

**Smith, John**

**DOB:** January 20th, 1984

**MRN:** Unarmed

**Date:** May 27th, 2022

**Follow-up:** in 1 week with X-Rays

**Diagnosis:** none

**Work Duty:** Full duty

**Chief Complaint:** Left side of neck 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 occasional sore pain to his left side of neck. He states the symptoms have been present since May 1st, 2022, at severe to mild level intensity and developed gradually. He denies any injury. He states symptoms are worse with lifting overhead and get better with ice. He admits to the radiation of symptoms . He has received previous treatment. He has taken the following medications to help with this condition: Simvastatin (Oral Pill)

**Allergies:**

1. Acetaminophen/Codeine (Oral Pill) Hallucinations
2. Sulfamethoxazole/Trimethoprim (Oral Pill) Hives
3. Penicillin V potassium (Oral Pill) Hives

**Medications:**

1. ZOCOR (Oral Pill)-9 gram 2x Daily As Needed
2. amLODIPine (Oral Pill) mcg 2x Daily

**Past Medical History:**

1. anxiety
2. COPD/Emphysema
3. hypertension
4. seizure disorder

**Past Surgical History:**

- REPAIR EXTEN. MUSCLE/TEN.
- Knee replacement
- Carpal tunnel release
- REPAIR EXTENSOR TENDON LE
- REPAIR EXTENSOR TENDON LE
- NEEDLE ASPIRATION-ABS/HEMATOMA

**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:** 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 pleasant demeanor. He is able to follow instructions. He is in no acute distress. Gait is antalgic

**Vitals:**

Ht: 5' 6"

Wt: 130 lbs

BMI: 20.980257

BP: 120 / 80

Pulse: 70

RR: 14

CV: Regular rate and rhythm

PL: Crackles

**The Patient has tenderness to palpation at:**

- AC Joint Shoulder right
- Bicipital Groove Shoulder right

**Range of motion:**

- Right Neck Cervical Extension 0°- 15° Left Neck Cervical Extension 0°-40°

**Strength:**

Right	Name	Left
5/5	Upper Spine Shoulder Abduction	5/5

5/5	Upper Spine Elbow Flexion	5/5
5/5	Upper Spine Elbow Extension	5/5
5/5	Upper Spine Hand Grasp	5/5
5/5	Upper Spine APB	5/5
5/5	Upper Spine FDI	5/5
5/5	Upper Spine ADM	5/5
5/5	Shoulder Abduction	5/5
5/5	Shoulder Forward Flexion	5/5
5/5	Shoulder Horizontal Abduction	5/5
5/5	Shoulder Internal Rotation	5/5
5/5	Shoulder External Rotation	5/5

**Spine Strength:**

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

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

**Plan:** John Smith presents signs and symptoms consistent with: none

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

Treatment plan includes:

- Tylenol
- Rest, ice, compress, elevate
- Coban

The patient will follow up in 1 week with X-Rays.

**Work Duty:**

Full duty