BRIGHTSEAT HEALTH

4333 OLD BRANCH AVE

TEMPLE HILLS MD 20748

MED RECORDS RETRIEVAL

11/26/2019

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3382012804 | Yasmine (BSH) Mathews | 2022-08-05 | 2022-08-05 | [Show EMR](https://remoteworksystem.net/EMR/EMRMainDashboard?appointmentId=59624) |
| 0106065054 | Marie Tsodzou | 2021-12-06 | 2021-12-06 | [Show EMR](https://remoteworksystem.net/EMR/EMRMainDashboard?appointmentId=56529) |
| 8523263650 | Marie Tsodzou | 2021-11-22 | 2021-11-22 | [Show EMR](https://remoteworksystem.net/EMR/EMRMainDashboard?appointmentId=56404) |
| 4536151544 | Marie Tsodzou | 2021-11-15 | 2021-11-15 | [Show EMR](https://remoteworksystem.net/EMR/EMRMainDashboard?appointmentId=56339) |
| 7008001372 | Dana T/Hill Foster NP | 2019-11-26 | 2019-11-26 | [Show EMR](https://remoteworksystem.net/EMR/EMRMainDashboard?appointmentId=36811) |

**Office Visit**
**History And Physical**
1- Patient Compliant

**CC:**Follow up post car accident injury.

Vitals:  BP 119/73, HR 90, temp 97.8, wt155 , HT 5’4’’, LMP: post menpause

**HISTORY OF PRESENT ILLNESS**

 This is a 55yr old female who presents to the clinic for the first time with complaints of severe abdominal pain. Flank pain and headaches.  The patient was in an MVA on November 11/11/2021, she ended up in the hospital, and the various CT scans of the head/neck/lumbar spine/face were negative. Chest X-ray was also negative.

**ALLERGIES:**PCN, BENADRYL, HYDROCORTIZONE

**Current Medication-**

-         Tylenol as needed.

**PMHX:**

-         None

**Past Surgeries:**

**Social Hx:**

-         Denies alcohol, smoking and or drug use.

-         No drugs

-         Works

-         Sexually active sometimes

-         Walking on exercise

-         College education

-         Lives in single-family home.

**Family History:**

-         Father had HTN

**Hospitalization/Major Diagnostic procedures:**none

**ROS: as per HPI**

**General/Constitutional**- Denies fever, chills, fatigue, night sweats,  recent weight gain/loss

**Ophthalmologic**- denies eye pain,  denies change in vision,  denies blurred vision

Head: Complaints of severe headaches and loss of balance after the car accident.

**ENT-** denies nasal congestion, denies difficulty swallowing, denies ear pain, denies nose/throat problems, denies sore throat, denies swollen glands

**Endocrine-** denies weakness, denies weight loss

**Respiratory**- Denies breathing problems, denies cough, denies SOB, denies wheezing

**Cardiovascular**- denies chest pain, denies dyspnea on exertion.

**Gastrointestinal**- reports GERD symptoms but manageable

**Hematology-**  denies bleeding problems, denies easy bruising

**Genitourinary**- denies blood in urine, frequent urination, painful urination

**Muskuloskeletal**- generalized muscle pain, right flank pain, aches all over.

**Skin**- white spot on the forehead (reaction from cortisone shot).

**Breast** denies drainage, mass, or discoloration.

**Neurologic-**Denies balance, difficulty speaking, dizziness, fainting, headache, loss of strength, denies numbness and tingling to hands and feet.

**PHYSICAL EXAMINATION:**

Vitals:  noted above

**GENERAL:**well-appearing, well-nourished, in no acute distress. Alert and oriented to time person and place

**EYES-**extraocular movement intact (EOMI), conjunctiva clear, PERLA, upper and lower eyelids normal

**EARS-**Auditory canal clear, tympanic membrane intact and clear

**Oral Cavity-**mucosa moist, pink and moist oral mucosa, oropharynx,

**Throat-**clear, no erythema, uvula midline, no tonsillar enlargement

**Neck/Thyroid-**neck supple, no cervical lymphadenopathy

**Skin-**no rash, normal for ethnicity, discolored frontal head from reaction to cortisone medication.

**Heart-**S1, S2 normal, regular rate and rhythm, no murmurs, no gallop, no rubs, no jugular venous distension.

**Lungs-**clear to auscultation bilaterally, good air movement, no wheezing, rales, rhonchi

**Chest-**normal shape and expansion, costochondral tenderness from the impact of the car accident.

**Abdomen:**Bowel sounds present, tenderness/swelling to the right quadrant. no rebound or guarding

**Back-** CVS tenderness

    Breast: soft, no mass or discoloration.

**Musculoskeletal-**limited range of motion due to pain in all extremities, worsening right flank pain.

**Extremities-**+ bilateral lower extremity edema, good capillary refill in nail beds

**Peripheral pulses-**2+ radial, 2+ dorsalis pedis, and symmetrical

**Neurology-**Alert and oriented, unsteady gait,  speech normal, cranial nerves 2-12 grossly intact, motor strength normal on both upper and lower extremities

**PSYCH-**worried about what could be causing more severe pain than expected.

**ASSESSMENT –**

1.     Physical after Car accident.

o    Labs: recently completed.

o   2 wks follow up lab review

o   Abdominal/pelvic ultrasound to find the cause of severe right quadrant abdominal pain, which radiates to the flank area.

o   Order for walker placed for patient

o   The patient was referred to a neurologist for having severe headaches.

o   The patient was referred to orthopedics.

o   The patient was referred to physical therapy to help her regain mobility.

o   Xray of the right hip and right elbow was ordered.

o   Ibuprofen 600mg po every 8hrs prn for pain. Dispense 40 tabs.

* Refill Robaxin 750mg po TID prn for muscle spasm.

11/15/2021

SEEN IN OFFICE

SEE MD MANUAL NOTES

UNAVAILABLE ON FILE

11/22/2021

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12/12/2021

**Office Visit**
**History And Physical**
1- Patient Compliant

**CC:** Follow

**Allergies**: PCN, IODINE, BENADRYL

BP 141/85, HR 85, TEMP 97.6, WT 155LBS, HT 5’4’’

**HPI:**

The patient had abdominal/pelvic ultrasound ordered due to c/o RUQabdominal pain which radiates to the flank area. She also had an x-ray of the right elbow. She presents today for a follow-up to review the results.

**Assessment/Plan**

**Multiple uterine fibroids: D25.9**

-         Referred to GYN (Dr. Austin). She suffers from anemia which could be a result of uterine fibroids. Does not take her iron pill as directed but she is encouraged to do so. she is also encouraged to take food items high in iron.

**Right elbow arthritis with minimal degenerative changes: M19.021**

-         The patient Is advised on the disease progression of arthritis with age. she has been educated on lifestyle modifications and dietary changes. She was given Ibuprofen 600mg po prn during the last visit. She will be seeing an orthopedic doctor this week.

**Severe allergies: TX78.40XA**

The patient has been referred to an Immunologist for further allergy testing. She has such as

08/05/2022

**Office Visit**
**History And Physical**
1- Physicals

CC- Allergic reaction to poison Ivy

B/P- 113/83          P- 85

WT- 151             HT- 5'5

TEMP- 97.9

ALLERGIES- PCN, BENADRYL, LATEX, ASPRIN, iodine, Ivy, medicated cortisone, Wax sting,

2- History of Present Illness

Client is an AA female reporting for allergic reaction to poison Ivy/annual examination

3- Family History

Mother- HTN, T2DM

Father- Not known

Siblings: None

4- Social History

She is single, divorced

G5, P5, ( 4 premature delivery) No abortion /miscarriages

She is a substitute teacher , A CNA, phlebotomist, and teaches CPR in PG college.

She denies the use of tobacco, ETOH, or drugs.

5- Past Medical History

She is not on any medications except for Ibuprofen since the recent MVA.

G5, P5, (4 premature delivery) No abortion /miscarriages

LMP= 07/15/2022 regular.

6- Review of Systems

Constitutional: No fevers, no chills, no night sweats, no weight loss

Eye: No change of vision, no eye pain, No visual problems, no diplopia, no blurry vision

ENMT: No ear pain, no nasal congestion, no sore throat

Respiratory: No shortness of breath, no cough

Cardiovascular: No Chest pain, no pressure, no palpitations, no syncope, no loss of consciousness

Gastrointestinal: no change in bowel habits, No nausea, no vomiting, no diarrhea, no constipation, no melena, no anorexia

Genitourinary:  no discharge, no dysuria , no change in urinary frequency,

Hema/Lymph: No bruising tendency, no swollen lymph glands

Musculoskeletal: Multiple joint pain, and has  muscle pain, no swelling, no change in range of motion

Integumentary: No rash, no pruritus, no abrasions

Neurologic: no headache, no paresthesia, no limb weakness, Alert & oriented X 3

Psychiatric: No anxiety, no depression, no suicidal ideation

All other systems reviewed and negative.

7- Physicals

General: Well developed, well nourished. Denies pain. Alert and oriented, no acute distress.

Eye: Pupils round, equal Normal appearing conjunctiva. (Sclera are non-icteric and the conjunctiva are pink bilaterally) No scleral icterus.

HENT: Normocephalic, moist oral mucosa, no scleral icterus, no sinus tenderness. Oropharynx clear and without edema, injection nor exudate. The uvula is midline.

Neck: Supple, non-tender, with a full range of motion, no lymphadenopathy.

Lungs: No respiratory distress. Lungs are clear to auscultation with good air exchange. Non-labored respiration. No crackles, no wheeze

Heart or Cardiovascular: Normal rate, regular rhythm, no murmur, gallop or rub. There is no peripheral edema.

Abdomen: Soft, supple, non-distended. No tenderness to palpation. Bowel sounds are present and normal. No masses or organomegaly noted.

Musculoskeletal: No gross deformity of extremities. All extremities move well with a full range of motion and strength. tenderness on spine and para-spinal palpation out of proportion to light touch. SEE HPI.  No swelling.

Skin: Skin is warm, dry and pink. No rashes or lesions.

Neurologic: Awake, alert, and oriented to person, place and time. Cranial nerves II-XII are grossly intact. Sensation to light touch intact.  No focal motor deficits.

Psychiatric: Cooperative, appropriate mood, affect, and thought.

8- Assessment/Plan

1- VitalSigns

Lab work order

Referral to Allergist

Follow up as needed