

CONSULTATION NOTE

Date: January 15, 2025

CHIEF COMPLAINT:

Patient presents with persistent headaches over the past 2 weeks.

HISTORY OF PRESENT ILLNESS:

The patient reports bilateral frontal headaches, worse in the morning. No associated nausea, vomiting, or visual changes. Patient has tried over-the-counter analgesics with minimal relief.

REVIEW OF SYSTEMS:

Constitutional: No fever, chills, or weight loss

Neurological: Headaches as above, no focal deficits

PHYSICAL EXAMINATION:

Vital Signs: BP 128/78, HR 72, RR 16, Temp 98.6F

General: Alert and oriented, no acute distress

HEENT: Normocephalic, atraumatic, PERRLA, EOMI

Neurological: CN II-XII intact, no focal deficits

ASSESSMENT AND PLAN:

1. Tension-type headache
 - Trial of prophylactic therapy
 - Stress reduction techniques
 - Follow-up in 2 weeks
2. Rule out secondary causes
 - Order brain MRI if symptoms persist
 - Monitor blood pressure