**CHIEF COMPLAINT:** @CHIEFCOMPLAINT@

Notes:

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

Historian: Patient

Complaint: [-\*\*\*-]

Time course: [-Sudden, Gradual, Unknown-], Onset was [-\*\*\*-] prior to arrival.

Lasting [-\*\*\*-]

Currently Symptomatic: [-Worse-], Quality [-Aching, Dull-]

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

Associated with: [-Nothing-]

Exacerbated by: [-\*\*\*-]

Relieved by: [-\*\*\*-]

**PMH**

@HXPMH@

@PROB@

**PSHx**

@HXPSH@

**Medications**

@EDPTMEDCONT@

**Allergy**:

@ALG@

**SOCIAL:**

[-@SOCX@-]

[-Drug use, Employment, School, Seatbelt-]

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL : No fever, No chills.

ENT: No rhinorrhea, no sore throat

CARDIOVASCULAR : No Chest Pain.

RESPIRATORY : No Cough, No SOB.

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

GU : No dysuria, frequency

MUSCULOSKELETAL : No arthralgias.

SKIN : No rash.

HEME : No easy bleeding or bruising.

PSYCH : No sleep changes. No anxiety or depression.

NEUROLOGIC : No headaches or weakness.

**PHYSICAL EXAM:**

@VS@

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

HEAD :  Normocephalic, Atraumatic,

EYES : Normal to inspection, Extraocular movements intact.

ENT :  OP moist. Normal Ear inspection, Nares patent.

NECK :  Supple , normal inspection. No JVD.  Normal Range of Motion. No nuchal rigidity. No abnormality of the thyroid. No lymphadenopathy.

CARD :  Regular rate and rhythm, heart sounds normal.

RESP :  No respiratory distress, breath sounds normal.

ABD : Soft, nontender, BS present, soft, no organomegaly[-liver and spleen not palpable.-]

BACK : Non-tender. No CVA tenderness.

MUSC : Full ROM bilateral upper and lower extremities.

SKIN : Color normal, no rash, warm, dry.

NEURO : No motor/sensory deficit. Gait stable.  Cranial Nerves 2-12 grossly intact.

PSYCH :  Awake & alert, lucid. Mood/affect normal.

**ASSESSMENT**:

[-Considered and obtained old records and reviewed.-] [-Summary-]

[-Acute problems-]

[-Old problems-]

[-\*\*\*-]

@RESULTRCNT(24h)@

**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.-]

[-Lab tests reviewed, oximetry reviewed-]

[-Independent Imaging reviewed-]

[-Cardiovascular imaging studies-].

[-Chronic illness with severe exacerbation-]

[-acute illness that may pose life threatening or disability-]

[-Multiple trauma-]

[-Psychiatric self harm potential-]

**DIAGNOSIS:**

@DIAGX@

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*