Patient: **WUNDERLICH, ANNA W** Date: **02 Jan 2009 0807 MST** Appt Type: **ACUT$**
Treatment Facility: **CHCSII ITT Facility** Clinic: **CHCSII Test Clinic** Provider: **USER, TEST**
Patient Status: **Outpatient**

Reason for Appointment: PC GENERIC DEMO

AutoCites Refreshed by USER, TEST @ 02 Jan 2009 0809 MST

Problems
Chronic:
• Allergic rhinitis

Allergies
• No Known Allergies

Vitals
Vitals Written by USER, TEST @ 02 Jan 2009 0855 MST
BP: 120/75, HR: 72, RR: 12, T: 98.7 ℉, WT: 125 lbs

SO Note Written by USER, TEST @ 02 Jan 2009 0854 MST
Chief complaint
The Chief Complaint is: URI.
History of present illness
The Patient is a 25 year old female.

Patient with several day history of upper respiratory infection symptoms to include nasal congestion, nonproductive cough, mild malaise and myalgias. Patient denies fever, chills, no shortness of breath or chest pain.
Patient is healthy with no major medical problems.
No recent travel or unusual exposure.
No history of reactive airway disease.
Current medication
Zyrtec P.O. 10 Mg One Tab Each Day As Needed Next Is Flonase NAS 0.05% Spray 2 Sprays Each Nostril Each Day.
Personal history
This visit is not deployment related. Patient not late on menses, not trying to become pregnant and is not breast feeding. Patient has not expressed any depressive symptoms, no problems with activities of daily living, no concerns over domestic violence, and no dietary concerns. Patient is a non smoker and occasionally consumes alcohol on a social basis. No communication barriers, no barriers to learning, and no conflicts with religious practices identified.
Review of systems
Generalized malaise, mild myalgias, nasal congestion, sneezing and non productive cough. No headache, no visual symptoms, no neck stiffness, no ear pain, no shortness of breath, no chest pain, no palpitations, no wheezing. No abdominal pain, mild decreased appetite but taking po fluids well, no nausea or vomiting, no diarrhea or constipation, urinating normally, no dysuria, no frequency. Patient denies any joint pain or rashes.

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Physical findings
General: no apparent distress, alert, non-toxic appearing
HEENT: PERRLA, sclera non-icteric, mild conjunctival injection, TM's: normal, non-erythematous, good light reflex. Nares: congested Sinuses: non-tender Pharynx: membranes moist, non-erythematous, no exudate, uvula non-swollen and midline
Neck: supple, no adenopathy, no masses
Chest: non labored breathing, no accessory muscle usage, no wheezing or rhonchi, no dullness to percussion
CV: regular rate and rhythm, normal S1, physiologic split S2, no murmur or rub, no S3
Abdomen: normal contour, normal bowel sounds, non-tender, no guard or rebound, no organomegally or masses
Extremities: full range of motion, no joint tenderness or calor
Skin: good turgor, no jaundice, no lesions
Neuro: grossly intact, no obvious sensory or motor deficits noted, normal gait
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A/P Written by USER, TEST @ 02 Jan 2009 0906 MST
1. UPPER RESPIRATORY INFECTION: Viral upper respiratory infection: no evidence of invasive bacterial infection, non toxic and well hydrated. Most likely patient has a self limiting viral infection. Do not see where any further testing or imaging is necessary at this time.

Treatment:
1. Supportive care, rest, good hygiene, encourage to take oral fluids.
2. Tylenol 325mg two tablets every four hours as needed for fever or pain
3. Afrin 2 puffs in each nostril every 12 hours for no more than three days
4. Sudafed 30mg one tablet by mouth every six hours as needed for congestion
5. Patient is to return to the clinic or Emergency Room if symptoms worsen or change significantly. The patient verbalized understanding and agreement of treatment plan.

Disposition Written by USER, TEST @ 02 Jan 2009 0908 MST
Released w/o Limitations
Follow up: with PCM.

Signed By USER, TEST (Training Tool Application, CHCSII ITT Facility) @ 02 Jan 2009 0909