

Auburn Montgomery Student Health Services

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

Date: 08/18/21

PATIENT: BUCHANAN GURI, PEYTON **DOB:** 04/11/1995 **Gender:** FEMALE **MRN:** S00141091 **AGE:** 26 Years

VISIT TYPE: Office Visit Established

CHIEF COMPLAINT: Follow up with BP log.

HISTORY OF PRESENT ILLNESS: Patient presents to clinic for a follow up with a BP log due to elevated BP at last visit. Home readings are as follows: 8/15/2021: 131/95 and 125/93; 8/16/2021: 130/93 and 133/97; 8/17/2021: 133/93 and 116/92; 8/18/2021: 120/92.

She reports HR is typically elevated around 100-110 bpm at rest per her apple watch. This has been ongoing for about a year now. Denies chest pain, SOB, dizziness, or near syncope.

VITALS: BP: 124/86 **Site:** LEFT ARM **Position:** SITTING **Pulse:** 122; **Temp:** 98.1; **Resp:** 16; **Ht:** 66 in.; **Wt:** 204.3 lbs.; **BMI:** 32.97; **Pulse Oximetry:** 99%; **FDLMP:** 07/28/21

ALLERGIES: Penicillins; amoxicillin

MEDICATIONS:

Adderall 10 mg tablet (1 tablet PO once daily)
Bromfed DM 2 mg-30 mg-10 mg/5 mL oral syrup (TAKE 10 MILLILITERS BY ORAL ROUTE EVERY 6-8 HOURS as needed for cough and congestion.)
Nikki (28) 3 mg-0.02 mg tablet (1 tablet daily)
nortriptyline 10 mg capsule (2 TABS PO QHS for migraines)
omeprazole 20 mg capsule, delayed release

PAST MEDICAL HISTORY: ADHD, migraines

PAST SURGICAL HISTORY: Denies

SOCIAL HISTORY: Denies smoking, drinking, or illicit drug use

FAMILY HISTORY: Denies

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 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:

EKG (1 unit(s)): Office Procedure

ASSESSMENT:

R00.0 - TACHYCARDIA, UNSPECIFIED (PRIMARY)

I10 - ESSENTIAL (PRIMARY) HYPERTENSION

PLAN:

EKG- sinus tachycardia at 110 BPM w/ no ischemic changes.

Referral to cardiology for echo and holter monitor.

Referral: Cooper, Dr. Amy (Cardiology)

Instructions: Echo, holter monitor.

Electronically signed by Lindsey Barton, CRNP on 08/30/21 8:47 PM

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