Heard, Amber
ALLERGIES: NKDA
DOB: [redacted]

Heard, Amber
ALLERGIES: NKDA
DOB: [redacted]
Mobile: [redacted]
EMAIL: [redacted]
DATE: 12/17/15

Subjective Data
Phone Consultation: head ache

HPI: Ms. Amber Heard is a 29-year-old English speaking Caucasian female with a past medical history of insomnia, anxiety and attention deficit disorder. Today the patient reports a head ache after she bumped her head while standing up 2 days ago. The patient reports no loss of consciousness, no nausea or vomiting. No change in mental status, or vision changes.
Last seen in the office on 12/23/2015 the patient has not experienced any cardiovascular events. Symptomatically she denies chest pain or dyspnea, PND, orthopnea and ankle edema she denies palpitations, syncope or pre-syncope.

PAST MEDICAL HISTORY:
1. Insomnia G47.00
2. Anxiety F41.9
3. Attention Deficit Hyperactivity Disorder F90.9

Home Medications Active
1. Ambien 10 mg tablet by mouth at QHS
2. Gabapentin 300 mg tablet by mouth daily at QHS
3. Xanax 0.25 mg tablet by mouth q 6 hrs PRN anxiety
4. Gabapentin 100mg 2 capsules Q 4-6 hrs.

Allergies Reaction
NKDA

PAST SURGICAL HISTORY
Denies any previous surgical history

REVIEW OF SYSTEMS:
9 Point ROS negative except as stated in HPI

Objective Data
PHYSICAL EXAM:
Vital Signs

Heart Rate:	66 and regular
Respiration Rate:	14 and regular
SBP:	122
DBP:	90
Temperature:	98 F topical
Pulse Oximetry Reading:	98% on room air

PLT / Def: 47
Date: 04/11/2022
Judge: PSA
Case: CL-2019-0002911

Heard, Amber
ALLERGIES: NKDA
DOB: [redacted]

Weight:
Height:
BMI:
General: well nourished male in NAD, alert and orientedx4
Skin: intact, normal color, moisture, hair distribution, texture, turgor, buccal/ conjunctival mucous membranes, cap refill,<2 seconds, and nail beds. No signs of: cyanosis. mottling, jaundice.
HEENT: Normocephalic and atraumatic, PERLA, TM clear x 2, oropharynx clear no exudates
Neck: supple, trachea midline, no JVD, no carotid bruits noted
Pulmonary: CTAB no r/r/w
Cardiac: RRR no m/r/g, 2+ pulses x 4, good cap refill, +S1, S2 no S3, S4
Abdomen: + bowel sounds, soft nt/nd, no pulsatile masses, no organomegaly
Back: no CVA tenderness.
Extremities: no clubbing or cyanosis, no edema noted B/L on upper/ lower extremities, pulses +3upper/lower. Cap refill <2 seconds. 5/5 strength B/L upper extremities.
Neurological: At present the patient is awake, alert and fully oriented. There is no evidence of cognitive or language dysfunction. Cranial nerves: Visual fields are full. Extraocular movements full. There is no evidence of nystagmus noted. There is no facial asymmetry noted.

ASSESSMENT/PLAN:

1. Discussion Interval history, symptoms, exam, lifestyle.
2. OTC Tylenol 650 mg PO q 8 hours or/Ibuprofen 600 mg q 12 hours PO for headache.
3. Reassurance
4. Dr. Kipper is aware of the medial pan and is in agreement.
5. The patient understands medical plan, all questions answered
6. The patient was told to contact Dr. Kipper or Monroe AGACNP if there any questions or changes to health. The patient was also instructed to go directly to the emergency room or dial 911 should she experience dizziness, extreme sleepiness. breathing problems, nausea and vomiting, confusion, difficulty walking, slurred speech, memory loss, poor coordination, seizures or numbness or paralysis in any part of the body.

Kipper