CZAR SACRAMENTO, PA-C (Chula Vista)

******Mr. Sacramento is a very difficult dictator. Keep in mind that he does tend to use routine phrases, especially when he's mumbling/slurring. Samples belowshould be used to help reduce blanks. However, keep in mind that these are only samples, and it is still up to you, the MLS, to ensure that the text matches what was dictated.******

Sample #1:

CHIEF COMPLAINT:
Left foot pain and ankle pain.

HISTORY OF PRESENT ILLNESS:
This is a 25-year-old female who twisted her foot yesterday while wearing high heels. She states that she was able to walk on afterwards but has increasing pain and swollen. She denies numbness, tingling, or other symptoms at this time.

PAST MEDICAL HISTORY:
None.

PAST SURGICAL HISTORY:
No surgeries.

SOCIAL HISTORY:
The patient does smoke occasionally. The patient denies drug use. The patient's last menstrual period was 2 weeks ago, denies being pregnant.

MEDICATIONS:
None.

ALLERGIES:
No known drug allergies.

REVIEW OF SYSTEMS:
GENERAL: No fever, no weight loss.
EYES: No vision changes, pain.
EAR, NOSE, AND THROAT: No congestion or sore throat.
CARDIOVASCULAR: No chest pain or palpitations.
RESPIRATORY: No shortness of breath, cough.
GASTROINTESTINAL: No abdominal pain, nausea, vomiting, diarrhea.
MUSCULOSKELETAL: Left foot and ankle pain.
NEUROLOGICAL: No black outs, seizures, or headache.

All else negative.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.5, BP 116/70, pulse 77, respirations 17, pain 8/10, pulse oximetry 98% on room air, which is interpreted as normal for this patient.

GENERAL: This patient is well developed, well nourished, non-toxic appearing.
HEENT: Reveals normocephalic, atraumatic. Bilateral TMs are normal. Oropharynx is normal. Moist mucus membranes. Eyes: PERRLA. Funduscopic examination: No pupil edema. No cotton wool spots. No AV nicking.
NECK: Supple, nontender. No midline tenderness. No pain on range of motion of the neck, chin-to-chest, or turning to either side.
CHEST: S1 and S2, regular rate and rhythm.
LUNGS: Bilaterally clear to auscultation. No accessory muscle use is seen.
ABDOMEN: Soft, nontender, nondistended. No rebound or guarding. Normoactive bowel sounds.
EXTREMITIES: Normal to inspection and palpation with the exception of left lower extremity. No pain on palpation of the left hip, left knee. Positive tenderness to the left ankle. The patient has posterior dorsal pedal pulses. Sensation to light touch.
NEUROLOGICAL: The patient has intact cranial nerves II-XII. No sign of focal weakness, lateralization, or cerebellar signs.

DIAGNOSTIC STUDIES:
I went ahead and got the following diagnostic studies. X-ray of the foot and ankle was negative for fracture, dislocation, or foreign body.

I gave this patient an air cast splint and crutches, placed by tech and evaluated by myself to be neurovascularly intact. This was properly immobilized.

EMERGENCY ROOM DECISION MAKING:
This is a 25-year-old female who is coming in for foot and ankle pain. The symptoms are most consistent with sprain and strain. X-ray studies are negative. The patient is neurovascularly intact. No signs of any neurovascular or neurological compromise, so outpatient therapy is felt appropriate. The patient to be discharged home in stable condition.

DIAGNOSES:
1. Sprain ankle.
2. Acute interpretation of pulse oximetry is 99% on room air which is normal for this patient.

DISCHARGE PLAN:
For this patient to follow up at Chula Vista Family Health Center in the next 1 to 2 days for recheck. For this patient to get prescription for Vicodin and ibuprofen. For this patient to please return if increased pain, development fever, or other change in symptoms.

Scheduled medication(s) had patient specific approval from the supervising physician.

Sample #2:

CHIEF COMPLAINT:
Rash all over body.

HISTORY OF PRESENT ILLNESS:
This is a 32-year-old female who is coming in for rash all over body that has been going on for the last 5 days. She says that it started on her arms and now it is on her lower extremities as well. She denies any

symptoms of fever. She says it is very itchy. She says that when she puts water on it, it is worse. She went to the Scripps Emergency Room, and she was told that it is a local skin irritation, and she had appointment with her primary doctor in the next few days, but she says due to the itching, she got concerned and came to the emergency room for treatment. The patient also shares the bed with her son, and her son has not developed any rash.

PAST MEDICAL HISTORY:
None.

PAST SURGICAL HISTORY:
No surgical history.

SOCIAL HISTORY:
Lives with family.

IMMUNIZATIONS:
Up to date.

MEDICATIONS:
None.

ALLERGIES:
No allergies.

REVIEW OF SYSTEMS:
GENERAL: No fever, no weight loss.
EYES: No vision changes, pain.
ENT: No congestion or sore throat.
CARDIOVASCULAR: No chest pain or palpitations.
RESPIRATORY: No shortness of breath, cough.
GASTROINTESTINAL: No abdominal pain, nausea, vomiting, diarrhea.
MUSCULOSKELETAL: No joint pain or back pain.
NEUROLOGICAL: No black outs, seizures, or headache.
DERMATOLOGIC: Positive rash.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 98.5; BP of 135/73; pulse of 74; respiratory rate 16; pain 0/10; pulse ox 99% on room air, normal for the patient.
GENERAL: This patient is well developed, well nourished, non-toxic appearing.
HEENT: Reveals normocephalic, atraumatic. Bilateral TMs are normal. Oropharynx is normal. Moist mucus membranes. Eyes: PERRLA. Funduscopic examination: No pupil edema. No cotton wool spots. No AV nicking.
NECK: Supple, nontender. No midline tenderness. No pain on range of motion of the neck, chin-to-chest, or turning to either side.
CHEST: S1 and S2, regular rate and rhythm.
LUNGS: Bilaterally clear to auscultation. No accessory muscle use is seen.
ABDOMEN: Soft, nontender, nondistended. No rebound or guarding. Normoactive bowel sounds.
EXTREMITIES: Normal to inspection and palpation.

NEUROLOGICAL: The patient has intact cranial nerves II-XII. No sign of focal weakness, lateralization, or cerebellar signs.
DERMATOLOGIC: The patient has fine papules seen throughout the body. It is all over on the upper arms. There appears to be no signs of red streaking, no signs of any ecchymosis, no other acute findings.

EMERGENCY ROOM DECISION MAKING:
This is a 32-year-old female who is coming in here for rash all over the body. We were concerned about possible viral exanthem. The patient is up to date with immunizations, afebrile here, has no URI symptoms or other symptomatology, and is only complaining of rash. We were concerned about possible scabies or possible mite. The patient has her son who is sharing the bed with her and does not have any rash. It has been going on for 5 days, so it is felt that if this was parasitic that it should be infecting multiple people in the family. We were concerned about possible meningococcemia. The patient is afebrile, nontoxic appearing. Did consider possible fungal infection. The patient has no central clearing, is not discolored. The patient is assessed and thought to be clinically well, so outpatient therapy is felt to be appropriate. The patient is going to be discharged home.

DISCHARGE DIAGNOSES:
1. Allergic reaction.
2. Acute interpretation of pulse oximetry which is 99% on room air, normal for the patient.

DISPOSITION:
The patient will be discharged.

PLAN:
As follows: The patient to follow up with her primary doctor as previously scheduled; the patient given prescription for Claritin and hydrocortisone because the patient is wanting to continue breastfeeding. For this patient, please return to the emergency room if develop fever or if other family contacts are having developed a rash.

Sample #3:

HISTORY OF PRESENT ILLNESS:
This is an 18-year-old female who is coming here for cough and fever that have been going on for the last one day. She denies any vomiting or diarrhea symptoms. She denies any abdominal cramping. She was also seen here one day ago for miscarriage. She says that it has actually gotten better. She is coming in today because of the fever and cough. She denies any vomiting or other symptoms.

PAST MEDICAL HISTORY:
Asthma.

PAST SURGICAL HISTORY:
No surgical history.

SOCIAL HISTORY:
The patient denies smoking, drinking, or drug use.

IMMUNIZATIONS:
Up to date.

MEDICATIONS:
Macrobid.

ALLERGIES:
No known allergies.

REVIEW OF SYSTEMS:
GENERAL: No fever, no weight loss.
EYES: No vision changes, pain.
ENT: No congestion or sore throat.
CARDIOVASCULAR: No chest pain or palpitations.
RESPIRATORY: Positive fever and cough.
GASTROINTESTINAL: No abdominal pain, nausea, vomiting, diarrhea.
MUSCULOSKELETAL: No joint pain or back pain.
NEUROLOGICAL: No black outs, seizures, or headache.

All other review of systems negative.

PHYSICAL EXAMINATION:
GENERAL: This patient is well developed, well nourished, non-toxic appearing.
HEENT: Reveals normocephalic, atraumatic. Bilateral TMs are normal. Oropharynx is normal. Moist mucus membranes. Eyes: PERRLA. Funduscopic examination: No pupil edema. No cotton wool spots. No AV nicking.
NECK: Supple, nontender. No midline tenderness. No pain on range of motion of the neck, chin-to-chest, or turning to either side.
CHEST: S1 and S2, regular rate and rhythm.
LUNGS: Positive erythema of the throat.
ABDOMEN: Soft, nontender, nondistended. No rebound or guarding. Normoactive bowel sounds.
EXTREMITIES: Normal to inspection and palpation.
NEUROLOGICAL: The patient has intact cranial nerves II-XII. No sign of focal weakness, lateralization, or cerebellar signs.

EMERGENCY ROOM DECISION MAKING:
This is an 18-year-old female who is coming in for fever and cough. I felt this is most consistent with a pharyngitis. The patient is going to get antibiotic therapy to help with this. We did consider possible mono. The patient has no abdominal pain or tenderness. With regard to the miscarriage, she is not having any pain or tenderness here, is clinically well appearing, so outpatient therapy is felt to be appropriate. The patient is going to be discharged home in stable condition.

DIAGNOSES:
1. Pharyngitis.
2. Acute interpretation of pulse oximetry which is 99%, normal for the patient.

DISPOSITION:
The patient will be discharged.

PLAN:
As follows: For this patient to follow up in the Chula Vista Family Health Center in the next 1-2 days; for this patient to get educational materials and prescription for azithromycin, Robitussin, prednisone, and Proventil; and for this patient to please return to the emergency room sooner for increased pain or develops fever or other change in symptoms.