

Eileen Murphy-Sinclair FNP-C NPI# 1598536906 Soul Housing 145 S. Fairfax Ave, Suite 200, Los Angeles, CA 90036

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Name: Hanna Lillith Date	
DOB H.T	
W.T	
Chief Complaint:	
History:	
Medical History:	
Surgical History:	
Family History:	
Talling Flistory.	
Casial History	
Social History:	
Allergies:	
Medications:	
Review of Systems:	
Constitutional:Denies weight loss, weight gain, or fatigue. Denies fever, chills, or night sw	eats.
Heent: Denies headaches, vision changes, hearing loss, nasal congestion, and sore throa	at Normal
examination findings as described above for head, eyes, ears, nose, and throat.	an rionna
CAGITITIATION INTUITINGS AS ACSONDED ABOVE FOR FIEAU, Eyes, Ears, 1103E, AND INTUAL.	
Congrely Weight loop, unight goin, or fetigue Denies forces shills, or right surest-	
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: 1980-01-20 00:00:00

Weight Lbs: Optio ratione omnis

Height In: Dolores quis non duc

Bmi In: Velit amet possimus

Body Temp Result F: Aliquid repudiandae

Physical Exam:

General Appearance: Patient is alert, oriented, and appears well-nourished and well-developed. No apparent distress.

Skin: Skin is warm, dry, and intact with normal color and turgor. No rashes, lesions, or abnormalities noted.

Head: Normocephalic and atraumatic. No tenderness or deformities.

Eyes: Pupils equal, round, and reactive to light and accommodation (PERRLA). Extraocular movements intact. Sclerae are white, conjunctivae are pink, and no discharge or abnormalities noted. Visual acuity normal.

Ears: Ears are symmetrical with no discharge or lesions. Tympanic membranes are intact and pearly gray with good light reflex. Hearing is normal.

Nose: Nasal mucosa is pink and moist. No septal deviation or polyps. No sinus tenderness.

Mouth/Throat: Oral mucosa is pink and moist. Teeth are in good repair. Pharynx is non-erythematous and tonsils are not enlarged. No lesions or abnormalities noted.

Neck: Neck is supple with full range of motion. No lymphadenopathy or masses. Thyroid is non-palpable and without enlargement.

Chest/Lungs: Chest is symmetrical with normal respiratory effort. Breath sounds are clear to auscultation bilaterally. No wheezes, rales, or rhonchi.

Cardiovascular: Heart sounds are normal with regular rate and rhythm. No murmurs, rubs, or gallops.

Peripheral pulses are 2+ and equal bilaterally. No edema noted.

Abdomen: Abdomen is flat and non-tender with active bowel sounds in all quadrants. No masses or organomegaly. No signs of hepatosplenomegaly.

Genitourinary: External genitalia are normal in appearance. No hernias or masses. No tenderness on palpation.

Musculoskeletal: Full range of motion in all joints. No deformities, swelling, or tenderness. Muscle strength is 5/5 bilaterally in all extremities.

Neurological: Alert and oriented to person, place, and time. Cranial nerves II-XII intact. Motor and sensory

functions are normal. Reflexes are 2+ and symmetric. Gait is steady.

Psychiatric: Patient has normal mood and affect. Appropriate behavior. Speech is clear and coherent. No

signs of anxiety or depression.

Endocrine: No thyroid enlargement or tenderness. No signs of hormonal imbalance.

Hematologic/Lymphatic: No palpable lymphadenopathy. No signs of bruising or bleeding.

Allergic/Immunologic: No signs of allergic reactions. Skin tests, if performed, are negative.

ASSESSMENTS/CARE PLAN:

Code: I10.

Description: Essential (primary) hypertension

Code: A51.39

Description: Other secondary syphilis of skin

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