PROGRESS NOTE

Patient Name	Mary Johnson	Patient Number	987654321
Admission Date	January 5, 2025	Discharge Date	

Treatment Summary

Chief Complaint
Severe abdominal pain and nausea for 48 hours.

History of Present Illness
Mary Johnson is a 34-year-old female presenting with a 48-hour history of severe, intermittent abdominal pain localized to the right lower quadrant. She describes the pain as sharp, rated 8/10 at its worst, and worsened by movement or palpation. Associated symptoms include nausea and two episodes of non-bloody vomiting. She denies diarrhea, constipation, or changes in bowel habits.

She reports no fever or chills but states she feels "off." She denies recent travel, changes in diet, or use of over-the-counter medications for the pain. Last menstrual period was three weeks ago, and she denies the possibility of pregnancy.

Past Medical History
1. Migraines, managed with sumatriptan as needed.
2. No history of gastrointestinal or gynecological disorders.

Past Surgical History
Cholecystectomy at age 29.

Family History
1. Mother: Alive, age 62, with hypothyroidism.
2. Father: Deceased at age 67 from colon cancer.
3. Sibling: Brother, age 38, with no significant medical history.

Social History
1. Non-smoker.
2. Occasional alcohol use (1-2 glasses of wine per week).
3. Works as a school teacher.
4. No illicit drug use.

Review of Systems
1. General: Fatigue, no weight loss.
2. Gastrointestinal: Abdominal pain, nausea, and vomiting. No diarrhea or blood in stool.
3. Genitourinary: No dysuria or hematuria.
4. Reproductive: Regular menstrual cycles. No history of pelvic inflammatory disease.
5. Neurological: No headaches or dizziness.

Medications
[redacted] 50 mg as needed for migraines.

Allergies
Penicillin: Rash.

Physical Examination

Vital Signs
1. Temperature: 99.2°F
2. Heart Rate: 92 bpm
3. Respiratory Rate: 16 breaths/min
4. Blood Pressure: 128/76 mmHg
5. Oxygen Saturation: 98% on room air

General
Alert and oriented, appears mildly uncomfortable.

Abdomen
Tenderness to palpation in the right lower quadrant with guarding. Positive rebound tenderness. No palpable masses or organomegaly. Bowel sounds are hypoactive.

Cardiovascular
Regular rate and rhythm, no murmurs.

Respiratory
Clear to auscultation bilaterally.

Extremities:
No edema or cyanosis.

Assessment and Plan

Assessment:
1. Right lower quadrant abdominal pain, likely acute appendicitis.
2. Nausea and vomiting, secondary to abdominal pathology.
3. History of migraines, stable.

Plan:
Diagnostics
1. Order abdominal ultrasound and CT abdomen/pelvis to confirm the diagnosis.
2. CBC and CMP to evaluate for leukocytosis and electrolyte imbalances.
3. Urinalysis to rule out urinary tract infection or nephrolithiasis.
4. Serum beta-HCG to rule out pregnancy.

Treatment
1. NPO status in preparation for possible surgery.
2. Start IV fluids (normal saline) for hydration.
3. Administer IV ondansetron for nausea.
4. Initiate empiric antibiotics (ceftriaxone and metronidazole) after confirming no contraindications.

Referral
Consult general surgery for evaluation and possible appendectomy.

Follow-Up:
Continuous monitoring for any worsening symptoms or signs of peritonitis.

Provider Printed Name	Provider Signature	Date
David Lee, DO	Dr. David Lee	January 5, 2025