing)

nebulizer and compressor (1 nebulizer machine w/ accessories to use for asthma)

PAST MEDICAL HISTORY: Asthma, chronic headaches.

PAST SURGICAL HISTORY: Umbilical hernia repair at age 3.

SOCIAL HISTORY: Lives with both parents. Attends school. denies alcohol, tobacco, and illicit drug use.

FAMILY HISTORY: Mother- T2DM, HTN.

REVIEW OF SYSTEMS:

CONSTITUTIONALS: All 14 point review of systems negative except those listed in HPI.

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PHYSICAL EXAMINATION:

GENERAL: GENERAL: No apparent distress noted; Well developed; Pleasant.

HEENT: Head- normocephalic; atraumatic. Eyes- sclera white, conjunctiva pink, EOMI. No Nystagmus. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; No maxillary or frontal sinus tenderness. Throat- pink without exudates. No anterior or posterior cervical nodes palpated; No palpable thyroid abnormality or enlargement.

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; + tenderness over umbilicus; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted. No CVA tenderness.

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.

ORDERS:

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

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

Abbott Binax Now Rapid COVID (1 unit(s)): In-House Lab

RESULTS:

UA:

Appearance: clear

Color: yellow

Glucose: Negative

Bill: Negative

Ketones: Negative

Sp: 1.020

Blood: Negative

pH: 6

Protein: Positive

Urobilinogen: Negative

Nitrites: Negative

Leukocytes: Negative

CS: NO

Comments: Trace protein

INFLUENZA:

Value: Negative

Abbott Binax Now Rapid COVID :

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Value: Negative

ASSESSMENT:

J45.20 - Mild intermittent asthma, uncomplicated (PRIMARY)
R06.02 - SHORTNESS OF BREATH
R10.9 - UNSPECIFIED ABDOMINAL PAIN
R51.9 - HEADACHE, UNSPECIFIED

PLAN:

Given 800mg ibuprofen in the office at 1440. Waited until 15:45. No relief in headache. He continues to rate pain 6-7/10. Given maxalt 5mg PO x 1 dose. Waited for 30 min. No relief. He was given a second 5mg dose of maxalt to take at home. Rx for ketorolac if no improvement. Referral to neurology for eval. Differential diagnoses include migraine headache vs. tension headache.

Recheck BP was 158/98. He was instructed to monitor his BP twice daily at home. Write down a log and return if BP remains > 140/90. His mother is at bedside. They have a BP cuff at home and she will monitor it. Go to nearest ER if headache persists or worsening symptoms. They verbalized understanding.

ketorolac 10 mg tablet

Refills: 0 Qty: 20 TABLET(S)

Instructions: TAKE 1 TABLET (10 MG) BY ORAL ROUTE EVERY 6 HOURS AS NEEDED FOR headache

Referral: Green, Dr. Hamp (Neurologist)

Instructions: Chronic persistent headaches.

Electronically signed by Lindsey Barton, CRNP on 03/29/22 4:56 PM

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