MEDICAL EXAMINATION REPORT

Patient Information:

Name: John Doe

Date of Birth: 03/15/1985

Age: 39 years

Gender: Male

Patient ID: PT-89456

Date of Examination: January 15, 2025

Time: 4:45 PM

Referring Information:

Referring Physician: Emergency Department

Reason for Visit: Motor vehicle accident - rear-end collision

Insurance Claim: CLM-2025-001

Chief Complaint:

Patient presents with neck pain, headache, and lower back discomfort following motor vehicle accident earlier today.

History of Present Illness:

39-year-old male involved in rear-end collision while stopped at intersection. Patient's vehicle was struck from behind. Patient reports immediate onset of neck stiffness and pain radiating to shoulders. Denies loss of consciousness. Denies numbness or tingling in extremities.

Vital Signs:

Blood Pressure: 128/82 mmHg

Heart Rate: 76 bpm

Respiratory Rate: 16 breaths/min

Temperature: 98.4°F (36.9°C)

Oxygen Saturation: 98% on room air

Physical Examination:

GENERAL: Alert and oriented x3. In mild distress due to pain.

HEAD: Normocephalic, atraumatic. No visible contusions.

NECK: Tenderness to palpation of cervical paraspinal muscles bilaterally.
Reduced range of motion with flexion, extension, and rotation.
No midline tenderness. No step-offs.

BACK: Tenderness in lumbar region. Normal alignment.

NEUROLOGICAL: Cranial nerves II-XII intact. Motor strength 5/5 in all extremities. Sensation intact. Reflexes 2+ and symmetric.

Diagnostic Studies:

X-Ray Cervical Spine (3 views): No fracture or dislocation identified. Normal alignment maintained.

X-Ray Lumbar Spine (2 views): No acute fracture. Normal disc spaces.

Diagnosis:

1. Cervical strain (whiplash injury) - ICD-10: S13.4
2. Lumbar strain - ICD-10: M54.5
3. Post-traumatic headache - ICD-10: G44.309

Treatment Plan:

1. Muscle relaxants: Cyclobenzaprine 10mg PO TID x 7 days
2. Pain management: Ibuprofen 600mg PO TID with food
3. Ice therapy: 20 minutes every 2-3 hours for first 48 hours
4. Physical therapy: Referred for 6 weeks of therapy, 2x per week
5. Soft cervical collar for comfort as needed
6. Activity: Light duty, avoid heavy lifting (>10 lbs) for 2 weeks
7. Follow-up: 1 week or sooner if symptoms worsen

Work Status:

Modified duty for 2 weeks. Re-evaluate at follow-up.

Prognosis:

Good. Expected recovery time: 6-8 weeks with physical therapy.

Physician:

Dr. Sarah Mitchell, MD

Emergency Medicine

License #: MD-45678

Signature: [Signed electronically]

Date: January 15, 2025

HOSPITAL DISCHARGE SUMMARY

Patient: Sarah Martinez

Date of Birth: 07/22/1990

Age: 34 years

Gender: Female

MRN: 234567

Admission Date: January 20, 2025, 8:30 PM

Discharge Date: January 23, 2025, 11:00 AM

Length of Stay: 3 days

Insurance Claim: CLM-2025-002

Admitting Diagnosis:

Acute appendicitis with suspected perforation

Final Diagnosis:

1. Acute appendicitis, gangrenous - ICD-10: K35.80

2. Localized peritonitis - ICD-10: K65.0

Hospital Course:

Ms. Martinez presented to Emergency Department with 18-hour history of progressive right lower quadrant abdominal pain, nausea, vomiting, and fever. Pain initially periumbilical, migrating to RLQ. Denies diarrhea.

Physical Examination on Admission:

- Vitals: T 101.8°F, BP 118/76, HR 98, RR 18
- Abdomen: Guarding and rebound tenderness in RLQ
- McBurney's point tenderness positive
- Rovsing's sign positive
- Psoas sign positive

Laboratory Results:

- WBC: 16,500/µL (elevated)
- Neutrophils: 88% (elevated)
- CRP: 8.5 mg/dL (elevated)
- Hemoglobin: 13.2 g/dL (normal)

Imaging:

CT Abdomen/Pelvis with contrast (January 20, 2025):

- Distended appendix measuring 12mm in diameter
- Periappendiceal fat stranding
- Small amount of free fluid in RLQ
- No abscess formation identified
- Impression: Acute appendicitis

Procedure Performed:

Laparoscopic appendectomy - CPT: 44970

Date: January 20, 2025, 11:45 PM

Surgeon: Dr. Robert Chen, MD, FACS

Anesthesia: General endotracheal

Operative Findings:

Gangrenous appendix with localized perforation at tip. Significant inflammation of surrounding tissue. No gross contamination of peritoneal cavity. Appendix removed successfully via laparoscopic approach. Peritoneal cavity irrigated with 2L warm saline. No complications.

Pathology Report:

Specimen: Appendix, 7.5 cm in length

Microscopic: Acute appendicitis with transmural inflammation, gangrenous changes, and focal perforation. No evidence of malignancy.

Postoperative Course:

Patient tolerated procedure well. Started on IV antibiotics (Ceftriaxone + Metronidazole) for 48 hours, then transitioned to oral antibiotics. Diet advanced gradually from clear liquids to regular diet. Pain controlled with oral analgesics. Ambulating independently by POD #2.

Discharge Medications:

1. Augmentin 875mg PO BID x 7 days
2. Oxycodone 5mg PO Q6H PRN pain x 5 days
3. Acetaminophen 500mg PO Q6H PRN pain
4. Colace 100mg PO BID (stool softener)

Discharge Instructions:

1. Activity: Light activity only. No heavy lifting (>10 lbs) x 4 weeks
2. Wound care: Keep incisions clean and dry. Remove dressings in 48 hours
3. Diet: Regular diet as tolerated. Increase fiber intake
4. Warning signs: Fever >101°F, increasing pain, redness at incisions, drainage from wounds, persistent vomiting
5. Return to work: 2 weeks (desk job), 4 weeks (physical labor)

Follow-up:

Surgical clinic in 2 weeks for wound check and staple removal

Total Hospital Charges:

- Emergency Department: $1,850

- Surgery (Laparoscopic appendectomy): $8,500

- Anesthesia: $2,200

- Hospital Room (3 days): $4,500

- Laboratory/Imaging: $1,200

- Medications: $500

TOTAL: $18,750

Attending Physician:

Dr. Robert Chen, MD, FACS

General Surgery

License #: MD-78901

Date: January 23, 2025