SAMPLE PATIENT RECORDS

The follow "sample patient records" are fictitious. Any possible relation or similarity to real patients is purely incidental.

MR2017002
Date of Service: 02/06/2016

Patient name: Maurine West
Age: 45
Gender/Sex: female
Ethnicity: Caucasian

Height: 69 inches
Weight: 203 lbs
BMI: 30.0
Blood pressure: 158/76
Pulse: 92
Respirations: 18
Temperature: 99.3
Pulse oximetry: 98%

PAST MEDICAL HISTORY
Diabetes mellitus (E11.9)
Hypertension (I10)
Hyperlipidemia (E78.5)
Vitamin d deficiency (E55.9)

CHIEF COMPLAINT
Right upper quadrant pain

History of Present Illness
This 45 year old overweight white female presents with right upper quadrant pain x 3 weeks. Pain is increasingly persistent and now associated with nausea after meals. She has tried OTC bismuth subsalicylate (Pepto-Bismol©), magnesium hydroxide and aluminum hydroxide (Mylanta©) and omeprazole (Prilosec©) without improvement.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain Yes. Fever No. Fatigue No. Loss of appetite Yes. Nausea Yes. Vomiting No.
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Eyes: Vision changes No. Blurred vision No. Double vision No. Seeing spots No.
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No.
Cardiovascular: Chest pain No. Chest pressure No. Shortness of breath No. Irregular heart beat No. Murmurs No.

Respiratory: Coughing No. Difficulty breathing No. Asthma/wheeze No. Coughing up blood No.
Gastrointestinal: Constipation No. Diarrhea No. Heart burn Yes. Bloody stools No. Pain in stomach Yes. Ulcers No. Hepatitis No.
Genitourinary: Painful urination No. Frequent urination No. Bloody urine No. Kidney stone No. Incontinence No. Loss of libido No. Sexual difficulty No. Infection No.
Women: Irregular periods No. Premenstrual depression No. Hot flashes No. Menstrual cramps No. Vaginal discharge No. Nipple discharge No. Breast lumps No..

PHYSICAL EXAMINATION
General. The patient is well developed, morbidly obese and in no acute distress.
HEENT - Normocephalic, no lesions, PERRLA, EOM's full.
Neck - Supple, no masses or swelling.
Chest - Normal respiratory effort. Normal expansion.
Heart - Heart rate is normal. Regular rhythm.
Abdomen - Soft, non-distended. Bowel sounds are normoactive. Tenderness to palpation RUQ.
Skin - No rashes, no lesions noted.
Extremities - No clubbing, cyanosis; there is trace edema bilateral lower extremities.
Psychiatric - Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
None available for review

ASSESSMENT
Abdominal pain (R10.9)
Cholelithiasis (H80.00)

PLAN
Prescription(s) provided today for:
Omeprazole (Prilosec) 20mg tab, 1 QD #30
Ursodial (Actigall) 300mg TID #90

Diagnostics Ordered.
Obtain abdominal ultrasound, RUQ. US is clinically supported and medically indicated to assess for intraabdominal pathology. *Prescription provided today.*
Labs: Complete metabolic panel (CMP), CBC with differential.

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
4 weeks, review US results.

MR2017003
Date of Service: 02/16/2016

Patient name: Katherine Flake
Age: 58
Gender/Sex: female
Ethnicity: caucasian

Height: 65 inches
Weight: 128 lbs
BMI:
Blood pressure: 108/68
Pulse: 76
Respirations: 16
Temperature: 97.8
Pulse oximetry: 98%

PAST MEDICAL HISTORY
Hypertension (I10)
Asthma (J45.909)
Vitamin d deficiency (E55.9)
Osteoporosis (M81.0)

CHIEF COMPLAINT
UTI

History of Present Illness
This 58 year old white female of thin stature presents with symptoms of urinary tract infection. She reports burning pain with urination x 2 days.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain No. Fever No. Fatigue No. Loss of appetite No. Nausea No. Vomiting No.
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Eyes: Vision changes No. Blurred vision No. Double vision No. Seeing spots No.
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No.
Cardiovascular: Chest pain No. Chest pressure No. Shortness of breath No. Irregular heart beat No. Murmurs No.
Respiratory: Coughing No. Difficulty breathing No. Asthma/wheeze No. Coughing up blood No.
Gastrointestinal: Constipation No. Diarrhea No. Heart burn Yes. Bloody stools No. Pain in stomach Yes. Ulcers No. Hepatitis No.
Genitourinary: Painful urination Yes. Frequent urination Yes. Bloody urine No. Kidney stone No. Incontinence No. Loss of libido No. Sexual difficulty No. Infection No.

PHYSICAL EXAMINATION
General. The patient is well developed, of thin stature and in no acute distress.
Neck - Supple, no masses or swelling.
Chest - Normal respiratory effort. Normal expansion.
Heart - Heart rate is normal. Regular rhythm.
Abdomen - Soft, non-distended, non-tender
Skin - No rashes, no lesions noted.
Extremities - No clubbing, cyanosis, edema
Psychiatric - Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
Urine dipstix – Positive for WBC, RBC, bacteria and Nitrates
ASSESSMENT
UTI (N39.0)

PLAN
Prescription(s) provided today for:
Cipro 500mg, 1 tab po BID x 3 days #6 tabs

Diagnostics Ordered.
Send urine specimen for Urinalysis and Urine C&S.

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
2 months

MR2017004
Date of Service: 02/16/2016

Patient name: Harriet Moore
Age: 67
Gender/Sex: female
Ethnicity: black

Height: 67 inches
Weight: 166 lbs
BMI:
Blood pressure: 167/88
Pulse: 76
Respirations: 20
Temperature: 97.9
Pulse oximetry: 94%

PAST MEDICAL HISTORY
Diabetes mellitus (E11.9)
Hypertension (I10)
Hyperlipidemia (E78.5)
COPD (J44.9)

CHIEF COMPLAINT
High blood pressure

History of Present Illness
This 67 year old obese black female presents with high blood pressure. She is currently taking amlodipine 5mg QD and HCTZ 12.5mg QD.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain No. Fever No. Fatigue No. Loss of appetite No. Nausea No. Vomiting No.
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Eyes: Vision changes No. Blurred vision No. Double vision No. Seeing spots No.
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No.
Cardiovascular: Chest pain No. Chest pressure No. Shortness of breath No. Irregular heart beat No. Murmurs Yes.
Respiratory: Coughing No. Difficulty breathing No. Asthma/wheeze No. Coughing up blood No.
Gastrointestinal: Constipation No. Diarrhea No. Heart burn Yes. Bloody stools No. Pain in stomach Yes. Ulcers No. Hepatitis No.
Genitourinary: Painful urination No. Frequent urination no. Bloody urine No. Kidney stone No. Incontinence No. Loss of libido No. Sexual difficulty No. Infection No.

PHYSICAL EXAMINATION
General. The patient is well developed, obese and in no acute distress.
Neck - Supple, mild left thyromegaly.
Chest - Normal respiratory effort. Normal expansion.
Heart - Heart rate is normal. Regular rhythm, grade 2 systolic murmur.
Abdomen – Soft, non-distended, non-tender
Skin – No rashes, no lesions noted.
Extremities – No clubbing, cyanosis, edema
Psychiatric – Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
(01/14/2016) 12-lead ECG: NSR, significant for left ventricular hypertrophy.

ASSESSMENT
Hypertension (I10)
Thyroid goiter (E04.9)

PLAN
Prescription(s) provided today for:
Increase amlodipine 10mg QD. #30 tabs refill x 3
Increase HCTZ 25mg QD. #30 tabs refill x 3

Diagnostics Ordered.
Obtain thyroid ultrasound. Prescription provided.

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
4 weeks, HTN

MR2017005
Date of Service: 05/09/2016

Patient name: Janice Jenkins
Age: 52
Gender/Sex: female
Ethnicity: black

Height: 64 inches
Weight: 176 lbs
BMI:
Blood pressure: 156/76
Pulse: 102
Respirations: 18
Temperature: 98.4
Pulse oximetry: 98%

PAST MEDICAL HISTORY
Asthma (J45.909)
COPD (J44.9)
Vitamin d deficiency (E55.9)
Osteoporosis (M81.0)
Rheumatoid arthritis, left hand (M05.6042)

CHIEF COMPLAINT
Shortness of breath
Pain, left hand

History of Present Illness
This 52 year old black female with long-standing asthma presents increased shortness of breath x 2 weeks. She is also complaining of increased pain in the left hand.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain No. Fever No. Fatigue No. Loss of appetite No. Nausea No. Vomiting No.
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Eyes: Vision changes No. Blurred vision No. Double vision No. Seeing spots No.
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No.
Cardiovascular: Chest pain No. Chest pressure Yes. Shortness of breath No. Irregular heart beat No. Murmur No.
Respiratory: Coughing Yes. Difficulty breathing No. Asthma/wheeze Yes. Coughing up blood No.
Gastrointestinal: Constipation No. Diarrhea No. Heart burn No. Bloody stools No. Pain in stomach No. Ulcers No. Hepatitis No.

Musculoskeletal: Loss of muscle size No. Muscle tenderness or Pain No. Painful joints Yes. Joint stiffness Yes.

PHYSICAL EXAMINATION
General. The patient is well developed, obese and in no acute distress.
Neck - Supple, no mass or lesions
Chest – Increased respiratory effort. Reduced excursion.
Heart - Heart rate is increased (102). Regular rhythm
Abdomen – Soft, non-distended, non-tender
Skin – No rashes, no lesions noted.
Extremities – No clubbing, proximal IPJ deformities left 2nd and 3rd digits.
Psychiatric – Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
(01/14/2016) Pulmonary Function Test (PFT)

	LOWER LIMIT OF NORMAL	PRE-BRONCHO-DILATOR	% OF PREDICTED VALUE
Forced vital capacity (FVC)	2.21 L	2.42 L	83%
Forced expiratory volume in 1 second (FEV_1)	1.84 L	1.52 L	63%
FEV_1/FVC ratio		58.2%	
Forced expiratory time	73.4%	11.2 sec	

ASSESSMENT
Asthma, exacerbation (J45.909)
Rheumatoid arthritis, left hand (M05.6042)

PLAN
Prescription(s) provided today for:
albuterol HFA (Ventolin©) inhaler 2 puffs q6h prn shortness of breath #1
montelukast (Singulair©)10mg tab, 1 QHS #30
tiotropium bromide (Spiriva)18mcg/Handihaler,1capdaily (inhale 2 puffs per capsule)
vilanterol fluticasone (Breo-Elipta©) 100-25 mcg,1 puff daily
predisone (Medrol© dose pack) 4mg, take as directed

Diagnostics Ordered.
X-ray left hand, AP and lateral views
Labs – CBC, Westergren sed rate, C-Reactive Protein, RA latex, Lyme titre with PCR, Consult Rheumatology

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
4 weeks

MR2017006
Date of Service: 02/07/2016

Patient name: Antonio Perez
Age: 74
Gender/Sex: male
Ethnicity: latino

Height: 63
Weight: 188 lbs
BMI: 33.3
Blood pressure: 138/68
Pulse: 84
Respirations: 18
Temperature: 97.7
Pulse oximetry: 98%

PAST MEDICAL HISTORY
Neck back pain (M54.2)
Diabetes mellitus with neuropathy (E11.21)
Hypertension (I10)
Heart failure (I50.9)
Hyperlipidemia (E78.5)

CHIEF COMPLAINT
Neck pain

History of Present Illness
This 74 year old latino male presents with neck pain of the past 3 months. He works in culinary arts. He has been taking Naprosyn 500mg BID. He describes the pain as constant, dull, aching, and stiffness. He rates the pain on VAS as 7/10. The pain is associated with sharp, shooting pain with numbness and tingling in the right upper extremity and headaches in the right occipital region.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain No. Fever No. Fatigue No. Loss of appetite No. Nausea No. Vomiting No..
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Neurology: Numbness No. Tingling No. Lightheaded/dizziness No. Fainting No. Weakness No. Tremor No. Seizure No. Memory loss No..
Eyes: Vision changes No. Blurred vision No. Double vision No. Seeing spots No..
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No..
Cardiovascular: Chest pain No. Chest pressure No. Shortness of breath No. Irregular heart beat No. Murmurs Yes..

Respiratory: Coughing No. Difficulty breathing No. Asthma/Wheezing No. Coughing up blood No..
Gastrointestinal: Constipation No. Diarrhea No. Heart burn No. Bloody stools No. Pain in stomach No. Ulcers No. Hepatitis No..
Musculoskeletal: Loss of muscle size No. Muscle tenderness or Pain Yes. Painful joints Yes. Joint stiffness No..
Psychiatric: Depression No. Anxiety Yes. Panic attacks No. OCD Yes. Manic episodes No. Bipolar No. Homicidal thoughts No. Suicidal thoughts No. Hallucination No. Pyschosis No. Other No..
Men: Burning on urination No. Dripping after urination No. Prostate problems No. Difficulty starting urination No. Loss Libido/Sex drive No. Loss frequency/firmness of erections No..

PHYSICAL EXAMINATION
Cervical Spine - There is tenderness on palpation noted in the cervical paraspinal muscles, including sternocleidomastoid, splenius capitus, splenius cervicis, upper trapezius, levator scapulae, rhomboid minor, supraspinatus. There is tenderness to palpation along the cervical facet processes. There is pain and trigger point formation present in the bilateral trapezius muscle groups, right levator scapulae and right rhomboid minor There is pain and restricted cervical ROM, with reduction in flexion, extension and lateral side-bending with pain that is approximately 10 to 15%.
Spurling's Test (Cervical Compression Test). Positive, right. There is increased pain and radicular symptoms elicited when the volar aspect of both hands are applied on top of the patient's head followed by passive lateral flexion of the patient's neck 30 degrees (cephalo-caudal pressure) to the affected side and then a downward axial compression.
Thoracic Spine - full range of motion in all planes. There is no pain on thoracolumbar rotation.
Neurological.
Cranial nerves - Cranial nerves II-XII intact. No asymmetry noted.
Motor - Strength is 4/5 in right upper extremity.
Sensory - Tactile sensation is intact to light touch.
Reflexes, upper - Biceps (C5) and brachioradialis (C6) nerve roots, triceps reflex (C6, C7) nerve roots, deep tendon reflex is 1+ diminished, right.
General. The patient is well developed, well-nourished, and in no acute distress.
HEENT - Normocephalic, no lesions, PERRLA, EOM's full.
Neck - Supple, no masses or swelling.
Chest - Normal respiratory effort. Normal expansion.
Heart - Heart rate is normal. Regular rhythm. Grade 3 systolic murmur.
Abdomen - Soft, non-tender, non-distended.
Skin - No rashes, no lesions noted.
Extremities - No clubbing, cyanosis, or edema.
Psychiatric - Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
01/26/2016 X-ray cervical spine
No fracture. Degenerative changes noted. Straightening of normal cervical lordosis.

ASSESSMENT

Neck pain (M54.2)
Cervical radiculopathy (M54.12)
Muscle pain and spasm (M62.830)

PLAN
Opioid Management.
Opioid management was discussed with the patient today. Opioid agreement was reviewed with the patient, and patient understands pain medications may only be prescribed by one provider, including ED visits. Medications will not be written early for lost or stolen medication. The patient agrees to remain compliant with all treatments and recommendations. Urine drug testing will be monitored. Opioid pain medications are being prescribed in good faith for pain control necessary to maintain physical function and quality of life. Failure to comply with opioid agreement or use of a controlled and dangerous substance in any way other than prescribed is considered a violation of the pain management agreement and is reason for termination from the practice.

Potential side effects were discussed at length as well as risk for abuse and dependency. All medications prescribed are to be used solely by the patient. Any diversion of medication is also reason for termination from the practice. The patient was advised against driving while on opioid pain medications or using heavy equipment until the effects are well known to the patient. The findings, medications, impression, and treatment plan were discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

The patient was educated on proper storage, disposal and safe keeping of controlled and dangerous substances. NJ Prescription monitoring program (NJPMP) was utilized to obtain the patient's prescribed controlled and dangerous substance use history. No inconsistencies were noted. Relevant questioning of the patient revealed no current issues of aberrancy, diversion, or addiction. Any side effects of the medication have been addressed with the patient, including constipation. The patient acknowledges that the(se) medication(s) have helped to maintain basic activities of daily living and physical function. Emphasis was placed on preventing or reducing the risk for drug tolerance, abuse and dependence. Continued analgesia for pain control remains medically necessary and clinically supported to maintain activities of daily living.

Prescription(s) provided today for:
Tramadol 50 mg tab, q6h prn pain (#30 tabs)
Continue naproxyn sodium 500mg BID #60
Cyclobenzaprine 10mg QHS #30

Therapy and Alternative Treatments.
Recommend physical therapy referral for evaluation and treatment of the cervical and lumbar spine 2-3 times per week x 4 weeks, with focus on improving cervical spine ROM, stabilization, strength and condition of internal and external oblique, and posterior paraspinal musculature; lumbar spine ROM, core muscle activation, strength and conditioning of the mutltifidi, internal/external oblique musculature and posterior serrape. Include core plank/bridge program

and gluteus medius, gluteus maximus strengthening. Progress as tolerated. *Prescription provided today.*

Diagnostics Ordered.
Obtain of the MRI cervical spine. Despite conservative treatment, pain has persisted > 6 weeks and is limiting the patient's functional capacity. MRI is clinically supported and medically indicated to assess for intraspinal pathology. Prescription provided today.

Obtain EMG/NCV of the right upper extremity. The study is clinically supported and medically indicated to assess for radiculopathy vs. neuropathy and to ascertain temporal, diagnostic and prognostic information related to injury and symptom complex. Prescription provided today.

Pending response to physical therapy and results of diagnostic imaging - May benefit from cervical epidural steroid injection (CESI). Clinical findings are consistent with radiculopathy. Recommend CESI under fluoroscopic guidance to decrease pain and improve function. Also, the injection provides both diagnostic and therapeutic value. Injection risks, benefits, and alternative were discussed. *Patient to consider.*

Therapy and Alternative treatments.
Recommend physical therapy referral for evaluation and treatment of the cervical and lumbar spine 2-3 times per week x 4 weeks, with focus on improving cervical spine ROM, stabilization, strength and condition of internal and external oblique, and posterior paraspinal musculature; lumbar spine ROM, core muscle activation, strength and conditioning of the mutltifidi, internal/external oblique musculature and posterior serrape. Include core plank/bridge program and gluteus medius, gluteus maximus strengthening. Progress as tolerated. *Prescription provided today.*

Recommend trigger point injections (TPI) to the paraspinals muscles for both diagnostic and therapeutic pain reduction and improve physical function.

Recommend acupuncture evaluation and treatment to modulate pain and improve ROM, to include neurofunctional acupuncture with electrostimulation. *Patient to consider.*

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
2 weeks, meds, repeat TPI as indicated

Office Procedure Completed Today.

Trigger point injection.
CPT 20552 (1 to 2 muscle groups).

Informed Consent.
Risks, benefits and hazards including vasovagal syncope, skin infection, pneumothorax, needle breakage, hematoma formation and alternative therapies discussed with the patient and verbal/written consent obtained.

Description of Procedure.
Patient was placed in the prone position. Trigger point formation over the right trapezius, levator scapulae and rhomboid minor muscle groups were identified and confirmed by the presence of a local twitch with referred pain. The area(s) over each myofascial spasm was prepped with an alcohol swab. Each individual trigger point was isolated between two palpating fingertips. A 3-mL syringe with a 25g x 5/8 inch needle was inserted at a 30-degree angle into the center of the myofascial spasm. Negative aspiration was performed. A total of 0.5 mL of 0.25% bupivacaine was injected into each trigger point followed by direct acupressure technique to improve myofascial release, reduce the risk for and prevent possible hematoma formation.

Post Procedure.
The patient tolerated the procedure well without any apparent difficulties or complications. The patient demonstrated improved range of motion, 100% myofascial release, and 90% pain reduction. The patient was reminded about possible post-injection soreness and possible rebound spasm and reminded to maintain active range of motion of the injected muscle, but to avoid over-use of the injected area for the next 2 to 3 days. The patient was encouraged to use warm, moist and gentle stretching as part of a routine pain management program to prevent and reduce further myofascial spasm and trigger point formation.

MR2017007
Date of Service: 02/06/2016

Patient name: Brenda Shutts
Age: 28
Gender/Sex: female
Ethnicity: caucasian

Height: 64inches
Weight: 132 lbs
BMI: 22.7
Blood pressure: 118/66
Pulse: 74
Respirations: 16
Temperature: 97.9
Pulse oximetry: 100%

PAST MEDICAL HISTORY
Vitamin D deficiency (E55.9)
Migraine (G43.109)

CHIEF COMPLAINT
Headache/migraine

History of Present Illness
This 28 year old white female with long-standing history of migraines present with headache and associated nausea and vision changes. She is in need of medication refills.

REVIEW OF SYSTEMS
General: Weight loss No. Weight gain No. Fever No. Fatigue No. Loss of appetite Yes. Nausea Yes. Vomiting No.
Skin: Skin problem No. Rash No. Psoriasis No. Slow healing No. Easy bruising No. Itching No..
Eyes: Vision changes Yes. Blurred vision Yes. Double vision No. Seeing spots No.
ENT: Ear pain No. Hearing loss No. Ringing in ears No. Nose bleed No. Sore throat No. Hoarseness No. Dental problems No.
Cardiovascular: Chest pain No. Chest pressure No. Shortness of breath No. Irregular heart beat No. Murmurs No.
Respiratory: Coughing No. Difficulty breathing No. Asthma/wheeze No. Coughing up blood No.
Gastrointestinal: Constipation No. Diarrhea No. Heart burn Yes. Bloody stools No. Pain in stomach Yes. Ulcers No. Hepatitis No.
Women: Irregular periods Yes. Premenstrual depression No. Hot flashes No. Menstrual cramps No. Vaginal discharge No. Nipple discharge No. Breast lumps No..

PHYSICAL EXAMINATION
General. The patient is well developed, morbidly obese and in no acute distress.
HEENT - Normocephalic, no lesions, Pupils unequal, right < 2 mm, left 3 to 4 mm, EOM's full.

Neck - Supple, no masses or swelling.
Chest - Normal respiratory effort. Normal expansion.
Heart - Heart rate is normal. Regular rhythm.
Abdomen - Soft, non-distended, non-tender. Bowel sounds are normoactive.
Skin - No rashes, no lesions noted.
Extremities - No clubbing, cyanosis; there is trace edema bilateral lower extremities.
Psychiatric - Alert and responsive, normal cognition and judgement. Pleasant affect.

Diagnostics.
CT Brain/Head (12/22/2015) No evidence of mass, lesion or hydrocephalus. Negative for vascular or soft tissue abnormality.

ASSESSMENT
Migraine (G43.109)

PLAN
Prescription(s) provided today for:
Ibuprofen 800mg TID prn headache #90 refill x 3
Sumatriptan (Imitrex) 25mg tab Q2h prn x 4 for migraine (mas 100mg/day) #12 tabs/30-days, refill x 3

The findings, medications, impression, and treatment plan was discussed at length with the patient today, including risks, benefits, alternatives, and rationale for the treatment plan. The patient agrees with the plan of care.

Follow up.
4 months