Subjective:

The patient, Justin Lewis, reports a history of anxiety and previous use of Xanax, which was discontinued over 10 years ago. He describes experiencing overthinking, anxiety, and depression during that time. The patient also has a history of alcohol use disorder, with his last relapse occurring after a period of sobriety since August 19th. He mentions a recent four-day alcohol bender and feeling unwell with symptoms such as vomiting, headache, neck and shoulder pain, and sore calves.

Justin expresses concern about a possible seizure, as he woke up halfway off the bed and has no history of seizures. He also reports a recent episode of low blood pressure (90/58), which is unusual for him, as his blood pressure is typically normal. The patient completed a PHP program on Friday and was planning to transition to sober living but relapsed due to being triggered by his roommate's substance use. He is currently unsure about his living situation and plans for detox.

The patient has already seen another nurse practitioner, Lindsay, who ordered medications for nausea, pain, anxiety, and sleep, including melatonin and Vistaril. He is scheduled to meet with Nurse Holly tomorrow for a follow-up.

Objective:

Vital signs: Blood pressure was 90/58 earlier in the day; current blood pressure not mentioned. No dizziness reported.

Physical examination findings: The patient reported headache, soreness in the back of the neck and shoulder blades, and sore calves.

Diagnostic test results: Not mentioned.

Assessment & Plan:

1. Anxiety:

- Patient has a history of anxiety and previous use of Xanax. Currently prescribed hydroxyzine (Vistaril) for anxiety management.

- Plan: Continue hydroxyzine as needed for anxiety. Monitor patient's response to hydroxyzine and adjust dosage if necessary. Encourage patient to engage in counseling and PHP program for additional support.

2. Insomnia:

- Patient has difficulty sleeping and is currently prescribed 10 mg melatonin.

- Plan: Continue melatonin 10 mg at bedtime for sleep. Monitor patient's sleep quality and adjust treatment if necessary. Encourage patient to practice good sleep hygiene and consider non-pharmacological interventions.

3. Alcohol use disorder:

- Patient has a history of alcohol use disorder and recently relapsed after a period of sobriety.

- Plan: Encourage patient to attend detox program and re-engage in PHP program for support in maintaining sobriety. Monitor patient's progress in detox and PHP program. Assess for any additional support or resources needed to maintain sobriety.

4. Hypotension:

- Patient reported an episode of low blood pressure (90/58) without any current medications.

- Plan: Monitor patient's blood pressure regularly. Assess for any potential causes of hypotension and address accordingly. Consider further evaluation if hypotension persists or worsens.

5. Nausea and pain:

- Patient experiencing nausea and pain, possibly related to alcohol withdrawal or hangover.

- Plan: Medications ordered for nausea and pain management. Monitor patient's response to medications and adjust treatment if necessary. Encourage patient to report any worsening or persistent symptoms.

6. Seizure risk:

- Patient expressed concern about the possibility of having experienced a seizure, although no confirmed history.

- Plan: Monitor patient for any signs or symptoms of seizure activity. Consider further evaluation if patient reports or exhibits any seizure-like symptoms. Educate patient on seizure precautions and when to seek medical attention.

Follow-up:

- Patient to meet with Nurse Holly daily for monitoring and support.

- Reassess patient's progress and adjust treatment plan as needed.