**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

**CHIEF COMPLAINT:** @CHIEFCOMPLAINT@

Notes:

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

Historian: Patient

Pain Location: [-Diffuse-]

Worst Headache of life: [-No-]

Change in character from prior HA [-No-]

Complicating Factors: None

Occurred: [-\*\*\*-] prior to arrival. Patient currently has symptoms. Symptoms are [-Worse, Persistent-]

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

Quality: [-Achy, Pressure-]

Associated with: [-No injury, no URI symptoms-]

Exacerbated by: [-Nothing-]

Relieved by: [-Nothing-]

**HPI:**

PMH: @HXPMH@

 @PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: @SOCX@

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: [-No fever-]

EYES: [-Photophobia-]

ENT: [-No rhinorrhea, no sore throat, no sinus pain.-]

CARDIOCVASCULAR: [-No Chest Pain-]

RESPIRATORY: [-No SOB-]

GI: [-Nausea, no vomiting-]

MUSCULAOSKELETAL: [-No arthralgia-]

SKIN: No rash

NEURO: [-Headache as described-]

HEME: [-No easy bleeding-]

PSYCH: [-No anxiety-]

**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. No Nuchal rigidity

CARD: Regular rate and rhythm, heart sounds normal

RESP: No respiratory distress, breath sounds normal

BACK: Normal Inspection

MUSC: Normal ROM

SKIN: [-Color normal-]

NEURO: Patient is alert, lucid and oriented times 3. EOMI, facial and jaw muscle strength intact, hearing grossly intact, speech is without dysarthria, and shoulder shrug is strong. No focal motor, sensory or cerebellar deficits are noted. Speech and gait are normal. Patient has 5/5 muscle strength in the upper and lower extremities. Sensory exam is intact to lite touch on arms and legs bilaterally. [-Cerebellar exam is intact on "finger to nose" ,"heel shin" and gait is stable.-] [-Patient has no pronator drift. Romberg signs are absent.-]

PSYCH: Mood/ affect normal

**MEDICAL DECISION MAKING**:

Patient is here for [-typical migraine, no significant change in character from previous headaches and -] with a benign exam. There is no evidence for an infectious process such as sinusitis, meningitis or encephalitis, inflammatory process such as temporal arteritis, increased cranial pressure, trauma, intracranial hemorrhage, or chronic process such as tumor formation. No recent trauma to cause SDH or post-concussive syndrome. No recent chiropractic neck manipulation to cause vertebral or carotid artery dissection. There is no indication for CT or further radiographic study at this time. [-Will discuss management with the patient.-]

**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.

Patient's PCP is @PCP@.

**DIAGNOSIS:**

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*