

Name: Kibo Connor Date: 11-Jul-2024 DOB: 19-Mar-2014

Head: May be 4

H.T W.T

Chief Complaint:
History:
Medical History:
Surgical History:
Family History:
Social History:
Allergies:
Medications:
Review of Systems:
Constitutional: May Be `1
Heent: May be 2
General: May be 3
Skin: Denies rashes, itching, or bruising. Skin is warm and dry with normal turgor.

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Eyes: Denies vision changes, redness, or discharge. Pupils are equal, round, and reactive to light and accommodation. Extraocular movements are intact. Mouth\_throat: May be 5 Neck: Denies lumps, swelling, or stiffness. Neck is supple with full range of motion. No lymphadenopathy. Cardiovascular: Denies chest pain, palpitations, or edema. Heart rate and rhythm are regular. No murmurs, rubs, or gallops. Peripheral pulses are intact. 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. Gastrointestinal: Denies abdominal pain, nausea, vomiting, diarrhea, or constipation. Abdomen is soft, nontender, and non-distended. Bowel sounds are normal. Respiratory: Denies cough, shortness of breath, or wheezing. Breath sounds are clear to auscultation bilaterally. No rales, rhonchi, or wheezes. Vital Sign: **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: A01.00 Description: Typhoid fever, unspecified Code: T43.211A Description: Poisoning by selective
serotonin and norepinephrine reuptake inhibitors, accidental (unintentional), initial encounter
Follow Up:
Chief Complaint:
History:
Medical History:
Surgical History:
Family History:
Social History:

## Allergies:

Sint asperiores aut - Finding reported by subject or history provider

## **Medications:**

panadol CF - 01

## **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:
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Physical Exam:
General Appearance: Patient is alert, oriented, and apperas well-nourished adnd well-developed
Head and Neck:
Eyes:
Ears:
Nose:

Mouth & Throat:
Cardiovascular:
Respiratory System:
Abdomen:
Musculoskeletal System:
Neurological System:
Genitourinary System:
Psychosocial Assessment:
ASSESSMENTS/CARE PLAN:
Code: Z3A.12 Description: 12 weeks gestation of pregnancy
Follow Up:
VISIT CODES:
99345; Home/res Visit New Patient 99349 Home Visit Established