Student Name: Patricia East Date: 11/11/2019

Chief Complaint: Nasal congestion and drainage

Demographic Data:

Gender: Female

Age: 28 y/o

Race: White

Code Status: Full

Allergies: no known allergies

Past Medical History: scoliosis, asthma

Past Surgical History: deviated septum, two broken bones

Social History:

Assistive Devices: hearing aids

Smoking: no smoking

Alcohol: very rare, one drink/month

Drugs: no drug use

History of Present Illness: Patient, 28 years old, presents in the clinic with nasal congestion and nasal drainage. She states that she started having symptoms on 11/9. The drainage is felt in the back of her throat and nose. She states that she has had a constant feeling of being stuffy and runny. She feels the most stuffy when waking up from her sleep and over the day her nose starts to be runny. She says that taking a shower helps relive her nasal congestion and helps all the runny drainage to come out. She has not taken anything for her symptoms.

Review of Systems: (positives highlighted)

General	Fatigue, weight changes, fevers, chills, night sweats, fatigue
Skin	Dryness, rashes, lesions, non-healing sores, hair changes, puritis
HEENT	Headache, head injury, blurry vision, double vision, earache, drainage, change in hearing, nasal congestion, nose bleeds, nasal drainage, dry mouth, sore throat, swallowing difficulty,
Cardiac	Chest pain, palpitations, diaphoresis, dyspnea, PND, Orthopnea, claudication
Respiratory	Wheezing, cough, difficulty breathing, increase in sputum production
GI	Nausea, vomiting, diarrhea, constipation, abdominal pain, heartburn, jaundice, Hematochezia, Melena
GU	Hesitancy, frequency, urgency, burning, hematuria, incontinence, flank pain, flow changes
MSK	Swelling, stiffness or soreness in joints, back or neck pain
Neuro	Weakness, numbness, LOC, syncope, dizziness, headache, coordination changes, recent falls

Vital Signs:

Temp: 97.6 F, oral.

Pulse: 79

Resp: 14

BP: 122/78

Pain: 0

Weight: 150 lbs.

Height: 5’ 4”

Examination:

General: Patient is A/O x 3, does not appear to be in distress. She appears to be stated age. Overall, the patient looks healthy.

Skin: No rashes or lesions. Burn mark present on L forearm. Hair and nails are well groomed. Skin is warm. Turgor > 3 seconds. Capillary refill > 3 seconds.

Head and Neck: Normocephalic, no tracheal deviation, thyroid is not palpable without nodes. Carotid pulses present bilaterally. Lymph nodes are nontender or palpable.

Eyes: Eyelids are clean, no crust or drainage. Sclera is slightly red. Conjunctiva is pink and moist. PERRLA and EOM’s intact. Rosemburg 20/20. Red light reflex is present.

Ears: External ear appears to be clean with no drainage. Ear wax is present in ear. Tympanic membrane is present and pearly gray bilaterally.

Nose: Septum is midline, turbinates are pink and moist. No polyps are present. Sinuses were palpated and are tender.

Throat: Tonsils present. Some drainage in back of throat. Uvula midline. Uvula and soft palate move up and down symmetrically. Good dentation. Mouth and mucosa are moist and pink.

Cardiac: S1 and S2 are present. PMI present. No gallops or murmurs.

Respiratory: Lung sounds are clear, no wheezes or crackles bilaterally. Breathing is nonlabored, respiratory rate is 14/minutes.

Abdominal: Bowel sounds are normoactive in all four quadrants. No pain when light/deep palpation. No presences of masses or enlarged organs, no CVA tenderness.

Extremities: All pulses are 2+ and present bilaterally. Epitrochlear is nontender and nonpalpable. Capillary refill > 3 seconds. No edema. All extremities are symmetric. Homan’s sign is negative.

MSK: full active ROM. Gait is steady. Strength is 5/5 bilaterally.

Neuro: DTR are present bilaterally and are 2+. Rhombergs is negative