History and Physical #1
Name: A.S.
Date of Birth: 04/11/1995
Date: 7/10/19

Chief Complaint:
"headache x 10 days"
"Chest pain x 1 week"

History of Presenting Illness:
Patient is a 24 years old female with hx of GERD comes into the office complaining of headache x 10 days. Describes the headaches starting unilaterally and sometimes bilateral ranging from the front of head to the back and as 8/10 in severity, intermittent characteristic and electrifying/heaviness sensation. Pt tried tylenol and rest with only some relief. describes the headaches as being worse in the afternoon. admits to having some sensitivity to sounds, chest pain, and dizziness. The dizziness is described as starting 10 days ago alongside the headache and describes the sensation as being room spinning. States the dizziness comes and goes throughout the day and denies being sick recently. patient denies fever/chills, nausea/vomiting, sensitivity to light, neck stiffness. Patient states that she believes it could be due to the stress of school and spending multiple hours in front of the screen.

Chest pain: Patient states the chest pain started Friday last week and only lasted one day with a electrifying sensation localized to the upper left chest wall with no radiation. Rates the pain as being 8/10 and tried to take ranitidine with no relief. states has a hx of GERD. Pain eventually resolved on its own the next day.

Pertn neg.- Fam hx early MI, Fam hx SAH (mom died)
- PE/DVT
- Ø OCP
- head trauma

Past Medical History:
- GERD – 2017

Past Surgical History:

Family history:
- Father: alive, diagnosed with Non-insulin dependent diabetes mellitus, Hypertension.
- Mother: alive, Non-insulin dependent diabetes mellitus.
- Siblings: alive - 1 brother(s) , 1 sister(s) - healthy

Social History
- Tobacco use: denies any tobacco use
- Alcohol use: denies any alcohol use
- Sexual history:
  - admits to being sexually active
  - uses condoms sometimes
  - no hx of STD
  - LMP: 06/12/19

Allergies: N.K.D.A.

Medications:
- Ranitidine 150 mg tablet PO

Review of Systems:
Constitutional: admits to dizziness and headache denies generalized weakness, denies fever/chills, weight loss, fatigue
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R
ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: denies shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: admits to chest pain, denies palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: denies abdominal pain and diarrhea, denies nausea, vomiting, denies hematemesis; No melena or hematochezia
Genitourinary: denies decreased urinary frequency; No dysuria, frequency or hematuria; no flank pain R; no flank pain; no suprapubic pain
MSK: denies limitations or weakness in joints
Psychiatry: denies anxiety or panic attacks, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: BP 105/75, HR 71, RR 16, Ht 5ft 1.75 in, Wt 197.7, BMI 36.45, Oxygen sat % 99.

General: Patient is A/O x 3; not in any distress; verbalizing well
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical with some periorbital swelling noted; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, no neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; no adventitious sounds
Cardiovascular: S1 and S2 present RRR; no murmurs/gallops present
Abdomen: Soft, nondistended non tender with no guarding, No rebound or rigidity. Bowl sounds present; tympanic to percussion
Extremities: no presence of deformities, edema, tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

DDx-Headache:
1) Tension headache
2) migraine headache
3) Hormone headache

DDx – Dizziness:
1) BPPV
2) labyrinthitis
3) Meniere's disease

DDx – chest pain:
1) MI
2) Pneumonia
3) GERD

Assessment/plan:
Patient is a 24 years old female with hx of GERD c/o headache, dizziness, and chest pain.

Headache – most likely consistent with tension headache

- Start Excedrine 250-250-65 mg tablets PO - Take 2 tablets orally once a day for 30 days
- Advised patient to follow up if headache does not resolve with medication or patient develops new symptoms - Consider cl Nurse

Dizziness – consistent with begnin paroxysmal positional vertigo

- Started meclizine HCl 25 mg tablets PO - 1 tablet PRN
- Advised patient to stay hydrated and reduce the stressors
- advised patient to follow up if dizziness continues or worsens

Chest pain – most likely 2/2 GERD

- Order bedside EKG - r/o other chest pain etiologies due to significant past medical history
- Stop ranitidine 150 mg
- Start pantoprazole delayed release 40 mg tablet – 1 tablet once a day
- Advised patient to follow up if symptoms persist or worsen

Patient education: The headache you are experiencing is consistent with a tension type headache. This type of headache is usually brought on by stress. This headache can be reduced by getting rid of the stress or we can manage it symptomatically with medications such as ibuprofen, Tylenol, and Excedrin. The dizziness is consistent with begnin paroxysmal vertigo which can occur due to the fluid in your ears responsible for balance builds up due to obstruction. This obstruction sometimes resolves by itself and reobstruct causing you to have bouts of dizziness that resolve by itself. The chest pain you experience does not sound like a typical cardiac related chest pain, which is why we believe it to be related to your GERD which is also known for causing chest pain. We are changing your GERD medication to a stronger acid reducing medication which will help to relieve any further GERD symptoms you experience.

History and Physical #2
Name: B. W.
Date of Birth: 03/27/1962
Date: 7/10/19

Chief Complaint: "back pain x 2 days"

History of Presenting Illness:
Patient is a 57 yo male with hx of enlarged prostate, crohn's dx in remission comes into the office with complaint of lower back pain x 2 days. Patient was playing sports when he tried to go pick something up off the ground and caused his back to "lock up". patient denies any trauma to the area and states he has had similar episodes in the past for the past 5 years. Patient reports the pain as being 9/10 and has been using hot/cold compresses and took 2 ibuprofen with some muscle relaxants. Patient now reports back pain has improved to 7/10 today. Pain is bilateral and only radiates to sides from midline. Patient denies any fever/chills, urinary incontinence, fecal incontinence, numbness/tingling in groin.
has hx of Crohn's. last colonoscopy was 2years ago. Denies any GI symptoms.

Ø focal weakness
Ø trauma.
Ø urinary [illegible]

Past Medical History:
- Crohn's disease - 2015
- Enlarged prostate - 2013

Past Surgical History:
- Colectomy - 08/1998

Family history:
- Father: deceased, diagnosed with Hypertension
- Mother: deceased.
- Siblings: deceased.
- Children: alive - 2daughter(s)

Social History
- Tobacco use: Former smoker – quit over 10 years ago
- Alcohol use: admits to alcohol use socially
- Sexual history: admits to being sexually active with women only and uses condoms every time with no hx of STD

Allergies: N.K.D.A.

Medications:
- Flomax 0.4 mg – once a day

Review of Systems:
Constitutional: denies dizziness, denies generalized weakness, denies fever/chills, weight loss, fatigue
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R

ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: denies shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: denies chest pain, denies palpitations; no paroxysmal nocturnal dyspnea
Gastrointestinal: denies abdominal pain and diarrhea, denies nausea, vomiting, denies hematemesis; No melena or hematochezia
Genitourinary: denies decreased urinary frequency; No dysuria, frequency or hematuria; no flank pain R; no flank pain; no suprapubic pain
MSK: admits to back pain and limitations of flexion of lower back; denies weakness in joints
Psychiatry: denies anxiety or panic attacks, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: BP 100/70, HR 87, RR 16, Ht 5 ft 6 in, Wt 157.6, BMI 25.43, Pain scale 7

General: Patient is A/O x 3; not in any distress; verbalizing well
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical with no periorbital swelling noted; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, no neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; no adventitious sounds
Cardiovascular: S1 and S2 present RRR; no murmurs/gallops present pulses 2/4 bilateral
Abdomen: Soft, nondistended non tender with no guarding, No rebound or rigidity. Bowl sounds present; tympanic to percussion
Musculoskletal: no swelling or deformity , paravetebrae discomfort, SLR positive about 45 degrees bilateral
Extremities: no presence of deformities, edema, tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

DDX:
1) Muscle strain
2) herniated disc
3) degenerative disc disease

Assessment/plan:
Patient is a 57 yo male with hx of enlarged prostate, crohn's dx in remission comes into the office with complaint of lower back pain x 2 days most likely consistent with muscle spasm secondary to muscle strain.

Muscle spasms/ back pain
- Start meloxicam 15 mg tablet PO – take 1 tablet by mouth once a day PRN
- Start cyclobenzaprine HCl 10 mg tablet PO – take 1 tablet twice a day PRN

- Advised patient to use hot compresses
- Advised patient to follow up if symptoms don't resolve or worsen

Crohn's disease

- Stable – currently in remission
- Advised to follow up with GI

Patient education:

The back pain you experienced was most likely due to muscle strain that caused the muscles to go into spasm. The treatment only consists of symptom relief with pain control and muscle relaxants and hot compresses. In the future it is best to stretch before any rigorous workouts and not over exerting yourself.

History and Physical #3
Name: E.J.O
Date of Birth: 04/11/1995
Date: 7/16/19

Chief Complaint: "pelvic pain x 6 months"

History of Presenting Illness:
Ms. O is a 25 yo female with a pmhx of anemia comes into the office with complaint of pelvic pain x 6 months. Patient describes the pain as being intermittent and sharp stabbing quality with severity of 7/10 on pain scale on the right side. States that the pain gets worse when she has her periods. States she has not tried any medication for pain relief. Pts last menstrual period was 7/10/19. Admits to having urinary frequency but denies any dysuria, dyspareunia, metrorrhagia, menorrhagia, metromenorrhagia, vaginal discharge, fever/chills.

Past Medical History:
- Anemia – 2017

Past Surgical History:
- Denies any pshx

Family history:
- Father: alive, Hypertension.
- Mother: alive, Endometriosis
- Siblings: alive - 1 sister – endometriosis

Social History
- Tobacco use: denies any tobacco use
- Alcohol use: denies any alcohol use
- Sexual history:
  - admits to being sexually active
  - uses condoms sometimes
  - with history of chlamydia infection
  - LMP: 07/10/19

Allergies: N.K.D.A.

Medications:
- Denies taking any medications

Review of Systems:
Constitutional: denies dizziness and headache generalized weakness, denies fever/chills, weight loss, fatigue
Eyes: No eye pain, visual disturbance, or discharge; no diplopia; no photophobia, No loss of vision L; no loss of vision R
ENT: denies discharge, denies otalgia, no dysphagia or odynophagia; no nasal congestion, no nasal discharge
Respiratory: denies shortness of breath, no cough, wheezing or hemoptysis.
Cardiovascular: denies chest pain, denies palpitations; no paroxysmal nocturnal dyspnea

Gastrointestinal: denies abdominal pain and diarrhea, denies nausea, vomiting, denies hematemesis; No melena or hematochezia
Genitourinary: Admits to pelvic pain and increased urinary frequency; No dysuria, frequency or hematuria; no flank pain R; no flank pain;
MSK: denies limitations or weakness in joints
Psychiatry: denies anxiety or panic attacks, denies depression
Skin: denies itching, burning, rashes or lesions
Neurologic: denies headaches or dizziness, no tremors, no numbness/tingling
Hematologic: denies any easy bruising or bleeding, hx of bleeding disorders
Endocrine: denies polyuria, polydipsia, polyphagia, No heat or cold intolerance

Physical Exam:
Vitals: BP 110/74, HR 76, RR 16, Ht 5ft 1 in, Wt 115, BMI 21.82, Oxygen sat % 99. Temperature?

General: Patient is A/O x 3; not in any distress; verbalizing well
Head: Normocephalic/atraumatic; no masses or lesions noted; non tender to palpation
Eyes: symmetrical with some periorbital swelling noted; no masses/lesions/discharge noted; sclera/conjunctiva clear; EOM and PERRLA intact
ENT: symmetrical; no deformities noted; no erythema; no swelling noted; airway clear
Neck: Trachea midline; no signs of goiter, no neck stiffness
Respiratory: symmetrical chest rise; breath sounds present in all lung fields; no adventitious sounds
Cardiovascular: S1 and S2 present RRR; no murmurs/gallops present
Abdomen: Soft, nondistended non tender with no guarding, No rebound or rigidity. Bowl sounds present; tympanic to percussion
Pelvic: Patient refused
Extremities: no presence of deformities, edema, tenderness; full AROM; equal pulses in upper and lower extremity
Neurological: A/O x 3; Cranial nerves grossly intact; strength intact; sensation grossly intact

DDx-Headache: ectopic Appy
1) Ovarian cyst
2) PID
3) Urinary tract infection
4) Endometriosis
5) Ovarian torsion

Assessment/plan:
Patient is a 25 yo female with hx of anemia c/o pelvic pain most likely consistent with ovarian cyst but other ddx are just as likely based on history alone.

Pelvic pain – most likely secondary to ovarian cyst
- Referral to gynecologist
- US of pelvis/transvaginal
- Offered pain relief – patient refused
- Ordered UA with reflex culture
- Ordered GC/chlamydia – patient refused

Patient education:

Based on your pelvic pain, there are a multitude of etiologies that can be causing the pain. Our most likely suspicion is that you have an ovarian cyst that can be causing you pain just based on the size and pushing on other organs. It can also be causing you pain due to the torsion of the entire ovary which would cut off the blood supply to the ovary and is an emergency situation. We have ordered a few lab tests and some imaging studies to help us better understand what is causing the pain. Once we have the results of these studies and lab work we will be able to get a better understanding as to what is causing the pain and what our management/treatment steps should be.