Smith, John
DOB: January 20th, 1984
MRN: 789
Date: April 29th, 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 male who presents with the complaint 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, 2020, at mild to severe level intensity and developed suddenly. He admits to injury: " felt pain while lifting a box". He states symptoms are worse with sleeping, getting dressed, and driving 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. SYNTHROID (Oral Pill)-25-mg 2x Daily
2. Simvastatin (Oral Pill)-100 mcg 2x Daily
3. ZOCOR (Oral Pill)-3 mcg 2x Daily As Needed

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

Past Surgical History:
- NEEDLE ASPIRATION-ABS/HEMATOMA
- ARTHROPLASTY TOTAL KNEE
- ARTHROPLASTY TOTAL KNEE
- Hysterectomy
- I&D FURUNCLE
- I&D SEBACEOUS CYST-1
- I&D SEBACEOUS CYST-1
- I&D SEBACEOUS CYST-1

- REPAIR EXTEN. MUSCLE/TEN.
- test name

Family History:
Mother's Conditions: hypertension, and arthritis
Fathers's Conditions: heart disease, cancer, and stroke
Grand Parents Conditions: cancer, hypertension, and stroke
Siblings Conditions: hypertension

Social History:
Occupation: Engineer
Martial Status: single
Smokes: yes - 1 pack/daily
Drinks: yes - 1 per sitting/daily
Hand Dominance: right

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:

BMI: 0.0

Skin Exam positive for:

- Normal

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

Strength:

Right	Name	Left
5/5	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+
2+	Triceps	2+
1+	Brachioradialis	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

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

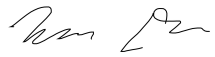
- Physical Therapy - Traction, Modalities, Posture training
- NSAIDS
- Tylenol

The patient will follow up in 1 month.

Work Duty:

Full duty

Dr. Ryan, Doctor



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