CONSULTATION NOTE

Date: {{CURRENT_DATE}}
Patient: {{PATIENT_NAME}}
Provider: {{AUTHOR_NAME}}

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