Subjective:

Established Patient Visit

November 3, 2014

JB is a 9 year old black male.

Informants: Patient and his mother DB.

Chief Complaint (CC):

“My throat hurts and I can barely swallow.”

History of Present Illness (HPI):

9 year old black male presents with red, swollen and tender throat. It started hurting on the previous day while he was at school. He rates the pain 8/10 on a scale of 1-10. The pain is burning and scratchy. Talking makes the pain worse and warm or cold liquids helps decrease the pain. He has not tried any medications to help alleviate the pain. He denies any associated symptoms such as fever, cough, nasal congestion, nausea, vomiting, or ear pain. No one else in the home has been sick recently but several classmates have been absent from school.

Past Medical History (PMH):

No known food or drug allergies. Denies current use of prescription or over the counter medications. Immunizations up to date. Had flu shot 10/10/14. No significant medical history. No history of injuries, hospitalizations, or surgeries.

Family History (FH):

Father is 34 years old with no significant medical history. Mother is 32 years old with no significant medical history. They have one other child, a 4 year old boy, with no significant medical history. Paternal grandfather has a history of HTN. Paternal grandmother has a history of DM. Maternal grandfather has a history of HTN. Maternal grandmother has a history of HTN.

Social History (SH):

JB is currently in the 3rd grade at Oxford Elementary School, AL. He lives with his mother, father, and brother in Oxford, AL in a single family home. He eats an unrestricted diet. Mother reports the use of smoke alarms in the home. JB wears his seatbelt and uses a helmet when riding his bicycle. There are no firearms in the home. The family has no pets in the home. JB denies the use of drugs, alcohol, or tobacco. The family is of the Baptist faith. JB has BCBS PEEHIP insurance and his mother does not express concerns related to cost of care.

Review of Systems (ROS):

1. Constitutional Symptoms: Denies any recent weight loss or gain. Denies fever, recent, or repeated infections. Denies fatigue or inability to independently perform activities of daily living.
2. Eyes: Does not wear glasses. Denies double or blurred vision. Denies using any medications for his eyes. Denies redness, excessive tearing, pain, or trauma to the eyes. Last eye exam was at least 1 ½ years ago.
3. Ears, Nose, Mouth, and Throat: Ears: Denies any difficulty hearing. Denies tinnitus, infection, pain, vertigo, or the use of assistive devices. Nose: Denies difficulty smelling. Denies discharge, obstruction, epistaxis, or sinus problems. Mouth and teeth: Denies the use of oral tobacco. He does not floss but brushes his teeth daily with fluoride toothpaste. His last dental visit was approximately 1 year ago and no dental caries were present. Denies bleeding of gums, changes in sense of taste, mouth odor, ulcers, or sores on tongue. Throat: Complains of sore throat, hoarseness, and difficulty swallowing.
4. Cardiovascular: Participates in regular physical activity. Denies history of abnormal heart sounds, murmur, chest pains, palpitations, dyspnea, activity intolerance, hypertension, or irregular rate or rhythm. No history of ECG or cholesterol level. No edema, claudication, or varicose veins.
5. Respiratory: Denies being exposed to second hand smoke. Denies a history of respiratory infections or exposure to TB. He has never had a TB skin test. Denies difficulty breathing, wheezing, hemoptysis, sputum production, or night sweats.
6. Gastrointestinal: Eats an unrestricted diet with little attention to nutritional value. Denies use of nutritional supplements, heartburn, epigastric pain, abdominal pain, nausea, vomiting, food intolerance, flatulence, diarrhea, or constipation. Usual bowel movements daily without difficulty. Denies changes in stools, hemorrhoids, or jaundice.
7. Genitourinary: Denies nocturia, dysuria, or incontinence. Denies sexual activity or presence of venereal disease.
8. Musculoskeletal: Regular physical activity. Denies neck pain or stiffness, joint pain or swelling, back pain, paralysis, deformities, or changes in range of motion.
9. Integumentary: Denies regular skin care practices or use of sunscreen. Denies nail deformity, hair loss, moles, or bruising.
10. Neurologic: Denies muscle weakness, syncope, stroke, seizures, paresthesias, involuntary movements, tremors, headaches, or memory loss.
11. Psychiatric: Denies nightmares, mood changes, depression, anxiety, nervousness, insomnia, or suicidal thoughts
12. Endocrine: Denies thyroid problems, cold or heat intolerance, polydipsia, polyphagia, or polyuria. Denies changes in skin, hair, or nail texture. Denies unexplained weight changes or changes in facial or body hair.
13. Hematologic/Lymphatic: Denies bruising, unusual bleeding, fatigue, anemia, history of blood transfusion, or swollen or tender glands. Unknown history of hgb/hct results.
14. Allergic/Immunologic: Denies seasonal allergies or previous allergy testing. Denies any potential for blood or body fluid exposure. Denies immunosuppression in self or family. Denies use of steroids.

Objective:

Height: 53 in (50th percentile), Weight: 76 lbs (75th percentile), BMI: 19.0 (85th percentile)

Vital Signs: Temp 98.6, BP: 120/68, Pulse: 90, RR: 23, O2 sat: 99% on RA

1. Constitutional: JB is well-nourished, well-developed 9 year old black male. He is in no acute distress.
2. Eyes: Conjunctiva pink, sclera white. Pupils are equal, round, reactive to light, and accommodating at 5 mm bilaterally. No redness or drainage from the eyes.
3. Ears, Nose, and Throat: Ears: Hearing is adequate. No drainage from the ears. Tympanic membranes clear. No redness or drainage, wax present. Nose: Mucosa pink, septum midline. No nasal drainage or congestion. No tenderness of the frontal or maxillary sinuses. Throat: Oral mucosa moist and pink. Oropharynx erythematous without exudate. Tonsils present. No evidence of bleeding gums or foul odor. No ulcers or sores.
4. Cardiovascular: Normal S1, S2. No S3, S4. Regular rate and rhythm. No clicks, gallops, or murmurs. No carotid bruits. No edema or varicose veins.
5. Respiratory: Clear to auscultation and percussion bilaterally. No rales, wheezes, or rhonchi. RR even and unlabored.
6. Gastrointestinal: Bowel sounds normal in all four quadrants. Soft, non-distended, non-tender.
7. Genitourinary: No costovertebral tenderness present.
8. Musculoskeletal: No tenderness or swelling to the joints. No abnormal curvature of the spine. Bilateral upper and lower extremities strong and equal.
9. Integument/Lymphatic: No cyanosis, ecchymosis, or petechiae. No swollen or tender glands or lymph nodes.
10. Neurologic: No tremors or involuntary movements. Alert and oriented to person, place, time, and situation. Able to answer all questions appropriately.
11. Psychiatric: Patient calm and cooperative. No anxiety or nervousness. No hyperactivity or behavioral problems. Interacts appropriately with mother and staff.
12. Hematologic/Immunologic: No evidence of bruising or bleeding. No swollen or tender glands or lymph nodes.

Diagnostic Tests:

87880 Strep Screen – negative

87804 QW Flu – negative

Assessment:

CPT Code: 99213 Established Patient / Intermediate

Differential Diagnoses:

1. Strep Throat 034.0 – sore and scratchy throat, difficulty swallowing, oropharynx is red but no exudate or patches are present, no fever, headache, nausea, vomiting, stomachache, rash, negative strep screen
2. Seasonal Allergies 477.9 – red, sore scratchy throat with difficulty swallowing which can be caused by the irritation of post nasal drip associated with seasonal allergies, he denies sneezing, wheezing, nasal congestion, coughing, itchy or watery eyes, or runny nose; no history of allergies
3. Flu 487 – red, sore throat with difficulty swallowing, but denies fever, chills, fatigue, body aches, runny nose, nausea, vomiting, or diarrhea; negative flu screen
4. Mononucleosis 075 – red, sore throat with difficulty swallowing, denies fatigue, malaise, fever, swollen lymph nodes, headache, or skin rash.
5. Pharyngitis 462 – red, sore throat with difficulty swallowing. No symptoms that often accompany pharyngitis are present such as sneezing, runny nose, headache cough, fever. However the strep was negative, the flu was negative, he has not had fever or swollen lymph nodes, and he does not have a history of allergies. Therefore, acute pharyngitis is my definitive diagnosis.

Diagnosis:

Acute Pharyngitis 462

Plan:

The following plan has been discussed and agreed on by CH and TH for the diagnosis of:

Acute Pharyngitis

1. Educate the mother that treatment will be symptomatic only at this time.
2. Instruct them to use one of the following for pain relief:
3. Motrin
4. Tylenol –
5. Indicated for this patient for pain relief.
6. The exact site and mechanism of analgesic action is not clearly defined, but it appears to produce analgesia by elevating the pain threshold.
7. 10-15 mg/kg every 4 to 6 hours not to exceed 5 doses (50-75 mg/kg) in 24 hours

76 lbs ÷ 2.2 = 34.5 kg x 15 mg = 517.5 mg ~ 500 mg every 4 to 6 hours

1. Available in brand name and generic: Tylenol and acetaminophen
2. Costs:
3. Wal-Mart $4.97
4. CVS $7.99
5. Target $5.69
6. Instruct them to use warm saline gargles to soothe the throat.
7. Instruct them to use hard candy or lozenges to soothe the throat.
8. Educate them to call the office if pain becomes more severe or if dyspnea, drooling, inability to swallow, or inability to fully open his mouth occurs.
9. Advise them to increase fluid intake.
10. Schedule for follow-up in 3-4 days if there is no significant improvement of symptoms. Sooner if symptoms worsen.