Patient Name: Jane Doe
Date of Birth: May 15, 1980
Gender: Female
Race: Caucasian
Medical Record Number: JD123456789

Chief Complaint:
Jane Doe presents to the clinic with a chief complaint of recurrent headaches associated with visual disturbances.

History of Present Illness:
Ms. Doe is a 44-year-old female who reports experiencing headaches for the past six months. She describes the headaches as bilateral, dull pressure-like sensation, primarily located at the temples, with intermittent exacerbations. She notes that the headaches are often preceded by visual disturbances, including shimmering lights and zigzag patterns, lasting approximately 20-30 minutes. The headaches typically resolve spontaneously but leave her feeling fatigued. She denies any associated symptoms such as nausea, vomiting, phonophobia, or photophobia. Ms. Doe states that these headaches occur about twice a week and have been progressively worsening in intensity and frequency.

Past Medical History:

Migraine headaches: Ms. Doe reports a long-standing history of migraines since adolescence, characterized by throbbing unilateral headaches associated with nausea, vomiting, and sensitivity to light and sound. She has not had any formal evaluation or treatment for her migraines in the past.
Hypothyroidism: Ms. Doe has been diagnosed with hypothyroidism for which she takes Levothyroxine 50 mcg daily. She reports good adherence to her medication regimen and denies any recent changes in thyroid function or symptoms of hypothyroidism.
Seasonal allergies: Ms. Doe reports a history of seasonal allergies, primarily manifesting as nasal congestion and sneezing during the spring and fall seasons.
Medications:

Levothyroxine 50 mcg daily
Over-the-counter ibuprofen for headache relief as needed
Allergies:
No known drug allergies

Family History:

Mother: History of migraines
Father: Hypertension, diabetes
Social History:
Ms. Doe is a non-smoker and reports occasional alcohol consumption, approximately 1-2 drinks per week. She works as an office manager and describes her job as predominantly sedentary. She denies any illicit drug use.

Review of Systems:

Constitutional: Reports occasional fatigue but denies fever, chills, or unintentional weight changes.
Neurological: Reports no focal weakness, numbness, or tingling. Denies seizures or changes in consciousness.
Eyes: Reports intermittent blurred vision during migraine episodes but denies double vision or changes in visual acuity.
Ears, Nose, Throat: Denies any ear pain, hearing loss, or throat discomfort. Reports occasional nasal congestion associated with allergies.
Cardiovascular: Denies chest pain, palpitations, or shortness of breath.

Physical Examination:

General: Alert and oriented x3, in no acute distress.
Vital Signs: Blood pressure 120/80 mmHg, heart rate 72 bpm, respiratory rate 16 breaths/min, temperature 98.6°F orally.
Head: Normocephalic, atraumatic. No tenderness to palpation over the scalp or temporomandibular joints.
Neck: Supple, without lymphadenopathy or thyromegaly.
Neurological: Cranial nerves II-XII intact. No focal neurological deficits appreciated.
Fundoscopic exam: Normal optic discs, no evidence of papilledema.
Assessment:

Chronic migraines with aura
Hypothyroidism
Plan:

Initiate prophylactic migraine therapy with amitriptyline 25 mg orally at bedtime. Educate patient on potential side effects including sedation, dry mouth, and weight gain. Advise monitoring for improvement in headache frequency and severity over the next 4-6 weeks.
Schedule follow-up appointment in 4 weeks to assess response to treatment and consider titration of amitriptyline dosage if needed.
Consider neuroimaging (e.g., MRI brain) if there is any change in headache characteristics, onset of focal neurological deficits, or inadequate response to treatment.
Continue Levothyroxine 50 mcg daily for hypothyroidism. Monitor thyroid function tests annually or as clinically indicated.
Recommend lifestyle modifications including stress management techniques, regular exercise, adequate hydration, and avoidance of known migraine triggers (e.g., certain foods, alcohol, irregular sleep patterns).
Patient Education:
Ms. Doe was provided with education materials regarding migraine management strategies, including the importance of maintaining a headache diary to track headache frequency, triggers, and response to treatment. She was also counseled on the role of lifestyle modifications, stress reduction techniques, and the appropriate use of abortive medications for acute migraine relief.