

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 2/9/15 TIME: 10:00 PT. HISTORY REVIEWED / UPDATED: 1
 PATIENT NAME: Amanda Brasington DOB: 3/23/85 AGE: 29
 PRESENT COMPLAINT: Stuffy nose, sinus pressure => Symptoms times
1 wk but sinus congestions began @ the end of the wk. Tried
Mucinex D, sudafed. Drainage yellow-green. & fever. (+) cough.
 MEDICATIONS: Birth Control, Topomax (migraines). LMP: 2/1/15

Temp	Pulse	Resp	B/P	HT	WT	Allergies
98.7	99		113/81	65.2	159.4	Amaxil

INITIAL VISIT	2/12	RETURN VISIT
Skin <u>W/PI</u>		
Sinuses <u>Maxillary-tender, Frontal-nontender</u>		
Ears <u>(+) fluid & redness</u>		
Eyes <u>clear</u>		
Nose <u>draining green mucous</u>		
Throat <u>& redness, (+) PND</u>		
Neck/ Back <u>adenopathy Bilateral, tender</u>		
Heart <u>RRR</u>		
Lungs <u>CTA</u>		
Abdomen <u>Soft</u>		
GU/GI		
Extremities <u>edema</u>		

DIAGNOSIS:	TESTS	RESULTS
<u>Acute Sinusitis</u>		

PLAN:
 ① Azithromax (2 pack) 250mg x 5d
 ② Prednisone 5mg Dose pack x 6d
 ③ cont. Mucinex DM
 ④ RTZ if no improvement x 1wk

CALL BACK:
 2/10/15 - left message to call 545. (C)
 2/11/15 - Pt. returned call states she is starting to feel better, will continue to take meds as instructed. (C)

PRACTITIONER SIGNATURE: Vannduek/Porter STAFF SIGNATURE: [Signature]

AUDIT DATE: _____ COMMENTS: _____
 PHYSICIAN SIGNATURE: _____

Date

2/1/15

Name

Amanda Brasington

1. What is the reason for your visit today? stuffy nose, sinus pressure
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: Amoxil
4. List any medicines or drugs you take: Birth control, Topamax
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? Yes Why? Gave birth
7. Have you ever had surgery? Yes Why? C-section
8. Have you ever had a serious accident? NO
9. Have you had serious or recent problems with:

ears or throat	NO YES	cough	NO YES	kidneys	NO YES	gallbladder	NO YES
allergies	NO YES	thyroid	NO YES	weight loss	NO YES	liver	NO YES
lung infections	NO YES	skin problems	NO YES	ulcers	NO YES	depression	NO YES
						headaches	NO 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? 12 Date of your last period? 2/1/15
- How often do you have your periods? 1/month Are they regular? YES
- How many days do they last? 5-7
- 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? 1 How many children are living? 1
- 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? 28
- 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