

PHYSICAL EXAMINATION RECORD CONTINUED:

7-7-14

Kyle Tanager

stated he was bitten by a tick
that was successfully removed.
He requested proper coverage
as wife is receiving from
her physician.

P: Doxycycline 100 mg BID x 10d
Lorazepam, cont

3-20-15

Colchicine

Disp 13 .6 mg

Sig ~~1.2 mg x 1 then~~ $\frac{.6}{.6} \times 1$ then $\frac{.6}{.6}$ an
to mg 1 hr later hour later.

If another attack occurs repeat.

Disp 13 total, no refills. called into
409 0611, Walgreens Brown Springs Road.

S: stated the great toe is
very tender to touch. no
known injury. & anti-
inflammatory meds.

O: the great toe is swollen &

tender & 1st proximal joint

A: benign inflammatory process

P: Ibuprofen 800 mg. p.o. q 8h x 3.

also no relief, Colchicine .6 mg
po repeat q 8h in 1 day (only
once) Lorazepam, cont

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 10/04/04

Name James Kyle Taylor

1. What is the reason for your visit today? TB Skin Test
 2. Is there anything about you and your health that we need to know? No

- *3. List medicine, drugs, or food you are allergic to: NONE
 *4. List any medicines or drugs you take: NONE

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
 stroke

diabetes/sugar
 blood problem or disease
cancer

tuberculosis
 birth defects
 mental retardation

nerve or mental problems
 asthma
 died before age 50
 other "family" disease

6. Have you ever been in the hospital? No Why? _____
 7. Have you ever had surgery? No Why? _____
 8. Have you ever had a serious accident? No
 9. Have you had serious or recent problems with:

ears or throat	<u>NO</u> YES	cough	<u>NO</u> YES	kidneys	<u>NO</u> YES	gallbladder	<u>NO</u> YES
allergies	<u>NO</u> YES	thyroid	<u>NO</u> YES	weight loss	<u>NO</u> YES	liver	<u>NO</u> YES
lung infections	<u>NO</u> YES	skin problems	<u>NO</u> YES	ulcers	<u>NO</u> YES	depression	<u>NO</u> YES
						headaches	<u>NO</u> YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
 11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
 *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
 If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?
 How much smokeless tobacco do you use a day? _____
 *13. How often do you drink beer, wine, wine coolers, or liquor?
 Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
 If you drink beer, wine, wine coolers, or liquor, do you have:
 (less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
 *15. Have you ever used I.V. drugs? NO YES
 16. Have you ever had a blood transfusion? NO YES
 17. Do you have any tattoos? NO YES
 18. Have you ever been treated for a venereal disease? NO YES
 19. Have you had more than one sex partner in the past 5 years? NO YES
 20. Have you ever had sex with a member of your own sex? NO YES
 21. Have you had or been around anyone with hepatitis? NO YES
 22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? _____ Date of your last period? _____
 How often do you have your periods? _____ Are they regular? _____
 How many days do they last? _____
 Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
 B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
 Do you check them regularly? YES NO
 *C. How many times have you ever been pregnant? _____ How many children are living? _____
 Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
 Were any of your children premature? NO YES
 How old were you when your first child was born? _____
 D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;
 diaphragm? NO YES
 E. Did you have problems with any of these methods? NO YES
 F. Have you ever had an abnormal PAP smear? NO YES

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 3/10/08 TIME: 1010 PT. HISTORY REVIEWED / UPDATED 1 / 1

PATIENT NAME: Kyle Taylor DOB: _____ AGE: _____

PRESENT COMPLAINT: (L) eye had some discharge this a.m., slightly itchy. (Pulled out after noticing in shower). No redness. (Person he works with, has an eye that is red). Not bothersome.

MEDICATIONS:

Temp	Pulse	Resp	B/P	HT	WT	LMP:
						Allergies
						<u>NKMA</u>

INITIAL VISIT		RETURN VISIT
Skin		
Sinuses		
Ears		
Eyes	Ø redness, Ø pruritus	
Nose	Ø discharge	
Throat		
Neck/ Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS:	TESTS	RESULTS
<u>(L) eye P discharge</u>		
<u>nasal exam</u>		

PLAN: Ø recurrent RTA

CALL BACK: _____

PRACTITIONER SIGNATURE: [Signature]

STAFF SIGNATURE: [Signature]

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 6/14/07 TIME: 1335 PT. HISTORY REVIEWED / UPDATED 1 / 1
 PATIENT NAME: Kyle Taylor DOB: _____ AGE: _____

PRESENT COMPLAINT: Has strep. Has already diagnosed himself (ran a strep test). Pt feeling light headed, & cough, HA. Rapid strep on sm ⊕, wife. No known penicillin Sore throat from

ALLERGIES: Penicillin LMP: _____

Temp	Pulse	Reso	B/P	HT	WT	Allergies
<u>98.6</u>			<u>138/88</u>			<u>NKMA</u>

INITIAL VISIT		RETURN VISIT
Skin <u>clear</u>		
Sinuses		
Ears		
Eyes		
Nose		
Throat		
Neck/ Back		
Heart		
Lungs		
Abdomen		
GU/GI		
Extremities		

DIAGNOSIS:	TESTS	RESULTS
<u>Strep pharyngitis</u>	<u>Quins Strep</u>	<u>⊕</u>

PLAN: 1) Pen Vee. K 500mg tid X 10 days
2) RTC if not resolving
 CALL BACK: 6/20/07 - let message to call back
6/22/07 Pt. Stopped by clinic, states he is feeling much better at this time.

PENICILLIN VK 500MG
 30 Tablets
 NDC: 51855-010-24
 Lot: H01730808
 Exp: 04/30/2008

PRACTITIONER SIGNATURE: [Signature] STAFF SIGNATURE: [Signature]

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 5-6-13 TIME: 13⁰⁰pm PT. HISTORY REVIEWED/UPDATED: 1 / 1

PATIENT NAME: Kyle Taylor DOB: _____ AGE: _____

PRESENT COMPLAINT: 90% pain @ periumbilical area & ear "popping". 4 fingers, 1 same hand

MEDICATIONS: <u>150</u>					LMP: _____	
Temp <u>98.3</u>	Pulse <u>86</u>	Reso _____	BP <u>150/92</u>	HT _____	WT _____	Allergies <u>N/A</u>

INITIAL VISIT	RETURN VISIT
Skin	
Shinets <u>4 pressure</u>	
Ears <u>4 redness, 4 puff</u>	
Eyes <u>Clear</u>	
Nose <u>patent</u>	
Throat <u>Red, 4 exudate</u>	
Neck/Back <u>4 anterior-posterior</u>	
Heart <u>3'32 5 @</u>	
Lungs <u>Clear 2up</u>	
Abdomen	
GU/GI	
Extremities	

DIAGNOSIS:	TESTS	RESULTS
<u>Narrows car...</u>		
<u>BP elevated</u>		

PLAN: ass symptoms
Limit. RFL
Re v BP 7/27

CALL BACK: _____

PRACTITIONER SIGNATURE: [Signature] STAFF SIGNATURE: _____

AUDIT DATE: _____ COMMENTS: _____

PHYSICIAN SIGNATURE: _____

SERVICES CONSENT FORM

NAME: _____

DATE OF BIRTH: _____

I AM REQUESTING CARE FOR MYSELF OR MY ABOVE NAMED DEPENDENT AND
GIVE MY CONSENT FOR TREATMENT. I AM RESPONSIBLE FOR ALL BILLS
INCURRED AT THE NURSING CARE CENTER.

SIGNATURE: Kyle Taylor

DATE: 10/06/04

SIGNATURE: Kyle Taylor

DATE: 10/6/04

SIGNATURE: Kyle Taylor

DATE: 6/14/07

SIGNATURE: Kyle Taylor

DATE: 3/10/08

SIGNATURE: Kyle Taylor

DATE: 5/6/13

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

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