**DISCHARGE DIAGNOSIS:**

@DIAGX@

Primary Care Provider: @PCP@

Notes:

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

Historian: Patient.

Time course: Gradual

Onset was [-\*\*\*-] prior to arrival

Currently Symptomatic: [-worse-]

Complicating Factors: [-None-]

Quality: Burning, Frequency

Associated with: No Vaginal Discharge. [-Abdominal pain, Blood in stool, Antibiotic use recently, Diarrhea, Fever, Hematemesis, Nausea, Recent travel, UTI symptoms, Vomiting, Vaginal discharge/bleeding-]

[-Pregnancy risks: Status post hysterectomy, LMP

Ectopic pregnancy risk: Prior ectopics, History of PID, IUD-]

Exacerbated by: Urination

Relieved by: [-Nothing-]

**HPI:**

PMH: @HXPMH@

@PROB@

Past Surg: @HXPSH@

Allergies: @ALG@

Meds: @EDPTMEDCONT@

Social: @SOCX@

**REVIEW OF SYSTEMS:**

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

CARDIOCVASCULAR: No chest pain

RESPIRATORY: No Cough, No SOB.

GI: No vomiting

GU: As described

MUSCULAOSKELETAL: [-No back pain-]

SKIN: No rash

PSYCH: No Sleep Changes

NEUROLOGIC: No headaches

**PHYSICAL EXAM:**

@VITALSMULTIPLE@

GENERAL: Vital Signs and temperature 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

CARD: Regular rate and rhythm, heart sounds normal

RESP: No respiratory distress, breath sounds normal.

ABD: [-Soft, non-tender-]

BACK: non-tender. [-No CVA tenderness-].

MUSC: Normal ROM.

SKIN: Color normal

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

PSYCH: Mood and affect normal

**MEDICAL DECISION MAKING**:

Lower urinary tract irritation suggestive of possible urinary tract infection. No evidence of pyelonephritis[- or symptoms to suggest vaginitis-]. Urinalysis is indicated. [-Pregnancy testing is ordered-]

**RESULTS:**

Labs: @RESULTRCNT(48h)@

**URGENT CARE COURSE**:

[-Evidence for urinary tract infection by urinalysis. Will treat with antibiotics.-]

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@*