

Auburn Montgomery Student Health Services

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

Date: 09/24/21

PATIENT: BRUNSON, DARRYL **DOB:** 08/26/2002 **Gender:** MALE **MRN:** 4963 **AGE:** 19 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Yearly Physical

HISTORY OF PRESENT ILLNESS: The patient is a 19 YOM who is accompanied by his mother. He has a history of asthma, GERD, obesity. He comes today with no complaints. He is sexually active, 3 partners in the past.

VITALS: BP: 133/89 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 97; **Temp:** 98.5; **Resp:** 16; **Ht:** 70 in.; **Wt:** 279.6 lbs.;
BMI: 40.11; **Pulse Oximetry:** 98%

GROWTH PERCENTILES:

Weight/Age: >97

Height/Age: 56

Weight/Height: N/A

BMI/Age: >97

Head Circumference/Age: N/A

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

albuterol sulfate HFA 90 mcg/actuation aerosol inhaler (as directed)

omeprazole 20 mg capsule, delayed release (once daily)

PAST MEDICAL HISTORY: asthma, obesity, GERD

PAST SURGICAL HISTORY: None

SOCIAL HISTORY: Lives at home with parents. Denies smoking, drinking, or illicit drug use. Sexually active. Sometimes uses protection.

FAMILY HISTORY: Father-Diabetes, other: HTN, obesity

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. 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; Nontender; Nondistended. Bowel sounds present x 4 quadrants. No masses or organomegaly noted.

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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:

COMP METABOLIC PANEL (QUEST) (1 unit(s)): Quest Diagnostics
GC AND CHLAMYDIA COLLECTION (1 unit(s)): In-House Lab
HEMOGLOBIN A1c (1 unit(s)): Quest Diagnostics

ASSESSMENT:

E66.9 - OBESITY, UNSPECIFIED (PRIMARY)
Z83.3 - FAMILY HISTORY OF DIABETES MELLITUS
Z82.49 - FAM HX OF ISCHEM HEART DIS & OTH DIS OF CIRC SYS
Z11.3 - ECT SCREEN FOR INFECT W SEXL MODE OF TRANSMISS

PLAN:

Pt here for yearly physical. No complaints. Hx of sexual activity with at least 3 partners. Requests routine STI testing. Will get GC urine today and he will come back for blood work next week. CMP, A1C today due to family history of Diabetes and current obesity. No family history of HLD. Pt agrees, follow up yearly as well as based on lab results. Encouraged to eat a healthy diet, exercise, work on weight loss. Will continue home medications. No new meds today.

Electronically signed by Maranda Fain, CRNP on 09/24/21 3:32 PM

M. Fain, CRNP