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Name: Hanna Lillith

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.

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

Vital Sign:

Date: 2024-07-10 10:45:00

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:

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