**DISCHARGE DIAGNOSIS**:

@DIAGX@

Primary Care Provider: @PCP@

**CHIEF COMPLAINT:** @CHIEFCOMPLAINT@

**Notes:**

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

Historian: Patient.

[-No-] Subjective Fevers

[-No-] Sick contacts

Associated Symptoms [-none-]

Symptoms began [-several days-] prior to arrival. Patient currently has symptoms. Symptoms are [-worse-].

Severity: Maximum: [-Severe-]

Current: [-Moderate-]

Exacerbated by: [-Nothing-]

Relieved by: [-minimal with OTC medicines-]

**HPI:**

PMH: @HXPMH@

@PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social:

[-@SOCX@-]

**REVIEW OF SYSTEMS:**

CONSTITUTIONAL: [-Subjective fever-], No chills.

CARDIOCVASCULAR: [-No chest pain-]

RESPIRATORY: Cough, [-non-] productive, [-No SOB-].

ENT: As described

GI: No vomiting

MUSCULOSKELETAL: [-No arthralgia-]

SKIN: No rash

PSYCH: [-Sleep change due to illness-]

NEUROLOGIC: [-No headaches-]

**PHYSICAL EXAM:**

@VS@

GENERAL: Vital Signs and temperature reviewed, well appearing, Patient appears comfortable, Alert and lucid

HEAD: Atraumatic

EYES: Normal to inspection

ENT: External ears normal to inspection, Nares patent. Tympanic membranes clear bilaterally. Oropharynx is moist no erythema or exudate. No trismus. Mouth normal to inspection.  No tenderness on palpation of the sinuses

NECK: Normal inspection, No Cervical chain lymphadenopathy.

CARD: Regular rate and rhythm, heart sounds normal

RESP: No respiratory distress, breath sounds normal. No pain with compression of the chest wall.

BACK: Normal Inspection

MUSC: Normal ROM

SKIN: Color normal

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

PSYCH: Mood and affect normal

**ASSESSMENT**:

Upper respiration infection. Strep pharyngitis unlikely based on exam and symptoms. No evidence for acute bronchitis, sinusitis, pneumonia, otitis. Presentation is consistent with viral URI which will be treated symptomatically. No indication for diagnostic testing.

@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.-]

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.

**DIAGNOSIS**:

@DIAGX@

Medications on Discharge

@EDPTMEDSTART@

*@MEMD@*

*@NOW@, @TD@*