Patient: John Doe
Date of Birth: 1970-01-01
Date of Consultation: 2024-04-24
Referring Physician: Dr. Jane Smith

Reason for Consultation:
Mr. John Doe, a 54-year-old male, presented today with a chief complaint of experiencing a persistent dull ache in his lower right abdomen. He stated that he first noticed this discomfort **approximately two weeks ago** while lifting a heavy box at work. The pain is described as a constant, aching sensation that worsens with any straining or heavy lifting. It does not radiate to any other areas and is not relieved by rest or changes in position. Mr. Doe reports that the pain has been causing him significant discomfort, making it difficult to concentrate at work and disrupting his sleep.

History of Present Illness:
Mr. Doe elaborated on his symptoms, describing the dull ache as a deep, throbbing sensation that seems to intensify after meals. He denied any nausea, vomiting, constipation, or diarrhea. He also denied any fever, chills, or urinary urgency or burning. He clarified that he has not noticed any blood in his stool. Mr. Doe reported that he has not tried any over-the-counter pain medications to manage the discomfort. He denied any recent travel, history of similar abdominal pain, or contact with anyone who might be unwell.

Past Medical History:
Mr. Doe's past medical history is significant for **well-controlled hypertension** that is managed with a daily medication. He has no history of any major surgeries or hospitalizations. He denies any allergies to medications or other substances.

Medications:
Mr. Doe is currently taking **Losartan 50mg daily** for his hypertension. He clarified that he is adherent to his medication regimen and has not started any new medications recently.

Social History:
Mr. Doe is a construction worker and works **full-time, approximately 40 hours per week**. He admits to occasional **social smoking**, typically limiting himself to a few cigarettes on weekends with friends. He denies any history of recreational drug use. He drinks **a moderate amount of alcohol**, typically one or two beers with dinner most evenings.

Family History:
Mr. Doe's family history is significant for his father having been diagnosed with **colon cancer** at the age of 65. There is no other family history of any digestive disorders or abdominal pain syndromes.

Physical Examination:
Upon general examination, Mr. Doe appeared in **no acute distress**. His vital signs were within normal limits, with a blood pressure of 128/80mmHg, heart rate of 78 beats per minute, respiratory rate of 16 breaths per minute, and temperature of 98.6°F.

Abdominal examination revealed mild tenderness in the lower right quadrant upon palpation. There was no guarding or rigidity noted, and bowel sounds were normoactive. No masses or organomegaly were palpable. The rest of the physical examination, including a heart exam, lung exam, and neurological exam, was unremarkable.

Assessment:
Based on the detailed history of persistent right lower quadrant abdominal pain that worsens with straining and is associated with a family history of colon cancer, a preliminary diagnosis of **possible appendicitis** or **inflammatory bowel disease** is considered. However, further workup may be needed to confirm the diagnosis and rule out other possibilities such as a kidney stone or a hernia.