**DISCHARGE DIAGNOSIS:**

@DIAGX@

**CHIEF COMPLAINT :** @CHIEFCOMPLAINT@

Notes :

This is a @AGE@ @SEX@ [-\*\*\*-]

Historian: Patient

Location: [-\*\*\*-]

Time course: [-Gradual-]

Onset was [-\*\*\*-] prior to arrival, Episodes [-\*\*\*-]

Currently Symptomatic: [-Worse-]

Complicating Factors: [-None-]

Quality [-Aching, Dull-]

Severity: Maximum [-Severe-]; Current severity [-Moderate-].

Associated with: [-No Flank pain, Groin pain, No Trauma, No Recent travel, No UTI-]. [-Abdominal distention, Vomiting, Diarrhea, Fever-].

[-Pregnancy risks: Status post hysterectomy, LMP

Ectopic pregnancy risk: Prior ectopic, History of PID, IUD-]

Exacerbated by:

Movement

Relieved by:

Nothing

**HPI:**

PMH: @HXPMH@

 @PROB@

PSurg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: [-@SOCX@-]

**REVIEW OF SYSTEMS :**

CONSTITUTIONAL: No fever-

CARDIOCVASCULAR: No Chest Pain

RESPIRATORY: No SOB

GI: Abdominal pain as described. [-No nausea, No vomiting.-]

GU: No dysuria

MUSCULAOSKELETAL: No arthralgia

SKIN: No rash

HEME: No easy bleeding

PSYCH: No anxiety

NEUROLOGIC: No headaches

**PHYSICAL EXAM :**

@VS@

GENERAL: Patient is afebrile, Vital signs reviewed, well appearing, Patient appears [-comfortable-], Alert and lucid.

HEAD: Atraumatic

EYES: Normal to inspection

ENT: OP moist, Nares patent

NECK: Normal inspection, Normal Range of Motion.

CARD: Regular rate and rhythm, heart sounds normal

RESP: No respiratory distress, breath sounds normal

ABD: Soft, [-tender to palpation \*\*\*-], [-negative Murphy’s Sign, Negative Obturator and Rovsing sign, No peritonitis-]. BS present, no organomegaly or masses.

BACK: non-tender. [-No CVA tenderness-].

MUSC: Normal ROM

SKIN: Color normal

NEURO: Awake, alert, and lucid. No motor deficits.

PSYCH: Mood/ affect normal

**ASSESSMENT:**

Abdominal pain

[-No gross pain to suggest an acute abdomen, but will discuss signs and symptoms for return to an emergency department and consideration of further studies.-]

I feel a pulmonary or cardiac component is unlikely at this time base on the history and exam.

@RESULTRCNT(24h)@

**URGENT CARE COURSE**:
[-Patient to go to the emergency department immediately with significant changes or worsening symptoms. Will also go if symptoms persist for 12-24 hours.-]

Medications, medical history, allergies, surgical history, hospitalizations, family history, social history, ROS and vitals entered by medical assistant and reviewed by myself.

[-I discussed with the patient the diagnosis, treatment plan, indications for return to the urgent care or emergency department, and for expected follow-up. The patient verbalized an understanding. The patient is asked if there are any questions or concerns. We discuss the case, until all issues are addressed to the patient's satisfaction.-]

Follow up plan per the discharge instructions urgent care or emergency department in the next 12-24hrs if increasing symptoms, significant changes, pain, or concerns.

**DIAGNOSIS**:

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*