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Name: Patient Super 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: 2024-07-09 00:00:00 **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: H01.123

Description: Discoid lupus erythematosus of right eye, unspecified eyelid

Code: C43.122

Description: Malignant melanoma of left lower eyelid, including canthus

Code: A00.0

Description: Cholera due to Vibrio cholerae 01, biovar cholerae

## Follow Up:

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

## **VISIT CODES:**

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