John,Smith
DOB: January 20th, 1984
MRN: Unarmed c1
Date of Encounter: June 12th, 2022

Return:
Diagnosis: S/P Right Elbow I&D SEBACEOUS CYST-1 (10000) and INCISION AND REMOVAL OF FB/SUTURES-SIMPLE (10120)
Work Duty: Full duty

History of Presenting Illness
John Smith presents today for first post-op visit up. Since surgery, the patient admits to Falls and Vomiting. He states his pain is not controlled without medication. Pain is graded at level intensity. He is not ambulatory

Examination: John Smith is an awake, alert and oriented male that appears his stated age. He has a pleasant demeanor. He is able to follow commands appropriately. He is in no acute distress.

Vitals:
Ht: 5' 6"
Wt: 130 lbs
BMI: 20.980257
BP: 120 / 80
Pulse: 70
RR: 14
CV: Murmur
Pulm: Crackles

Skin: Incision is
- Drainage

Vascular Exam:
- Radial Pulse 2+
- Brachial Pulse 3+
- Capillary Refill 4+

Sensation Exam:
- Absent sensation - Is tribute on is abset

Strength:

Right	Name	Left
5/5	Elbow Flexion	5/5

Assessment: John Smith is a 38 year old male S/P:

- Right Elbow I&D SEBACEOUS CYST-1
- Right Elbow INCISION AND REMOVAL OF FB/SUTURES-SIMPLE

Plan: Treatment plan includes:

- NSAIDS
- Rest, ice, compression, elevation
- Surgery I&D SEBACEOUS CYST-1
- Suture Removal
- Coban
- Walker

The patient will follow up in . The patient was provided with Coban and Walker. The patient is happy with the plan moving forward.