Smith, John
DOB: January 20th, 1984
MRN: Unarmed
Date: May 13th, 2022

Follow-up: in 1 month
Diagnosis: other spondylosis with radiculopathy, cervical region (m47.22)
Work Duty: Full duty

Chief Complaint: Right side of neck, right shoulder, right posterior arm, and right forearm pain, numbness, weakness, and tingling

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 numbness, weakness, tingling and burning, stabbing pain to his right side of neck, right shoulder, right posterior arm, and right forearm. He states the symptoms have been present since January 1st, 2022, at mild to severe level intensity and developed suddenly. He admits to injury: " felt pain while lifting box". He states symptoms are worse with driving, sleeping, and getting dressed and get better with rest, and medication. He admits to the radiation of symptoms down right arm . 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. Acetaminophen/Codeine (Oral Pill) Hallucinations
2. Penicillin V potassium (Oral Pill) Hives

Medications:
1. ZOCOR (Oral Pill)-9 gram 2x Daily As Needed
2. LEVOXYL (Oral Pill)-7 mcg Once Daily
3. SYNTHROID (Oral Pill)-200 mcg Once Daily As Needed
4. ABILIFY (Oral Pill)-6 mcg 2x Daily As Needed

Past Medical History:
1. anxiety
2. COPD/Emphysema
3. hypertension
4. seizure disorder

Family History:
Mother's Conditions: none
Fathers's Conditions: arthritis
Grand Parents Conditions: cancer, hypertension, and stroke
Siblings Conditions: cancer, hypertension, and stroke

Social History:
Occupation: Engineer
Martial Status: single
Smokes: No
Drinks: No
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: John Smith is an a&o x 3 male that appears equal to the stated age. He has a pleasent demeanor. He is able to follow instructions. He is in no acute distress.

Vitals:

Ht: 5' 10"
Wt: 134 lbs
BMI: 19.224897

Skin Exam positive for:

- Normal

The Patient has tenderness to palpation at:
- Cervical Spine Neck right
- Male Skeletal C Geo

Strength:

Right	Name	Left
4/5	Upper Spine Shoulder Abduction	/5
5/5	Upper Spine Elbow Flexionn	/5
5/5	Upper Spine Elbow Extension	/5
5/5	Upper Spine Hand Grasp	/5
5/5	Upper Spine APB	/5

5/5	Upper Spine FDI	/5
5/5	Upper Spine ADM	/5

Spine Strength:

Name	value
Cervical Spine Flexion	5/5
Cervical Spine Extension	5/5
Thoracic/Lumbar Flexion	5/5
Thoracic/Lumbar Extension	5/5

Reflexes:

Right	Name	Left
2+	Biceps	2+
1+	Triceps	2+

The patient has a positive:

- Spurling on the right Neck
- Pain with Cervical Flexion on the right Neck
- Pain with Cervical Extension on the right Neck

Distribution Of Radiation:

- C6-Right

Diagnostic Studies:

To view x-rays of the cervical spine demonstrate diffuse degenerative changes with disc space narrowing sclerosis and osteophyte formation.

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

1. Other spondylosis with radiculopathy, cervical region (M47.22)

Plan: John Smith presents signs and symptoms consistent with: other spondylosis with radiculopathy, cervical region (m47.22)

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

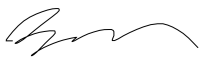
- Physical Therapy - Traction, Modalities, Posture exercices
- NSAIDS
- Tylenol

The patient will follow up in 1 month.

Work Duty:

Full duty

Dr. Ryan, Doctor



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