

Consultation Report

PATIENT NAME	SSN / ID	DOB	AGE	SEX	EXAM DATE	ATTENDING PHY	REFERRAL
Janet Smith*	MDR-825	3/25/1941	65	F	06-01-2006	Urfan Dar, M.D.	John Williams, M.D.

Chief Complaint : Patient is a 65 year old lady who presents to us with complaints of low back pain, left hip pain and left lower leg pain, neck pain dating back 8 years. Patient says sitting too long, laying in bed as the cause of pain/injury. Patient reports pain as throbbing, sharp, constant in neck, back, left leg. Pain radiates from left to right particularly standing still, laying still. Pain is relieved by medication.

Medications : Celebrex 200 mg once a day
Tylenol 2 in am, 2 in pm

Allergies : Sulfa - hives

Hospitalization & Surgery : 1. The patient was admitted for herniated disk in 6/1997. Surgery was performed in Methodist Hospital by Roberto Aranibar, M.D.
2. The patient was admitted for ruptured disk in 8/1997. Surgery was performed in Methodist Hospital by Roberto Aranibar, M.D.
3. The patient was admitted for hysterectomy in 6/1975. Surgery was performed in NIX Hospital by Felipe Estrada, M.D.

Medical History : High blood pressure, fatigue, arthritis, ulcers

Family History : Mother: High cholesterol.
Father of age 92: Arthritis.
Father's Mother: Arthritis.

Systems Review : Constitution: No history of fever or chills. No history of loss of appetite. No history of weakness. No history of weight gain or loss.
Eyes, Ears, Nose and Throat: No dizziness. No hoarseness. No history of nose bleed. No history of sinusitis. No change in voice. No discharge. No glasses/contacts. No other eye problems.
Respiratory: No history of pain in chest. No claudication. No history of cough. No dyspnea. No edema. No hemoptysis. No history of murmurs. No nocturia. No orthopnea. No palpitation. No pleuritic pain. No history of shortness of breath. No sputum. No wheezing.
Psychiatric: No history of anxiety or depression. No history of suicidal thoughts.
Neurologic: No depression. No dizziness or fainting. No headache. No weakness or paralysis. No seizures. No tremors.
Hematologic: No anemia. No history of abnormal bleeding.

Physical Exam : General: Well developed, well nourished patient. Alert and oriented.
Eyes: No evidence of conjunctivitis, discharge or visual abnormalities.
HENT: Hearing seems normal. Tongue in mid line, no fasciculation seen. Tonsils not enlarged.
Neck: Thyroid gland not enlarged. Trachea central in position.
Heart: S1 and S2 appear normal. No S3, S4 or murmur. JVP not increased.
Respiratory: Equal breath sounds. No evidence of any dullness or tenderness on the chest. Antero-posterior diameter of the chest seems normal. No evidence of rales. Movements with respiration appear bilaterally, symmetrically and normal. Trachea seems in midline. No wheezing.
Lymphatic: No lymphadenopathy.
Musculoskeletal: Normal examination of gait. No clubbing. No cyanosis. Normal capillary refill.
Neurologic/Back: Cranial nerves normal. No evidence of motor weakness. Deep tendon reflexes normal. Gait normal.
Psychiatric: Normal mood. Oriented to time and place.

Impression : Neck pain
Pain, hip 719.45

Co-Morbidity : Pain, knee 749.46

Plan : 2 month office follow up.
Brief course of physical therapy.
Hip joint injection with steroid. Plans, risks and options were discussed with the patient in detail.

Signature : _____ (Urfan Dar, M.D.)