

Auburn Montgomery Student Health Services

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

Date: 02/10/22

PATIENT: FAIN, MARANDA **DOB:** 01/20/1989 **Gender:** FEMALE **MRN:** 5020 **AGE:** 33 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Headache and nausea

HISTORY OF PRESENT ILLNESS: Mrs. Fain is a 33 yo female here today with headache intermittently for the past few days. She was recently diagnosed with COVID last week. She has a history of tension headaches that are usually relieved with Duexis. She states these headaches are different. She has noticed sinus pressure, jaw pain, and occasionally her teeth hurt. She reports low grade fever as well and nausea. She has tried tylenol, duexis, and maxalt with no relief.

VITALS: BP: 112/75 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 97; **Temp:** 99.4; **Resp:** 17; **Ht:** 68 in.; **Wt:** 144 lbs.;
BMI: 21.89; **Pulse Oximetry:** 100%; **FDLMP:** 01/31/22

ALLERGIES: Augmentin ((Rash) or (C/O a rash))

MEDICATIONS:

No Known Medications

PAST MEDICAL HISTORY: PCOS

PAST SURGICAL HISTORY: C-section

SOCIAL HISTORY: Married. 2 children. Drinks socially. Denies smoking or illicit drug use.

FAMILY HISTORY: Father- COPD; Mother- healthy

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. Ears- tympanic membranes clear. Ear canals are patent. Nose- septum- midline; + bilateral maxillary tenderness but no 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.

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:

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INFLUENZA (1 unit(s)): In-House Lab
THERAPEUTIC INJECTION ADMIN (3 unit(s)): Injection
Toradol 60 MG (1 unit(s)): Injection
Ondansetron 4mg/ml (1 unit(s)): Injection
Solumedrol 125mg/2ml (1 unit(s)): Injection

RESULTS:

INFLUENZA:

Value: Negative

Toradol 60 MG :

Site Given: Left Ventral Gluteal

Dosage Given: 60 milligram(s)

Administered By: Bicknell, Miranda - RN

Ondansetron 4mg/ml:

Site Given: Right Ventral Gluteal

Dosage Given: 4 milligram(s)

Administered By: Bicknell, Miranda - RN

Solumedrol 125mg/2ml:

Site Given: Right Ventral Gluteal

Dosage Given: 125 milliliter(s)

Administered By: Bicknell, Miranda - RN

ASSESSMENT:

R51.9 - HEADACHE, UNSPECIFIED (PRIMARY)

R11.0 - NAUSEA

PLAN:

Given meds in office. Rest. Follow up as needed or if no improvement. Possibly related to recent COVID infection.

Electronically signed by Lindsey Barton, CRNP on 02/10/22 11:31 AM

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