Identification
Name: JC
Sex: Male
DOB: 1/1/1986
Address: N/A
Date and Time: 1/11/2020 at 8:36pm
Ethnicity: Caucasian
Marital Status: Married
Religion: N/A
Informant: Self – reliable
Source of Referral: Self

Chief Concern: s/p MVA, need Worker's compensation

History of Present Illness
Mr. JC is a reliable 34 yo Caucasian male, with PMHx of PTSD x 10 years, presenting s/p MVA 6 days ago complaining of H/A with muscle pain. Car was t-boned, pt admits he wore a seat belt, hit his head on the steering wheel followed by the airbag, hurt his neck, has L shoulder pain, and L flank pain. Pt also had a panic attack in the car before getting rescued by EMS. Pt describes the H/A occurred after he was released from the hospital on the same day, 7/10, getting worse, starting from his cervical region and now moving to his forehead. Pt has light sensitivity, decreased ROM, 1x nausea yesterday. Denies LOC, vomiting, diarrhea, palpitations, SOB.

Past Medical History
Present Illnesses: Neck pain, H/A, PTSD
Past Medical Illnesses: PTSD after serving in the military x 10 years
Childhood Illnesses: Denies any
Hospitalizations: Denies any
Immunizations: Up to date
Past Surgical History: none

Medication
Sertraline, 50mg PO QD, for PTSD, last dose last night

Allergies
NKDA

Family History
Mother – deceased by 58 from ACS
Father – 62 alive and well

Social History
Mr. JC is a male living with his wife. He is a driver for a company, working 6 days a week. Pt denies alcohol, cigarettes, nor illicit drug use.

Review of Systems

- General – Denies fever, chills, night sweats, recent weight loss/gain, loss of appetite, weakness, fatigue
- Skin, Hair, Nails –Denies changes in texture, excessive dryness/sweating, discolorations, pigmentations, moles/rashes, pruritis, or changes in hair distribution
- Head – Admits to H/A x 6 days, 7/10, getting worse, moving from cervical region to forehead. Also had trauma to head during MVA. Denies vertigo.
- Eyes – Admits to photophobia. Unsure about his last eye exam, 20/20 b/l eyes, does not know about the pressure. Denies visual disturbances, lacrimation, or pruritus.
- Ears – has pain, discharge, and muffled hearing on L ear. Denies tinnitus, nor hearing aids.
- Nose/Sinuses – Denies difficulty breathing, stuffy nose, rhinorrhea or epistasis.
- Mouth/throat – last dental visit unknown. Denies sore throat, mouth ulcers, bleeding gums, sore tongue, voice changes, or use of dentures.
- Neck – Admits to stiffness/decreased ROM. Denies localized swelling/lumps.
- Breast – Denies lumps, pain, or nipple discharge.
- Pulmonary System – Denies SOB, wheezing, hemoptysis, cyanosis, orthopnea, DOE, PND.
- Cardiovascular System – Denies chest pain, HTN, palpitations, irregular heartbeat, edema of ankles/feet, syncope, or known heart murmur.
- GI System – has regular bowel movements, and good appetite. Denies intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, diarrhea, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.
- GU System – Denies urinary frequency or urgency, oliguria, polyuria, dysuria, nocturia, incontinence
- Sexual History – married, monogamous relationship with wife x 20 years. Denies use of condoms, anorgasmia or history of STIs.
- Nervous System - See ROS for Head. Admits to numbness and tingling worsening from his L forearm to his thumb and pointer. Denies migraines, seizures, LOC, ataxia, loss of strength, change in cognition/mental status/memory, or weakness.
- Musculoskeletal – See ROS for Neck. Admits to muscle/joint pain at his neck and L shoulder. Denies deformity, swelling, redness, or arthritis.
- Peripheral Vascular System – Denies intermittent claudication, coldness/trophic changes, varicose veins, peripheral edema, or color change.
- Hematologic System – Denies anemia, easy bruising/bleeding, lymph node enlargement, blood transfusions, or history of DVT/PE.
- Endocrine System – Denies polyuria, polydipsia, polyphagia, heat/cold intolerance, goiter, excessive sweating, or hirsutism.
- Psychiatric – Admits to PTSD x 10 years, and had to restart his medication post-MVA. Denies depression or OCD.

General Survey
34yo M, A/Ox3, well groomed and dressed, looks his age, in NAD.

Vital Signs
Temperature: 99.8°F
Respiratory Rate: 18 breaths/min, unlabored
Pulse: 88bpm
Blood pressure: 130/82 (right arm)

Oxygen Saturation: 98% room air
Height: 5’10” ; Weight: 210lb ; BMI: 30.1

Physical Exam

Skin, Hair, Nails
Skin: warm, moist, good turgor, even texture, nonicteric. No scars, lesions, tattoos, or opacities
Nails: no clubbing, lesions, or infections noted. Capillary refill <2 seconds throughout.
Hair: average quantity, distribution, & texture, no evidence of seborrhea or lice.
Head: average sized head, atraumatic, non-tender to palpation throughout.

Eyes
Eyebrows & Eyelashes – average quantity, full distribution. No lesions noted
No redness, lesions, swelling, masses, inflammation, or excessive tearing/dryness noted.
Symmetrical alignment OU. Sclera white, conjunctiva & cornea clear.
Visual acuity - uncorrected 20/20 OS, 20/20 OD, 20/20 OU
Visual fields full OU, PERRLA, EOMs full with no nystagmus; photophobia noted on exam.
Fundoscopy – Red reflex intact, Cup:Disk < 0.5, no evidence of copper wiring, A-V nicking, hemorrhage, hard exudates, cotton wool spots, papilledema or neovascularization OU.

Ears
Symmetrical & average size. No evidence of lesions/masses/trauma on or around the ear.
No pain upon palpation on tragus or manipulation of auricle.
Bilateral EAC wnl & TM's intact and pearly grey, with light reflex in normal position. No evidence of FB noted AU. Auditory acuity, Weber and Rinne wnl AU.

Nose
Nose – Symmetrical. No obvious masses/lesions/deformities/trauma/discharge. Nontender to palpitation, no bogginess, no step-off noted. Nostrils patent bilaterally.
Unremarkable nasal mucosa and septum on exam.
Bilateral frontal & maxillary sinuses nontender to palpation. Equal transillumination glow

Mouth
Unremarkable lips, gingivae, mucosa, palate, tongue, oropharynx and uvula on exam.
Teeth - No obvious dental caries nor missing teeth noted
Mallampati Score 3, Tonsil grade 1.

Neck
Trachea midline. No masses, lesions, scars, or palpable adenopathy. Decreased ROM; tenderness to palpation at midline cervical region. No carotid bruits noted.
Thyroid - Non-tender, no palpable masses, thyromegaly, or bruits noted.

Thorax and Lungs
Chest - symmetrical, no deformities/evidence trauma/tenderness to palpitation. Lateral to AP diameter 1:1.
Respiration - unlabored / no paradoxic respirations or use of accessory muscles noted.
Lungs - Clear to auscultation and percussion bilaterally. No adventitious sounds.

Heart
RRR; S1 & S2 normal. No murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds appreciated.

Abdominal
No evidence of scars, masses, distension, striae, heriations, or abnormal pulsations.
BS present in all 4 quadrants. Tympany to percussion throughout. Non-tender to percussion or to light/deep palpation. No evidence of organomegaly, guarding or rebound tenderness, CVAT bilaterally.

Musculoskeletal
No soft tissue swelling, erythema, ecchymosis, atrophy, or deformities noted in all extremities. Tenderness to palpation noted along midline cervical region, along trapezius b/l, L flank, and from L elbow to hand. Decreased ROM noted at cervical region. Sensations, strength (5/5) and pulses (2+) intact b/l.

Nervous
Mental status – A&O x 3. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted.
Cranial Nerves – intact
Motor/Cerebellar - Full active/passive ROM of all extremities without rigidity or spasticity. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength 5/5 b/l. Gait normal with no ataxia. Tandem walking and hopping show balance intact.

Problem List

1. Unspecified headache, potential concussion
2. Muscle pain
3. PTSD

Impression

Mr. JC is 34yo male presenting s/p MVA 6 days ago. The worsening headache that occurred after the MVA, accompanied by the head trauma, light sensitivity and nausea, suggest that the pt may be suffering from a concussion. As for the cervical, trapezius, and L flank tenderness, it is probably due to muscle strain from the whiplash and the impact. The numbness and tingling experienced at the L forearm to thumb and pointer may be due to median nerve compression due to inflammation from some of the effected muscles on the L arm.

Plan

1. Advised patient to go to the ER to r/o brain injury with a CT scan
2. If muscle pain continues, consider prescribing muscle relaxers and advising to rest.