

# Document: Provider Notes

## Student Documentation

### Subjective

Daniel "Danny " Rivera, 8 year old male of Puerto Rican descent. CC: "patient's abuela brought him in because he has been feeling sick and coughing a lot and feel kind of tired."

HPI: Cough onset 5 days ago, pt describe cough "gurgly and watery" . reports sputum color is clear. Reports coughing every few minutes and worse at night. Patient denies smoking but exposed to secondhand smoke in the house through father and grandfather. Reports does not know what makes his cough worse. Alleviating factors of the cough is some cough medicine in the morning. Reports having cough medicine everything for the past 5 days, describes it as purplish in color one spoon full and giving my mom. Has physical exercise everyday still able to run around and play and cough not making it difficult to play gets bored with easy school work. Reports currently having a runny nose and frequent rhinorrhea denies any sneezing. Reports nasal drainage clear and watery also thin. Reports a 3/10 in Right ear. Denies any pain to the left ear. Patient reports history of frequent ear infections around 2 years of age. Can I use any ear drainage or hearing problems. Had hearing test at school approximately about a month ago.

Current Medication: Multi vitamin every day "gummy dinosaur", cough med for the past 5 days

## Model Documentation

Danny reports a cough lasting four to five days. He describes the cough as "watery and gurgly." He reports the cough is worse at night and keeps him up. He reports general fatigue due to lack of sleep. He reports pain in his right ear. He is experiencing mild soreness in his throat. He reports his mother treated his cough symptoms with over-the-counter medicine, but it was only temporarily effective. He reports frequent cold and runny nose, and he states that he had frequent ear infections as a child. He reports a history of pneumonia in the past year. He reports normal bowel movements. He denies fever, headache, dizziness, trouble swallowing, nosebleed, phlegm or sputum, chest pain, trouble breathing and abdominal pain. He denies cough aggravation with activity.

one spoonful. Patient reports a sore throat. Denies asthma diagnosis, reports immunizations are current, has a history of pneumonia at age 7 and frequent cough. Denies seasonal allergies, food allergies, and medication allergies. Denies any fever, and cough stays the same with activity

Immunizations:

up-to-date but has not had the flu vaccine in the last 12 months. Relevant family history father has hx asthma and no family history of allergies

Hepatitis B series completed at 6 months, hepatitis A series completed at 15 months pneumococcal vaccine at 15 mts,

DTAP @ 6 YEARS

MMR@ 6 YEARS

Varicella vaccine@ 6 YEARS

Polio Vaccine @ 6 YEARS

Allergies: NKDA

PHM Hx: pneumonia @ AGE 7 YRS, out patient clinic treatment, no surgeries or hospitalizations

SocHx:

In the third grade

Out for two weeks last year because of pneumonia

Live with Mother, Father, grandmother, grandmother cares for child while parents are working

Primarily speaks English in the house but

sometimes Spanish

Fam Hx:

Mother: type 2 diabetes, hypertension, hypercholesterolemia, spinal stenosis, obesity

Father: smoker, hypertension, hypercholesterolemia,

Asthma as a child

Maternal grandmother: type 2 diabetes and hypertension

Maternal grandfather: smoker, eczema.

Paternal grandmother: died at age 52 of a car accident

Paternal grandfather: no known history

ROS:

VS:

B/P: 120/76 MMHG (MAP 91 mmhg)

RR: 28

HR: 100

o2SAT: 96% RA

Temp: 37.2C /98.6 F

General: reports frequent colds, and feeling kind of tired.

Denies any chills, fever, or night sweats.

HEENT: denies any headaches, nosebleeds, vision difficulty, watery eyes, redness, eye pain, sinus pain.

Resp: patient denies difficulty breathing, chest tightness, chest pain.