Patient 1

Subjective:
45-year-old female with no significant PMH presents with right eye irritation that started 2 days ago. Pt states there was pus coming out of her right eye and it felt like something was in her eye. She states that it felt like her eye was glued shut in the morning. Pt also says that last night she noticed pus in the left eye. She applies chamomile tea every 4 hours to clean her eyes and cleaned them both before coming to urgent care. She reports having this irritation a couple of times before but never took antibiotics. Admits to itching. Denies wearing contacts, blurriness, tearing, acute visual loss, fever, chills, night sweats.

Objective:
Vital Signs:
BP: 118/82, HR 97/min, RR 16, O_2 Sat 97% RA, Temp 98.7 °F Oral
Physical Exam
General: A&O x3, well appearing, well nourished, in no acute distress
HEENT:
Head: Normocephalic, atraumatic, no visible or palpable masses
Eyes: Right Eye: Visual acuity intact, PERRLA, EOM intact, erythematous conjunctiva, sclera non-icteric Left Eye: Visual acuity intact, PERRLA, EOM intact, conjunctiva clear, sclera non-icteric
Ears: EACs clear, TMs pearly white with intact light reflex in normal position AU
Nose: No external lesions, mucosa non-inflamed, septum and turbinates unremarkable
Mouth: Mucous membranes moist, no mucosal lesions
Throat: Mucosa non-inflamed, uvula midline, no tonsillar hypertrophy or exudate
Lymph Nodes: no palpable adenopathy
Heart: Regular rate and rhythm, S1 S2 present, no murmurs, rubs, or gallops
Lungs: clear to auscultation bilaterally, no adventitious sounds noted
Abdomen: nondistended, BS present in all 4 quadrants, no bruits noted, soft and nontender to palpation, no masses noted
PV: no cyanosis, clubbing, edema, pulses 2+ bilaterally in upper and lower extremities
Neuro: cranial nerves 2-12 intact with no focal, motor or sensory abnormality noted in upper or lower extremities

Assessment:
45-year-old female with no significant PMH presents with right eye irritation x2 days. History and findings consistent with bacterial conjunctivitis of right eye.

Plan:
- Bacterial Conjunctivitis of right eye
    - Start Ofloxacin Solution, 0.3%, Ophthalmic, 1-2 drops into affected eye q2-4h x2 days, then 1-2 drops qid x5 days
    - Pt instructed on proper eye hygiene
- Pt advised to go to ED if new or worsening symptoms develop including but not limited to difficulty seeing, severe headache, facial swelling, and/or chest pain.
- Pt advised to follow up with PCP and/or Ophthalmology

Patient 2

Subjective:
48-year-old male with PMH of Ulcerative Colitis presents with right sided flank pain that started 2 days ago. Pt reports that he ate bad blueberries 3 days ago which led to vomiting that night. The next day he began feeling pain on the right side of his back and thought it was due to the effort from the vomiting. Pain does not radiate anywhere, and he rates it a 4 or 5/10. Pt states nothing makes the pain better or worse. Denies fever, chills, night sweats, weight loss, abdominal pain, oliguria, dysuria, hematuria.

Objective:
Vital Signs:
BP: 159/105, HR 98/min, RR 16, O_2 Sat 97% RA, Temp 100.9 °F Oral

Physical Exam
General: A&O x3, well appearing, well nourished, in no acute distress
HEENT:
- Head: Normocephalic, atraumatic, no visible or palpable masses
- Eyes: PERRLA, EOM intact, conjunctiva clear, sclera non-icteric bilaterally
- Ears: EACs clear, TMs pearly white with intact light reflex in normal position AU
- Nose: No external lesions, mucosa non-inflamed, septum and turbinates unremarkable
- Mouth: Mucous membranes moist, no mucosal lesions
- Throat: Mucosa non-inflamed, uvula midline, no tonsillar hypertrophy or exudate

Lymph Nodes: no palpable adenopathy
Heart: Regular rate and rhythm, S1 S2 present, no murmurs, rubs, or gallops
Lungs: clear to auscultation bilaterally, no adventitious sounds noted
Abdomen: nondistended, BS present in all 4 quadrants, no bruits noted, soft and nontender to palpation, no masses/lesions/scars noted, Right sided CVA tenderness noted
PV: no cyanosis, clubbing, edema, pulses 2+ bilaterally in upper and lower extremities
Neuro: cranial nerves 2-12 intact with no focal, motor or sensory abnormality noted in upper or lower extremities

U/A:

LEU	Neg	PRO	1+
NIT	Neg	pH	6.0
URO	Neg	BLO	3+

Assessment:
48-year-old male with PMH of Ulcerative Colitis presents with right sided flank pain that started 2 days ago. UA shows proteinuria and hematuria.

Plan:
- Based on 3+ blood and 1+ protein on UA, right sided CVA tenderness and elevated BP, patient advised to proceed to ER for CT scan and bloodwork for further evaluation and treatment.

Patient 3

Subjective:
24-year-old male with no significant PMH presents with an abscess on his right big toe. Pt says he had an ingrown nail that started bothering him a week ago and 3 days ago he noticed the abscess forming. Pt states it has gotten bigger over the past 3 days. Denies fever and any redness, swelling, drainage, or tenderness of toe.

Objective:
Vital Signs:
BP: 120/76, HR 78/min, RR 18, O_2 Sat 98% RA, Temp 98.1 °F Oral
Physical Exam
General: A&O x3, well appearing, well nourished, in no acute distress
Skin: abscess noted in right big toe near lateral nail plate
HEENT:
Head: Normocephalic, atraumatic, no visible or palpable masses
Eyes: PERRLA, EOM intact, conjunctiva clear, sclera non-icteric bilaterally
Ears: EACs clear, TMs pearly white with intact light reflex in normal position AU
Nose: No external lesions, mucosa non-inflamed, septum and turbinates unremarkable
Mouth: Mucous membranes moist, no mucosal lesions
Throat: Mucosa non-inflamed, uvula midline, no tonsillar hypertrophy or exudate
Lymph Nodes: no palpable adenopathy
Heart: Regular rate and rhythm, S1 S2 present, no murmurs, rubs, or gallops
Lungs: clear to auscultation bilaterally, no adventitious sounds noted
Abdomen: nondistended, BS present in all 4 quadrants, no bruits noted, soft and nontender to palpation, no masses noted
PV: no cyanosis, clubbing, edema, pulses 2+ bilaterally in upper and lower extremities
Neuro: cranial nerves 2-12 intact with no focal, motor or sensory abnormality noted in upper or lower extremities

Assessment:
24-year-old male with no significant PMH presents with an abscess on his right big toe x3 days.
Plan:
- Cellulitis:
  - Start Bactrim DS tablet 160mg/800mg PO BID x10 days
- I&D of abscess:
  - Prep: Skin cleaned with betadine.
  - Guidance: Palpation used for guidance.
  - Technique: 18-gauge needle used to incise the skin contiguous with the abscess.
  - Yield: purulent fluid.
  - Result: substantially decompressed the swelling
  - Dressing: clean dressing placed
  - Tolerance: patient tolerated well
  - Disposition: pt sent home in stable condition
- Pt advised to apply warm compress to the site.
- Pt advised to proceed to ED if new or worsening symptoms develop including but not limited to fever, chills, swelling, redness, pain or other concerning symptoms.

Patient 4

Subjective:
6-year-old female with Down's syndrome presents with right arm pain x1 day. Per mother, they were at the park yesterday and she noticed her daughter fell by a metal slide. She is not sure how the daughter fell but said by the time she got to her, pt was grabbing her arm crying from the pain, but it later went away. Later on that night when she was changing her out of her shirt, she noticed her daughter looked in pain when she was taking her shirt off of the right arm. Mother did not give her any medications for the pain. ROS difficult to assess as patient could not respond to most questions.

Objective:
HR 91/min, RR 18, O_2 Sat 97% RA, Temp 99.4 °F Oral

Physical Exam
General: alert, well appearing, well nourished, in no acute distress
HEENT:
- Head: Normocephalic, atraumatic, no visible or palpable masses
- Eyes: PERRLA, EOM intact, conjunctiva clear, sclera non-icteric bilaterally
- Ears: EACs clear, TMs pearly white with intact light reflex in normal position AU
- Nose: No external lesions, mucosa non-inflamed, septum and turbinates unremarkable
- Mouth: Mucous membranes moist, no mucosal lesions
- Throat: Mucosa non-inflamed, uvula midline, no tonsillar hypertrophy or exudate

Lymph Nodes: no palpable adenopathy
Heart: regular rate and rhythm, S1 S2 present, no murmurs, rubs, or gallops
Lungs: clear to auscultation bilaterally, no adventitious sounds noted
Abdomen: nondistended, BS present in all 4 quadrants, no bruits noted, soft and nontender to palpation, no masses noted
PV: no cyanosis, clubbing, edema, pulses 2+ bilaterally in upper and lower extremities
Neuro: cranial nerves 2-12 intact with no focal, motor or sensory abnormality noted in upper or lower extremities
Musculoskeletal: no soft tissue swelling, erythema, ecchymosis or deformities in bilateral upper and lower extremities. Non-tender to palpation. Passive FROM of all upper and lower extremities. Active ROM difficult to assess. No evidence of spinal deformities.

X-ray: Closed nondisplaced fracture of surgical neck of right humerus

Assessment:
6-year-old female with Down Syndrome presents with right arm pain x1 day. X-Ray showed closed nondisplaced fracture of surgical neck of right humerus.
Plan:
- Closed nondisplaced fracture of surgical neck of right humerus
  - Sugar Tong splint using Ortho-Glass and sling applied
  - Post sling application evaluation revealed patient is neurovascularly intact. Pt tolerated procedure well
  - Parent advised to follow up with PCP and/or Orthopedics as soon as possible.
- Right arm pain:

- OTC Tylenol/Motrin as needed for pain/swelling
- RICE instructions given
- Parent advised to have child avoid strenuous activities with extremity at this time
- Parents advised to proceed to ED if any worsening or concerning symptoms develop including, but not limited to, increase in pain, swelling, numbness, tingling, fever, or chills.