Medical Record

Patient Information:

Name: John Doe

Date of Birth: January 15, 1985

Gender: Male

Patient ID: 123456

Date of Visit: March 8, 2000

Chief Complaint:

Pain in the neck and upper back

History of Present Illness (HPI):

Onset: The pain started approximately 1 month ago.

Location: Cervical region (neck and upper back).

Duration: Persistent, worsening over time.

Characteristics: Dull, aching pain with occasional sharp, shooting pains down the arms.

Aggravating Factors: Prolonged sitting, certain neck movements.

Relieving Factors: Rest, over-the-counter pain medications, gentle neck exercises.

Associated Symptoms: Numbness and tingling in the arms, occasional headaches.

Past Medical History:

Chronic Conditions: Hypertension, Type 2 Diabetes.

Previous Surgeries: Appendectomy (2010).

Medications: Metformin, Lisinopril, Ibuprofen (as needed for pain).

Allergies: No known drug allergies.

Social History:

Occupation: Office worker.

Smoking: Non-smoker.

Alcohol Use: Occasionally.

Exercise: Infrequent.

Family History:

Father: Hypertension, Heart disease.

Mother: Type 2 Diabetes.

Siblings: Healthy.

Review of Systems:

General: No fever, no weight loss.

Musculoskeletal: Pain in the neck and upper back, no other joint pain or swelling.

Neurological: Numbness and tingling in the arms, occasional headaches.

Cardiovascular: No chest pain, no palpitations.

Respiratory: No shortness of breath, no cough.

Physical Examination:

General: Alert, well-nourished, in no acute distress.

Vital Signs:

Blood Pressure: 130/85 mmHg.

Heart Rate: 78 bpm.

Respiratory Rate: 16 breaths/min.

Temperature: 98.6°F (37°C).

Inspection: No obvious deformities, swelling, or redness in the cervical region.

Palpation: Tenderness over the cervical spine, particularly at C4-C6 levels.

Range of Motion: Limited in all directions due to pain.

Strength: 4/5 in the upper extremities.

Reflexes: Normal deep tendon reflexes in the upper extremities.

Sensation: Decreased sensation in the C6 dermatome.

Special Tests: Positive Spurling's test indicating possible cervical radiculopathy.

Assessment:

Primary Diagnosis: Cervical spinal stenosis.

Differential Diagnoses: Cervical spondylosis, herniated disc, cervical radiculopathy.

Plan:

Imaging: Order MRI of the cervical spine to assess the degree of stenosis.

Medications: Prescribe a short course of oral steroids for inflammation, continue ibuprofen for pain management.

Referral: Refer to a neurologist for further evaluation.

Physical Therapy: Recommend physical therapy for neck strengthening exercises and pain management.

Activity: Advise patient to avoid activities that exacerbate pain; recommend ergonomic adjustments at work.

Follow-Up: Schedule follow-up appointment in 4 weeks to review MRI results and assess response to treatment.

Patient Education:

Discussed the nature of the condition, potential causes, and treatment options.

Instructed on proper use of medication and importance of adhering to prescribed therapy.

Encouraged patient to report any worsening symptoms or new concerns.