EHR Report

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Clinical Report: Recorded Assessment and Supporting Data

Patient: Michael Rodriguez (MRN: 00291837, DOB: 1975-04-22, Male)
Encounter Date: 2025-05-01 (Outpatient)
Clinician: Dr. Aisha Patel

EHR-Recorded Assessment:
The provided EHR explicitly states the clinician's assessment as: **Chronic mechanical low back pain**.

Supporting Clinical Findings (from EHR Data):

*   **Chief Complaint:** Chronic lower back pain.
*   **History of Present Illness:**
    *   Pain present for 3 months (consistent with chronic definition).
    *   Worse when sitting.
    *   No history of trauma.
    *   Absence of numbness/tingling (suggests absence of significant radiculopathy).
*   **Physical Exam (Musculoskeletal):**
    *   Tenderness over L4-L5 region.
    *   Limited forward flexion.
*   **Absence of Red Flags:** No mention of fever, weight loss, night sweats, bowel/bladder dysfunction, saddle anesthesia, or progressive neurological deficits in the provided data, which would raise concern for non-mechanical causes.
*   **Vitals:** Within normal limits (BP 132/84, HR 78, Temp 36.7C, SpO2 98%).
*   **Past Medical History:** Hypertension, Hyperlipidemia (unrelated to current back pain presentation).
*   **Current Medications:** Amlodipine, Atorvastatin.

Clinical Interpretation:
Based on the provided EHR data, the clinician's assessment of "Chronic mechanical low back pain" is well-supported by the patient's history and physical examination findings. The duration of pain (3 months) fulfills the criteria for chronic pain. The description of pain worsening with sitting and the absence of trauma, numbness, or tingling aligns with a mechanical etiology rather than a radicular or inflammatory process. The physical exam findings of L4-L5 tenderness and limited forward flexion are also consistent with musculoskeletal low back pain. The EHR does not contain information to suggest alternative, more serious etiologies (e.g., fracture, infection, malignancy, cauda equina syndrome).

Uncertainty/Missing Information:
*   Specific pain intensity (e.g., 0-10 scale) is not provided.
*   Detailed neurological exam findings (e.g., strength, reflexes, sensation in extremities) are not fully documented beyond the absence of numbness/tingling.
*   Impact of pain on daily activities or functional limitations is not explicitly detailed beyond being "worse when sitting."
*   Previous treatments or response to NSAIDs are not detailed.
*   Imaging results (e.g., X-ray, MRI of the lumbar spine) are not available in the provided EHR, which could offer further insights into structural causes or rule out specific pathologies.