Medical Specialty:Consult - History and Phy.

Sample Name: Migraine without Aura - Consult

Description: The patient with gradual onset of a headache problem, located behind both eyes.

(Medical Transcription Sample Report)

CHIEF COMPLAINT: Headaches.HEADACHE HISTORY: The patient describes the gradual onset of a headache problem. The headache first began 2 months ago. The headaches are located behind both eyes. The pain is characterized as a sensation of pressure. The intensity is moderately severe, making normal activities difficult. Associated symptoms include sinus congestion and photophobia. The headache may be brought on by stress, lack of sleep and alcohol. The patient denies vomiting and jaw pain.PAST MEDICAL HISTORY: No significant past medical problems.PAST SURGICAL HISTORY: No significant past surgical history.FAMILY MEDICAL HISTORY: There is a history of migraine in the family. The condition affects the patient's brother and maternal grandfather.
ALLERGIES: Codeine.CURRENT MEDICATIONS: See chart.PERSONAL/SOCIAL HISTORY: Marital status: Married. The patient smokes 1 pack of cigarettes per day. Denies use of alcohol.NEUROLOGIC DRUG HISTORY: The patient has had no help with the headaches from over-the-counter analgesics.REVIEW OF SYSTEMS:ROS General: Generally healthy. Weight is stable.
ROS Head and Eyes: Patient has complaints of headaches. Vision can best be described as normal.ROS Ears Nose and Throat: The patient notes some sinus congestion.ROS Cardiovascular: The patient has no history of any cardiovascular problems and denies any present problems.ROS Gastrointestinal: The patient has no history of gastrointestinal problems and denies any present problems.ROS Musculoskeletal: No muscle cramps, no joint back or limb pain. The patient denies any past or present problem related to the musculoskeletal system.
EXAM:Exam General Appearance: The patient was alert and cooperative, and did not appear acutely or chronically ill.Sex and Race: Male, Caucasian.Exam Mental Status: Serial 7's were performed normally. The patient was oriented with regard to time, place and situation.Three out of three objects were readily recalled after several minutes. The patient correctly identified the president and past president. The patient could repeat 7 digits forward and 4 digits reversed without difficulty. The patient's affect and emotional response was normal and appropriate. The patient related the clinical history in a coherent, organized fashion.
Exam Cranial Nerves: Sense of smell was intact.Exam Neck: Neck range of motion was normal in all directions. There was no evidence of cervical muscle spasm. No radicular symptoms were elicited by neck motions. Shoulder range of motion was normal bilaterally. There were no areas of tenderness. Tests of neurovascular compression were negative. There were no carotid bruits.Exam Back: Back range of motion was normal in all directions.Exam Sensory: Position and vibratory sense was normal.Exam Reflexes: Active and symmetrical. There were no pathological reflexes.
Exam Coordination: The patient's gait had no abnormal components. Tandem gait was performed normally.Exam Musculoskeletal: Peripheral pulses palpably normal. There is no edema or significant varicosities. No lesions identified.IMPRESSION DIAGNOSIS: Migraine without aura (346.91)COMMENTS:

The patient has evolved into a chronic progressive course. Medications Prescribed: Therapeutic trial of Inderal 40mg - 1/2 tab b.i.d. x 1 week, then 1 tab. b.i.d. x 1 week then 1 tab t.i.d.OTHER TREATMENT: The patient was given a thorough explanation of the role of stress in migraine, and given a number of suggestions about implementing appropriate changes in lifestyle.RATIONALE FOR TREATMENT PLAN: The treatment plan chosen is the most effective and should result in the most beneficial outcome for the patient. There are no reasonable alternatives.FOLLOW UP INSTRUCTIONS: The patient was instructed to return to the clinic in 3 weeks.