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Name: David

Date

DOB

H.T

W.T

Chief Complaint:

History:

Medical History:

Surgical History:

Family History:

Social History:

Allergies:

Medications:

Review of Systems:

Constitutional: Denies weight loss, weight gain, or fatigue. Denies fever, chills, or night sweats.

Heent: Denies headaches, vision changes, hearing loss, nasal congestion, and sore throat. Normal examination findings as described above for head, eyes, ears, nose, and throat.

General: Weight loss, weight gain, or fatigue. Denies fever, chills, or night sweats.

Skin: Denies rashes, itching, or bruising. Skin is warm and dry with normal turgor.

Head: Denies headaches, trauma, or dizziness. Scalp and skull are normal upon.

Eyes: Denies vision changes, redness, or discharge. Pupils are equal, round, and reactive to light and accommodation. Extraocular movements are intact.

Ears: Denies hearing loss, tinnitus, or ear pain. Tympanic membranes are clear with normal landmarks.

Nose: Denies nasal congestion, discharge, or nosebleeds. Nasal passages are clear.

Mouth & Throat: Denies sore throat, difficulty swallowing, or mouth sores. Oral mucosa is moist, and oropharynx is clear without erythema or exudates.

Neck: Denies lumps, swelling, or stiffness. Neck is supple with full range of motion. No lymphadenopathy.

Respiratory: Denies cough, shortness of breath, or wheezing. Breath sounds are clear to auscultation bilaterally. No rales, rhonchi, or wheezes.

Cardiovascular: Denies chest pain, palpitations, or edema. Heart rate and rhythm are regular. No murmurs, rubs, or gallops. Peripheral pulses are intact.

Gastrointestinal: Denies abdominal pain, nausea, vomiting, diarrhea, or constipation. Abdomen is soft, non-tender, and non-distended. Bowel sounds are normal.

Genitourinary: Denies dysuria, hematuria, or urinary frequency. Denies genital lesions or discharge. Normal urination.

Musculoskeletal: Denies joint pain, swelling, or stiffness. Full range of motion in all extremities. No deformities or tenderness.

Neurological: Denies weakness, numbness, or seizures. Cranial nerves II-XII are intact. Strength and sensation are normal. Reflexes are 2+ and symmetrical.

Psychiatric: Denies anxiety, depression, or mood changes. Normal affect and behavior. Oriented to person, place, and time.

Endocrine: Denies polyuria, polydipsia, or heat/cold intolerance. Thyroid is not enlarged.

Hematologic/Lymphatic: Denies easy bruising, bleeding, or lymph node enlargement. No pallor or cyanosis.

Allergic/Immunologic: Denies known allergies. Denies history of frequent infections.

Integumentry: Denies rashes, itching, or bruising. Skin is warm and dry with normal turgor.

Vital Sign:

Date: 2009-12-01 00:00:00

Weight Lbs: Dolore in Nam eaque

Height In: Dolorum nostrud faci

Bmi In: Minus laborum exerci

Body Temp Result F: Tempore consequatur

Physical Exam:

General Appearance:

Head and Neck:

Eyes:

Ears:

Nose:

Mouth & Throat:

Cardiovascular:

Respiratory System:

Abdomen:

Musculoskeletal System:

Neurological System:

Genitourinary System:

Psychosocial Assessment:

ASSESSMENTS/CARE PLAN:

Code: I10.

Description: Essential (primary) hypertension

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Code: I10.

Description: Essential (primary) hypertension

Code: A66.2

Description: Other early skin lesions of yaws

Code: I10.

Description: Essential (primary) hypertension

Code: A18.4

Description: Tuberculosis of skin and subcutaneous tissue

Follow Up:

Follow Up:

- Follow Up with PCP for Further Medical Management
- Follow Up with Psychiatrist

VISIT CODES:

99345; Home/res Visit New Patient 99349 Home Visit Established