**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

Notes:

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

Historian: Patient.

[-Right-] side

[-Crusting is present-]

Associated with: [-no vision loss, No URI symptoms-].Patient [-does not wear glasses or contact lenses-].

[-No Trauma-]

Quality: [-Achy, Fullness-]

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

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

Exacerbated by: [-Eye opening-]

Relieved by: [-nothing-]

**HPI:**

PMH: @HXPMH@

 @PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: [-@SOCX@-]

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: No fever.

EYES: As Described

ENT: [-No sore throat. No rhinorrhea.-]

CARDIOVASCULAR: No Chest Pain.

RESPIRATORY: No Cough, No SOB.

GI: No nausea.

MUSCULOSKELETAL: No arthralgias.

SKIN: No Rash.

NEUROLOGIC: [-No headaches-]

**PHYSICAL EXAM:**

@VS@

@VISION@

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

HEAD:  Atraumatic

EYES: Injected at [-The conjunctiva-]. Pupils are equal and reactive to light, Extraocular muscles intact. [-Vision grossly intact.-] [-Tonometry pressure \*\*\*, abnormal fluorescein uptake \*\*\*, negative Seidel sign. Visual acuity as per staff notes.-]

ENT: Nares patent. Tympanic membranes clear bilaterally. Oropharynx is moist. No trismus. Mouth normal to inspection.  No tenderness 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.

BACK: Normal Inspection

SKIN: Color normal

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

PSYCH:  Mood/affect normal.

**MEDICAL DECISION MAKING**:

Patient presents with complaints of red eyes and exam consistent with [-conjunctivitis-], which will be treated with topical antibiotics. No evidence for visual disturbance, no evidence of foreign body by history. [-Follow-up with ophthalmology in a timely fashion if not improving.-]

**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@*