**DISCHARGE DIAGNOSIS:**

@DIAGX@

**CHIEF COMPLAINT :** @CHIEFCOMPLAINT@

Notes :

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

Historian: Patient

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

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

Time course: [-Gradual-]

Currently Symptomatic: [-Worse-]

Complicating Factors: [-None-]

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

Associated with: [-Swelling, Pain-]

Tetanus status: [-Tetanus up-to-date-]

**HPI:**

PMH: @HXPMH@

 @PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: @SOCX@

**PMH**

@HXPMH@

@PROB@

**PSHx**

@HXPSH@

**Medications**

@EDPTMEDCONT@

**Allergy**:

@ALG@

**SOCIAL:**

[-@SOCX@-]

**REVIEW OF SYSTEMS :**

CONSTITUTIONAL: No fever, No chills.

CARDIOVASCULAR: No chest pain.

RESPIRATORY: No Cough, No SOB.

GI: No Abdominal pain, No nausea, No vomiting.

GU: No dysuria, frequency

MUSCULOSKELETAL: No arthralgias.

Heme: No easy bleeding or bruising

SKIN: As described

NEUROLOGIC: No headaches or weakness.

**PHYSICAL EXAM :**

@VS@

GENERAL: 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

BACK: [-Normal Inspection-]

MUSC: Normal ROM

SKIN: Abscess: [-\*\*\*-]. Otherwise, color normal, no rash, warm, dry.

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

PSYCH: Mood/ affect normal

**ASSESSMENT**:

History and exam is consistent with [-an abscess-].  As the patient has [-fluctuance/induration-], an incision and drainage is appropriate.  No evidence for sepsis, bacteremia, necrotizing fasciitis.  No proximal streaking or symptoms of systemic infection. Will review antibiotic risks and benefits with the patient. Tetanus status is [-up-to-date-]

@RESULTRCNT(24h)@

@EDPTMEDSTART@

@DX@

**URGENT CARE COURSE**:

[-For Procdoc\*\*\*-]

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.

*@MEMD@*

*@NOW@, @TD@*