

Auburn Montgomery Warhawk Health Services

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

Date: 01/09/23

PATIENT: WALKER, DAVID **DOB:** 05/28/1960 **Gender:** MALE **MRN:** 5106 **AGE:** 62 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: left thigh and knee pain

HISTORY OF PRESENT ILLNESS: Mr. Walker is a 62 yo male here today for left knee and left thigh pain since NYE. He was helping a friend down some stairs and lost his balance. He reports he fell about 7 steps down. States pain has progressively gotten worse. He has not taken any otc meds for pain because ibuprofen has caused him to have stomach issues recently. Denies hip pain. He has been wearing a knee brace ever since.

VITALS: BP: 149/98 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 101; **Temp:** 98.3; **Resp:** 16; **Ht:** 66.5 in.; **Wt:** 181.8 lbs.; **BMI:** 28.9; **Pulse Oximetry:** 98%

ALLERGIES: No Known Drug Allergies

MEDICATIONS:

Ozempic 0.25 mg or 0.5 mg (2 mg/1.5 mL) subcutaneous pen injector
diclofenac 1 % topical gel
glimepiride 2 mg tablet
hydrochlorothiazide 12.5 mg capsule (TAKE ONE CAPSULE BY MOUTH ONE TIME DAILY)
lisinopril 20 mg tablet (TAKE ONE TABLET BY MOUTH ONE TIME DAILY)
metformin 1,000 mg tablet
methocarbamol 750 mg tablet
pantoprazole 20 mg tablet,delayed release (TAKE ONE TABLET BY MOUTH ONE TIME DAILY)

PAST MEDICAL HISTORY: T2DM, HTN, chronic joint pain, herniated disc in cervical spine with bilateral arm pain and numbness in left finger tips. He goes to orthopedist in Athens, GA.

PAST SURGICAL HISTORY: right inguinal hernia repair 10 years ago.

SOCIAL HISTORY: Works on campus. Denies smoking, drinking, or illicit drug use.

FAMILY HISTORY:

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

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organomegaly noted.

MUSCULOSKELETAL: Normal range of movement x 4 extremities; 2+ DP and PT pulses bilaterally. + TTP Left mid thigh and left lateral knee. + FROM left knee. Negative valgus/varus. Negative A/P drawers. + able to squat to parallel.

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.

ASSESSMENT:

W19.XXXA - Unspecified fall, initial encounter (PRIMARY)

M79.652 - Pain in left thigh

M25.562 - Pain in left knee

PLAN:

Recommended he go to Baptist Ortho Now as he will need an x-ray and ultimately and ortho referral. He verbalized understanding.

Electronically signed by Lindsey Barton, CRNP on 01/10/23 9:29 AM

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