

# DEMO REPORT

Patient Name: John Doe

Date of Exam: 02/05/2023

Chief Complaint: The patient presented with complaints of headaches, fatigue, and decreased energy levels. History of Present Illness: The patient reported experiencing headache for the past 2 weeks, accompanied by fatigue and decreased energy levels. The headaches are described as throbbing in nature and located in the frontal region, lasting for approximately 4 hours a day. The patient also reported feeling excessively tired and lacking energy, making it difficult to carry out daily activities. No associated symptoms like nausea, vomiting, or sensitivity to light or sound were reported. Past Medical History: The patient has a history of hypertension and is currently on medication. No history of migraines, head injuries or any other neurological conditions was reported. Physical Exam: Vital Signs: Blood Pressure: 130/80 mmHg, Pulse: 72 beats/minute, Respirations: 18 breaths/minute, and Body Temperature: 97.7°F Head: No visible swelling or deformities. The frontal and temporal regions are non-tender on palpation. Eye: Pupils are equal, round, and reactive to light. No evidence of nystagmus or diplopia. Ear: Tympanic membranes are intact, with normal mobility and no evidence of fluid behind the eardrums. Nose: No evidence of any nasal discharge or congestion. Throat: Pharynx is clear, with no erythema or exudates. Diagnostic Studies: A CT scan of the head was performed, which showed no evidence of any intracranial abnormalities. Impression: The patient's presentation is consistent with a primary headache disorder, most likely tension-type headache. Plan: The patient was advised to stay hydrated, maintain good sleep hygiene, and practice relaxation techniques. Over-the-counter pain relievers were prescribed for symptom relief. The patient was also advised to follow-up in 2 weeks or earlier if symptoms worsen.

Signature: Dr. Jane Doe, M