Smith, John
DOB: January 20th, 1984
MRN: Unarmed c1
Date: June 27th, 2022

Follow-up: in 1 month.
Diagnosis: other spondylosis with radiculopathy, lumbar region (m47.26)

Chief Complaint: Right lower back and left lower back pain

History Of Presenting Illness:
John Smith is a very pleasant 38 year old, left-hand dominant male who works as an engineer. He comes in today complaining of constant and dull, achy, sore pain to his right lower back and left lower back. He states the symptoms have been present since June 1st, 2022, at moderate to severe level intensity and developed suddenly. He admits to injury: "felt pain while tying my shoes.". He states symptoms are worse with driving, standing and pain in bed and get better with rest and heat. He admits to the radiation of symptoms down right leg . He has not received treatment for this issue in the past. He has taken the following medications to help with this condition: TYLENOL (Oral Pill) 500 mg TID

Allergies:
1. Sulfamethoxazole/Trimethoprim (Oral Pill) - Hives
2. SYNTHROID (Oral Pill) - 1234

Medications:
1. amLODIPine/Hydrochlorothiazide/Valsartan (Oral Pill) mg 1x Daily

Past Medical History:
1. Anxiety
2. Kidney disease
3. Seizure disorder

Past Surgical History:
- Tonsillectomy
- ARTHROPLASTY TOTAL KNEE
- NEUROLYSIS CARPAL TUNNEL
- REPAIR EXTENSOR TENDON LE
- REPAIR SHOULD CUFF AVULSI
- Aortic valve replacement

Family History:
Mother's Conditions: blood clots
Fathers's Conditions: heart disease and stroke
Grand Parents Conditions: cancer and stroke
Siblings Conditions: heart disease

Social History:
Occupation: Engineer
Martial Status: single
Smokes: No

Drinks: yes - 1 per sitting/weekly
Hand Dominance: left

Review of Systems:
General: fever or chills and trouble sleeping
Neurological: tingling
Skin: none
Hematologic: none
Musculoskeletal: muscle or joint pain and back pain
Endocrine: none
Psychiatric: none

Physical Examination:
General Examination: John Smith is an awake, alert and oriented male. He appears stated age. He has a pleasent demeanor. He is able to follow instructions. He is in distress. Gait is antalgic.

Vitals:
Ht: 5' 6"
Wt: 130 lbs
BMI: 20.980257
BP: 98.6°F
Pulse: 70
RR: 14
Temp: 98.6°F
CV: Regular rate and rhythm
Pulm: CTAB

Skin Exam positive for:
- Normal

Vascular Exam:

Right	Name	Left
2+	Femoral Pulse	2+
2+	Popliteal Pulse	2+
2+	Dorsalis Pedis Pulse	2+
2+	Posterior Tibial Pulse	2+
2+	Capillary Refill	2+

Neuro Exam:
- Normal sensation distally

The patient has tenderness to palpation at:
- Right Lumbar Musculature

- Left Lumbar Musculature
- L3
- L4

Range of motion:
- Right Hip Flexion 105°
- Left Hip Flexion 120°
- Right Hip Extension 5°
- Left Hip Extension 30°

Strength:

Right	Name	Left
5/5	Hip Flexion	5/5
5/5	Hip Extension	5/5
5/5	Hip Abduction	5/5
5/5	Knee Flexion	5/5
5/5	Knee Extension	5/5

The patient has a positive:
- Straight Leg Raise on the Right
- Pain with Lumbar Flexion on the Right
- Pain with Lumbar Extension on the Right

Distribution Of Radiation:
- S1-Right

Assessment: John Smith is a 38 year old male with:

1. Other spondylosis with radiculopathy, lumbar region (M47.26)

Plan: John Smith presents signs and symptoms consistent with: other spondylosis with radiculopathy, lumbar region (m47.26)

Diagnosis and treatment plan was reviewed with the patient at today's visit. Treatment plan includes:

- Physical Therapy - Lumbar Radiculopathy
- NSAIDS
- Tylenol
- Rest, ice, compression, elevation

The patient will follow up in 1 month.