**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

Notes:

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

Historian: Patient.

Dental Pain. Associated Symptoms [-none-]

No trauma, No recent dental procedure

Symptoms began [-\*\*\*-] prior to arrival. Patient currently has symptoms. Symptoms are [-worse-].

Severity: Maximum: [-Severe-]

Current: [-Moderate-]

Exacerbated by: [-Eating, Chewing-]

Relieved by: [-minimal with OTC medicines-]

**HPI:**

PMH: @HXPMH@

 @PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: @SOCX@

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: No fever.

ENT: [-No Rhinorrhea, No sore throat. Dental pain as described-].

CARDIOVASCULAR: No Chest Pain.

RESPIRATORY: No SOB.

GI: No nausea.

MUSCULOSKELETAL: No arthralgias.

SKIN: No Rash.

NEUROLOGIC: [-No headaches-]

**PHYSICAL EXAM:**

@VS@

GENERAL: Patient is afebrile, Vital signs reviewed, Well appearing, Alert and lucid.

HEAD:  Atraumatic

EYES: Normal to inspection. Extraocular movements are intact.

ENT: External ears normal to inspection, Nares patent. Oropharynx is moist without posterior erythema and exudate. Pain at tooth # [-\*\*\*-]. No pain on palpation of the sinuses.

NECK:  Normal ROM, No nuchal rigidity. [-No lymphadenopathy.-]

CARD:  Regular rate and rhythm, heart sounds normal.

RESP:  No respiratory distress, breath sounds normal.

SKIN: Color normal

NEURO: Awake & alert, lucid, no motor/sensory deficit.

PSYCH:  Mood/affect normal.

![https://epicblb.overlakehospital.org/WBS_prd/ACWebBlobService.ashx?env=prd&action=1&filename=static_TMP3669451820673950010.png&user=RKLEIN&module=P2P.HYPERSPACE&token=FIW2rEI%2FgX4ap1dBZ4AqNKHNEpotQOJ7an1mGhUtYyHLQk0CTsSt5a8OJ7kiP3QR6bhUfRydyKcu22H3AxtfU7hSFfvdoPv50xMLSRn9z06O7M58yyOpT7dYJ4KZwhRL](data:None;base64...)

**MEDICAL DECISION MAKING**:

Patient with dental pain. No evidence of facial cellulitis or abscess. No sinus component. No evidence of strep pharyngitis. Will discuss short term management and a timely follow up with dental service.

@EDMEDS@

**URGENT CARE COURSE**:

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.

@MEDADMIN@

**DIAGNOSIS:**

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*