Patient: Dekan, Richard W
DOB: 09/11/1960 64 year/M Wt: 215 lb(98 kg) Stated; Ht:
MRN: DEKRI000 PROVIDER: Gale Gregory-Laine, DO
Acct #: 100046 Generated: 04/09/2025 00:07
DOS: 02/03/2025 06:40

PHYSICIAN CHART

CHIEF COMPLAINT:
Eye problem

VITALS HISTORY:
02/03/2025 06:55 Weight:215 lb(98 kg) Stated; Height: BMI:0

02/03/2025
06:55 BP: 131/89 Arm Supine (Automatic) MAP: 103 mmHG, Temp: 98 ºF Oral, HR: 76 Supine Awake , RR: 15, O2 Sat: 98% , Pain: 0/10 (Number scale)

CURRENT MEDICATIONS:
ACYCLOVIR Dose: 400 mg Route: Orally Frequency: Three times a day
LIPITOR Dose: 1 tablet(s) Route: Orally Frequency: Daily
VIAGRA Dose: 1 tablet(s) Route: Orally Frequency: As needed
Medication Reconciliation Completed and Signed by M. Ramirez, RN @ 02/03/2025 06:56:08

ALLERGIES:
Patient or patient family denies any allergies

MODE OF ARRIVAL:
The patient arrived by walk in. Patient arrived unaccompanied.

HISTORY OF PRESENT ILLNESS:
This patient is a 64 year old male who presents with a chief complaint of Eye problem. Provider assessment time was 02/03/2025 06:53 and Comments: left eyelid irritation for 5 days. no visual disturbances. cataract surgery months ago. no problems -[GG@02/03/2025 07:34]. The onset was 5 day(s) prior to arrival. The symptoms are (in the) left eye(s). There has been no eye discharge. The severity of the pain was mild. The patient has experienced no loss of vision. The eye problem developed spontaneously. There has been no foreign body exposure. There has been no chemical exposure. There was no trauma to the eye. There has been no recent URI symptoms, high speed machinery use or welding. There is no history of contact lens use, glaucoma, recent eye operation or other eye disease. There is no history of having had a similar problem in the past. Other History / Staff Note: PATIENT WITH CONCERN FOR 5D OF LEFT EYE, TENDER AND SWOLLEN. NO RECALL FOR TRAUMA BUT WORKS IN A RESTAURANT, NO PAIN, NO FEVERS, HAS NOT TAKEN ANY MEDICATIONS FOR THIS BUT HAS BEEN DOING WARM COMPRESSES WITHOUT RELIEF. -[MW@02/03/2025 06:55].

ROS
CONSTITUTIONAL: Denies any constitutional symptoms.
EYES: Denies any eye problems. Left eyelid swelling and redness, no eye pain -[GG@02/03/2025 07:35].
ENT: Denies any ear problems. Denies any nose problems. Denies any throat problems. Denies any mouth problems.
RESPIRATORY: Denies any respiratory problems.
CV: Denies any cardiovascular problems.
GI: Denies any GI problems.
GU: Denies any GU problems.
NEUROLOGICAL: Denies any neurological problems.

MUSCULOSKELETAL: Denies any musculoskeletal problems.
INTEGUMENTARY: Denies any skin problems.
ALLERGIC/IMMUNOLOGIC: Denies any allergic/immunologic problems.
HEMATOLOGIC: Denies any hematologic problems.
ENDOCRINE: There has been no change in weight. Denies heat or cold intolerance. Denies excessive thirst, hunger, or urination.
PSYCHIATRIC: Denies any psychiatric problems.

PAST MEDICAL HISTORY (PHYS):
No significant Past Medical History.

FAMILY HISTORY (PHYS):
No significant Family History.

SOCIAL HISTORY (PHYS):
No significant Social History.
Habits: No reported alcohol use. No reported illegal drug use.

INITIAL VITALS AT PRESENTATION:
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02/03/2025
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PHYSICAL EXAMINATION
Constitutional: The patient was alert. The patient was not ill-appearing. The patient was in mild distress.
Neck: Negative for anterior, posterior and preauricular cervical adenopathy.
Eyes: The visual acuity was 20/ 30 in the right eye and 20/ 40 in the left eye without correction. Right eyelid(s) negative for redness, warmth, discharge, pustule(s), foreign body, swelling, ecchymosis, tenderness, abrasion(s) and laceration(s). Left eyelid(s) negative for redness, warmth, discharge, pustule(s), foreign body, swelling, ecchymosis, tenderness, abrasion(s) and laceration(s). Everting the lids was negative for redness, pustule, edema and foreign body. Conjunctival exam was negative for redness, ciliary injection, swelling, subconjunctival hemorrhage, foreign body, a pinguecula and a pterygium. There was no discharge present. Corneal exam was negative for abrasion(s), ulcer, cloudiness, haziness, laceration, opacity and foreign body. There was no flourescein uptake. There was no hyphema present. The pupils were reactive and equal extraocular movements were intact.
ENT: The airway was patent. Right tympanic membrane negative for redness, bulging, dullness, retraction and perforation. Left tympanic membrane negative for redness, bulging, dullness, retraction and perforation. The nose was negative for discharge, injection and swelling. Sinus exam was negative for tenderness.
Neurological: The patient was oriented to person, place and time. Memory was intact.
Psychiatric: Affect was appropriate.

DIAGNOSTIC CONSIDERATIONS FOR EYE PROBLEM:
DIAGNOSTIC CONSIDERATIONS: Chalazion, Conjunctivitis, viral, Corneal abrasion, Hordeolum (stye), Orbital cellulitis and Periorbital cellulitis.
(I have considered the above as the potential cause of the patient's condition. I have based my consideration on a limited patient encounter, and my considerations may not be all-inclusive. History, physical examination, and/or diagnostic studies, in combination with medical judgment, have been used

in determining the final diagnosis)

MDM:
Problems Addressed: The patient has no chronic disease processes affecting care.
Reviewed and Analyzed Data: Review of external records included the old records.
Risk of Morbidity: Antibiotic medications were considered but not prescribed: EES OINTMENT -[GG@02/03/2025 08:10].
Disposition Management: Signed by G. Gregory-Laine, DO @ 02/03/2025 08:10:41.

SOCIAL DETERMINANTS:
ECONOMIC STABILITY: Income / Employment: The patient has no income or employment issues. Housing: The patient has no housing issues. The patient has no housing concerns. Food: The patient has no Food Issues. Transportation: The patient has no Transportation Issues. HEALTHCARE:The patient has full access to healthcare. EDUCATION: The patient has no literacy or language issues. SOCIETAL DETERMINATES: Community: The patient has no community issues.

PROVIDER TREATMENT NOTES:

CONSULTATION(S):
HAGAR -[GG@02/03/2025 08:10]

ADDITIONAL NOTES:
Prudent Layperson: Prudent Layperson Standard: The patient has presented with significant concern that an emergency condition exists. The patient is a prudent layperson. The patient is protected under the Prudent Layperson Standard.

ORDERS AND RESULTS:
ED Orders:
Placed Orders:
Visual acuity Placed at 02/03/2025 07:38, GG, DO; Completed at 02/03/2025 07:38, GK, RN
Eye exam set up Placed at 02/03/2025 07:38, GG, DO; Completed at 02/03/2025 07:38, GK, RN
ERYTHROMYCIN (Emycin) 5mg/gm * - 1 inch(es) Ophthalmic Apply to left eye. Placed at 02/03/2025 07:39, GG, DO; Completed at 02/03/2025 07:45, GK, RN

PROCEDURES:
Eye Procedure The eye exam was performed at 02/03/2025 07:10 swelling and redness clear. icteric, red or subconjunctival hemorrhage. The associated symptoms are erythema. The cause of the issue was none uncorrected. The visual acuity for the right eye was 20. The visual acuity for the left eye was 20. The visual acuity for both eyes was 20/20. The left pupil was reactive. Using a woods lamp and fluorescein strips. The examination revealed no abnormalities. The left eye was irrigated. Using 20 ml Syringe. Signed by G. Gregory-Laine, DO @ 02/03/2025 07:48:21

IMPRESSION:
LEFT EYELID SWELLING
PAIN LEFT EYELID
BLEPHARITIS LEFT EYELID
WORRIES - [R45.82]
COUNSELING

return if worsenig x or decrease in vision EYELID SCRUBS BLEPHARITIS VS STYE

DISPOSITION (PHYS):
The disposition time decision was 02/03/2025 07:42.
Discharge.
Discharge: The patient was discharged to home. The patient's condition upon discharge was good. Education was provided to the patient in reference to the final impressions, Diagnostic study results, treatment, prognosis and need for follow up. Based on the medications I am prescribing, I have made any necessary changes to the patients medications.
Instructions given to the patient: A Blank Discharge Instruction and the patient was advised to return if worsening or increasing pain.
Follow up provider: Alprin, Clifford (Family Practice / Primary Care) , 3338 OAKWELL CT , 107 , SAN ANTONIO TX 78218, (210) 822-3646.
Follow up: NONE and , ,.
Follow up: NONE and Hager, Aaron , MD (Ophthalmology) , 3338 OAKWELL CT , 212 , San Antonio TX , (210) 930-2015.
Follow up: Within 1 days.
Prescriptions: ERYTHROMYCIN 0.5% EYE OINTMENT Administer 0.5 inch(es) 3 times a day (TID) Ocular Dispense: 3.5 gm Generic allowed No refills Rx Num 1296342
VIGAMOX 0.5% EYE DROPS Administer 1 drop(s) 3 times a day (TID) Ocular Dispense: 1 bottle(s) Generic allowed No refills Rx Num 1296343
Excuse:
No work starting 2/3/2025. Return on 2/4/2025.

CALL BACK:
Call Back - Closed
Disposition Type Discharged

SIGN OFF:
G. Gregory-Laine, DO
Chart electronically signed by G. Gregory-Laine, DO @ 02/03/2025 08:11:04
M. Williams, MD

ADDENDUM

The Emergency Clinic at Alamo Heights
6496 N New Braunfels Ave, San Antonio, TX 78209
(210) 930-4500

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PHYSICIAN CHART

PHYSICIAN CHART CALLBACK
02/05/2025 07:31 - Daren Hersh
BETTER