Dayton Internal Medicine-Springfield

Test, Hayley

24 Y old Female, DOB: 11/07/1991
Account Number: 17530
4928 BOSART ROAD, SPRINGFIELD, OH-45503
Guarantor: Test, Hayley
PCP: Jennifer M Dyer
Appointment Facility: Dayton Internal Medicine Clinic Inc

08/24/2016 **Progress Notes: UGO NWOKORO, MD**

Current Medications

Taking
- Atenolol 25 mg tablet 1 tablet oral Once a day, Notes: atenolol 25 mg oral tablet
- Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension

Social History

Tobacco Use:
Tobacco Use/Smoking
Are you a *current smoker*
How often do you smoke cigarettes? *every day*
How many cigarettes a day do you smoke? *6-10*
How soon after you wake up do you smoke your first cigarette? *after 60 minutes*
Are you interested in quitting? *Thinking about quitting*
Drugs/Alcohol:
Drugs
Have you used drugs other than those for medical reasons in the past 12 months? *Yes*
Heroin? *Yes noe in treatment*
Alcohol Screen (Audit-C)
Did you have a drink containing alcohol in the past year? *Yes*
How often did you have a drink containing alcohol in the past year? *2 to 4 times a month (2 points)*
How many drinks did you have on a typical day when you were drinking in the past year? *1 or 2 drinks (0 point)*
How often did you have 6 or more drinks on one occasion in the past year? *Never (0 point)*
Points *2*
Interpretation *Negative*

Allergies

Sulfacetamide Sodium

Review of Systems

General/Constitutional:
Patient denies headache, change in appetite, lightheadedness.
Respiratory:
Patient denies cough, wheezing, sputum production, shortness of breath with exertion.

Reason for Appointment

1. Fever
2. Cough

History of Present Illness

Constitutional:
Fatigue all day.
Fever for 2-3 days with chills, low grade.
Night sweats new onset.
Interim History:
Was hospitalized with a diagnosis of pneomonia.

Vital Signs

Temp 101.1 F, HR 112 /min, BP 143/82 mm Hg, Wt 186 lbs, BMI 27.46 Index, Ht 69 in, RR 18 /min, Oxygen sat % 92 %, Ht-cm 175.26 cm, Wt-kg 84.37 kg.

Examination

General Examination:
GENERAL APPEARANCE: alert, , mild distress.
HEAD: normocephalic.
EYES: normal.
EARS: normal.
NOSE: nares patent.
ORAL CAVITY: tongue in midline, gums normal, missing teeth.
THROAT: tonsils red, swollen.
NECK/THYROID: no thyromegaly, trachea midline.
LYMPH NODES: no cervical adenopathy.
SKIN: normal.
HEART: tachycardia, systolic ejection murmur, pericardial friction rub.
LUNGS: good air movement, no wheezes, rales, rhonchi.
CHEST: normal.
BREASTS: not examined.
ABDOMEN: normal.
RECTAL: not examined.
BACK: normal.
FEMALE GENITOURINARY: not examined.
MALE GENITOURINARY: not applicable.
MUSCULOSKELETAL: normal.
EXTREMITIES: no edema.
PERIPHERAL PULSES: 2+ dorsalis pedis.
NEUROLOGIC: nonfocal.
PSYCH: alert, oriented, cognitive function intact, judgement and insight good, judgement and insight good.

Cardiovascular:
Patient denies dizziness, heart problems. Patient complaining of fluid accumulation in the legs.
Hematology:
Patient denies easy bruising. Patient complaining of anemia.

Assessments

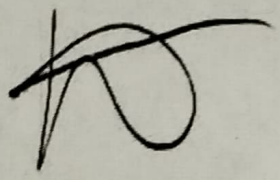
1. Acute pericarditis, unspecified - I30.9 (Primary)

Treatment

1. Acute pericarditis, unspecified
LAB: Autoimmune Profile
Notes: WILL GET EKG
STRESSED SMOKING CESSATION.

Follow Up

4 Weeks



Electronically signed by Ugochukwu Nwokoro , MD on 08/09/2016 at 03:36 PM EDT

Sign off status: Completed

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