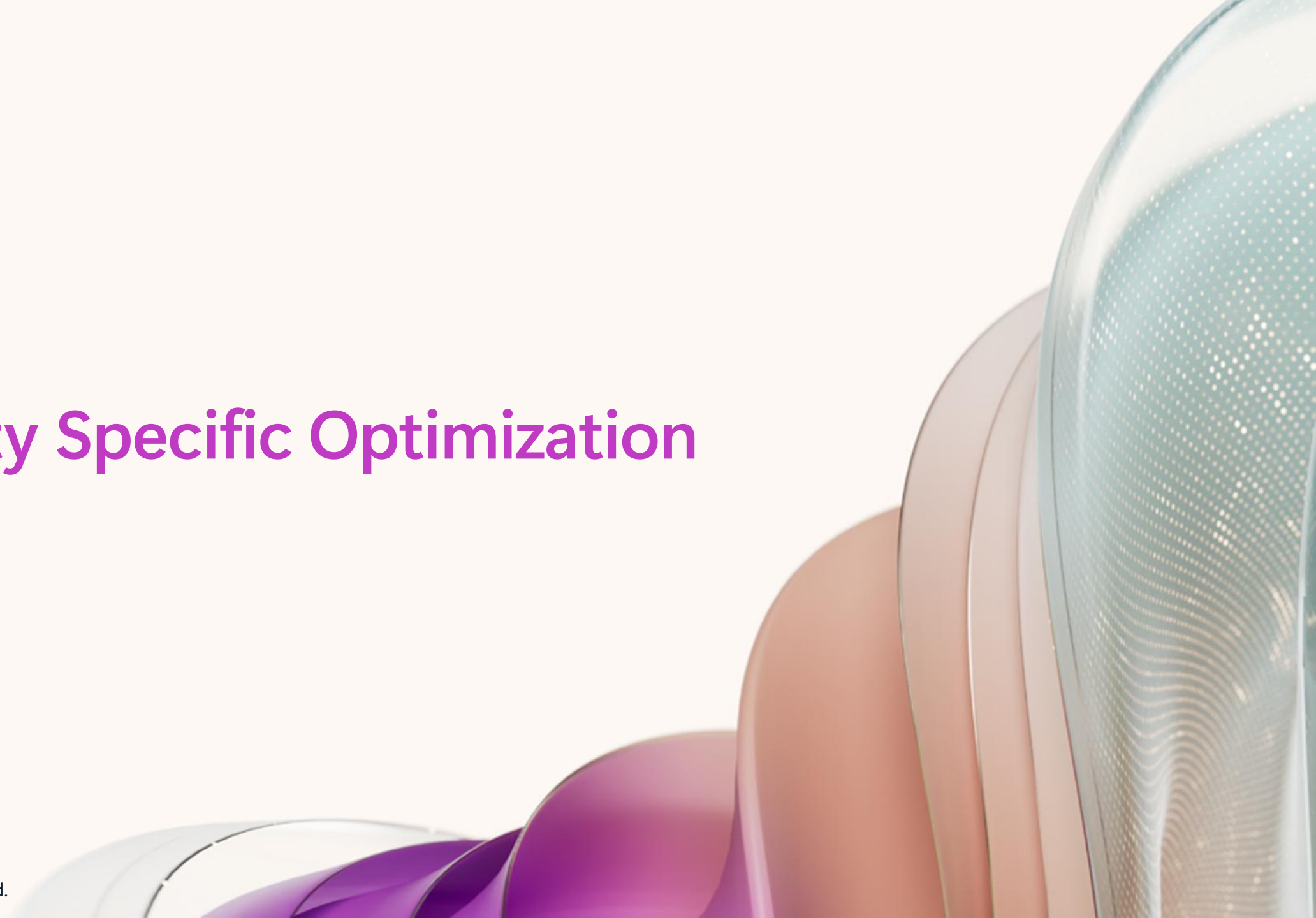
Microsoft

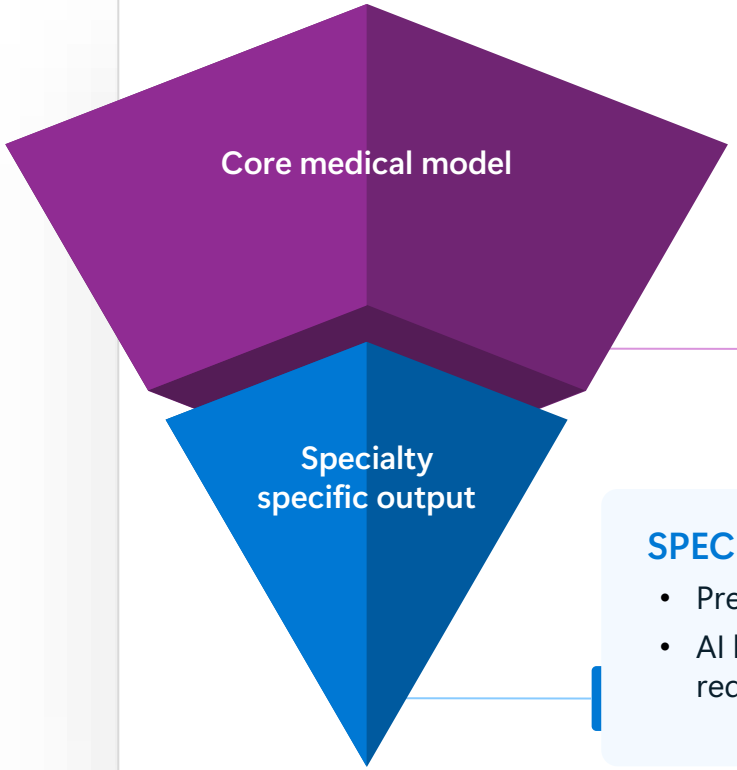
Specialty Specific Optimization

September 2025



Microsoft

AI model



CORE MEDICAL MODEL WITH SOME SPECIALTY REFINEMENT

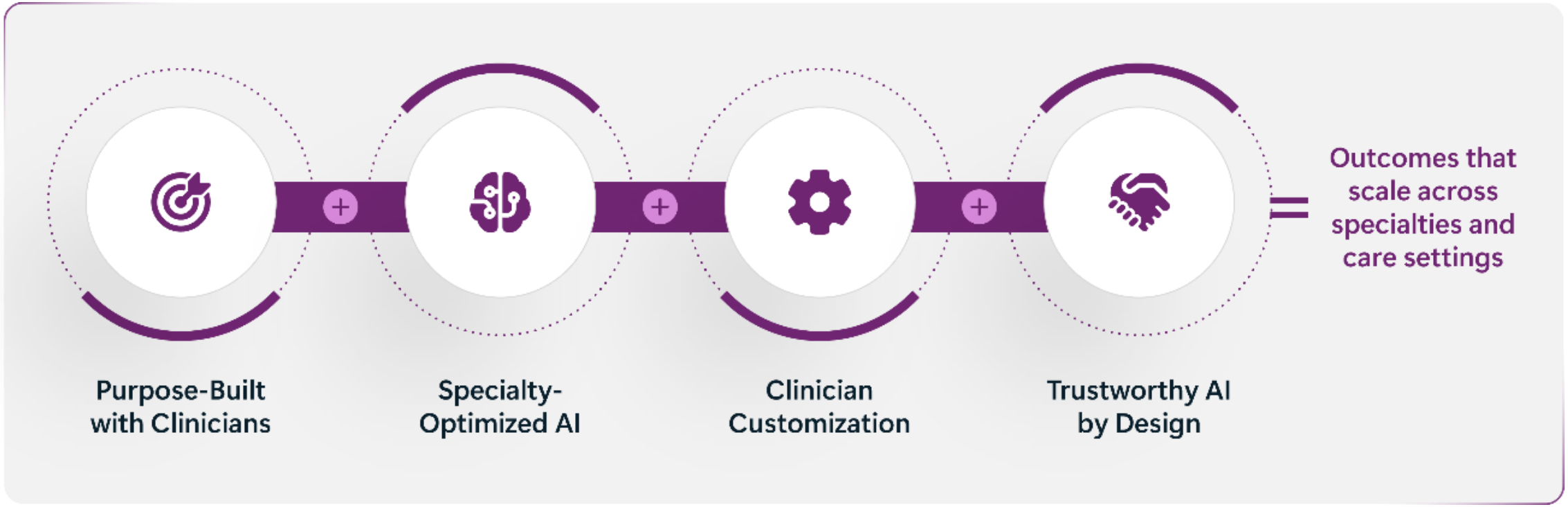
- Broad range of medical terminology and documentation standards with increased capture of specialty specific content.
- Summary may contain inaccuracies for specialized content.
- Content is viewable in the transcript and provides base for further specialized AI learning.

SPECIALTY SPECIFIC OUTPUT

- Precise capture of specialty specific content.
- AI has matured to incorporate specialty requirements in unique model output.

Our model training is on **real clinical encounters** verified by medical professionals ensuring it meets the medical community's documentation requirements.

AI Model



Specialty Model Development

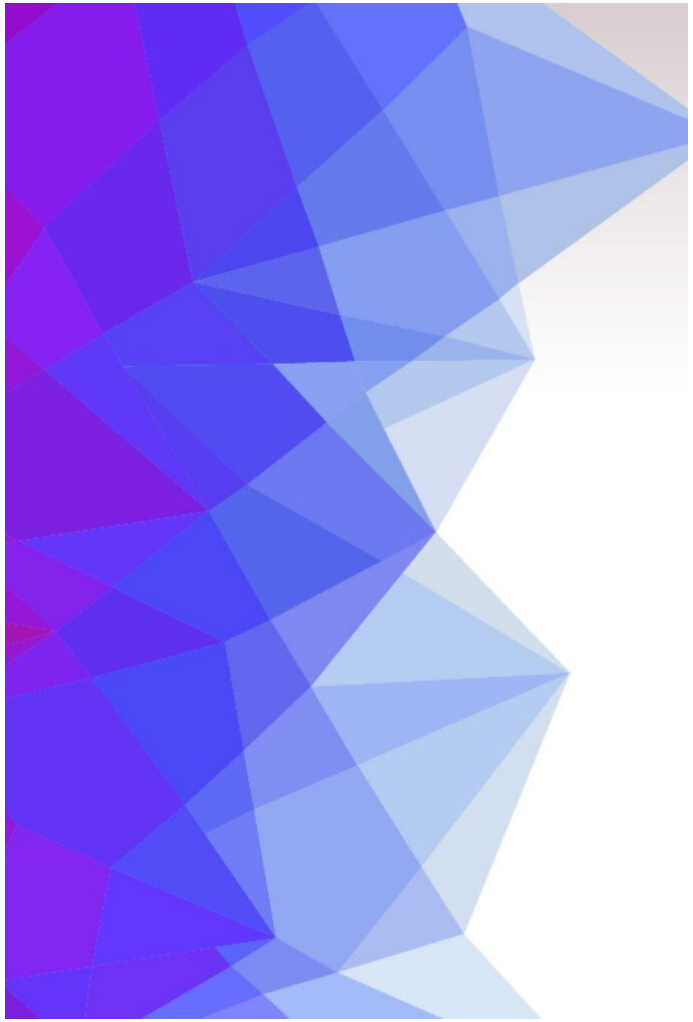
Prioritized work for specialty specific optimization and rapid response improvements

Unique specialty models development based on

- Customer insights
- Microsoft clinician experts' knowledge and research
- National association recommendations
- Collaboration with early access specialty specific clinicians

Continue focus on additional subspecialty requirements overlay

Overview of improvements



- HPI captures specialty specific content
- Physical exam includes required specialty specific subheadings and findings
- Exam findings will be based on the transcript, converting colloquial conversation to medical terminology
- Results content written in appropriate section depending on the source of the information and specialty requirements
- The Assessment and Plan section provides precise terminology required for specialty-specific diagnosis and treatments, formatted in a bulleted list or paragraph
- Past procedures written in appropriate section depending on the source of the information
- Overall documentation design according to specialty recommendations

Benefits of Specialty Specific Refinement

- Enhances accuracy in medical documentation and patient care.
- Reduces clinician cognitive burden and potential errors.
- Facilitates faster and more efficient patient data processing.
- Improves clinician satisfaction and adoption of technology.

Optimized Specialties

Cardiology	Dermatology	Addiction Medicine	Emergency Dept	Allergy & Immunology	GYN
Endocrinology	Family/Internal Medicine	ENT	Nephrology	Geriatrics	Hospice & Palliative Care
Gastroenterology	Neurology	General Surgery	Pain Medicine	Infectious Disease	OB
Medical Oncology	OB/GYN	Inpatient	Pulmonology	Podiatry	Interventional Cardiology
Ophthalmology	Orthopedics	Neurosurgery	Surgical Oncology	Physical Medicine & Rehab	Interventional Radiology
Pediatrics	Psychiatry	Physical Therapy	Sports Medicine	Urgent Care	Occupational Therapy
		Rheumatology	Urology		Speech Language Pathology
					Psychology

Specialties with bullet A/P (not paragraph)

- Cardiology
- Dermatology
- Endocrinology
- Primary Care
- Gastroenterology
- OB/GYN
- Psychiatry

Specialty examples

Addiction Medicine

Documenting progress notes in Addiction Medicine faces challenges such as time constraints, ensuring consistency and accuracy, and managing the complexity of cases.

Additionally, healthcare providers must navigate regulatory compliance, maintain patient confidentiality, and facilitate interdisciplinary communication.

Addressing these issues is crucial for improving patient care and supporting healthcare providers in their documentation efforts.

Addiction Medicine: History of Present Illness

General Content

The patient is a 46-year-old male who presents for evaluation of anxiety, panic attacks, and medication management.

He reports experiencing mild illness symptoms, which he manages by maintaining adequate hydration. He is actively engaged in Alcoholics Anonymous (AA) meetings and maintains communication with fellow participants outside of these sessions. He has established connections with individuals from his church, including a couple who are also in recovery. He finds solace in his faith and expresses gratitude for the positive aspects of his life.

He has encountered difficulties in obtaining his medication refills due to a transition from Kimberly to Emily. He was initially provided with a 20-day supply, which expired on 03/08/2024. Despite contacting Rite Aid, he was informed that no new prescription had been issued and the previous one appeared to have been canceled. He communicated this issue via the portal and was subsequently contacted by an on-call provider who arranged for a 2 to 3-day supply. He has a prior authorization for a year's supply of his medications. His current medication regimen includes Suboxone 12 mg film administered three times daily, gabapentin, and duloxetine. He reports significant improvement in his sleep quality since starting duloxetine. He also takes Xanax, which he finds beneficial in managing his panic attacks. He has previously tried Klonopin and lorazepam but found Xanax to be the most effective.

Specialty-specific Content

The patient is a 46-year-old male who presents for evaluation of anxiety, panic attacks, and medication management.

Interim History: He reports experiencing mild illness symptoms, which he manages by maintaining adequate hydration. He is actively engaged in Alcoholics Anonymous (AA) meetings and maintains communication with fellow participants outside of these sessions. He has established connections with individuals from his church, including a couple who are also in recovery. He finds solace in his faith and expresses gratitude for the positive aspects of his life.

Treatment and Interventional History: He has encountered difficulties in obtaining his medication refills due to a transition from Kimberly to Emily. He was initially provided with a 20-day supply, which expired on 03/08/2025. Despite contacting Rite Aid, he was informed that no new prescription had been issued, and the previous one appeared to have been canceled. He communicated this issue via the portal and was subsequently contacted by an on-call provider who arranged for a 2 to 3-day supply. He has a prior authorization for a year's supply of his medications.

Social History:
- Actively engaged in AA meetings
- Maintains communication with fellow AA participants
- Established connections with individuals from his church; Finds solace in his faith

Medications:
Current:
- Suboxone 12 mg film three times daily
- Gabapentin
- Duloxetine
- Xanax

Discontinued:
- Klonopin
- - Lorazepam

Addiction Med: Physical and Mental Status Examination

General Content

Musculoskeletal/Extremities: Increased muscle tension noted in the right shoulder and trapezius muscles.

Specialty-specific Content

Physical Exam
General: Well-nourished, well-developed.
Skin: No signs of self-harm or drug use. No lesions, rash, or abnormalities.

Mental Status Exam
Speech Characteristics: Speech is clear, coherent, and of normal rate and volume.
Mood and Affect: Affect is congruent with the stated mood.
Thought Processes: Thought processes are logical and goal-directed.
Thought Content: No evidence of delusions or obsessions.
Harmful Thoughts: The patient reports no suicidal or homicidal ideation.
Perceptual Disturbances: No hallucinations or other perceptual disturbances reported.
Sensorium and Cognitive Functions: The patient is alert and oriented to person, place, and time.
Memory and concentration appear intact.
Insight and Judgment: The patient demonstrates good insight and judgment regarding their condition and treatment.
Motivation: The patient shows motivation to engage in treatment and adhere to medication regimen.

Addiction Med: Assessment and Plan

General Content

1. Anxiety.
He reports that Xanax has been the most helpful medication for his anxiety. He is advised to continue his current dosage of Xanax. If Xanax ceases to be effective, a transition to an alternative benzodiazepine will be considered instead of increasing the Xanax dosage.
2. Panic attacks.
He finds Xanax to be the most effective medication for his panic attacks. He is advised to continue his current regimen of Xanax. If there is any change in the effectiveness of Xanax, a switch to another benzodiazepine will be considered.
3. Medication management.
He has been experiencing issues with getting his medications filled due to a switch in providers. He has a year's prior authorization for his medications. He is advised to communicate with his provider to ensure a smooth transition and avoid any gaps in medication supply.

Specialty-specific Content

Problems:
- Depression
- Anxiety
- Obsessive-Compulsive Disorder (OCD)

Clinical Impression: The patient reports a notable improvement in her contamination fears, which she attributes to her ongoing therapy with Dr. Dailey. However, she continues to experience significant paranoia, particularly related to the internet and feeling unsafe at night. This paranoia impacts her ability to sleep alone, necessitating that she sleeps with her mother for reassurance. Despite these challenges, she can manage her daily activities with some support from her family. Her anxiety remains pronounced, especially at night, affecting her overall sense of safety and well-being.

Therapeutic Intervention: During the session, cognitive-behavioral strategies were discussed to address her paranoia and anxiety. The patient was encouraged to work with her therapist, Dan, to develop specific goals, such as being able to sleep in her own bed. Psychoeducation was provided to help her understand the nature of her symptoms and the importance of gradual exposure to feared situations.

Plan:
- Continue current medication regimen.
- Refill medications.

Follow-up:
- Next appointment scheduled in four weeks to monitor medication effectiveness and overall mental health.
- Goals for the next session include evaluating the impact of mindfulness exercises on stress levels and discussing any further adjustments needed in the medication regimen.

Allergy & Immunology

Targeted Improvements:

Overall Note: Style enhancements specific to the practice scope of an allergy & immunology clinician.

Allergies:

- Adjusted format to include reaction, severity, and management of each allergy in this section.

Physical Exam:

- An optimized Physical Exam that replaces HEENT with separate sections.
- Current workflow for clinician does not change. Clinician verbalization will be documented as is currently done. Only sections which are verbalized will be extracted.

Results

- Improved capture of allergy-specific results including allergy testing and date of study, when verbalized.

Assessment/Plan:

- Enhanced capture of visit findings, recommendations and education provided within scope of the visit.

Allergy & Immunology: Allergies

General Content

ALLERGIES
The patient has had an allergic reaction to PEANUTS, CASHEW, WALNUT, PECAN, PISTACHIO, HAZELNUT.

Specialty-specific Content

ALLERGIES
-PEANUTS: Delayed vomiting 2 to 3 hours after ingestion, diagnosed around 6 months of age, positive skin test, potential for IgE mediated sensitivity.
-CASHEW: Positive skin test.
-WALNUT: Oral itchiness and irritation, positive skin test.
-PECAN: Positive skin test.
-PISTACHIO: Positive skin test.
-HAZELNUT: Positive skin test.
-SEASONAL ALLERGIES: Very mild, typically worse in the spring, managed with oral antihistamines if needed.

Allergy & Immunology: Physical Exam

General Content

PHYSICAL EXAM
Nose does look a little inflamed. Mucus is draining top. Throat looks good.

Specialty-specific Content

PHYSICAL EXAM
Nose: Nasal mucosa appears inflamed with mucus drainage.
Throat: Oropharynx appears normal.

Allergy & Immunology: Results

General Content

RESULTS
Laboratory Studies
Allergy testing was positive to cashew, walnut, pecan, pistachio, hazelnut, and negative for peanut, almond, Brazil nut.

Specialty-specific Content

RESULTS
Allergy Testing
- Skin testing: Positive to cashew, walnut, pecan, pistachio, hazelnut. Negative for peanut, almond, Brazil nut

Allergy & Immunology: Assessment and Plan

General Content

ASSESSMENT AND PLAN
1. Food protein-induced enterocolitis syndrome (FPIES) to peanut.
Given the potential for the development of an IgE-mediated sensitivity, it is prudent to conduct further testing. The initial skin test yielded a negative result; however, due to concerns, a serum IgE test for peanut will be conducted. If the result is negative or low, an oral challenge to peanut will be initiated in a supervised hospital setting. This is due to the potential delayed nature and severity of reactions and the possible need for intravenous fluids.

2. IgE-mediated food allergy to tree nuts.
The testing and history are consistent with an IgE-mediated sensitivity to tree nuts. It is recommended to completely avoid tree nuts.

Specialty-specific Content

ASSESSMENT AND PLAN
1. Food protein-induced enterocolitis syndrome (FPIES) to peanut.
- History of delayed vomiting 2 to 3 hours after eating peanut on two separate occasions.
- Initial skin test was negative.
- Discussed the potential for development of an IgE-mediated sensitivity.
- Serum IgE test for peanut will be conducted. If negative or low, an oral challenge to peanut will be initiated in a supervised hospital setting due to the potential delayed nature and severity of reactions and possible need for intravenous fluids.

2. IgE-mediated food allergy to tree nuts.
- Recent oral itchiness and irritation with walnuts and pine nuts on separate occasions.
- Skin testing was positive to cashew, walnut, pecan, pistachio, and hazelnut; negative for peanut, almond, and razolutt.
- Recommended complete avoidance of tree nuts.

Cardiology

Targeted Improvements:

- Incorporated specific diagnostic test names as headers in the results section with the findings for each listed below each header as bullet points.

- Formatted exam with system headers and incorporated medical shorthand where appropriate to match generally used formatting for cardiology exams.

- Updated format to output of diagnosis with bulleted list below which includes interventions, recommendations, referrals, orders, etc.

Cardiology: History of Present Illness

General Content

The patient presents for evaluation of multiple medical concerns. She has been experiencing episodes of dizziness, which she attributes to her heart condition. She is currently on chlorthalidone for blood pressure management and diltiazem 120 mg daily. She continues to take diltiazem and has experienced episodes of dizziness, one of which was severe enough to make her feel as though she might faint. She reports no chest pain or shortness of breath. She does not currently see a therapist and has not fainted recently, although she did experience fainting spells in her youth.

She underwent knee replacement surgery in 04/2024 and is on Zoloft 150 mg daily. She has gained 20 pounds, which she attributes to her knee condition. She is considering increasing her exercise regimen. She reports no swelling unrelated to her knee surgery.

She reports feeling well post-ablation but occasionally experiences irregular breathing, which she believes is due to anxiety. She rates her discomfort as 9 out of 10 prior to the ablation. Her symptoms have been recurring for the past 3 to 4 months, particularly during physical therapy sessions. She spent two months at her daughter's house, which she found stressful. She reports irregular breathing when stressed but does not wake up gasping for breath.

She also uses a vaginal cream and takes minocycline as needed.

ALLERGIES She is allergic to ERYTHROMYCIN with nausea.

Specialty-specific Content

The patient presents for evaluation of multiple medical concerns, accompanied by episodes of dizziness, which are attributed to her heart condition.

Reports ongoing episodes of dizziness, one of which was severe enough to feel as though fainting might occur. No chest pain or shortness of breath is reported. Currently on chlorthalidone for blood pressure management and diltiazem 120 mg daily. Continues to take diltiazem and has experienced episodes of dizziness. Does not currently see a therapist and has not fainted recently, although fainting spells occurred in youth.

Underwent knee replacement surgery in April 2024 and is on Zoloft 150 mg daily. Reports a 20-pound weight gain, attributed to the knee condition, and is considering increasing exercise. No swelling unrelated to knee surgery is reported.

Felt well post-ablation but occasionally experiences irregular breathing, believed to be due to anxiety. Rated discomfort as 9 out of 10 prior to the ablation. Symptoms have been recurring for the past 3 to 4 months, particularly during physical therapy sessions. Spent two months at daughter's house, which was stressful. Reports irregular breathing when stressed but does not wake up gasping for breath.

Uses a vaginal cream and takes minocycline as needed.

Past Surgical History: - Knee replacement surgery in April 2024

SOCIAL HISTORY
- Exercise: Walking more post knee surgery; previously sedentary except for physical therapy

ALLERGIES - Erythromycin: Nausea

Cardiology: Physical Examination

General Content

PHYSICAL EXAM
Lungs are clear.
Heart sounds are normal.

Specialty-specific Content

PHYSICAL EXAM
Cardiovascular: Heart sounds normal.
Respiratory: Lungs clear to auscultation.
Neck: No bruits.
Abdomen: No pain or swelling reported.
Extremities: No leg swelling, feet with burning sensation and occasional numbness.

Cardiology: Assessment and Plan

General Content

Assessment and Plan
1. Cardiac murmur.
She presents with a 4-6 systolic murmur at the upper right sternal border, exhibiting mild radiation to the carotids. This is likely indicative of aortic stenosis. Her symptoms could be attributed to severe aortic stenosis; however, the relative preservation of her S2 suggests a moderate condition. Previous records indicate diastolic dysfunction, suggesting a possible past echocardiogram. She does not exhibit significant volume overload at present. An echocardiogram will be conducted today to evaluate her overall cardiac structure and function, as well as the valvular disease. Depending on the results and the severity of her aortic stenosis, a transcatheter aortic valve replacement (TAVR) may be considered.

Follow-up
The patient will follow up in 3 to 4 weeks after her echocardiogram is done to discuss results and next steps.

Specialty-specific Content

Assessment and Plan
1. Cardiac murmur: Likely indicative of aortic stenosis. Symptoms could be attributed to severe aortic stenosis; however, the relative preservation of S2 suggests a moderate condition.
- Conduct echocardiogram today to evaluate overall cardiac structure and function, as well as valvular disease
- Consider TAVR depending on results and severity of aortic stenosis

Follow-Up
- Follow up in 3 to 4 weeks after echocardiogram to discuss results and next steps

Dermatology

Targeted Improvements:

Overall Note:
- Style enhancements specific to the practice scope of dermatology clinician.

Physical Exam:
- An optimized physical exam that includes the following sections: Skin, Nails, Scalp, and Lymph Nodes.
- Current workflow for clinician does not change. Clinician verbalization will be documented as is currently done. Only sections which are verbalized will be extracted.

Results:
- Improved capture of results with diagnostic test names, dates, and findings.

Procedure:
- Modified to only include procedures completed during the encounter. All other procedures discussed will be listed in the HPI section under the header “Past Surgical History”.

Assessment & Plan:
- Enhanced capture of visit findings, recommendations, and education provided within scope of the visit.

Dermatology: History of Present Illness

General Content

The patient presents with alopecia and nail changes.

She has been experiencing hair loss since her late 20s, which has progressively worsened. Topical Rogaine was used briefly, but she found it difficult to apply to her scalp. The hair loss is generalized, with no associated itching or burning. Currently, she is asymptomatic.

Her nail issues began with her right thumbnail, first noticed when she was 11 years old, and have since progressed to all her nails. This issue also appeared on her toes.

Supplemental Information
She was diagnosed with hyperthyroidism this year.

Specialty-specific Content

The patient presents for alopecia and nail changes in a new patient visit.

She has been experiencing hair loss since her late 20s, which has progressively worsened over the past 20 years. She initially had a significant amount of hair, but the loss has continued without stopping. She tried using topical Rogaine for a while but found it challenging to apply consistently across her scalp. The hair loss is generalized, with a noticeable spot where the scalp is visible. There is no associated itching or burning, and she is currently asymptomatic. Despite visiting doctors in the past, her concerns were not taken seriously due to the initial volume of her hair. Her father also experienced early hair loss.

Her nail issues began with her right thumbnail when she was around 11 years old. Over the years, the problem has progressed to affect all her fingernails and, more recently, her toenails. She recalls her toenails being straight and problem-free in the past, but now they are affected similarly to her fingernails.

She was diagnosed with hyperthyroidism this year, although she believes she has had symptoms for approximately four years. She has a history of thyroid checks over the years, which did not indicate any problems until recently.

Dermatology: Physical Examination

General Content

Skin: Few scattered moles are present, described as 2 to 6 mm tan-brown skin colored macules and papules.
Lesions
- Right buccal mucosa: Erythematous papule with a whitish center
- Right proximal posteromedial thigh: Pink plaque with reticulated scale
- Left great toenail: Purplish discoloration under the nail at the distal medial quarter
- Left anterior vertex scalp: Scar-like atrophic papule next to a subcutaneous nodule, measuring about 7 or 8 mm
Nails: Purplish discoloration under the left great toenail at the distal medial quarter

Specialty-specific Content

HEENT: On the right buccal mucosa, there is an erythematous papule with a whitish center.
Skin: Few scattered moles, described as 2 to 6 mm tan-brown skin-colored macules and papules. On the right proximal posteromedial thigh, there is a pink plaque with reticulated scale.
Nails: The left great toenail shows purplish discoloration under the nail at the distal medial quarter.
Scalp: On the left anterior vertex scalp, there is a scar-like atrophic papule next to what feels like a subcutaneous nodule, measuring about 7 or 8 mm.

Dermatology: Assessment and Plan

General Content

1. Seborrheic Dermatitis.
He has some redness and scaling in the beard area. It was recommended to use a dandruff shampoo like Head and Shoulders or Selsun Blue twice a week for the face and scalp.
2. Actinic Keratosis.
A total of 14 actinic keratoses were treated with cryotherapy. These were located on the right preauricular area, right shin, temples, right dorsal hand, and scalp.
3. Seborrheic Keratosis.
Cryotherapy was performed on the seborrheic keratosis on the right leg.
4. In Situ Squamous Cell Carcinoma.
Cryotherapy was performed on the in situ squamous cell carcinoma on the right sternal notch.
5. Xerosis.
Moisturizer was recommended for the management of xerosis on the legs. He was advised to apply moisturizer from the knee down and to the entire leg once the knee is healed.
6. Steatotic Eczema.
A poorly defined patch of erythema and excoriations was noted over the entire central back. Triamcinolone 1% cream was prescribed to be used twice a day when itchy, with assistance from his wife.
7. Lentigines.
A lentigo on the left lower eyelid was noted. Aldara cream was recommended to be used for a full 8 weeks to ensure it stays away.

Follow-up
Return in 6 months for follow-up.

Specialty-specific Content

1. Seborrheic Dermatitis.
- Use dandruff shampoo like Head and Shoulders or Selsun Blue twice a week for the face and scalp.

2. Actinic Keratosis.
- Treated 14 actinic keratoses with cryotherapy located on the right preauricular area, right shin, temples, right dorsal hand, and scalp.

3. Seborrheic Keratosis.
- Performed cryotherapy on the seborrheic keratosis on the right leg.

4. In Situ Squamous Cell Carcinoma.
- Performed cryotherapy on the in situ squamous cell carcinoma on the right sternal notch.

5. Xerosis.
- Recommended applying moisturizer from the knee down and to the entire leg once the knee is healed.

6. Steatotic Eczema.
- Prescribed triamcinolone 1% cream to be used twice a day when itchy, with assistance from his wife.

7. Lentigines.
- Recommended Aldara cream for a full 8 weeks to ensure the lentigo on the left lower eyelid stays away.

8. History of Melanoma and Nonmelanoma Skin Cancer.
- Regular follow-ups are necessary.

Follow-up
Return in 6 months for follow-up.

Emergency Medicine

Targeted Improvements:

- Adjust the opening statement to include various pertinent medical histories that are discussed during the visit, e.g. "This is a ___-year-old ___ with a history of ___, ___, and ___, presenting today with ___"
- Adjust the history and note if the patient was not the primary historian, in cases where the patient is altered, unconscious, or otherwise unable to verbalize, and also note who provided the history (family, EMS, bystander, etc.).
- Focus on the chronological capture of the history in the order it occurred, instead of the information as it was reported by the patient.
- Note any factors that limit the patient's access to medical care or to follow through with care plans.
- Document GPA status for patients with OB or gyn related complaints.
- Avoids the use of pejorative or judgmental language like "admits to".
- The physical exam now notes if a chaperone was present during sensitive portions of the exam.
- The A&P is a modified version of the current ED MDM, containing an initial assessment, differential diagnosis, ED course, final assessment, clinical impression, disposition, and patient education, and critical care.
  - o The DDx is modified to avoid stating that a condition was completely ruled out, instead, the model should state that various observations and test results should result in a condition not being considered.
  - o The disposition has been updated to capture specific return precaution details, and additional detail about what care team the patient will be admitted to, or if the patient has been signed out to an oncoming clinician.

Emergency Medicine

Recent Improvements:

- Updates to the physical exam prompt improving the routing of physical exam findings to the appropriate body system.
- Preventing inappropriate items from being included in the ED course, such as events that took place before the ED visit or will take place after the visit.
- Preventing documentation that states the patient arrived on foot.
- Limiting inferences being made in the disposition following the initial recording, before all data is gathered .
- Limit the use of terms such as 'lethargy', 'lethargic', 'extreme', 'severe', 'significant', unless verbalized by the clinician.
- Prevent the inclusion of the date in the ED course.

Emergency Medicine: History of Present Illness

General Content

The patient is a ___-year-old female who presents to the emergency room for evaluation of sepsis.

She was previously evaluated by Dr. ___ and another physician in ___ where a urine test suggested the possibility of sepsis. She reports experiencing pain upon palpation of her flank and back, which has been present for several weeks and is progressively worsening. She also reports fever, chills, and sweats, which have been ongoing for 3 weeks. She has not measured her temperature at home but reports waking up drenched in sweat. She sought medical attention at Bayfront Hospital last Friday, where she was seen by Dr. ___. This was her second visit to the same doctor within a week. During her first visit, she was informed that she had an infection that would resolve on its own. She was not prescribed antibiotics but received morphine and Zofran intravenously. She has not received any antibiotics in the past 3 weeks. She rates her current pain level as 10 out of 10 and requests pain medication. She has no history of pyelonephritis.

Three weeks ago, she began experiencing vomiting, inability to retain food, excessive sweating, and increased back and abdominal pain. She continues to experience vomiting, severe diarrhea, and cramping. The diarrhea has been present for 3 weeks. She has lost 20 pounds over the past few weeks, dropping from 170 to 150 pounds. Her last episode of vomiting occurred this morning, during which she only expelled water.

Specialty-specific Content

This is a ___-year-old female with a history of endometriosis and severe interstitial cystitis presenting with symptoms suggestive of sepsis.

Three weeks ago, the patient began experiencing vomiting, inability to retain food, excessive sweating, and increased back and abdominal pain. She reports that the pain in her flank and back has been progressively worsening and is now severe enough to cause wincing upon touch. She also reports fever, chills, and sweats, which have been ongoing for 3 weeks. She has not measured her temperature at home but notes waking up drenched in sweat. She sought medical attention at ___ Hospital last Friday, where she was seen by Dr. ___. This was her second visit to the same doctor within a week. During her first visit, she was informed that she had an infection that would resolve on its own. She was not prescribed antibiotics but received morphine and Zofran intravenously. She has not received any antibiotics in the past 3 weeks. She rates her current pain level as 10 out of 10 and requests pain medication. She has no history of pyelonephritis.

She continues to experience vomiting, severe diarrhea, and cramping. The diarrhea has been present for 3 weeks. She has lost 20 pounds over the past few weeks, dropping from 170 to 150 pounds. Her last episode of vomiting occurred this morning, during which she only expelled water.

Emergency Medicine: Assessment and Plan

General Content

ASSESSMENT AND PLAN
1. Syncope.
He experienced a syncopal episode while cleaning out a gutter, followed by dizziness and a fall. He did not recall passing out. He reported shortness of breath and has had a lingering cold for about 2 months, with symptoms including coughing up phlegm, especially at night. His initial EKG showed a heart rate of 138, and he remains tachycardic despite IV fluids. Given his syncopal events, multifocal pneumonia, and persistent tachycardia, the pneumonia protocol recommended admission to the hospital. A chest x-ray and repeat EKG will be performed. A repeat troponin test will be conducted in about 30 minutes to monitor for any changes. He will be admitted to the hospitalist for ongoing management of syncope.

2. Multifocal pneumonia.
Crackles were noted in the left lung base, and a chest x-ray will be performed to confirm the diagnosis. He was started on IV ceftriaxone and azithromycin. He will be admitted to the hospitalist for ongoing management of pneumonia.

3. Tachycardia.
He remains tachycardic with a heart rate of 138 on the EKG. Despite IV fluids, his heart rate has not normalized. A repeat EKG will be performed, and a D-dimer test will be added to screen for blood clots. He will be admitted to the hospitalist for further management.

Specialty-specific Content

Initial Assessment:
Experienced a syncopal episode while cleaning out a gutter, followed by dizziness and a fall. Did not recall passing out. Reported shortness of breath and a lingering cold for about 2 months, with symptoms including coughing up phlegm, especially at night. Initial EKG showed a heart rate of 138, and he remains tachycardic despite IV fluids.

Differential Diagnosis:
- Pneumonia: Crackles in left lung base. Chest x-ray to confirm. Started on IV ceftriaxone and azithromycin.
- Blood Clot: Elevated D-dimer. CT pulmonary angiogram showed no evidence of PE.

ED Course:
- Chest x-ray performed.
- Repeat EKG performed.
- D-dimer test added.
- CT pulmonary angiogram performed, showing no evidence of PE but subpleural multifocal pneumonia.
- Started on IV ceftriaxone and azithromycin.

Final Assessment:
Blood work showed elevated white blood cell count. Troponin test slightly elevated. CT pulmonary angiogram showed subpleural multifocal pneumonia. Persistent tachycardia despite IV fluids.

Clinical Impression:
- Syncope
- Multifocal pneumonia
- Tachycardia

Disposition:
- Admission: Hospitalist for ongoing management of pneumonia and syncope.

Endocrinology

Targeted Improvements:

- Problem-based HPI will include required content for diabetes, osteoporosis, and thyroid-related visits.
- Incorporated the comprehensive endocrinological exam sub-headers, updated list:
  - General
  - Head and Neck
  - Abdomen
  - Extremities
  - Musculoskeletal
  - Neurological
  - Genitourinary
- Incorporated the comprehensive instructions to include Continuous Glucose Monitoring (CGM) results.
- Other note component updates:
  - Results section includes date of test and result of test, as applicable.
  - Procedure section will only contain those done during the current encounter.
  - Physician-preferred Assessment and Plan formatting

Endocrinology: Physical Examination

General Content

PHYSICAL EXAM
Lungs have a good sound.
Heart has a good sound.

RESULTS
Anemia is present, but better than before. A1c is 6.3. B12 is 299. Iron is lower. Vitamin D has improved.

no CGM results captured

Specialty-specific Content

PHYSICAL EXAM
General: No acute distress, overweight.
Cardiovascular: Heart rate and rhythm regular, no murmurs or extra heart sounds.
Respiratory: No signs of respiratory distress, clear breath sounds bilaterally.

RESULTS
Complete Blood Count (CBC):
-Anemia improved.

Hemoglobin A1c (HbA1c):
-Result: 6.3%.

Vitamin B12:
-Result: 299 pg/mL

Iron Studies:
-Iron levels are lower than previous.

Vitamin D:
-Vitamin D levels have improved from previously.

Continuous Glucose Monitoring (CGM):
- CGM System: Dexcom
- Hypoglycemia alerts: Alerts occur frequently, especially at night, causing disturbances.
- Hyperglycemia alerts: Alerts occur frequently, causing the patient to overcorrect.
- Other: The patient reports issues with the pump's frequent alerts, especially at night, leading to overcorrection and subsequent hypoglycemia.

Endocrinology: Assessment and Plan

General Content

ASSESSMENT AND PLAN
1. Thyroid Cancer.
Thyroid hormone levels were normal in XX. The ultrasound showed no red flags, but the technician's measurement was different from the prior technician. The possibility of the lymph node growing was discussed, but it does not necessarily indicate malignancy. The current dose of Synthroid 125 mcg will be continued. The patient will check MyChart for the blood work results in a couple of weeks. If the thyroglobulin levels are concerning, a biopsy may be recommended.

2. Diabetes Mellitus.
Her A1c has increased from 5.8 in XX to 6.1 in XX. A fingerstick test will be conducted today for prediabetes. She was advised to monitor her blood sugar levels at home and to reduce carbohydrate intake, including wine. She was also encouraged to engage in physical exercise, such as yoga and muscle strengthening exercises.

Specialty-specific Content

ASSESSMENT AND PLAN
1. Thyroid Cancer.
- The current dose of Synthroid 125 mcg will be continued.
- The patient will check MyChart for the blood work results in a couple of weeks.
- If the thyroglobulin levels are concerning, a biopsy may be recommended.

2. Diabetes Mellitus.
- A fingerstick test will be conducted today for prediabetes.
- Advised to monitor blood sugar levels at home and to reduce carbohydrate intake, including wine.
- Encouraged to engage in physical exercise, such as yoga and muscle strengthening exercises.

Follow up: Tentatively scheduled for 6 months.

Family Medicine / Internal Medicine

Targeted Improvements:

Physical Exam

- All verbalized content is documented with appropriate body system subheadings. Only sections which are examined or verbalized are documented.

- If examined and/or referred to as 'normal' or 'good', output for Cardiovascular, Respiratory, and Gastrointestinal includes a minimal set of normal findings.

Other section updates

- HPI includes a Past Surgical History subheading.

- Procedure section contains those done during *current* encounter.

- Assessment & Plan features the MEAT format:

Monitoring: Documentation of signs, symptoms, disease regression or progression, ongoing surveillance of condition

Evaluation: Summarization of pertinent PE findings, test results, medication effectiveness, response to treatment

Assessment: Discussion of condition, counseling, continued evaluation of condition such as ordering further tests

Treatment: Prescribing/continuation of medications, therapies, and/or referrals, plan for management of condition

Family Medicine: Physical Examination

Verbalization

Clinician: "I'm going to listen to your heart and lungs."
Patient: "Okay."
Clinician: "Take few deep breaths. Ok, now just breathe normally. I'd like to look at your throat. Can you open wide?"
Patient: "Ahhh."
Clinician: "Your throat is red and a little irritated. Next, I'm going to press on your belly. Any pain when I do this?"
Patient: "No."
Clinician: "Great, that all feels normal."

Original output

PHYSICAL EXAM

Heart was examined.

Lungs were auscultated.

Abdomen is normal.

Throat is red and mildly irritated.

Specialty-specific output

PHYSICAL EXAM

Throat: Red and mildly irritated.

Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.

Respiratory: Clear to auscultation, no wheezes, rales, or rhonchi.

Gastrointestinal: Soft, no tenderness, no distention, no masses.

Family Medicine : Assessment & Plan

M.E.A.T Format

The M.E.A.T. format includes documentation focusing on these areas: **M** = Monitoring, **E** = Evaluation, **A** = Assessment, **T** = Treatment.

Monitoring – Documentation of signs and symptoms, disease progression, disease regression, ongoing surveillance of the condition

Evaluation – Documentation of current state of condition, physical exam findings, test results, medication effectiveness, response to treatment

Assessment – Documentation of discussion of condition, review of records, counseling, how condition will be evaluated, ordering further test

Treatment – Documentation of care being offered for condition, prescribing or continuation of medications, referral to specialist, ordering diagnostic study, therapies, plan for management of condition

ASSESSMENT & PLAN

1. Hypertension.
- Blood pressure is consistently within normal range.
- Comprehensive metabolic panel was normal.
- Discussed potential to reduce blood pressure medication with continued weight loss efforts.
- Continue current regimen of medication, refill provided.

2. Generalized Anxiety Disorder.
- Experiences occasional nervousness and panic attacks.
- GAD-7 score is <5, suggesting well-controlled anxiety.
- Advised to continue with current counseling sessions.
- Medication may be considered in the future if symptoms worsen.

3. Health Maintenance.
- Overdue for an eye exam and has an appointment scheduled next week.
- Colonoscopy and mammogram results reveal normal findings.
- Advised to continue consuming more vegetables and less processed food.
- Pneumovax vaccine will be administered today.

Gastroenterology

Targeted Improvements:

- HPI enhanced to limit excessive use of “the patient” or overuse of pronouns, while also ensuring that the patient’s voice is still present with the use of direct quotes when needed and limiting symptom grading language like “severe” unless verbalized by the patient.
- HPI will also include verbalized past procedures under the header “Past Surgical History” rather than in the procedure section.
- Results section modified to include only results that were completed or interpreted during the visit and verbalized. Also updated to format the results section using specific diagnostic test names as headers, with the findings hyphenated below.
- Procedure section modified to only include GI specific procedures that were completed during the encounter. All other procedures discussed will be listed in the HPI section under the header “Past Surgical History”.
- AP section updated to remove redundancies and include comprehensive plan and precise medical terminology.

Gastroenterology: Physical Examination

General Content

No jaundice observed in the eyes or skin.
Lungs are clear bilaterally.
Heart sounds are normal. No murmurs, gallops, or rubs noted.
Abdomen is normal.

Specialty-specific Content

GENERAL: The patient is a 26-year-old male in no acute distress.

VITALS: BP: 130/76 mmHg, HR: 72 bpm, Temp: 96.6°F, RR: 16 breaths/min, SpO2: 98% on room air.

HEENT: Normocephalic, atraumatic. Oropharynx clear, no lesions. No cervical lymphadenopathy.

CARDIOVASCULAR: Regular rate and rhythm, no murmurs, rubs, or gallops. Peripheral pulses 2+ bilaterally.

RESPIRATORY: Clear to auscultation bilaterally, no wheezes, rales, or rhonchi.

ABDOMEN: Soft, non-tender, non-distended. No hepatosplenomegaly. Bowel sounds present in all quadrants. Mild epigastric tenderness noted.

EXTREMITIES: No edema, cyanosis, or clubbing. Full range of motion.

NEUROLOGICAL: Alert and oriented x3. Cranial nerves II-XII intact. No focal deficits.

SKIN: No rashes, lesions, or jaundice. Warm and dry to touch.

MUSCULOSKELETAL: No joint swelling or deformities. Normal gait.

PSYCHIATRIC: Appropriate affect and demeanor. No signs of anxiety or depression.

Gastroenterology: Results/Assessment and Plan

General Content

Results
Imaging
Abdominal CT on 01/23/2020 showed a normal CT of the abdomen.

Assessment and Plan
1. Chronic abdominal pain.
The patient's chronic abdominal pain is likely due to constipation and dietary factors. He reports a nagging pain in the mid-abdomen, which sometimes improves after bowel movements. Physical examination reveals increased stool burden in the colon. A fiber supplement will be initiated to help with constipation. He is advised to increase water intake to at least 48 ounces daily and avoid foods that trigger diarrhea.

Specialty-specific Content

Results
Abdominal CT on 01/23/2020:
- Normal CT of the abdomen.

Assessment and Plan
1. Chronic abdominal pain:
- Likely due to constipation and dietary factors.
- Initiate fiber supplement to help with constipation.
- Increase water intake to at least 48 ounces daily.
- Avoid foods that trigger diarrhea.

General Surgery

Targeted Improvements:

- HPI
  - Enhanced to include a dedicated Surgical History section as well as updated Social History and Family History section formatting.
  - Will limit use of pronouns and/or "the patient"

- Physical Exam
  - Updated formatting with system specific headers

- Assessment and Plan
  - Improved documentation of risks, benefits, and alternatives detail.

- Other Updates
  - Updated Formatting for Results content
  - Updated Procedure section to include updated procedure documentation formatting
    - Will only include procedures performed during encounter

General Surgery: History of Present Illness

General Content

The patient is a 65-year-old female who presents for follow-up after a colectomy.

She reports an overall improvement in her condition, with a decrease in abdominal pain. She experiences intermittent sharp pain and occasional burning sensations during urination. Her bowel movements are regular, typically occurring post-dinner, without any urgency. She maintains a good appetite and has not experienced any fevers or chills. She recalls a recent episode of stomach upset following the consumption of French dip but notes that it was not severe. She expresses concern about resuming boating activities in the upcoming summer.

Specialty-specific Content

The patient is a 65-year-old female who presents for follow-up after a colectomy performed on 02/01/2025 for diverticulitis.

Overall improvement in her condition is reported, with a decrease in abdominal pain. Intermittent sharp pain and occasionally burning sensations during urination are notes Bowel movements are regular, typically occurring post-dinner, without any urgency. She has a good appetite and does not report fevers or chills. She recalls a recent episode of stomach upset following the consumption of a French dip sandwich, but it was not severe. Se expresses concern about resuming boating activities this summer.

PAST SURGICAL HISTORY:
Colectomy on 02/01/2025 for diverticulitis.

General Surgery: Physical Examination

General Content

The incision on the neck shows some mild edema and there is still some flaking skin glue. On the left side of the neck, the patient reports a poking sensation, but the tail of the suture is not palpable.
Wheezes are present in both lungs. Normal respiratory movements.
The heart exhibits a regular rate and rhythm.
There is no edema in the arms, which have a normal color and easily palpable radial pulses. Mild edema is present in the legs, which are covered by compression stockings.

Specialty-specific Content

Neck: The incision on the neck shows some mild edema and there is still some flaking skin glue. On the left side of the neck, the patient reports a poking sensation, but the tail of the suture is not palpable.
Respiratory: Wheezes are present in both lungs. Normal respiratory movements.
Cardiovascular: The heart exhibits a regular rate and rhythm.
Extremities: There is no edema in the arms, which have a normal color and easily palpable radial pulses. Mild edema is present in the legs, which are covered by compression stockings.

General Surgery: Assessment and Plan

General Content

1. Abdominal pain.
The patient's symptoms, including constipation, lack of gas passage, and vomiting, suggest a potential small bowel obstruction. The hernia does not appear to be the cause of the obstruction as it is not incarcerated. The gallbladder is enlarged and inflamed. A small bowel follow-through will be conducted to rule out an obstruction. If an obstruction is detected, hospital admission will be necessary. He has been advised to abstain from smoking and meth use for a minimum of one month prior to any hernia repair procedure.

Specialty-specific Content

1. Abdominal pain.
The patient's symptoms, including constipation, lack of gas passage, and vomiting suggest a potential small bowel obstruction. The hernia does not appear to be the cause of the obstruction as it is not incarcerated. The gallbladder is enlarged and inflamed. A small bowel follow-through will be conducted to rule out an obstruction. If an obstruction is detected, hospital admission will be necessary. The patient has been advised to abstain from smoking and meth use for a minimum of one month prior to any hernia repair procedure. The risks, benefits, and alternatives of the small bowel follow-through and potential hospital admission were discussed. The patient understands that if an obstruction is found, immediate intervention may be required.

General Surgery: Procedure

General Content

PROCEDURE
The patient underwent a cholecystectomy and ERCP prior to this visit.

Specialty-specific Content

PROCEDURE
Procedure: Staple Removal from Abdominal Incision

All questions were answered and agreement to proceed was given after the following Pre-Procedure details were reviewed:
- Risks and Benefits: Discussed potential for minor discomfort during staple removal.
- Consent: Verbal consent obtained for staple removal.

Intra-Procedure:
- Site Preparation: Cleaned the incision site with antiseptic solution.
- Dressing: Applied adhesive skin closure strips and a sterile dressing over the incision site.

Post-Procedure:
- Tolerance Level: Tolerated the procedure well.
- Home Care Instructions: Advised to keep the incision site clean and dry, monitor for signs of infection, and avoid heavy lifting or straining for two more weeks.

Geriatric Medicine

Targeted Improvements:

- HPI
  - Enhanced to include a Functional Assessment section when verbalized.
  - Will limit use of pronouns and/or "the patient".

- Physical Exam
  - Updated formatting with comprehensive and system specific headers.

- Assessment and Plan
  - Improved documentation of treatment plan, rehabilitation, safety concerns, social services, and advanced care planning detail.

- Other updates
  - Updated formatting for Results content.
  - Updated Procedure section formatting and only include procedures performed during encounter.

Geriatric Medicine: Exam

General Content

Oral exam was performed.
Lungs are clear.
Heart has a regular rhythm, bradycardic.
Normal bowel sounds.
There is some thick fungus on the right great toe.

Specialty-specific Content

Vital Signs: Blood pressure is 116/62. Pulse is 46. Respiratory rate is 16. Oxygen saturation is 96%. Standing heart rate is 50. Blood pressure upon standing is 122/62.
Mouth/Throat: Oral exam performed. Good color. Teeth and tongue appear normal.
Respiratory: Lungs are clear.
Cardiovascular: Heart has a regular rhythm, bradycardic.
Gastrointestinal: Normal bowel sounds.
Skin: Thick fungus on the right great toe.

Geriatric Medicine: Results

General Content

Laboratory Studies
Potassium level was normal 4 months ago. Magnesium and phosphorus levels were normal last time. GFR was 79. Glucose was 143.

Specialty-specific Content

Labs
- Potassium level: 11/2024, Normal
- Magnesium level: Normal
- Phosphorus level: Normal
- GFR: 79
- Glucose: 143

Geriatric Medicine: Assessment and Plan

General Content

1. Potential discharge from SNF.
The patient's insurance has determined that tomorrow will be his final day of coverage, a decision which he and his wife are currently contesting. The nursing staff reported difficulty in maintaining his oxygen levels, prompting a chest x-ray that revealed an infiltrate. Consequently, he was prescribed Levaquin, which is contraindicated with his current medication, flecainide. The Levaquin was discontinued and replaced with azithromycin and doxycycline. Today's chest x-ray did not reveal any infiltrate. Given the recent complications, it is prudent to continue the antibiotic regimen until his pulmonology appointment tomorrow. He reports feeling better today compared to yesterday, with no significant issues in breathing or oxygen levels. He is advised to continue taking Tylenol for pain management and to use the lidocaine patch as needed. The scheduled Mucinex will be restarted. He reports no significant pain, pressure, or tightness, except for occasional sharp back pain when moving. He is advised to continue using Tylenol and the lidocaine patch for pain management. Narcotics are not recommended due to potential respiratory depression and constipation.

Specialty-specific Content

1. Potential discharge from SNF.
- The patient's insurance has determined that tomorrow will be his final day of coverage, a decision which he and his wife are currently contesting.
- The nursing staff reported difficulty in maintaining his oxygen levels, prompting a chest x-ray that revealed an infiltrate. Consequently, he was prescribed Levaquin, which is contraindicated with his current medication, flecainide. The Levaquin was discontinued and replaced with azithromycin and doxycycline. Today's chest x-ray did not reveal any infiltrate. Given the recent complications, it is prudent to continue the antibiotic regimen until his pulmonology appointment tomorrow. He reports feeling better today compared to yesterday, with no significant issues in breathing or oxygen levels.
- He is advised to continue taking Tylenol for pain management and to use the lidocaine patch as needed. The scheduled Mucinex will be restarted. He reports no significant pain, pressure, or tightness, except for occasional sharp back pain when moving. He is advised to continue using Tylenol and the lidocaine patch for pain management. Narcotics are not recommended due to potential respiratory depression and constipation.

Hospice & Palliative Care

Targeted Improvements:

- Shift documentation from purely objective findings to include the patient's emotional and subjective experiences, comfort levels, and quality of life.
- Documentation will reflect input from the interdisciplinary team (nursing, chaplains, spiritual guidance, social work, and family members) and integrate this input into the palliative care notes.
- Enhancements in the assessment and plan will target the inclusion of more information around goals of care discussions, advanced care planning, and patient wishes.
- Expanded social and spiritual histories aim to capture cultural values, faith-based preferences, and psychosocial factors that may influence the patient's goals and care decisions.
- The physical exam has been improved for the specialty contains dedicated locations for the Karnofsky Performance Status (KPS), Palliative Performance Scale (PPS), or ECOG status if verbalized by the clinician.

Hospice and Palliative Care: History of Present Illness

General Content

The patient is a ___-year-old female who is seen today in palliative care for follow-up to manage symptoms related to her cancer.

She reports an improvement in her overall condition over the past 1 to 2 weeks, with a decrease in depressive symptoms and an increase in appetite. Her sleep quality has also improved. She experiences intermittent nausea, but it is less severe than before. She alternates between Compazine and Phenergan and continues to take Zofran. She believes that Paxil has significantly improved her mood, although she has not taken it for several days. She acknowledges occasional feelings of sadness but notes that they are not as intense as previously experienced. She finds that physical activity, such as exercise, improves her mood, while prolonged bed rest leads to stiffness and feelings of depression. She recently attended church with her grandchildren. She continues to take olanzapine at night, which aids in both sleep and nausea management.

She experiences pain, particularly when standing or doing dishes, which manifests as an aching and throbbing sensation in her back. However, she feels that her current medication regimen is effective in managing this pain. She expresses satisfaction with her current medications and their efficacy, noting an increased ability to perform daily activities.

Specialty-specific Content

The patient is a ___-year-old female who is being seen today in palliative care for follow-up. She is accompanied by her grandbabies. The primary reason for this visit is to manage symptoms related to her cancer.

A significant improvement in her condition is reported over the past one to two weeks, with enhanced sleep quality and reduced depressive symptoms. Her appetite has also improved. Intermittent nausea is experienced, but it is less severe than previously reported. Paxil has been beneficial in managing depressive symptoms. She has a sufficient supply of olanzapine and Paxil for the next three months. Compazine, Phenergan, and Zofran are alternated for nausea management. A recent refill of famotidine has been obtained, and there is currently a sufficient supply.

Her back pain is described as aching and throbbing, particularly when standing for extended periods, such as when performing household chores like dishwashing. This discomfort necessitates periods of rest. Satisfaction with the current medication regimen is expressed, as it effectively manages pain.

Prolonged bed rest has caused stiffness and depression, leading to feelings of wasting life. Physical activity and exercise are found to improve overall well-being. She recently attended church with her grandbabies, which was a positive experience.

SPIRITUAL HISTORY: She attends church in ___ and finds this to be an important aspect of her life.

Hospice Palliative Care: Assessment and Plan

General Content

1. Chronic pain.
Her primary pain generator is her hip, and she has chronic pain due to osteoarthritis and cancer. She has been transitioned from tramadol to hydrocodone but reports no significant relief from hydrocodone. She prefers to use ibuprofen for pain management as it has been more effective for her in the past. Her kidney function is stable, allowing for the use of ibuprofen. A prescription for tramadol will be renewed, and she is advised to use ibuprofen 800 mg three times daily sparingly. Hydrocodone will be discontinued.

2. Diarrhea.
She has been experiencing frequent diarrhea, which has been somewhat managed with over-the-counter Kaopectate. Dehydration is suspected due to diarrhea. A prescription for Lomotil will be sent to her pharmacy to manage diarrhea if it worsens.

Follow-up
The patient will follow up in 3 weeks.

Specialty-specific Content

1. Urothelial carcinoma.
The patient is currently receiving infusion therapy for urothelial carcinoma. Pain management is a significant aspect of her palliative care. She has been transitioned from tramadol to hydrocodone but reports no significant relief from hydrocodone. She prefers to use ibuprofen for pain management as it has been more effective for her in the past. Her kidney function is stable, allowing for the use of ibuprofen. A prescription for tramadol will be renewed, and she is advised to use ibuprofen 800 mg three times daily sparingly. Hydrocodone will be discontinued. Goals of care include maintaining quality of life and managing pain effectively.

2. Chronic pain.
Her primary pain generator is her hip, and she has chronic pain due to osteoarthritis and cancer. She has been transitioned from tramadol to hydrocodone but reports no significant relief from hydrocodone. She prefers to use ibuprofen for pain management as it has been more effective for her in the past. Her kidney function is stable, allowing for the use of ibuprofen. A prescription for tramadol will be renewed, and she is advised to use ibuprofen 800 mg three times daily sparingly. Hydrocodone will be discontinued.

3. Diarrhea.
She has been experiencing frequent diarrhea, which has been somewhat managed with over-the-counter Kaopectate. Dehydration is suspected due to diarrhea. A prescription for Lomotil will be sent to her pharmacy to manage diarrhea if it worsens.

Follow Up: 05/20/2025

Hospital Setting (Inpatient)

Targeted Improvements:

Overall Note:
Style enhancements specific to inpatient documentation

HPI:
Specific inpatient course format, reason for admission, and presentation of detail in chronological order.

PHYSICAL EXAM:
More accurately capture relevant content with greater clinical specificity in a logical and concise format.

ASSESSMENT & PLAN:
- More accurately capture inpatient relevant content with greater clinical specificity including capturing code status when discussed.
- Assumption of studies being completed within admission unless otherwise stated as outpatient follow-up.
- Capture of discussion of the justification for admission or length of stay.
- Capture of differential diagnoses if discussed.
- Capture of care considerations including social determinants of health.

Hospital Setting (Inpatient): HPI

General Content

The patient is a 97-year-old male who presents to the emergency room for chest pain. He has a history of coronary artery disease, aortic valve regurgitation, type 2 diabetes with CKD stage 3, hypertension, GERD, and dyslipidemia. He reports experiencing chest discomfort, which he describes as pain. This episode began on Friday during his routine walk, necessitating him to halt and rest. Since then, even short distances trigger the onset of symptoms. His walking distance has been significantly reduced from a mile to approximately a quarter of a mile, with breathlessness occurring after only 15 to 20 feet. He reports no unusual sweating, nausea, headaches, weight changes, appetite alterations, fevers, or chills. He has a history of similar episodes dating back 20 years but reports no history of myocardial infarction. His last stress test was conducted between 10 to 20 years ago. He is currently on aspirin therapy. He also reports leg swelling, which he considers normal. His nephrologist has advised him to increase his water intake. He is under the care of XXX for his renal issues.

Supplemental Information: He has an umbilical hernia.

Specialty-specific Content

Reason for Admit: Chest Pain.

The patient is a 97-year-old male who presents to the emergency room for chest pain. He has a history of coronary artery disease, aortic valve regurgitation, type 2 diabetes with CKD stage 3, hypertension, GERD, and dyslipidemia.

He reports experiencing chest discomfort, which he describes as pain. This episode began on Friday during his routine walk, necessitating him to halt and rest. Since then, even short distances trigger the onset of symptoms. His walking distance has been significantly reduced from a mile to approximately a quarter of a mile, with breathlessness occurring after only 15 to 20 feet. He reports no unusual sweating, nausea, headaches, weight changes, appetite alterations, fevers, or chills. He has a history of similar episodes dating back 20 years but reports no history of myocardial infarction. His last stress test was conducted between 10 to 20 years ago. He is currently on aspirin therapy.

He also reports leg swelling, which he considers normal. His nephrologist has advised him to increase his water intake. He is under the care of XXX for his renal issues.

He has an umbilical hernia.

Hospital Setting (Inpatient): Physical Exam

General Content

Lungs are clear.
A robust murmur is present in the heart.
There is some ankle swelling.
An umbilical hernia is present.

Specialty-specific Content

Cardiac: A robust murmur is present.
Respiratory: Lungs are clear.
Abdominal: An umbilical hernia is present.
Extremities: There is some ankle swelling.

Hospital Setting (Inpatient): Assessment & Plan

General Content

1. COVID-19 infection.
She has been experiencing coughing, dizziness, chest heaviness, and shortness of breath for about a week. She will be started on COVID-19 medications.

2. Urinary tract infection (UTI).
She has had burning during urination for about 2 weeks and was previously treated with levofloxacin and clonidine without improvement. Antibiotics will be initiated to treat the UTI.

3. Diabetes mellitus.
She has not had insulin for 2 months due to the lack of pen needles and refrigeration at the shelter. Arrangements will be made to provide her with insulin pens that do not require refrigeration.

Specialty-specific Content

Code Status: DO NOT RESUSITATE

1. COVID-19 infection.
- She has been experiencing coughing, dizziness, chest heaviness, and shortness of breath for about a week.
- COVID-19 medications will be initiated.

2. Urinary tract infection (UTI).
- She has had burning during urination for about 2 weeks and was previously treated with levofloxacin and clonidine without improvement.
- Antibiotics will be initiated to treat the UTI.

3. Diabetes mellitus.
- She has not had insulin for 2 months due to the lack of pen needles and refrigeration at the shelter.
- Arrangements will be made to provide her with insulin pens that do not require refrigeration.

Care Considerations:
- The patient is currently residing at the Presbyterian shelter and has not received insulin therapy for the past 2 months due to a lack of pen needles and refrigeration facilities.
- The patient expressed interest in going to rehab if available instead of returning to the shelter.

Hospital Setting (Inpatient)Specialty: Assessment & Plan

GENERAL MODEL BASE

1. Chest pain.
He reports chest discomfort that began while walking and has persisted with minimal exertion. There is no evidence of a myocardial infarction based on two negative blood tests. An echocardiogram will be performed to assess cardiac function. A diuretic will be administered to reduce fluid retention, particularly around the heart and lungs, to improve his ability to exercise and breathe. If necessary, his nephrologist will be consulted.

2. Coronary artery disease.
He has a history of coronary artery disease and underwent a heart bypass approximately 20 years ago. His current symptoms and history will be reviewed, and appropriate adjustments to his treatment plan will be made as needed.

3. Aortic valve regurgitation.
He has a history of aortic valve regurgitation. The echocardiogram will help assess the current status of his valve function.

4. Type 2 diabetes with CKD stage 3.
His kidney function is slightly off today, with a creatinine level of 2.3 compared to 1.7 two years ago. He is advised to maintain adequate hydration as per his nephrologist's recommendations. His nephrologist will be consulted if necessary.

5. Hypertension.
His blood pressure will be monitored closely during his hospital stay. Any necessary adjustments to his antihypertensive medications will be made based on his readings.

Hospital Setting (Inpatient) Specialty: Assessment & Plan

HOSPTIAL SETTING TRANSFORMATION

Code Status: DO NOT RESUSCITATE.

1. Chest pain.
- He reports chest discomfort that began while walking and has persisted with minimal exertion.
- There is no evidence of a myocardial infarction based on two negative blood tests.
- An echocardiogram will be performed to assess cardiac function.
- A diuretic will be administered to reduce fluid retention, particularly around the heart and lungs, to improve his ability to exercise and breathe.
- If necessary, his nephrologist will be consulted.

2. Coronary artery disease.
- He has a history of coronary artery disease and underwent a heart bypass approximately 20 years ago.
- His current symptoms and history will be reviewed, and appropriate adjustments to his treatment plan will be made as needed.

3. Aortic valve regurgitation.
- He has a history of aortic valve regurgitation.
- The echocardiogram will help assess the current status of his valve function.

4. Type 2 diabetes with CKD stage 3.
- His kidney function is slightly off today, with a creatinine level of 2.3 compared to 1.7 two years ago.
- He is advised to maintain adequate hydration as per his nephrologist's recommendations.
- His nephrologist will be consulted if necessary.

5. Hypertension.
- His blood pressure will be monitored closely during his hospital stay.
- Any necessary adjustments to his antihypertensive medications will be made based on his readings.

Infectious Disease

Targeted Improvements:

HPI
- There is a strong focus on *chronological* history related to the condition: symptoms, diagnostic measures, treatments, medications, current treatments, and past treatments.

Social History
- A significant feature of this section is the inclusion of *exposure* history.

Physical Exam
- All verbalized content is documented with appropriate body system subheadings. Only sections which are examined or verbalized are documented.

Assessment & Plan
- This section emphasizes medical decision making as well as the discussion pertaining to risks and benefits of the treatment plan.

Infectious Disease: HPI

General Content

The patient presents for evaluation of cryptococcal infection.

He has a history of smoking and was initially diagnosed with a lung nodule during an emergency room visit for a hernia. Despite two bronchoscopies, no samples were obtained from the hilar lymph node. A subsequent biopsy through his back revealed necrosis but no fungal or bacterial presence. He has been asymptomatic throughout this period. He reports no significant daily cough, hemoptysis, or persistent dyspnea despite using the inhaler. He remains active, including playing golf. He reports no fevers, chills, night sweats, headaches, or blurry vision.

He has not had any recent travel except to Arizona and reports no exposure to farm animals. He occasionally works at Stone Rock where there are turkeys. He reports no unusual hobbies. He has no immunocompromising conditions and has never been tested for HIV. He has had a single partner for 43 years. He reports no known liver injury. He experienced neck soreness prior to the operation, which resolved postoperatively. He has been experiencing drainage from the surgical site, which ceased two days ago after he stopped applying gauze. He has sutures in the incision on his back and experienced skin peeling due to incorrect tape use. He underwent a resection of the bone. He had pneumonia 4 years ago, which resolved with antibiotics.

He has a lifelong history of asthma, primarily in childhood, and carries albuterol for occasional use, which has increased postoperatively.

He has an enlarged prostate, which was biopsied several years ago, revealing less than 5% involvement. His prostate issues have remained stable, although his PSA count slightly increased last year. He reports no pain but notes increased difficulty in urination.

He has been experiencing dry skin this year, which he attributes to wintering in Arizona. He also reports pruritus in his legs, which started on his left foot and has since scarred. The condition worsened in December 2024 but improved upon returning home and using local water. He applies oil to the affected areas, which provides relief.

He has hypertension and is on losartan.

Specialty-specific Content

The patient presents for evaluation of cryptococcal infection.

A history of smoking is noted, and a lung nodule was initially diagnosed during an emergency room visit for a hernia. Despite two bronchoscopies, no samples were obtained from the hilar lymph node. A subsequent biopsy through the back revealed necrosis but no fungal or bacterial presence. He has been asymptomatic throughout this period, reporting no significant daily cough, hemoptysis, or persistent dyspnea despite using the inhaler. He remains active, including playing golf. There are no reports of fevers, chills, night sweats, headaches, or blurry vision.

Recent travel includes trips to Arizona, with no exposure to farm animals. He occasionally works at Stone Rock where there are turkeys. No unusual hobbies are reported. There are no immunocompromising conditions, and he has never been tested for HIV. He has had a single partner for 43 years and reports no known liver injury. Neck soreness experienced prior to the operation resolved postoperatively. Drainage from the surgical site ceased two days ago after stopping gauze application. Sutures are present in the incision on his back, and skin peeling occurred due to incorrect tape use. A bone resection was performed. Pneumonia was diagnosed 4 years ago and resolved with antibiotics.

A lifelong history of asthma is noted, primarily in childhood. Albuterol is carried for occasional use, with increased usage postoperatively.

An enlarged prostate was biopsied several years ago, revealing less than 5% involvement. Prostate issues have remained stable, although the PSA count slightly increased last year. There is no pain, but increased difficulty in urination is noted.

Dry skin has been experienced this year, attributed to wintering in Arizona. Pruritus in the legs started on the left foot and has since scarred. The condition worsened in December 2024 but improved upon returning home and using local water. Oil application to the affected areas provides relief.

Hypertension is managed with losartan.

Infectious Disease: HPI

General Content

Supplemental Information
He had three stents placed in 2014.

SOCIAL HISTORY
The patient quit smoking about 15 years ago and used to smoke half a pack a day. He drinks beer and stopped drinking about 6 weeks ago. He does not report any recreational drug use. He lives with his wife and daughter lives in Center Point.

Specialty-specific Content

PAST SURGICAL HISTORY:
- Three stents placed in 2014
- Hernia repair
- Bone resection

SOCIAL HISTORY
Marital Status: Married
Occupations: Aircraft maintenance for United Airlines
Hobbies: Golf
Alcohol: Drinks beer, stopped drinking about 6 weeks ago
Tobacco: Quit smoking about 15 years ago, used to smoke half a pack a day
Sexual Practices: Single partner for 43 years
Living Condition: Lives with wife, daughter lives in Center Point
Exposure History: Travels to Arizona in winter, visited Montana last year and North Carolina the year before, exposure to doves in Arizona, no pets currently, used to have a cat that passed away in 2008, occasional work at Stone Rock with exposure to turkeys

Infectious Disease: Physical Exam

General Content

Neck was examined.
Lungs sound normal.
Abdomen was examined.
No lesions on the arms.

Specialty-specific Content

Neck: No pain on movement.
Lungs: Breath sounds normal.
Abdomen: No abnormalities noted.
Extremities: No lesions on the arms.
Skin: Incision site on back healing well, no drainage, dry.
Redness around the incision due to tape.

Infectious Disease: Results

General Content

Laboratory Studies
Biopsy of the lung nodule showed no fungus or bacteria, but necrosis was present.

Specialty-specific Content

Diagnostic Testing
- Biopsy of the lung nodule: No fungus or bacteria, but necrosis was present.

Infectious Disease: Assessment and Plan

General Content

1. Cryptococcal infection.
The patient has a history of smoking and a previously identified lung nodule. Recent findings include cryptococcus in the lung and necrosis in the lymph nodes. The necessity of treatment will be determined based on the serum antigen levels, which are pending from the Mayo Clinic. If the levels are significantly elevated, antifungal therapy will be initiated. If the levels are moderately elevated, further investigation will be required to rule out central nervous system involvement, necessitating brain imaging and cerebrospinal fluid analysis. An EKG will be ordered to establish a baseline before considering fluconazole treatment due to its potential impact on cardiac rhythm. He is advised to monitor for persistent headaches or blurry vision and report any changes.

2. Asthma.
He has a lifelong history of asthma and occasionally uses albuterol, especially post-operation. No significant daily cough, hemoptysis, or persistent shortness of breath is reported. He remains active, including playing golf.

3. Enlarged prostate.
He has a history of an enlarged prostate with a biopsy done approximately 5 years ago, showing less than 5% involvement. His PSA levels slightly increased last year, but he reports stable symptoms with no significant changes in urinary difficulties or pain.

4. Dry skin and itchy lesions.
He reports dry skin and itchy lesions, particularly on his legs and left foot, which have been managed with oil application. These symptoms are not typical of cryptococcal infection but are noted for monitoring.

5. Hypertension.
He is currently on losartan for high blood pressure management.

Specialty-specific Content

1. Cryptococcal infection.
The patient has a history of smoking and a previously identified lung nodule. Four years ago, a lung nodule was discovered incidentally during imaging for pneumonia. Subsequent bronchoscopies failed to obtain samples, but a biopsy through the back revealed necrosis without fungus or bacteria. Continued scans could not determine the nature of the nodule, leading to a resection. Recent findings include cryptococcus in the lung and necrosis in the lymph nodes. The necessity of treatment will be determined based on the serum antigen levels, which are pending from the Mayo Clinic. If the levels are significantly elevated, antifungal therapy will be initiated. If the levels are moderately elevated, further investigation will be required to rule out central nervous system involvement, necessitating brain imaging and cerebrospinal fluid analysis. An EKG will be ordered to establish a baseline before considering fluconazole treatment due to its potential impact on cardiac rhythm. He is advised to monitor for persistent headaches or blurry vision and report any changes.

2. Asthma.
He has a lifelong history of asthma, primarily during childhood, and occasionally uses albuterol, especially post-operation. No significant daily cough, hemoptysis, or persistent shortness of breath is reported. He remains active, including playing golf. No new treatment plans are necessary at this time.

3. Enlarged prostate.
He has a history of an enlarged prostate with a biopsy done approximately 5 years ago, showing less than 5% involvement. His PSA levels slightly increased last year, but he reports stable symptoms with no significant changes in urinary difficulties or pain. Continued monitoring of PSA levels and symptoms is recommended.

4. Dry skin and itchy lesions.
He reports dry skin and itchy lesions, particularly on his legs and left foot, which have been managed with oil application. These symptoms are not typical of cryptococcal infection but are noted for monitoring. No new treatment plans are necessary at this time.

5. Hypertension.
He is currently on losartan for high blood pressure management. No new treatment plans are necessary at this time.

Follow-up
The patient will follow up in 1 month.

Interventional Cardiology

Targeted Improvements:

Overall Note:
Style enhancements specific to interventional cardiology documentation with inclusion of various data points required for cardiology specific national registries.

HPI:
More logical arrangement of topics, including grouping cardiology related topics at the top of the section together. Inclusion of more robust discussion of cardiology symptoms.

PHYSICAL EXAM:
More accurately captures relevant content with greater clinical specificity in a logical and concise format.

ASSESSMENT & PLAN:
- More accurately captures interventional cardiology relevant content with greater clinical specificity.
- Capture of discussion of risks, benefits, and alternatives of treatment.
- Capture of differential diagnoses if discussed.

Interventional Cardiology: HPI

General Content

The patient is a 45-year-old gentleman who presents to the cardiology clinic to establish care for chest discomfort. There is a past medical history of COPD/asthma, higher body weight, and type 2 diabetes mellitus.

He reports experiencing mild chest pain characterized by a sensation of tightness. This discomfort, described as a pressure-like sensation, radiates down his left arm. He is generally active, with his occupation in security requiring him to be on his feet throughout the day. He does not report any correlation between physical activity and the onset of his symptoms.

Specialty-specific Content

The patient is a 45-year-old gentleman who presents to the cardiology clinic to establish care for chest discomfort.

He reports experiencing mild chest pain characterized by a sensation of tightness, which he first noticed approximately 2 months ago. This discomfort, described as a pressure-like sensation, radiates down his left arm. The onset of these symptoms is typically in the morning upon waking, with resolution by the afternoon. Despite an EKG indicating normal cardiac function, he was advised to seek further evaluation. His lifestyle is generally active, with his occupation in security requiring him to be on his feet throughout the day. He does not report any correlation between physical activity and the onset of his symptoms.

There is a past medical history of COPD/asthma, obesity class I, and type 2 diabetes mellitus. He has a past medical history of asthma and was previously informed of having osteoporosis in both knees, although this diagnosis was never confirmed. He also reports minor gastrointestinal issues. He has no history of surgical interventions. He has a smoking history of half a pack per day, but he quit 5 years ago. He does not consume alcohol.

He was previously informed of having diabetes by a urologist.

Interventional Cardiology: Exam

General Content

The patient is in no acute distress.
Jugular venous pressure in the neck is not elevated.
Lungs are clear throughout.
There is a summation gallop with an opening snap in the heart. No significant murmurs appreciated on exam. No volume overload. There is trace nonpitting lower extremity edema. Radial and DP pulses are 2+ and all equal. No radial femoral delay and no other surgical scars.
Abdomen is gravid.

Specialty-specific Content

General: No acute distress

Neck: No JVD

Heart: Summation gallop with an opening snap, no significant murmurs appreciated, no volume overload

Lungs: Clear throughout

Abdomen: Gravid

Extremities: Trace nonpitting lower extremity edema, 2+ radial and DP pulses, all equal, no radial femoral delay

Interventional Cardiology: Results

General Content

Laboratory Studies
A1c is 6.4. Total cholesterol is 208, triglycerides 183, HDL 48, and LDL 123. Creatinine is 1.4. Potassium is 4.4.

Imaging
Last echocardiogram in March 2024 showed LVEF 58%, normal RV function, no significant valvulopathy, grade 1 diastolic dysfunction. Myocardial perfusion imaging stress test done in March 2024 showed multiple areas of ischemia, read as high risk.

Specialty-specific Content

Labs
- A1c: 6.4
- Total cholesterol: 208 mg/dL
- Triglycerides: 183 mg/dL
- HDL: 48 mg/dL
- LDL: 123 mg/dL
- Creatinine: 1.4 mg/dL
- Potassium: 4.4 mmol/L

Imaging
- Echocardiogram: 03/2024, LVEF 58%, normal RV function, no significant valvulopathy, grade 1 diastolic dysfunction
- Myocardial perfusion imaging stress test: 03/2024, Multiple areas of ischemia, read as high risk

Interventional Cardiology: General Model Note Output

1. Congenital heart disease.
She likely has congenital heart disease, specifically congenital mitral stenosis. An in-depth review of her echocardiogram reveals a hockey-stick like appearance of the anterior leaflet of the mitral valve, significant asymmetry of the leaflet itself, and a well-functioning aortic valve with a bicuspid appearance and no significant aortic regurgitation. Given her history of being born with a heart defect described as a hole in her heart and hospitalization for over a month following her own delivery, it is assumed that she has a forme fruste of Shone's complex disease. There is no obvious supravalvular mitral ring or subaortic stenosis observed. Unfortunately, she had previously been advised to get a fetal echo which was not performed in the second trimester and her two prior pregnancies were fine. However, there is noted LV hypoplasia on her anatomy scan and I have reiterated that she should complete a fetal echo. Given the increased incidence of congenital heart disease in the offspring of parents with congenital heart disease, she is going to get this scheduled. I will also reach out to our MFM group regarding this and her delivery plan, I suspect she will need telemetry during delivery given her high PVC volumes in the past. It was a pleasure to meet her. I would like to transition her to my ACHD clinic for follow-up in her fourth trimester following delivery and we will repeat a congenital echo at that time. No medication changes today.

2. Pregnancy.
She is currently at 32 weeks and 3 days of pregnancy. She reports shortness of breath when lying flat and climbing stairs, which is consistent with her previous pregnancies. There is no evidence of severe disease or fluid in the lungs. She has trace nonpitting lower extremity edema, which is likely due to pregnancy. She is advised to stay active and monitor for any significant changes in her symptoms. A fetal echo has been recommended due to the noted LV hypoplasia on her anatomy scan. She will schedule this and follow up with the maternal-fetal medicine group. No medication changes are made today.

Interventional Cardiology: Specialty Model Note Output

1. Congenital heart disease:
- Likely congenital mitral stenosis with significant asymmetry of the anterior leaflet of the mitral valve and a hockey-stick like appearance.
- Aortic valve is well-functioning with a bicuspid appearance and no significant aortic regurgitation.
- Assumed forme fruste of Shone's complex disease based on history of being born with a heart defect and prolonged hospitalization post-delivery.
- No obvious supravalvular mitral ring or subaortic stenosis observed.
- Recommended fetal echo due to noted LV hypoplasia on anatomy scan.
- Increased incidence of congenital heart disease in offspring of parents with congenital heart disease; fetal echo to be scheduled.
- Coordination with maternal-fetal medicine group for delivery plan.
- Telemetry likely needed during delivery due to high PVC volumes in the past.
- Transition to ACHD clinic for follow-up in the fourth trimester post-delivery.
- Repeat congenital echo post-delivery.
- No medication changes today.

2. Pregnancy:
- Currently at 32 weeks and 3 days of pregnancy.
- Reports shortness of breath when lying flat and climbing stairs, consistent with previous pregnancies.
- No evidence of severe disease or fluid in the lungs.
- Trace nonpitting lower extremity edema likely due to pregnancy.
- Advised to stay active and monitor for significant changes in symptoms.
- Fetal echo recommended due to noted LV hypoplasia on anatomy scan.
- Follow-up with maternal-fetal medicine group.
- No medication changes today.

Interventional Radiology

Improvements:

Overall Note: Style improvements tailored for the IR practice.

HPI:

- Enhanced formatting and include grouping of IR related topics together.

Physical Exam:

- Objective findings Improvement: Observations, Measurements, Interventions.
- Improved content including ROM, strength testing, gait and other special testing performed when stated.

Assessment/Plan:

- Summarized visit findings, recommendations provided within the scope of Interventional Radiology, including planned interventions and rationale for skilled treatment and need for continuation of services.
- Enhanced capture of barriers that may impact outcomes including relevant co-morbidities.
- Goals captured if verbalized during patient encounter.

Interventional Radiology: History of Present Illness

General Medical Model

The patient is a 69-year-old woman who presents today for an initial follow-up after endovenous laser ablation of the left small saphenous vein and medical sclerotherapy of left posterior calf varicose veins performed on 04/20/2025.

She reports that the aspiration procedure was not performed, and she had anticipated spontaneous resolution of the condition. However, she continues to experience persistent soreness and tenderness upon palpation. She also notes the presence of a bulge, which is a new development post-laser treatment. She expresses a desire to expedite the healing process in order to be able to wear shorts by July. She recalls a previous treatment involving saline injections, during which several veins were incised to facilitate blood drainage. This procedure was beneficial in completely resolving the issue.

Specialty Specific Model

The patient is a 69-year-old woman who presents today for an initial follow-up after endovenous laser ablation of the left small saphenous vein and medical sclerotherapy of left posterior calf varicose veins performed on 04/20/2025.

She reports that the aspiration procedure was not performed, and she had anticipated spontaneous resolution of the condition. However, she continues to experience persistent soreness and tenderness upon palpation. She also notes the presence of a bulge, which is a new development post-laser treatment. She expresses a desire to expedite the healing process in order to be able to wear shorts by July.

Relevant clinical history:
She recalls a previous treatment involving saline injections, during which several veins were incised to facilitate blood drainage. This procedure was beneficial in completely resolving the issue.

Interventional Radiology: Physical Examination and Results

General Medical Model

PHYSICAL EXAM
There are some linear areas of tenderness and pigmentation on the skin. A vein on the medial aspect of the calf and ankle appears enlarged.

RESULTS
Imaging
Ultrasound shows a thrombosed vein behind the calf and another vein on the medial aspect of the calf and ankle that is slightly larger.

Specific Specialty Model

PHYSICAL EXAM
Observations:
- Tenderness upon palpation of the left posterior calf.

Interventions:
- Aspiration: Aspiration of the left posterior calf vein.

RESULTS
Imaging
- Ultrasound of the calf: Thrombosed vein behind the calf and another vein on the medial aspect of the calf and ankle that is slightly larger.

Interventional Radiology: Assessment and Plan

General Content

1. Post-procedural follow-up.
She presents for an initial follow-up after endovenous laser ablation of the left small saphenous vein and medical sclerotherapy of left posterior calf varicose veins performed on 04/20/2025. The primary area of concern is a thrombosed vein, which is more visible and causing tenderness. An ultrasound was performed to assess the deep veins in the groin and the medial aspect of the calf and ankle. The vein behind the calf has decreased in size, but there is a linear area of tenderness and pigment. The lump may take up to 2 months to resolve, and the tenderness should subside in a few weeks. She was informed that the lump will eventually resolve, but some pigmentation may persist. If the great saphenous vein becomes problematic, it will be addressed accordingly. She was advised to monitor her condition and return if symptoms worsen.

PROCEDURE
Endovenous laser ablation of the left small saphenous vein and medical sclerotherapy of left posterior calf varicose veins were performed on 04/20/2025.

Specialty-specific Content

Impression:
The primary area of concern is a thrombosed vein, which is more visible and causing tenderness. The vein behind the calf has decreased in size, but there is a linear area of tenderness and pigment. The lump may take up to 2 months to resolve, and the tenderness should subside in a few weeks. The lump will eventually resolve, but some pigmentation may persist.

Recommendations:
An ultrasound was performed to assess the deep veins in the groin and the medial aspect of the calf and ankle. If the great saphenous vein becomes problematic, it will be addressed accordingly. Monitor the condition and return if symptoms worsen.

Nephrology

Targeted Improvements:

Incorporated comprehensive physical exam subheaders, updated list:

- Vital Signs – blood pressure
- Neck – presence of lymphadenopathy, thyroid abnormalities or jugular venous distention
- Respiratory - breath sounds, cough, or signs of respiratory distress
- Lymphatic - swelling, tenderness, or enlargement of lymph nodes
- Gastrointestinal – renal mass or bladder distention
- Extremities - swelling, discoloration, or abnormal perfusion of extremity. Include information related to excoriation, bruising, skin lesions, and AV Fistula palpation and auscultation
- Skin - rash, wound, or lesion

Other note section updates:

- HPI: include PMH, PSH, and Interval History, and details pertinent to Nephrology history such as renal calculi and hematuria.
- Family History related to diabetes, blood pressure and kidney disease. Direct patient quotes added describing symptoms, e.g., “my skin is so itchy I scratched for 15 mins”.
- Review of Systems updated to capture nephrology specific symptoms across all body systems

Nephrology: History of Present Illness

General Content

The patient presents for evaluation of hypertension, gout, and kidney stones.
He reports a gradual weight gain, which he attributes to a sedentary lifestyle and poor dietary habits. He is expecting a baby boy in July.
His blood pressure has remained stable during his last visit, although he has not been monitoring it at home recently. He is on hydrochlorothiazide 12.5 mg, losartan 50 mg, and potassium supplements 20 mg twice daily.
He has not experienced any gout flare-ups since starting allopurinol 300 mg daily. He has no history of passing kidney stones but has had them detected on imaging studies.
He underwent an ultrasound in 2022, which showed normal results.
He is currently taking over-the-counter vitamin D supplements, the dosage of which he will communicate via message.

Specialty-specific Content

The patient presents for evaluation of hypertension, gout, and kidney stones.

A gradual weight gain is reported, attributed to a sedentary lifestyle and poor dietary habits. He is expecting a baby boy in July. Blood pressure has remained stable, although home monitoring has not been conducted recently. Current medications include hydrochlorothiazide 12.5 mg, losartan 50 mg, and potassium supplements 20 mg twice daily.

No gout flare-ups have occurred since starting allopurinol 300 mg daily.

There is no history of passing kidney stones, although they have been detected on imaging studies. An ultrasound in 2022 showed normal results. Over-the-counter vitamin D supplements are being taken, with the dosage to be communicated via message.

Nephrology: Physical Examination

General Content

PHYSICAL EXAM
Lungs were auscultated.

Vital Signs
Blood pressure is normal.

Specialty-specific Content

PHYSICAL EXAM
Vital Signs: Blood pressure is 123/80 mmHg.
Neurological: Slight tremor noted.
Respiratory: Breath sounds are clear.
Cardiovascular: Heart sounds are normal.
Extremities: No swelling in the feet.

Nephrology: Assessment and Plan

General Content

1. Hypertension.
His blood pressure is currently managed with nifedipine and losartan. The dosage of losartan was increased from 25 mg to 50 mg approximately 1 to 2 years ago. Nifedipine, a potent antihypertensive medication, has been causing ankle edema. His cardiac function is satisfactory, with a normal ejection fraction. The lymphatic system appears to be struggling with fluid return to the heart. He is advised to discontinue nifedipine and monitor his blood pressure in the morning. If it exceeds 130/80, he should take an additional dose of losartan. He should continue taking losartan at night and the salt tablet for now. He is also advised to limit his fluid intake to 50 to 60 ounces per day and elevate his legs while watching TV. A non-fasting lab test will be conducted in a few weeks, along with a urine sample. If his sodium levels remain stable, the salt tablet will be discontinued. If the swelling persists despite discontinuing nifedipine and the salt tablet, compression stockings or spironolactone may be considered.
2. Hyponatremia.
He was previously admitted to the hospital due to decreased sodium levels, likely caused by an RSV infection that led to an overproduction of ADH. He was given salt tablets, which improved his sodium levels. His latest laboratory result on 04/10/2025 showed a sodium level of 136. He is advised to continue the salt tablet for now. A non-fasting lab test will be conducted in a few weeks to monitor his sodium levels. If his sodium levels remain stable, the salt tablet will be discontinued.

Specialty-specific Content

1. Hypertension.
- His blood pressure is currently managed with nifedipine and losartan. The dosage of losartan was increased from 25 mg to 50 mg approximately 1 to 2 years ago.
- Nifedipine, a potent antihypertensive medication, has been causing ankle edema. His cardiac function is satisfactory, with a normal ejection fraction. The lymphatic system appears to be struggling with fluid return to the heart.
- He is advised to discontinue nifedipine and monitor his blood pressure in the morning. If it exceeds 130/80, he should take an additional dose of losartan. He should continue taking losartan at night and the salt tablet for now.
- He is also advised to limit his fluid intake to 50 to 60 ounces per day and elevate his legs while watching TV. A non-fasting lab test will be conducted in a few weeks, along with a urine sample. If his sodium levels remain stable, the salt tablet will be discontinued. If the swelling persists despite discontinuing nifedipine and the salt tablet, compression stockings or spironolactone may be considered.

2. Hyponatremia.
- He was previously admitted to the hospital due to decreased sodium levels, likely caused by an RSV infection that led to an overproduction of ADH. He was given salt tablets, which improved his sodium levels.
- His latest laboratory result on 04/10/2025 showed a sodium level of 136.
- He is advised to continue the salt tablet for now. A non-fasting lab test will be conducted in a few weeks to monitor his sodium levels.- If his sodium levels remain stable, the salt tablet will be discontinued.

Neurology

Targeted Improvements:

Incorporated the comprehensive neurological exam subheaders, updated list:

- General Appearance
- Mental Status (orientation, memory, attention/concentration, language, visuospatial skills, executive function
- Cranial Nerves (I-XII
- Motor examination (muscle bulk and tone, strength, coordination
- Reflexes (DTR, Plantar
- Sensory (light touch, pain, temperature, vibration and proprioception
- Gait and station (Gait and Romberg)

Other note section updates:

- HPI: include hand dominance, PMH, PSH, Interval History. include details pertinent to neuro hx like birth, developmental milestones, head injuries. Additionally, Family History related to neuro diseases was added. Direct patient quotes added when describing symptoms, like “worst headache of my life”.
- Medications: change format to include current meds and previous meds with sig details for prior authorizations
- Review of Systems: updated to capture neurologically important symptoms across all systems

Neurology: General Model Note Output

HISTORY OF PRESENT ILLNESS:
The patient presents for memory testing period
He reports a decline in his short-term memory, which has led to him undergoing memory testing period his children have noticed a change in his memory, including an incident where he left his truck running while he went to lunch with his two children. He often forgets a word on the list if he starts moving.

He has a history of a small stroke, which has led to confusion and compromised his ability to identify complex information, causing him to lose track of his tasks. His previous occupation involved survivability data for the military equipment, crash tests, and domestic violence.

He suffers from constant headaches, which he attributes to nerve damage from a neck operation. His sleep is satisfactory, aided by the use of a muscle relaxer, Flexeril. He also uses a CPAP machine for snoring.

He suffers from seasonal depression, which is well managed with medication, although he's not currently on an antidepressant.

He underwent neuropsychological evaluation with doctor Y, who referred him to doctor S, and neuropsychologist. He saw doctor S about six months ago who informed him that his memory is satisfactory but expressed concern about his visual learning.

SOCIAL HISTORY
He's not working currently. He moved here 10 years ago. He worked in the airport. He has three grown daughters, and 9 grandchildren.

FAMILY HISTORY
His father had dementia and Alzheimer’s.

PHYSICAL EXAM

RESULTS
Testing
Memory testing: patient was able to recall 3 out of 3 words. Patient was able to spell the word “world” backwards.

ASSESSMENT AND PLAN
1. Memory loss
His distractedness and inattention appeared to be more problematic than dementia. An amyloid pet scan will be ordered to exclude the possibility of Alzheimer's disease. He reports a history of a small stroke which he which may contribute to his memory issues. He has undergone a 0 cytological evaluation approximately 6 months ago, which indicated his memory was OK but highlighted concerns with visual learning. The results of his evaluation will be tracked down.

Neurology: Specialty Note Output

HISTORY OF PRESENT ILLNESS
The patient is a 68-year-old right-handed male presents with concerns regarding memory decline.
Reports indicate a noticeable deterioration in short term memory, described as forgetting one out of three tasks it distracted. An incident was noted where he left his truck running while having lunch with his grandsons, and unusual behavior for him. He also short-term recalling words if interrupted. Despite these challenges, he continues to drive, albeit more cautiously, and manages his finances without issues.
The onset of memory issues followed a small stroke, which has resulted in confusion and difficulty processing complex information. His professional background includes working with survivability data for military equipment and crash tests.
He experienced constant headaches, attributing to nerve damage from a previous neck injury. Sleep quality is maintained with the use of muscle relaxant, Flexeril, and he uses a CPAP machine for snoring. Seasonal depression is present but well managed, although he is not currently on an antidepressant.
A neuropsychological evaluation by doctor Y led to a referral to doctor S who assessed him approximately 6 months ago. Doctor S reported satisfactory memory function but noted concerns with visual learning.

Past Medical History:
-Small stroke leading to memory issues and confusion
-Constant headaches due to nerve damage from neck injury
-Seasonal depression
Past surgical history:
-Neck surgery resulting in nerve damage
Family history:
-Father had dementia, and possibly Alzheimer's, with significant decline in the last six years of life
-Mother maintained good memory

SOCIAL HISTORY
The patient is currently retired. He relocated to the area 10 years ago. His previous employment involved conducting survivability data analysis for military equipment, including crash testing period he also worked at an airport and grocery store. He is married and has three grown daughters and 9 grandchildren. He is originally from Maryland.
He does not consume alcohol, tobacco, or recreational drugs. His sleep is generally good, aided by a muscle relaxer, and he uses a CPAP machine for sleep apnea he typically stays up until he is very tired before going to sleep ensuring a decent night's rest. He did not report any significant caffeine intake.

RESULTS

Neurological testing:

Memory testing on 10/24/2024, able to recall 3 out of 3 words, able to spell the word “world” backwards

ASSESSMENT AND PLAN

1. Memory loss

The patient presents with destructiveness and inattention, which appear to be more problematic than dementia. There is a history of a small stroke, which may contribute to the memory issues. Neuropsychological evaluation conducted approximately 6 months ago indicated memory was intact with highlighted concerns with visual learning. The results of this evaluation will be tracked down. An it amyloid PET scan will be ordered to exclude the possibility of Alzheimer's disease.

Neurosurgery

Targeted Improvements:

Incorporated the comprehensive neurosurgical physical exam subheaders, updated list:

- General Appearance
- Mental Status (orientation, memory, attention/concentration, language, visuospatial skills, executive function)
- Cranial Nerves (I-XII)
- Motor examination (muscle bulk and tone, strength grading, coordination)
- Reflexes (DTR, Plantar)
- Sensory (light touch, pain, temperature, vibration and proprioception)
- Gait and station (Gait and Romberg)
- Details pertaining to Neurosurgical exclusive assessments/exams added to the model (Gaenslen's test, L'Hermitte sign, Spurling, etc)

Other note section updates:

- HPI: include hand dominance, PMH, PSH, Social History, and Interval History. Will also include comprehensive details pertaining to current or previous conservative treatments, for example the number of physical therapy sessions completed, number of injections, etc. Social history will have subheader formatting inclusive of marital status, occupation, sleep, diet, alcohol/tobacco/rec drugs, if applicable.
- Medications: change format to include current meds and previous meds with sig details for prior authorizations
- Assessment & Plan: prompted to be more inclusive of risks and benefits discussion

Neurosurgery: General Model Note Output

History of Present Illness
The patient presents for evaluation.

She underwent surgical removal of a large, atypical grade 2 meningioma. Post-surgery, she was recommended for radiation therapy, which she completed. She has been on a regimen of surveillance scans since then. Recently, she experienced a resurgence of symptoms, prompting her to consult her family physician, who referred her to a neurologist. The neurologist advised an MRI which revealed another abnormality. A CT scan showed no significant findings.

Her symptoms include shakiness, necessitating frequent stops, and occasional speech issues. She also reported an incident where her eyes appeared to roll for a brief moment while watching TV, although she does not experience any blurriness. She is right-handed and has noticed a tendency for her right thumb to bounce intermittently since her previous tumor. She reports no pain.

She is currently on a steroid regimen, taking one dose in the morning and another in the afternoon, and has requested a refill. She also reports difficulty sleeping. Benadryl has been beneficial.

MEDICATIONS
Benadryl

Physical Exam
Lungs: Lungs clear.
Gastrointestinal: No evidence of abdominal disease.
Neurological: A neurological exam was performed.

Results
Imaging
- Brain MRI: A new abnormality, most consistent with metastatic disease or a new tumor such as a glioma, or possibly radiation necrosis or treatment
- CT scan of the chest: Normal.
- CT scan of the abdomen: Normal
- CT scan of the pelvis: Normal.

Assessment and Plan
1. Meningioma.
The recent MRI revealed a new abnormality. Radiation necrosis is considered the most likely due to the patient's history of radiation therapy. An MR perfusion scan will be ordered to assess blood flow in the brain. Steroids will continue at 4 mg twice daily, and a supplement available on Amazon will be recommended to potentially reduce edema and assist in tapering off steroids. The patient will be presented at the tumor board for further discussion.

Neurosurgery: Specialty Note Output

History of Present Illness
The patient presents for evaluation of a meningioma.

She underwent a successful surgical removal of a large, atypical grade 2 meningioma by Dr. T. Post-surgery, she was recommended for proton-based radiation therapy under the supervision of Dr. V, which she completed by the end of 2023. She has been on a regimen of surveillance scans since then. Recently, she experienced a resurgence of symptoms, prompting her to consult her family physician, who referred her to a neurologist. The neurologist advised an MRI, initially scheduled for April, but was moved up due to her symptoms. The MRI revealed another abnormality, leading Dr. V to recommend a CT scan, which showed no significant findings.

Her symptoms include shakiness, necessitating frequent stops during activities such as going to the kitchen, and occasional speech issues, such as mispronouncing words. She also reported an incident where her eyes appeared to roll for a brief moment while watching TV, although she does not experience any blurriness. She is right-handed and has noticed a tendency for her right thumb to bounce intermittently since her previous tumor. She reports no pain.

She is currently on a steroid regimen, taking one dose in the morning and another in the afternoon, and has requested a refill. She also reports difficulty sleeping, for which she takes Benadryl, which has been beneficial.

MEDICATIONS
Current: Benadryl

Physical Exam
Mental Status Examination
Orientation: Oriented to person, place, and time.
Memory: Able to recall 2 out of 3 objects (pen, ball).
Language: Speech is fluent with occasional word-finding difficulty.

Cranial Nerve Examination
CN II: Visual fields intact bilaterally.
CN III IV VI: Extraocular movements intact.
CN VII: Facial movements symmetrical.
CN X: Palate elevation normal.
CN XI: Shoulder shrug strength normal.
CN XII: Tongue midline with normal movements.

Motor Examination
Muscle Bulk and Tone: Normal muscle tone.
Strength: 5/5 strength in upper and lower extremities.
Coordination: Finger-to-nose test normal.
Involuntary Movements: Intermittent right thumb bouncing.
Upper Extremity Drift Test: No upper extremity drift.

Sensory Examination
Light Touch, Vibration and Proprioception: No numbness or tingling reported.

Lungs: Lungs clear.
Gastrointestinal: No evidence of abdominal disease.

Results
Imaging
- Brain MRI: A new abnormality, most consistent with metastatic disease or a new tumor such as a glioma, or possibly radiation necrosis or treatment related changes.
- CT scan of the chest: No evidence of disease.
- CT scan of the abdomen: No evidence of disease.
- CT scan of the pelvis: No evidence of disease.

Assessment and Plan
1. Meningioma.
The recent brain MRI from 03/2025 revealed a new abnormality. Differential diagnosis includes metastatic disease, a new intracranial tumor such as a glioma, or radiation necrosis/treatment-related changes. Radiation necrosis is considered the most likely due to the patient's history of proton-based radiation therapy. An MR perfusion scan will be ordered to assess blood flow in the brain. Increased blood flow may indicate a neoplastic process, while decreased blood flow would suggest radiation necrosis. Steroids will continue at 4 mg twice daily, and a supplement available on Amazon will be recommended to potentially reduce edema and assist in tapering off steroids. The patient will be presented at the tumor board for further discussion. If the perfusion scan results are inconclusive, a biopsy may be considered.

OB/GYN

Currently, three specialty options are available within the OBGYN Specialty in Dragon Copilot. Clinicians should select the option that best aligns with their scope of practice:

OBGYN – Designed for providers who manage both obstetric and gynecologic care across a broad range of patient needs.

Gynecology – Focused on the health of the female reproductive system. It encompasses the diagnosis, treatment, and preventive care of conditions affecting the uterus, ovaries, fallopian tubes, cervix, vagina, and breasts. (Routine exams, Diagnosis and Treatment, Reproductive Health)

Obstetrics – Focused on the care of women during pregnancy, childbirth, and the postpartum period. (Prenatal Care, Postpartum Care)

OB/GYN

Targeted Improvements:

- CMS Guidelines for documentation.
- HPI to include gynecological history (age of menarche, last menstrual period, cycle length, duration, frequency/flow, menstrual pain), obstetrical history (if pregnant – gestational age), contraception, reproductive plans, perimenopausal/postmenopausal, past obstetrical history, past gynecologic history, PMH, family history, PSH, social history, sexual history, allergies, medications and review of systems.
- Physical Exam to include breasts, obstetric: uterine palpation (fundal height) fetal heart tones, genitourinary: speculum exam, bimanual exam, and external genitalia.
- Incorporated the OB/GYN physical exam headers/sub headers:
    - Breasts
    - Fundal Height
    - Fetal Heart Tones
    - External Genitalia
    - Speculum Exam
    - Bimanual Exam

OB/GYN: History of Present Illness

General Content

The patient presents for evaluation of a bump on her cervix.

She reports no abnormal discharge or pain. She is currently using natural family planning methods for pregnancy prevention. She conducted a cervical check yesterday due to the onset of her menstrual cycle and in an effort to ensure she is not pregnant. During this self-examination, she noticed a bump or cyst on the right side of her cervix. She has no other health concerns or changes to report.

Specialty-specific Content

The patient presents for evaluation of a bump on her cervix.

Reports no abnormal discharge or pain. Currently using natural family planning methods for pregnancy prevention. Conducted a cervical check yesterday due to the onset of her menstrual cycle and to ensure she is not pregnant. During this self-examination, noticed a bump or cyst on the right side of her cervix. No other health concerns or changes reported.

GYNECOLOGICAL HISTORY DISCUSSED:
- Last Menstrual Period: Imminent
- Contraception: Natural family planning

PAST GYNECOLOGIC HISTORY:
- Last Pap smear in 2020: Negative
- Recent Pap smear on September 6, 2024: Low-grade changes

PAST MEDICAL HISTORY:
- No significant changes reported

SEXUAL HISTORY:
- No concerns reported

OB/GYN: Physical Examination

General Content

Heart sounds are normal.
Vulvar and vaginal skin appear normal. Cervix appears normal overall. A small cyst is present at the 7 o'clock position on the cervix. The external skin of the cervix appears healthy. No significant abnormalities are observed. Some changes are noted at the 12 o'clock position on the cervix, but they do not appear aggressive. Mild changes are also observed at the 6 o'clock position on the cervix. The more prominent change is occurring between the 12 to 1 o'clock position and another smaller spot is present at the 6 o'clock position on the cervix. These changes do not appear to be extending into the endocervical space.

Specialty-specific Content

General Appearance: Alert, oriented, well-nourished, and in no acute distress.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.
Genitourinary:
External Genitalia: Normal appearance, no lesions or discharge.
Speculum Exam: Cervix is closed. A small cyst appears at the 7 o'clock position. There are mild changes at the 6 o'clock position and more prominent changes between the 12 to 1 o'clock position, but these do not seem aggressive or extend into the endocervical space. Vaginal walls are pink and healthy.
Bimanual Exam: No adnexal masses or tenderness.
Integumentary: Skin is warm, dry, and intact. No rashes or lesions.
Psychiatric: Calm, cooperative, and exhibits normal mood and affect.

OB/GYN: Assessment and Plan

General Content

1. Fibroid.
The ultrasound from July 2023 revealed small fibroids. The biopsy results were benign, suggesting that the fibroids are not the cause of the discomfort. A repeat ultrasound will be ordered to reassess the fibroids and check for any changes.

2. Ovarian Cyst.
The patient reports bloating, cramping, and fatigue, which could be attributed to an ovarian cyst. The previous ultrasound in April 2023 showed a cyst. A repeat ultrasound will be ordered to evaluate the current status of the cyst. If the cyst persists, a laparoscopy may be recommended to remove it. The patient will be advised to consider removing the ovary if the cyst is complex and persistent.

3. Hormone Replacement Therapy.
The patient is currently on hormone replacement therapy, including progesterone and a small amount of estrogen. She reports taking norethindrone for bleeding and cramping. It is recommended to switch to a different type of progesterone, such as Prometrium or bioidentical progesterone, to better manage her symptoms. The dosage of progesterone will be adjusted to help stop the bleeding and improve sleep.

4. Fatigue.
The patient reports feeling tired all the time. This could be related to her hormone levels or other underlying issues. The patient's thyroid and other labs have been checked and are normal. The repeat ultrasound will help determine if the ovarian cyst is contributing to her fatigue.

Follow-up
Return for follow-up after the ultrasound results are available.

Specialty-specific Content

1. Fibroid.
The ultrasound from July 2023 revealed small fibroids. The biopsy results were benign, suggesting that the fibroids are not the cause of the discomfort. A repeat ultrasound will be ordered to reassess the fibroids and check for any changes.- Order repeat ultrasound to reassess fibroids

2. Ovarian Cyst.
Reports of bloating, cramping, and fatigue could be attributed to an ovarian cyst. The previous ultrasound in April 2023 showed a cyst. A repeat ultrasound will be ordered to evaluate the current status of the cyst. If the cyst persists, a laparoscopy may be recommended to remove it. Consider removing the ovary if the cyst is complex and persistent.- Order repeat ultrasound to evaluate the current status of the ovarian cyst- Consider laparoscopy for cyst removal if persistent- Advise on potential ovary removal if the cyst is complex

3. Hormone Replacement Therapy.
Currently on hormone replacement therapy, including progesterone and a small amount of estrogen. Reports taking norethindrone for bleeding and cramping. It is recommended to switch to a different type of progesterone, such as Prometrium or bioidentical progesterone, to better manage symptoms. The dosage of progesterone will be adjusted to help stop the bleeding and improve sleep.- Switch to Prometrium or bioidentical progesterone- Adjust progesterone dosage to manage bleeding and improve sleep

4. Fatigue.
Reports of feeling tired all the time could be related to hormone levels or other underlying issues. Thyroid and other labs have been checked and are normal. The repeat ultrasound will help determine if the ovarian cyst is contributing to fatigue.- Evaluate fatigue in relation to hormone levels and ovarian cyst status

Follow-up
Return for follow-up after the ultrasound results are available.

Obstetrics

Targeted Improvements:

- CMS Guidelines for documentation.
- HPI to include obstetrical history (gestational age), contraception, reproductive plans, past obstetrical history, past gynecologic history, PMH, family history, PSH, social history, sexual history, allergies, medications and review of system.
- Physical Exam to include breasts, obstetric: uterine palpation (fundal height) fetal heart tones, genitourinary: speculum exam, bimanual exam, and external genitalia.
- Incorporated the OB physical exam headers/sub headers:
    - Breasts
    - Fundal Height
    - Fetal Heart Tones
    - External Genitalia
    - Speculum Exam
    - Bimanual Exam

OBSTETRICS: History of Present Illness

General Content

The patient presents for evaluation of gestational hypertension. She is accompanied by an adult female.

She reports decreased fetal movement today. Her last child was born at 34 to 35 weeks. She is experiencing blurred vision and headaches. Over-the-counter medications such as Tylenol have not been effective in managing her headaches.

Specialty-specific Content

HISTORY OF PRESENT ILLNESS
Patient presents for evaluation of gestational hypertension. Reports decreased fetal movement today and experiencing blurred vision and headaches. Tylenol has not been effective in managing headaches.

Since the last visit, blood pressure remains elevated but not in the severe range. Labs are coming back normal, pending urine results. Scheduled for induction at 37 weeks due to gestational hypertension. Last child was born at 34 to 35 weeks.

OBSTETRICAL HISTORY DISCUSSED:
Currently 36 weeks gestation.

PAST OBSTETRIC HISTORY:
Previous child born at 34 to 35 weeks.

PAST MEDICAL HISTORY:
Gestational hypertension.- No concerns reported

OBSTETRICS: Physical Examination

General Content

Fundal height is 37 cm. Fetal heart rate is 140 bpm. Cervix is closed.

Specialty-specific Content

PHYSICAL EXAM
Vital Signs: Blood pressure is normal.
General Appearance: Alert, oriented, well-nourished, and in no acute distress.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.
Obstetric: Fundal height is 37 cm. Fetal heart rate is 140 bpm.
Genitourinary:
Bimanual Exam: Cervix is closed.

OBSTETRICS: Assessment and Plan

General Content

1. Pregnancy.
She is currently 14 weeks and 5 days pregnant. She reports experiencing occasional gagging triggered by certain smells but does not feel the need for medication at this time. She has gained weight since her last appointment, indicating adequate nutrition. The due date is confirmed for 02/04/2026. She was advised to try ginger or ginger ale to help manage the symptoms. A pelvic exam was performed today, and the baby's heart rate was 153 bpm. She was informed that each pregnancy is unique, and she should contact the clinic if any concerns arise. Routine labs will be conducted today. An anatomy ultrasound is scheduled for her next visit in 5 weeks.

2. Cyst.
A cyst measuring approximately 2 cm in size was noted, which is slightly larger than the previous measurement. It was actively draining during the last check-up. No drainage was observed today. She was informed that the presence of a small ball-like structure is due to the cyst. If she notices any yellow discharge, it is likely from the cyst.

3. Hernia.
She has a hernia that may require surgical intervention. It was discussed that the hernia repair could be done simultaneously with the tubal ligation surgery. She was advised to consider waiting until her children are older to avoid heavy lifting, which could affect the hernia repair.

4. Tubal Ligation.
She expressed interest in tubal ligation after the birth of her baby. It was recommended to wait until she is 6 to 8 weeks postpartum for the procedure. The hormonal implications and permanence of the procedure were discussed. An alternative option of using a Mirena IUD was also presented, which could help with menstrual periods.

Follow-up
She will follow up in 5 weeks.

Specialty-specific Content

1. Pregnancy.
- She is currently 14 weeks and 5 days pregnant.
- She reports experiencing occasional gagging triggered by certain smells but does not feel the need for medication at this time.
- She has gained weight since her last appointment, indicating adequate nutrition. The due date is confirmed for 02/04/2026. A pelvic exam was performed today, and the baby's heart rate was 153 bpm. Routine labs will be conducted today.
- She was advised to try ginger or ginger ale to help manage the symptoms. An anatomy ultrasound is scheduled for her next visit in 5 weeks.

2. Cyst.
- A cyst measuring approximately 2 cm in size was noted, which is slightly larger than the previous measurement.
- No drainage was observed today.
- She was informed that the presence of a small ball-like structure is due to the cyst. If she notices any yellow discharge, it is likely from the cyst.

3. Hernia.
- She has a hernia that may require surgical intervention.
- It was discussed that the hernia repair could be done simultaneously with the tubal ligation surgery. She was advised to consider waiting until her children are older to avoid heavy lifting, which could affect the hernia repair.

4. Tubal Ligation.
- She expressed interest in tubal ligation after the birth of her baby.
- It was recommended to wait until she is 6 to 8 weeks postpartum for the procedure. The hormonal implications and permanence of the procedure were discussed. An alternative option of using a Mirena IUD was also presented, which could help with menstrual periods.

Follow-up: She will follow up in 5 weeks.

Gynecology

Targeted Improvements:

- CMS Guidelines for documentation.
- HPI to include gynecological history (age of menarche, last menstrual period, cycle length, duration, frequency/flow, menstrual pain), contraception, reproductive plans, perimenopausal/postmenopausal, past gynecologic history, PMH, family history, PSH, social history, sexual history, allergies, medications and review of system.
- Physical Exam to include breasts, genitourinary: speculum exam, bimanual exam, and external genitalia.
- Incorporated the GYN physical exam headers/sub headers:
  - Breasts
  - External Genitalia
  - Speculum Exam
  - Bimanual Exam

GYNECOLOGY: History of Present Illness

General Content

The patient presents for evaluation of a bump on her cervix.

She reports no abnormal discharge or pain. She is currently using natural family planning methods for pregnancy prevention. She conducted a cervical check yesterday due to the onset of her menstrual cycle and in an effort to ensure she is not pregnant. During this self-examination, she noticed a bump or cyst on the right side of her cervix. She has no other health concerns or changes to report.

Specialty-specific Content

HISTORY OF PRESENT ILLNESS
The patient presents for evaluation of a bump on her cervix.

Reports no abnormal discharge or pain. Currently using natural family planning methods for pregnancy prevention. Conducted a cervical check yesterday due to the onset of her menstrual cycle and to ensure she is not pregnant. During this self-examination, noticed a bump or cyst on the right side of her cervix. No other health concerns or changes reported.

GYNECOLOGICAL HISTORY DISCUSSED:
- Last Menstrual Period: Imminent
- Contraception: Natural family planning

PAST GYNECOLOGIC HISTORY:
- Last Pap smear in 2020: Negative
- Recent Pap smear on September 6, 2024: Low-grade changes

PAST MEDICAL HISTORY:
- No significant changes reported

SEXUAL HISTORY:
- No concerns reported

GYNECOLOGY: Physical Examination

General Content

Heart sounds are normal.
Vulvar and vaginal skin appear normal. Cervix appears normal overall. A small cyst is present at the 7 o'clock position on the cervix. The external skin of the cervix appears healthy. No significant abnormalities are observed. Some changes are noted at the 12 o'clock position on the cervix, but they do not appear aggressive. Mild changes are also observed at the 6 o'clock position on the cervix. The more prominent change is occurring between the 12 to 1 o'clock position and another smaller spot is present at the 6 o'clock position on the cervix. These changes do not appear to be extending into the endocervical space.

Specialty-specific Content

PHYSICAL EXAM
General Appearance: Alert, oriented, well-nourished, and in no acute distress.
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.
Genitourinary:
External Genitalia: Normal appearance, no lesions or discharge.
Speculum Exam: Cervix is closed. A small cyst appears at the 7 o'clock position. There are mild changes at the 6 o'clock position and more prominent changes between the 12 to 1 o'clock position, but these do not seem aggressive or extend into the endocervical space. Vaginal walls are pink and healthy.
Bimanual Exam: No adnexal masses or tenderness.
Integumentary: Skin is warm, dry, and intact. No rashes or lesions.
Psychiatric: Calm, cooperative, and exhibits normal mood and affect.

GYNECOLOGY: Assessment and Plan

General Content

1. Cervical fibroids.

The uterus, fallopian tubes, and ovaries are in a healthy state. However, there are two small areas on the cervix that require further investigation. These areas do not exhibit any alarming characteristics such as increased blood flow, which is typically associated with malignancies. The absence of blood flow suggests that these areas are likely benign calcified implants or nabothian cysts. A follow-up ultrasound will be scheduled in approximately 3 months to monitor any potential changes in these areas. If they remain stable, no further action will be necessary. However, if there is an increase in size, additional diagnostic measures will be considered.

Specialty-specific Content

1. Cervical fibroids

- The uterus, fallopian tubes, and ovaries are in a healthy state. Two small areas on the cervix do not exhibit any alarming characteristics such as increased blood flow, which is typically associated with malignancies. The absence of blood flow suggests that these areas are likely benign calcified implants or nabothian cysts.
- Schedule a follow-up ultrasound in approximately 3 months to monitor any potential changes in these areas. Discuss the importance of monitoring for changes and the rationale behind the follow-up ultrasound. Reassure that the absence of blood flow is a positive indicator, reducing the likelihood of malignancy.
- - If the areas remain stable, no further action will be necessary. If there is an increase in size, additional diagnostic measures will be considered. Educate on the benign nature of fibroids and nabothian cysts, emphasizing that they are common and typically not associated with infection or malignancy.

Follow-up: Follow-up ultrasound in approximately 3 months.

Occupational Therapy

Targeted Improvements:

Overall Note: Style enhancements specific to the practice scope of an occupational therapist.

HPI:
- Addition of pain assessment
- Enhanced social history capturing details such as occupational history, fall history, hobbies/activities, home environment and social/emotional support details.

Physical Exam:
- Captures ADLs & iADLs verbalized along with level of independence required to complete each activity
- Objective findings: Observations & Measurements (General appearance, posture, gait/movement patterns, sensory & motor skills, strength, ROM, cognitive status/comprehension, psychosocial) and any other special testing performed within OT scope.
- Captures Interventions completed during the visit and any relevant details verbalized.
- Precise numerical notation formatting and units of measure for common exam findings

Assessment/Plan:
- Summarized visit findings, continued limitations or deficits, goal progression and plan for future treatment including recommendations, precautions, restrictions and/or education provided within scope of occupational therapist and expected benefit and need for continuation of skilled services.
- Enhanced capture of barriers that may impact outcomes including relevant co-morbidities as verbalized.
- Goals suggestions for therapy that are specific, measurable, relate to outcomes directly discussed in the session and time-bound if verbalized.
- Follow Up visit recommendations

Occupational History: History of Present Illness

General Content

The patient is a 55-year-old male who presents for evaluation of right-sided weakness, sensory deficits, and mild cognitive changes following a left hemisphere stroke that occurred 3 weeks ago. He is a retired mechanical engineer, previously active in the community through volunteer work and woodworking. Prior to the stroke, he was independent in all activities of daily living (ADLs) and instrumental activities of daily living (IADLs). He currently resides in a single-story home with three steps to enter, living with his spouse and receiving weekly visits from his daughter. The bathroom is equipped with grab bars but lacks a ramp at the entrance. The bedroom and bathroom are on the same level of the home. He has strong support from both his spouse and daughter and participates in a virtual stroke support group weekly. Before the stroke, he was fully independent in mobility, self-care, and household tasks, including driving independently.

PAST MEDICAL HISTORY:
Hypertension
Type 2 Diabetes
High Cholesterol

Specialty-specific Content

The patient is a 55-year-old male who presents for evaluation of right-sided weakness, sensory deficits, and mild cognitive changes following a left hemisphere stroke that occurred 3 weeks ago. Relevant comorbidities include hypertension, type 2 diabetes, and high cholesterol.

Prior to his stroke, he was fully independent in mobility, self-care, household tasks, and driving.

SOCIAL HISTORY
Occupational History: Retired mechanical engineer, previously active in the community through volunteer work and woodworking.
Sports/Recreational Activities/Hobbies: Woodworking

Home Environment:
Type of Residence: Single story home
Person(s) Patient Resides with: Spouse, daughter visits weekly
Steps to Enter Home: Three steps
Handrails at Entrance: No ramp at the entrance
Number of Levels in Home: One
First Floor Bathroom: Bathroom has grab bars
Bedroom: Same level as bathroom

Social/Emotional Support: Strong support from spouse and daughter, participates in a virtual stroke support group weekly

Occupational History: Physical Exam/Objective

General Content

The patient exhibits a slow shuffling gait with right foot drop, using a quad cane. There is a forward flexed trunk and decreased right arm swing. Moderate impairment to balance is noted, requiring supervision during transfers. Right-sided hemiparesis is present, with decreased proprioception and light touch on the right upper extremity. Mild neglect of the right side is observed during tasks. Strength in the left upper and lower extremities is 4+ out of 5. Right upper extremity strength is 2 out of 5, and right lower extremity strength is 3 out of 5. Grip strength measures 10 pounds on the right and 28 pounds on the left.
The patient is alert and oriented x3, able to follow two-step commands. Mild difficulty with short-term memory and sequencing tasks is present.

Specialty-specific Content

Activities of Daily Living:
Grooming: Moderate Assistance
Dressing: Moderate Assistance
Functional Mobility (Transferring from bed to chair): Stand by Assistance

Observations:
Posture: Forward flexed trunk
Gait/Movement Patterns: Slow shuffling gait with right footdrop; using quad cane for assistance; decreased right arm swing; moderate impairment to balance requiring supervision during transfers
Sensory Skills: Decreased proprioception and light touch on right upper extremity
Motor Skills: Mild neglect of right side during tasks

Muscle Strength:
Left upper extremity: 4+/5
Left lower extremity: 4+/5
Right upper extremity: 2/5
Right lower extremity: 3/5

Grip strength: Right: 10 pounds; Left: 28 pounds

Cognitive Status/Comprehension: Alert and oriented x3; able to follow 2-step commands; mild difficulty with short-term memory and sequencing tasks

Interventions:
- ADL Retraining: Grooming and upper body dressing
- Functional Mobility Training: Transferring from bed to chair using quad cane
- Sensory Reeducation: Tactile stimulation

Occupational History: Assessment/Plan

General Content

1. Left hemisphere stroke.
He presents with significant right-sided weakness, sensory deficits, and mild cognitive changes following a left hemisphere stroke that occurred 3 weeks ago. His impairments limit his independence in ADLs, mobility, and safety within the home. OT is medically necessary to improve functional independence, reduce fall risk, and support emotional adjustment. The plan for care includes OT twice a week for 6 weeks, focusing on ADL retraining, cognitive rehab, safety, and caregiver education.

Specialty-specific Content

Post-stroke rehabilitation.
Patient exhibits significant right-sided weakness, sensory deficits, and mild cognitive changes following a left hemisphere stroke that occurred 3 weeks ago. These impairments limit his independence in ADLs, mobility, and safety within the home. Occupational therapy is medically necessary to improve his overall functional independence, reduce his fall risk, and support emotional adjustment. Will focus on ADL retraining, cognitive rehab, safety, and caregiver education.

Education: None provided.

Follow Up: OT twice a week for 6 weeks

Goals:
- The patient will complete upper body dressing with minimal assistance using adaptive techniques within the next 2 weeks.
- The patient will safely transfer from bed to chair independently using a quad cane in 4 weeks.

Oncology

Targeted Improvements:

- Optimized HPI now generates separate oncologic and interval histories for better integration with existing documentation practices.
- Additional focus is placed upon patient reported side effects and their management.
- Optimized exam includes an optional ECOG performance score, and oncology specific exam sub-headers.
- Results content routed to HPI vs results section depending on the source of the information, and the verbiage used to document results has been updated.
- The content of the results section is more accurate, avoiding the use of adjectives to describe results such as "WBC: Good".

Oncology: History of Present Illness

General Content

The patient is a 78-year-old female who presents for a new patient visit to establish care for a history of DCIS.

She underwent a right breast lumpectomy on 01/20/2020, following the detection of a calcification in her right breast during a routine mammogram in 10/2019. An ultrasound conducted on 11/03/2019 revealed a mass at the 2 o'clock position, 11 cm from the nipple in the retroareolar region, measuring 0.4 x 2 x 3 cm. Subsequent pathology results from an ultrasound-guided core needle biopsy performed on 12/05/2019 indicated grade 2, ER positive, PR positive DCIS. The lumpectomy successfully removed an 8 mm tumor with negative margins, and 5 lymph nodes were also excised, which were benign. She reports no complications or concerns post-procedure and has been diligently performing self-breast exams without detecting any abnormalities. She received radiation therapy post-lumpectomy but declined endocrine therapy. Her last mammogram, conducted in 01/2021, was normal.

She experiences back and knee pain, which have been attributed to age-related changes.

She has high cholesterol, a relatively new diagnosis, and is currently attempting to manage it through exercise and dietary modifications under the supervision of her primary care physician.

Specialty-specific Content

The patient is a 78-year-old female with a history of ductal carcinoma in situ (DCIS), stage 0, ER/PR positive, in the right breast. An ultrasound conducted on 11/03/2019 revealed a mass at the 2 o'clock position, 11 cm from the nipple in the retroareolar region, measuring 0.4 x 2 x 3 cm. She underwent a right breast lumpectomy on January 20, 2020, which successfully removed an 8 mm tumor with negative margins, and five lymph nodes were excised, all benign. Post-lumpectomy, she received radiation therapy but declined endocrine therapy. Her last mammogram in January 2021 showed no evidence of recurrence.

Since her last visit, the patient reports feeling well with no complications or concerns post-procedure. She has been performing self-breast exams regularly and has not detected any abnormalities. She experiences back and knee pain, attributed to age-related changes, and has been managing her newly diagnosed high cholesterol through exercise and dietary modifications under her primary care physician's guidance. There have been no hospitalizations or new symptoms reported since her last visit.

Oncology: Physical Examination

General Content

None.

Specialty-specific Content

General: ECOG 0
HEENT: No acute distress, no visual changes, no hearing loss.
Cardiovascular: Regular rate and rhythm, no murmurs, no chest pain.
Respiratory: Lungs clear to auscultation bilaterally, no shortness of breath.
Abdomen: Soft, non-tender, no hepatosplenomegaly, no abdominal pain.
Extremities: No edema, no swelling.
Skin: No rashes, no lesions.
Neurological: No focal deficits, no headaches, no dizziness.
Lymphatic: No lymphadenopathy.
Hematologic: No fevers, chills, or night sweats.
Psychiatric: No depression, no anxiety.

Oncology: Assessment and Plan

General Content

1. Elevated liver enzymes.
Elevated liver enzymes were noted, potentially due to a recent upper respiratory infection and potential liver irritation. The levels are not significantly high to warrant any immediate changes in the treatment plan. She was advised to continue her current medication regimen, including acyclovir, azithromycin, and Bactrim. She was also reminded to stay hydrated.
2. GVHD (Graft Versus Host Disease).
The possibility of GVHD recurrence was discussed, with a reduction in risk over time. Continuation of Jakafi was advised, and it was recommended to stay away from large gatherings during the flu season until the end of May. She was advised to wear a mask during church activities and other public gatherings. A pulmonary function test is scheduled for the end of January or early February to monitor lung function.3. Medication Management.
She is currently taking acyclovir, azithromycin, estradiol, famotidine, Advair, folic acid, Synthroid, magnesium, Singulair, Protonix, Jakafi 5 mg, tacrolimus, Kenalog, and ursodiol. The dose of tacrolimus has been reduced from 3 capsules to 2 capsules twice a day. She will continue tapering the dose by skipping the evening dose every 2 weeks, aiming to be on 2 capsules in the morning and 1 in the evening in 14 weeks.

Follow-up
Return in 7 weeks for follow-up after the pulmonary function test.

Specialty-specific Content

1. GVHD (Graft Versus Host Disease)
The patient has a history of GVHD with lung involvement. The risk of recurrence was discussed, noting that the risk decreases over time. The patient is currently on Jakafi, and it was advised to continue this medication. She was instructed to avoid large gatherings during the flu season until the end of May and to wear a mask during church activities and other public gatherings. A pulmonary function test is scheduled for the end of January or early February to monitor lung function.
The treatment plan includes continuing Jakafi, with the goal of preventing GVHD recurrence. The patient will remain on acyclovir, azithromycin, and Bactrim as prophylactic measures. The potential side effects of Jakafi, including immunosuppression and increased infection risk, were discussed. Supportive care measures include staying hydrated and avoiding exposure to infections.
The patient expressed concerns about the possibility of GVHD recurrence and the need for lifelong medication. It was explained that while GVHD can potentially recur, the risk decreases over time, and if it does recur, it is usually of a lower grade. The importance of continuing medication to prevent progression was emphasized.
2. Elevated liver enzymes
Elevated liver enzymes were noted, potentially due to a recent upper respiratory infection and potential liver irritation. The levels are not significantly high to warrant any immediate changes in the treatment plan. She was advised to continue her current medication regimen, including acyclovir, azithromycin, and Bactrim. She was also reminded to stay hydrated.
3. Medication Management
The patient is currently taking acyclovir, azithromycin, estradiol, famotidine, Advair, folic acid, Synthroid, magnesium, Singulair, Protonix, Jakafi 5 mg, tacrolimus, Kenalog, and ursodiol. The dose of tacrolimus has been reduced from 3 capsules to 2 capsules twice a day. She will continue tapering the dose by skipping the evening dose every 2 weeks, aiming to be on 2 capsules in the morning and 1 in the evening in 7 weeks.
Follow-up
Return in 7 weeks for follow-up after the pulmonary function test.

Ophthalmology

Targeted Improvements:

HPI:

- Addition of Past Ocular History/Surgeries

Physical Exam:

- Improvements to Physical Exam structure and formatting with specialty specific sub headers
- Improved content retrieval for medically relevant ophthalmological exam
- Precise numerical notation formatting and units of measure

Results:

- Removal of duplicative exam findings from results section

Assessment/Plan:

- Captures appropriate ophthalmological naming conventions, including laterality
- Limit redundancy in AP content
- Enhanced capture of detailed discussion related to risks/benefits analysis, cost considerations, options of intraocular lenses, and alternative options to surgical intervention.

Procedures:

- Only includes same-day procedures

Ophthalmology: Physical Examination

General Content

Specialty Testing
Eye exam showed LASIK flap is clear. There is a significant cataract in both eyes. Retina looks good. Eye pressures are good today.

RESULTS
Laboratory Studies
A1c was 6.9%.

Imaging
Corneal topography is stable without evidence of ectasia.

***Note:** In this example above, eye pressure measurements were not specifically verbalized. If verbalized, the output will contain numerical formatting with appropriate unit of measure.

Specialty-specific Content

Visual Acuity
Corrected:
OD: 20/100
OS: 20/70

Extraocular Muscles (EOM)
OD: Full and intact
OS: Full and intact

Intraocular Pressure (IOP)
OD: Normal
OS: Normal

Slit Lamp Exam
Cornea: Clear without staining; LASIK flap is clear.
Iris: No neovascularization or nodules
Lens: Nuclear sclerotic cataract

Fundus Exam
Optic Nerve: Flat and normal, pink, healthy and no edema
Macula: Normal contour, without hemorrhage, edema, drusen or exudate
Vessels: Normal contour, caliber without neovascularization
Periphery: Normal appearance without retinal tears, breaks, holes or mass

RESULTS
Laboratory Studies
A1c was 6.9%.
Imaging: Corneal topography is stable without evidence of ectasia.

Ophthalmology: Assessment and Plan

General Content

1. Nuclear sclerosing cataracts of both eyes.
He presents with visually significant cataracts in both eyes, with one eye at 2100 and the other at 2070, making him not legal to drive. The natural lens in his eyes is cloudy and turning yellow, indicating cataracts. A comprehensive discussion was held regarding the potential benefits and risks associated with cataract surgery.

2. Status post LASIK in each eye.
Corneal topography is stable without evidence of ectasia. The LASIK flap is clear, and there is no evidence of diabetic retinopathy in either eye.

3. Diabetes mellitus.
His last A1c was 6.9, indicating good control. There is no evidence of diabetic retinopathy in either eye.

Specialty-specific Content

1. Nuclear sclerotic cataracts, both eyes.
Visually significant cataracts in both eyes.

A comprehensive discussion was held regarding the potential benefits and risks associated with cataract surgery, including the use of monofocal lenses and extended depth of field cosmetic implants. The accuracy of lens implants post-LASIK was discussed, and the option of using the ORA computer to increase accuracy was presented. He was advised to consider these options and communicate his decision via email. Post-surgery, he will need to use a compounded eyedrop for 3 weeks for each eye and avoid lifting more than 20 pounds, rubbing his eyes, and swimming for a week.

2. Status post LASIK, both eyes.
LASIK flap is clear.

3. Diabetes mellitus.
His last A1c was 6.9%, indicating good control. There is no evidence of diabetic retinopathy in either eye.

Orthopedics

Targeted Improvements:

- CMS Guidelines for documentation.
- Continuous modifications and validation is in testing.
- Modifications made to the HPI for organization are:
  - Organize documented information and separate into multiple paragraphs.
- Exam will include a better format and organization.
  - Exam prompt has been designed to document various body sections in a list format.
- A/P will include a better layout and format.
  - Assessment and Plan is documented in a paragraph format with the plan under the assessment.
  - Clinician will have the option of updating “My Style” to a list format.

Orthopedics: History of Present Illness

General Content

The patient is a 44-year-old female who presents today 6 weeks status post right medial unicompartmental arthroplasty.

She reports a satisfactory recovery from her recent surgery, with no significant issues or pain. However, she notes persistent numbness in the area of the surgical intervention. She expresses overall satisfaction with the surgical outcome and is currently pain-free. She is employed at UPS but has been unable to return to work due to the physical demands of her job, particularly the requirement to navigate stairs. Her employer has proposed an alternative arrangement where she could perform seated tasks with intermittent breaks.

Specialty-specific Content

Chief Complaint: 44-year-old female presents 6 weeks status post right medial unicompartmental arthroplasty.

Reports satisfactory recovery from recent surgery. No significant issues or pain. Persistent numbness in the surgical intervention area. Overall satisfaction with surgical outcome. Currently pain-free.

Employed at UPS but unable to return to work due to physical demands, particularly navigating stairs. Employer proposed alternative arrangement for seated tasks with intermittent breaks.

Orthopedics: Physical Examination

General Content

General: Well-nourished, well-developed, in no acute distress.
Left Hand/Wrist: Focal tenderness at the basilar joint. Mild laxity at the basilar joint. Discomfort with application of an axial load. Good strength with thumb opposition. Able to make a good composite fist. No tenderness over the A1 pulley region. No catching or locking.

Specialty-specific Content

General: Well-nourished, well-developed, in no acute distress.
Musculoskeletal:
Left Hand/Wrist:
- Focal tenderness at the basilar joint.
- Mild laxity at the basilar joint.
- Discomfort with application of an axial load.
- Good strength with thumb opposition.
- Able to make a good composite fist.
- No tenderness over the A1 pulley region.
- No catching or locking.

Multi-section Specialty-specific Content

General: Well-nourished, well-developed.
Neurological: Awake, alert, oriented x4, and no focal deficit.
Respiratory: Clear to auscultation, no wheezing, rales or rhonchi.
Skin: No abnormalities, no rashes or lesions.
Musculoskeletal:
Gait:
- The patient ambulates with a non-antalgic gait without assistive device.
- The patient pronates bilaterally with weightbearing.
- The patient has good range of motion of their knees and ankles.

Right Knee:
- There is no soft tissue swelling, warmth, ecchymosis or erythema.
- There is no joint effusion.
- There is no tenderness along the medial and lateral joint line.
- There is no tenderness along the quadriceps or patellar tendon or along the length of the MCL.
- There is crepitus in the retropatellar space.
- Strength is 5/5 strength in flexion and extension.
- Right knee does open to varus and valgus stress testing.
- ACL is stable to anterior drawer and Lachman's with firm endpoint.
- Negative flexion pinch test, negative McMurray's.
- Calf and compartments are supple and nontender.
- Distal neurovascularly is intact.

Right Ankle:
- There are no deformities, ecchymosis, swelling, erythema, warmth.
- There is no tenderness.
- Range of motion of right ankle is good.
- Strength is 5/5 in dorsiflexion and plantarflexion.

Orthopedics: Assessment and Plan

General Content

1. Dupuytren's disease with nodules and cords, noncontractile: Limited Dupuytren's nodules and small cords present in the left palm and the ring finger and middle finger ray distribution. These do not cross the joint and are noncontractile at this time. Monitor for progression, such as nodules crossing the joint or pulling the finger down. Ensure the ability to lay the hand flat. If the condition worsens, notify the clinic. No immediate treatment is necessary.

2. Volar radial ganglion cyst: Small ganglion cyst in the volar radial aspect of the left wrist, minimally tender and fairly focal and small. No limitation to wrist or digit range of motion at this time. Continue with observation and use over-the-counter medication for mild pain and discomfort.

Follow-up: Monitor the condition monthly and notify the clinic if there is progression or other concerns.

Specialty-specific Content

1. Dupuytren's disease with nodules and cords, noncontractile: Limited Dupuytren's nodules and small cords present in the left palm and the ring finger and middle finger ray distribution. These do not cross the joint and are noncontractile at this time.

Monitor for progression, such as nodules crossing the joint or pulling the finger down. Ensure the ability to lay the hand flat. If the condition worsens, notify the clinic. No immediate treatment is necessary.

2. Volar radial ganglion cyst: Small ganglion cyst in the volar radial aspect of the left wrist, minimally tender and fairly focal and small. No limitation to wrist or digit range of motion at this time.

Continue with observation and use over-the-counter medication for mild pain and discomfort.

Follow-up:
Monitor the condition monthly and notify the clinic if there is progression or other concerns.

Otolaryngology

Targeted Improvements:

- An ENT optimized Physical Exam that replaces HEENT with separate sections.

  General:
  Head:
  Ears:
  Eyes:
  Nose:
  Oral cavity:
  Throat:
  Neck:
  Respiratory:
  Cardiovascular:
  Neurological:
  Skin:
  Others:

- Improved capture of ENT specific diagnostic procedures including laryngoscopy, rhinoscopy, videostroboscopy, cerumen removal etc.
- Improved capture of ENT specific results including audiometric and vestibular testing as well including date of study when verbalized. The addition of appropriate statements of personal review or interpretation of results.
- Capture of the risks, benefits and alternatives discussion in detail.
- Removal of past procedures from procedure section. These will only appear in the HPI or past surgical history when appropriate.
- A procedure section specifically designed to capture even the more complex in-office procedures.

Otolaryngology: Physical Exam

General Model PE Content

PHYSICAL EXAM
Ears were examined. Oral exam was performed.
Nasal endoscopy was performed.

Specialty-specific PE Content

PHYSICAL EXAM
Ears: Normal appearance, no abnormalities noted.
Nose: Normal structures observed, including inferior turbinate, middle turbinate, and septum.
Oral Cavity: No abnormalities noted. Dentures were removed for examination. Tongue and oral structures appeared normal.
Throat: Normal appearance of the epiglottis, base of tongue, vocal cords, arytenoids, vallecula, and piriform sinuses. No growths, tumors, or foreign bodies observed. Mild swelling noted.

Otolaryngology: Procedure

General Model Content

PROCEDURE
Cerumen was removed from both ears using suction.

Specialty-specific Content

Procedure: Bilateral cerumen removal

All questions were answered and agreement to proceed was given after the following Pre-Procedure details were reviewed:
- Risks and Benefits: Discussed potential discomfort and the benefits of improved hearing and ear health.
- Alternative Options: Discussed the use of ear drops to soften the wax
- Side effects: Discussed potential discomfort during the procedure.
- Consent: Verbal consent obtained.

Post-Procedure:
- Tolerance Level: Tolerated the procedure well with minimal discomfort.
- Home Care Instructions: Advised to use Debrox drops to soften remaining wax and follow-up in 3 weeks for further removal.

Otolaryngology: General Model Note Output

HISTORY OF PRESENT ILLNESS
The patient is a 79-year-old female who was referred from Lexington Family Physicians for a cerumen impaction.
She reports experiencing a sensation of crustiness in her ears, which has been present for approximately one month. She describes a feeling of fullness in her right ear upon waking, akin to having water trapped inside. She has been using Q-tips to remove the perceived fluid, which results in the Q-tip becoming excessively wet. She has no history of ear surgeries. Her hearing was previously reported as muffled but has shown recent improvement. She was previously informed that she is a suitable candidate for a hearing aid, but she is currently unable to afford one. Despite attempts to alleviate the symptoms with prescribed cream, the condition has progressively worsened. An attempt to irrigate the ear at her last appointment was unsuccessful due to time constraints. She was subsequently prescribed ear drops, which she obtained from the pharmacy, but these have not provided any relief. Over the past two days, she has noticed an improvement in her hearing, although it is unclear whether this is due to actual improvement or acclimatization to the reduced hearing in her right ear. She has been self-administering peroxide in an attempt to flush out the ear.

Supplemental Information
She goes to the thyroid doctor twice a year and is on methimazole.

MEDICATIONS
Methimazole

PHYSICAL EXAM
The patient is alert and oriented.
There is flaking in both ears. The left external auditory canal is now clear. The tympanic membrane on the left side is intact. Both ears are well aerated. There is a large wax impaction over the right eardrum. Extraocular motions are intact. Bilateral facial nerves are intact. Dentures are in place. No lesions are observed at the uvula or tongue. The neck is soft and flat with airways. There is bilateral thyroid fullness.

ASSESSMENT AND PLAN
1. Cerumen impaction.
The presence of flaky skin in both ear canals suggests a diagnosis of eczema. The left external auditory canal was successfully cleared during this visit. A prescription for Debrox drops has been provided, with instructions to administer them in the right ear for a duration of 2 weeks to facilitate the dissolution of the cerumen. Additionally, DermOtic drops have been prescribed for the management of eczema, but their use is to be deferred until the next consultation. She is advised to maintain regular ear cleaning every 6 months.

Follow-up
The patient will follow up in 2 weeks.

PROCEDURE
Cerumen was removed from the left external auditory canal using suction.

Otolaryngology: Specialty Note Output

HISTORY OF PRESENT ILLNESS
The patient is a 79-year-old female who was referred from Lexington Family Physicians for a cerumen impaction.
She reports experiencing a sensation of crustiness in her ears, which has been present for approximately one month. The right ear feels full, similar to having water trapped inside, particularly upon waking. Attempts to remove the perceived fluid with Q-tips result in the Q-tip becoming excessively wet. No history of ear surgeries is reported. Hearing was previously muffled but has shown recent improvement. She was informed that she is a candidate for a hearing aid but is currently unable to afford one. Despite using prescribed cream, the condition has worsened. An attempt to irrigate the ear at her last appointment was unsuccessful due to time constraints. Ear drops prescribed subsequently did not provide relief. Over the past two days, hearing has improved, though it is unclear if this is due to actual improvement or acclimatization to the reduced hearing in the right ear. Peroxide has been used in an attempt to flush out the ear.

She visits the thyroid doctor twice a year and is on methimazole.

MEDICATIONS
Methimazole

PHYSICAL EXAM
General: The patient is alert and oriented.
Ears: Flaking in both ears. Left external auditory canal is clear. Tympanic membrane on the left side is intact. Both ears are well aerated. Large wax impaction over the right eardrum.
Eyes: Extraocular motions intact.
Oral Cavity: Dentures in place. No lesions at the uvula or tongue.
Neck: Soft and flat airways. Bilateral thyroid fullness.
Neurological: Bilateral facial nerves intact.

ASSESSMENT AND PLAN
Cerumen impaction.

The presence of flaky skin in both ear canals suggests a diagnosis of eczema. The left external auditory canal was successfully cleared during this visit. A prescription for Debrox drops has been provided, with instructions to administer them in the right ear for a duration of 2 weeks to facilitate the dissolution of the cerumen. Additionally, DermOtic drops have been prescribed for the management of eczema, but their use is to be deferred until the next consultation. Regular ear cleaning every 6 months is recommended.

Follow-up in 2 weeks.

PROCEDURE
Procedure: Cerumen removal from the left external auditory canal
All questions were answered and agreement to proceed was given after the following
Pre-Procedure details were reviewed:
-Risks and Benefits: Discussed potential discomfort and temporary dizziness.
-Side effects: Discussed potential minor bleeding and temporary hearing changes.
-Consent: Verbal consent obtained.

Intra-Procedure:

Post-Procedure:
-Tolerance Level: Tolerated well
-Home Care Instructions: Advised to use Debrox drops in the right ear for 2 weeks to dissolve wax impaction. Instructed to avoid using DermOtic drops until the follow-up appointment.

Pain Medicine

Goals for Documentation:

- Balance brevity and detail to ensure comprehensive documentation while maintaining consistency and accuracy.
- Adhere to legal and ethical standards despite time constraints hindering thorough documentation.
- Maintain clinical integrity and facilitate effective communication and collaboration among healthcare teams essential for optimal patient outcomes.
- Enhance the documentation process, ensuring it supports accurate patient records, legal compliance, and seamless care coordination.

Pain Medicine: History of Present Illness

General Content

She reports persistent lower back pain, which she manages with morning walks and gentle yoga stretches. The onset of her back pain was preceded by hip pain, and the condition has progressively worsened with age. She experiences pain in her thighs and numbness down her legs upon standing from a seated position. Occasionally, she suffers from shooting, stabbing pain in her lower back and daily tingling sensations in her foot. She also reports occasional leg weakness when transitioning from sitting to standing but has not experienced any falls. There is no loss of bowel or bladder control. Her walking distance is limited due to the pain, which is disruptive to her daily activities as a teacher. Despite trying various types of shoes, she has not found relief. She experiences significant morning stiffness. She has received injections for hip pain from Dr. Doe, which were effective. She underwent physical therapy for her back over a year ago but did not find it beneficial. She has researched and implemented specific stretches for her diagnosed retrolisthesis. She also engages in pool walking when possible. She identifies sitting on the floor and repetitive bending motions as triggers for her pain. She takes Motrin as needed, sometimes exceeding the recommended dosage, and applies ice to the affected area. On particularly painful days, she resorts to taking Flexeril at night or half a dose, which provides some relief by the following morning. She is currently on Celebrex and takes 3 to 4 tablets of Motrin as needed, which occasionally provides relief. She has also tried Tylenol, but it was ineffective.

Specialty-specific Content

The patient presents for evaluation of back pain.

She reports persistent lower back pain, which she manages with morning walks and gentle yoga stretches. The onset of her back pain was preceded by hip pain, and the condition has progressively worsened with age. She experiences pain in her thighs and numbness down her legs upon standing from a seated position. Occasionally, she suffers from shooting, stabbing pain in her lower back and daily tingling sensations in her foot. She also reports occasional leg weakness when transitioning from sitting to standing but has not experienced any falls. There is no loss of bowel or bladder control.

Her walking distance is limited due to the pain, which is disruptive to her daily activities as a teacher. Despite trying various types of shoes, she has not found relief. She experiences significant morning stiffness. She has received injections for hip pain from Dr. Doe, which were effective. She underwent physical therapy for her back over a year ago but did not find it beneficial. She has researched and implemented specific stretches for her diagnosed retrolisthesis. She also engages in pool walking when possible. She identifies sitting on the floor and repetitive bending motions as triggers for her pain.

She takes Motrin as needed, sometimes exceeding the recommended dosage, and applies ice to the affected area. On particularly painful days, she resorts to taking Flexeril at night or half a dose, which provides some relief by the following morning. She is currently on Celebrex and takes 3 to 4 tablets of Motrin as needed, which occasionally provides relief. She has also tried Tylenol, but it was ineffective.

Pain Medicine: Physical Examination

General Content

Back and lower extremities were examined.

Specialty-specific Content

Musculoskeletal: Pain elicited upon forward flexion and backward extension of the lumbar spine. Pain radiates down the thigh with certain movements. No significant pain upon palpation of the upper back, but significant pain around the waist area. No weakness noted during resisted movements of the lower extremities.
Neurological: Sensation intact bilaterally in the lower extremities.

Pain Medicine: Assessment and Plan

General Content

1. Back pain. The patient's back pain is likely due to spinal stenosis, which is limiting his mobility. The presence of arthritis in the sacroiliac joint may also be contributing to his discomfort. He has been informed about the potential risks associated with surgical intervention, including the possibility of increased pain post-surgery. He has been advised to consult with his hepatologist regarding the use of over-the-counter ibuprofen. A prescription for gabapentin has been provided, with instructions to take one tablet at night initially. If well-tolerated, morning and afternoon doses can be added. A prescription for Robaxin has also been provided for use as needed. He has been advised to discontinue OxyContin while on these medications to avoid excessive sedation. If the current dosage of gabapentin proves insufficient, an increase in dosage will be considered. If the lower back or buttock area begins to cause pain, an injection into the sacroiliac joint will be considered.

2. Leukemia. He has a follow-up appointment with his hematologist on 05/03/2025.

Follow-up The patient is scheduled for a follow-up visit in 3 weeks.

Specialty-specific Content

1. Back pain.
- The patient's back pain is likely due to spinal stenosis, which is limiting his mobility. The presence of arthritis in the sacroiliac joint may also be contributing to his discomfort.
- Physical examination revealed no tenderness upon palpation of the back, and no pain radiating down the legs. Strength testing showed improvement in leg swelling.
- He has been informed about the potential risks associated with surgical intervention, including the possibility of increased pain post-surgery. He has been advised to consult with his hepatologist regarding the use of over-the-counter ibuprofen.
- A prescription for gabapentin has been provided, with instructions to take one tablet at night initially. If well-tolerated, morning and afternoon doses can be added. A prescription for Robaxin has also been provided for use as needed. He has been advised to discontinue OxyContin while on these medications to avoid excessive sedation. If the current dosage of gabapentin proves insufficient, an increase in dosage will be considered. If the lower back or buttock area begins to cause pain, an injection into the sacroiliac joint will be considered.

2. Leukemia.
- The patient has a history of leukemia and has been experiencing elevated white blood cell counts.
- He has a follow-up appointment with his hematologist on 05/03/2025.
- The patient has been counseled to discuss his ongoing elevated white blood cell counts with his hematologist.
- No new medications or therapies have been prescribed for leukemia at this time.

Follow-up
The patient is scheduled for a follow-up visit in 3 weeks.

Pediatrics

Targeted Improvements:

- **HPI**: Using logic from the identified visit type, output will include well-child specific subheadings to organize the information appropriately. Subheadings for a well-child or hybrid visit include nutrition/diet, activities/interests, sleep, screen time, dental health, school, daycare, developmental milestones, safety practices, SDOH, SOGI, gynecological history, voiding/stooling, vision/hearing, birth history, and PMH/PSH.
- **PE:** Will contain logic for age/gender specific findings in: HEENT, Abdomen, Genitourinary, Musculoskeletal, and Psychiatric. Will also include verbalize growth measurements like head circumference, length/height, and weight.
- **Assessment and Plan:** Model to include clearance information for sports and school physicals, daycare, therapy consults or referrals, and inclusive of child welfare concerns, CYS (child protective services), and parental well-being like post-partum depression recommendations

Pediatrics: General Model Output

HISTORY OF PRESENT ILLNESS
The patient is a 2-year-old child who presents for a well-child check. She is accompanied by her parents. The patient's mother reports that the child's sleep pattern remains consistent, with occasional instances of her spending approximately 2 hours in the crib. The child's sleep duration typically extends from 12 to 14 hours, inclusive of a daytime nap lasting between 1 to 1.5 hours. The child is currently residing at home with her parents, with plans to commence preschool at St. Anthony's in 09/2024. The child is socially active, participating in dance classes every Tuesday and previously engaged in swimming lessons. The child has a history of ear infection and diaper rash, both of which have resolved. She has no difficulties with bowel movements, although attempts at toilet training have been unsuccessful. The child is highly active and has recently been introduced to chewable vitamins and probiotics. She maintains good oral hygiene, brushing her teeth daily, and has no known food allergies. The child's mother has observed a skin condition resembling keratosis pilaris on the back of her arms, which is being managed with the application of moisturizers.

PHYSICAL EXAM
Lungs are clear on both sides. Heart has a regular rate and rhythm. No murmurs detected. Abdomen is soft with no organomegaly. Vital Signs Patient's weight is between the 50th and 75th percentile. Height is at the 50th percentile.

ASSESSMENT AND PLAN
1. Routine well-child examination.
The child is demonstrating satisfactory growth and development, with no requirement for additional immunizations or blood work at this time. The parents were advised to initiate toilet training when the child reaches 2.5 years of age. The child is currently on a regimen of chewable vitamins and probiotics, which is deemed appropriate. A recommendation was made for the child to have a dental check-up with a pediatric dentist within the next year. The parents were also advised to continue the application of moisturizers to manage the child's keratosis pilaris. Follow-up The patient is scheduled for a follow-up visit in 08/2024.

Pediatrics: Specialty Output

HISTORY OF PRESENT ILLNESS

The patient is a 2-year-old child who presents for a well-child check. She is accompanied by her parents.
Diet, Intake & Output: Patient eats well balanced meals inclusive of vegetable and fruits. She consumes chewable vitamins and probiotics. No known food allergies. She has no difficulties with bowel movements, although attempts at toilet training have been unsuccessful.
Sleep: The child's sleep duration typically extends from 12 to 14 hours, inclusive of a daytime nap lasting between 1 to 1.5 hours. The patient's mother reports that the child's sleep pattern remains consistent, with occasional instances of her spending approximately 2 hours in the crib.
Birth History: Mother reports patient was born vaginally, 5 days late. No history of birth trauma or complications.
Past Medical/Surgical History: The child has a history of ear infection and diaper rash, both of which have resolved.

Developmental Milestones:
Gross Motor: The child is highly active, able to jump and participate in physical activities such as dance classes.
Language: The child has a robust vocabulary and is socially interactive.
Psychosocial: The child is socially active, participating in dance classes every Tuesday and previously engaged in swimming lessons.
Interval History: The child has recently been introduced to chewable vitamins and probiotics. The child's mother has observed a skin condition resembling keratosis pilaris on the back of her arms, which is being managed with the application of moisturizers.

SOCIAL HISTORY

Living arrangements: The child is currently residing at home with her parents,
School: plans to commence preschool at St. Anthony's in 09/2024.
Hobbies: Dance classes and swim lessons
Dental hygiene: Brushes teeth daily, recommended to see dentist within the year.
Safety practices: patient sleeps alone in crib

Physical Exam
General: Appears well, no distress.
HEENT: Conjunctivae clear, sclerae anicteric, mucous membranes moist, oropharynx clear.
Neck: No adenopathy, supple, normal range of motion.
Cardiovascular: Regular rate and rhythm, no audible murmur, normal distal pulses.
Lungs / Chest: Lungs clear to auscultation bilaterally, no rales, rhonchi, or wheezes, normal respiratory effort.
Abdomen: Normal active bowel sounds, soft, non-tender, non-distended, no hepatosplenomegaly, no mass.
Extremities: Capillary refill < 2 sec, no clubbing, no cyanosis, no edema.
Genitourinary: Normal for age and gender.
Skin: No rash, normal skin turgor, normal texture and pigmentation.
Musculoskeletal: Normal symmetric bulk, normal symmetric tone
Neuro: alert, moves all extremities well, normal muscle bulk and tone
Psychiatric: appropriate mood and affect for age

ASSESSMENT AND PLAN

1. Routine well-child examination.
The child is demonstrating satisfactory growth and development, with no requirement for additional immunizations or blood work at this time. The parents were advised to initiate toilet training when the child reaches 2.5 years of age. The child is currently on a regimen of chewable vitamins and probiotics, which is deemed appropriate. A recommendation was made for the child to have a dental check-up with a pediatric dentist within the next year. The parents were also advised to continue the application of moisturizers to manage the child's keratosis pilaris.

Follow-up The patient is scheduled for a follow-up visit in 08/2024.
Referral for specialists or Therapies: Dentist

Physical Therapy

Targeted Improvements:

Overall Note: Style enhancements specific to the practice scope of a physical therapist.

HPI:

- Addition of Pain Assessment & Functional Status/Activity Limitations (PLOF/CLOF)
- Enhanced social history capturing details such as occupational history, hobbies/activities, home environment.

Physical Exam:

- Improvements to Objective findings: Observations, Measurements, Interventions
- Improved content retrieval including ROM, strength testing, gait and other special testing performed
- Precise numerical notation formatting and units of measure for common exam findings
- Improvements to capture therapeutic interventions performed at time of visit

Assessment/Plan:

- Summarized visit findings, recommendations and education provided within scope of physical therapist, including planned interventions and rationale for skilled treatment and need for continuation of services.
- Enhanced capture of barriers that may impact outcomes including relevant co-morbidities.
- Therapy goals captured if verbalized during encounter which meet following criteria: specific, measurable, actionable, relate to functional outcomes and time-bound.

Physical Therapy: History of Present Illness

General Content

The patient is a 50-year-old female who presents for an initial evaluation of chronic bilateral low back pain. She was referred by Dr. Joe from the Star Clinic after her annual physical exam on 01/02/2024.

She has been experiencing chronic bilateral low back pain since middle school, which has recently worsened. The pain intensifies when she sits for a long time is under stress, or during sudden weather changes. She reports no recent falls or back surgeries. A few years ago, Dr. Joe recommended Pilates, which she practices at home along with other exercises like squats and lunges using a kettlebell. These exercises, along with some online stretches, seem to alleviate her pain. However, she sometimes experiences pain while sleeping or sitting, occasionally has to shorten her walks due to discomfort. Despite this, she manages to walk around her neighborhood most of the time, experiencing only mild pain afterwards, which she manages with stretching and pain medication. She enjoys hiking but has refrained from it in the past couple of years due to her condition. She takes Advil 400 mg as needed for pain relief. Her goal is to find additional methods to manage her pain. She tries to walk or do Pilates at least four times a week. Her job as a program manager involves a lot of sitting and meetings, but she tries to stand as much as possible using a sit-to-stand desk. Prolonged sitting or standing exacerbates her back pain. She uses an antifatigue mat and has no work restrictions or disability. She describes her pain as sharp and radiating, located above the hip bone. She rates her current pain level as 2 to 3, with the worst pain in the past week being a 7. She is sometimes pain-free. She is currently undergoing hormone replacement therapy for menopause, which seems to help with inflammation and pain. Her pain is usually worse in the evenings after work. She had a few falls in middle school, landing on her tailbone on a 2 x 4, and similar incidents as an adult, but nothing recent. She played volleyball and basketball in high school. She reports no numbness or tingling down her legs or in her back and does not feel any radiating pain. Stretching and heat application seem to help. She has not tried chiropractic treatment or acupuncture.

Specialty-specific Content

Patient is a 50-year-old female presenting for an initial evaluation of chronic bilateral low back pain. She was referred by Dr. Joe from the Star Clinic after her annual physical exam on 01/02/2024. The patient has been experiencing chronic bilateral low back pain since middle school, which has recently worsened. She reports no recent falls or back surgeries. A few years ago, Dr. Davis recommended Pilates, which she practices at home along with other exercises like squats and lunges using a kettlebell. She takes Advil 400 mg as needed for pain relief. She is currently undergoing hormone replacement therapy for menopause, which seems to help with inflammation and pain. She played volleyball and basketball in high school. She reports no numbness or tingling down her legs or in her back and does not feel any radiating pain. Stretching and heat application seem to help. She has not tried chiropractic treatment or acupuncture.

Pain Assessment:
- Pain level: 2-3/10 currently, worst pain in the past week 7/10
- Laterality and location: Bilateral low back pain, located above the hip bone
- Pain frequency: Sometimes pain-free, usually worse in the evenings after work
- Pain quality: Sharp and radiating
- Alleviating factors: Stretching, heat application, Advil 400 mg, home exercises
- Aggravating factors: Prolonged sitting, standing, stress, weather changes

Functional Status/Activity Limitations:
Prior:
Current:
- Experiences pain while sleeping or sitting
- Occasionally shortens walks due to discomfort
- Manages to walk around her neighborhood most of the time, experiencing only mild pain afterwards
- No work restrictions

SOCIAL HISTORY
Type of Occupation: Program Manager

Sports/Recreational Activities/Hobbies: Enjoys hiking but has refrained from it in the past couple of years; walks around the neighborhood; practices Pilates at home; performs exercises like squats and lunges with a kettlebell

Fall History: Had a few falls in middle school, landing on tailbone on a 2 x 4; similar incidents as an adult, but nothing recent

Physical Therapy: Physical Examination

General Content

Patient exhibits increased moderate lordosis and mild kyphosis. Forward flexion is about 80 percent, trunk extension is about 80 percent, flexion to the left is about 90 percent, lateral flexion to the right is about 100 percent, and trunk rotation side to side is about 80 percent. Strength in the left leg is 5 out of 5 except for the hamstring which is 4 out of 5. Right leg strength is normal except for the hamstring which is probably 4 plus out of 5. Hip abductor muscles have a strength of 3 plus out of 5 bilaterally. There is good mobility in the lumbar spine, but decreased mobility in the thoracic spine. Left hip flexor shows fair amount of tightness.

Specialty-specific Content

Observations
Posture: Increased moderate lordosis in the lumbar spine, mild kyphosis in the thoracic spine, rounded shoulders, forward head posture.
Palpation: Moderate tightness in thoracic and lumbar spine muscles, fair amount of tightness in left hip flexor.
Balance: No specific balance issues noted.
Gait Analysis: No gait abnormalities observed, no use of assistance device, patient walks around the neighborhood (approximately 3 miles).

Measurements
Range of Motion (ROM):
- Forward Flexion: 80%
- Trunk Extension: 80%
- Left Lateral Flexion: 90%
- Right Lateral Flexion: 100%
- Trunk Rotation (Side to Side): 80%

Strength:
- Left Leg: 5/5 except hamstring 4/5
- Right Leg: Normal except hamstring 4+/5
- Hip Abductor Muscles: 3+/5 bilaterally

Interventions
Stretching Exercises:
- Prone Quad Stretch: Left leg, twice daily, for 30 seconds each
- Supine Figure 4 Stretch: Left glute with tennis ball X 10 seconds
- Seated Figure 4 Stretch: Left hip with tennis ball X 10 seconds

Strengthening Exercises:
- Clamshells: 3 sets of 10 repetitions with 3-second hold at the top, every other day
- Side Stepping with Red Band: Every other day for 3-4 minutes

Manual Therapy:
- Muscle work on low back and hip muscles

Physical Therapy: Assessment and Plan

1. Postoperative status following right shoulder open subpectoral biceps tenodesis and right shoulder arthroscopic extensive debridement.
His range of motion is satisfactory post-surgery, but there is a slight limitation in internal rotation on the right side compared to the left. He exhibits a shoulder hiking pattern during movements, which could potentially lead to upper neck pain. His strength is commendable, however, the quality of his movements differs between the right and left sides. He experiences pain in the upper trapezius and stiffness, particularly with lifting and sleeping on the affected side. A comprehensive physical therapy program will be initiated to strengthen the rotator cuff and the two muscles in the back. He was instructed to perform specific exercises, including T's and shoulder range of motion exercises, with a focus on maintaining proper form and avoiding neck tension. He was advised to use a 3-pound weight for external rotation endurance exercises, aiming for 27 repetitions on each side. He was also guided to perform isometric exercises at 45 degrees flexion. The exercises will be emailed to him, and he is scheduled for weekly follow-ups over the next month.
Follow-up
The patient will follow up once a week for the next month.

1. Postoperative status following right shoulder open subpectoral biceps tenodesis and right shoulder arthroscopic extensive debridement.
The patient demonstrates satisfactory range of motion post-surgery with a slight limitation in internal rotation on the right side compared to the left. A shoulder hiking pattern is observed during movements, which may contribute to upper neck pain. Strength is generally good, but the quality of movement differs between the right and left sides. The patient reports upper trapezius pain and stiffness, particularly with lifting and sleeping on the affected side. A comprehensive physical therapy program will be initiated to strengthen the rotator cuff and the muscles in the back. Specific exercises include T's and shoulder range of motion exercises, with an emphasis on proper form and avoiding neck tension. External rotation endurance exercises will be performed using a 3-pound weight, aiming for 27 repetitions on each side. Isometric exercises at 45 degrees flexion will also be included. The exercises will be emailed to the patient, and weekly follow-ups are scheduled for the next month.

Education: The patient was educated on the importance of strengthening the rotator cuff and back muscles to alleviate upper neck pain and improve functional movement. Proper form during exercises and avoiding neck tension were emphasized. The patient was instructed on the specific exercises to be performed at home and the importance of adherence to the home exercise program.

Follow Up: The patient will follow up once a week for the next month.

Goals:
Short Term Goals:
1. The patient will report a reduction in upper trapezius pain and stiffness by 50% during lifting and sleeping within 4 weeks.

Long Term Goals:
1. The patient will achieve symmetrical strength and movement quality between the right and left shoulders within 8 weeks.
2. The patient will return to climbing activities without pain or functional limitations within 12 weeks.

PM&R

Improvements:

Overall Note: Style improvements tailored for the PM&R practice.

HPI:

- Enhanced formatting to capture and organize into separate paragraphs.

Physical Exam:

- Objective findings Improvement: Observations, Measurements, Interventions.
- Improved content including ROM, strength testing, gait and other special testing performed when stated.
- Numerical notation formatting and units of measure for common exam findings are documented when stated.
- Improvements to capture therapeutic interventions performed at time of visit.

Assessment/Plan:

- Summarized visit findings, recommendations and education provided within the scope of podiatry, including planned interventions and rationale for skilled treatment and need for continuation of services.
- Enhanced capture of barriers that may impact outcomes including relevant co-morbidities.
- Therapy goals captured if verbalized during patient encounter.

PM&R: History of Present Illness

General Medical Model

The patient is a 65-year-old male who presents for back pain.

He reports experiencing neck pain, which he first noticed last night while attempting to sleep. The pain originates from the left mid-cervical region and radiates upwards, culminating in a headache. He describes the onset of pain as occurring when he lies on his back, with the headache subsiding upon movement. Additionally, he notes that even slight lateral head movements while in bed trigger the pain and headache, which promptly resolve upon returning his head to a neutral position. He recalls a previous visit to a healthcare provider for injections, during which he was unable to localize the pain due to its widespread nature. He believes this may have contributed to the ineffectiveness of the injections, as they were not administered at the correct site. However, he now reports an improvement in his condition, with the ability to more accurately identify the source of his pain.

Specialty Specific Model

The patient is a 65-year-old male who presents for back pain.

He reports experiencing neck pain, which he first noticed last night while attempting to sleep. The pain originates from the left mid-cervical region and radiates upward, culminating in a headache. The onset of pain occurs when he lies on his back, with the headache subsiding when he moves.

Additionally, he notes that even minimal lateral head movements while in bed trigger both the pain and headache, which promptly resolve upon returning his head to a neutral position.

He recalls a previous visit to a healthcare provider for injections, during which he was unable to localize the pain due to its widespread nature. He believes this may have contributed to the lack of efficacy, as the injections were not administered at the correct site. However, he now reports an improvement, with the ability to more accurately identify the source of his pain.

PM&R: Physical Examination

General Medical Model

PHYSICAL EXAM
Tenderness is noted over the ATF and slightly over the CF ligaments of the ankle. There is a slight anterior drawer with some guarding. Localized 1+ edema is present with slight ecchymosis. No erythema or open lesions are observed.

Specific Specialty Model

PHYSICAL EXAM
Musculoskeletal
Left Ankle: Tenderness noted over the anterior talofibular (ATF) and slightly over the calcaneofibular (CF) ligaments. Slight anterior drawer present with some guarding. Localized 1+ edema observed alongside slight ecchymosis.

Skin: No erythema or open lesions detected.

PM&R: Assessment and Plan

General Content

1. Foot pain.
The foot pain is not convincingly linked to his low back condition. He is advised to consult with a podiatrist for further evaluation. An x-ray of the right foot will be conducted, and the possibility of using a walking boot for a few weeks will be considered. The podiatrist will determine if an MRI is necessary. He is encouraged to try different models of ASICS shoes. The current regimen of gabapentin 300 mg twice daily will be maintained, and a refill will be provided. Meloxicam will also be continued, and a refill will be sent to Dallas Plaza Pharmacy.

2. Hip pain.
The hip pain could potentially be attributed to arthritis. An x-ray of the pelvis will be ordered to examine the hip joints.

3. Neck pain.
The neck pain is likely due to degenerative changes associated with aging and movement. He reports that gabapentin helps alleviate the neck pain. No immediate intervention is required unless symptoms worsen.

Follow-up
The patient will follow up in 4 to 6 weeks.

PROCEDURE
The patient underwent a robotic radical prostatectomy.

Specialty-specific Content

1. Foot pain.
The patient's foot pain does not appear to be related to his lower back issue. He is advised to schedule an appointment with a podiatrist for further evaluation.
An x-ray of the right foot will be obtained, and the use of a walking boot for several weeks may be considered. MRI will be decided if needed. The patient is encouraged to try different models of ASICS shoes for potential relief. He will continue taking gabapentin 300 mg twice daily and a refill will be provided. Meloxicam will also be continued with a prescription refill sent to Dallas Plaza Pharmacy.

2. Hip pain.
The patient's hip discomfort may be due to arthritis.
A pelvic x-ray will be ordered to assess the hip joints.

3. Neck pain.
The neck pain is most likely due to age-related degenerative changes and movement. The patient reports that gabapentin is helpful for managing this pain.
No further intervention is necessary at this time unless symptoms worsen.

Follow-up: The patient will return for follow-up in 4 to 6 weeks.

Podiatry

Improvements:

Overall Note: Style improvements tailored for the podiatry practice.

HPI:

- Enhanced formatting to capture and organize into separate paragraphs.

Physical Exam:

- Objective findings Improvement: Observations, Measurements, Interventions.
- Improved content including ROM, strength testing, gait and other special testing performed when stated.
- Numerical notation formatting and units of measure for common exam findings are documented when stated.
- Improvements to capture therapeutic interventions performed at time of visit.

Assessment/Plan:

- Summarized visit findings, recommendations and education provided within the scope of podiatry, including planned interventions and rationale for skilled treatment and need for continuation of services.
- Enhanced capture of barriers that may impact outcomes including relevant co-morbidities.
- Therapy goals captured if verbalized during patient encounter.

Podiatry: History of Present Illness

General Medical Model

The patient, a 58-year-old female, presents with right calcaneal pain, possibly indicative of plantar fasciitis. She reports no recent trauma but has a remote history of an ankle injury sustained at age 10.

The patient experienced an ankle injury at age 10 due to a fall, resulting in a growth plate fracture. She has since had a weak ankle prone to recurrent falls. Approximately 12 years ago, she sustained a fall while walking her dog, leading to torn tendons and ligaments, necessitating surgical intervention. Postoperatively, she developed neuropathic complications characterized by a sensation of stepping on a hot object under the balls of her feet. In 2011, she received injections that provided symptomatic relief. She was diagnosed with plantar fasciitis in 2017, which was successfully managed until 2018. In 2018, she fell again while walking her new dog, resulting in exacerbation of symptoms but no tendon or ligament tears. She received treatment at New Mexico Foot and Ankle, including orthotics, physical therapy, cryotherapy, and rest. Currently, she utilizes orthotics for prolonged standing or running in court and is unable to wear high heels due to decreased flexibility. She maintains a routine of walking a 3-mile path around her residence. Her medical history includes frequent falls and multiple toe fractures. The patient reports localized pain at the bottom of her feet, resembling the sensation of stepping on a foreign object, and is uncertain if this represents a recurrence of plantar fasciitis.

The patient has a history of knee pathology, with an eventual need for knee replacement surgery, although she is currently considered too young for the procedure. She has been receiving cortisone injections for the past year, with the most recent injection administered yesterday, resulting in an 80% improvement. She anticipates being able to perform a deep squat by tomorrow.

Specialty Specific Model

The patient, a 58-year-old female, presents with right calcaneal pain.

The patient continues to experience right calcaneal pain, and her ongoing symptoms include localized pain in the bottoms of her feet, resembling the sensation of stepping on a foreign object, and she is uncertain if this pain signifies a recurrence of plantar fasciitis.

Currently, she relies on orthotics for prolonged standing or when running in court and is unable to wear high heels due to decreased flexibility. She maintains an active lifestyle, regularly walking a 3-mile path around her home.

In 2018, she fell while walking her new dog, resulting in an exacerbation of symptoms, although no tendon or ligament tears were detected. She sought care at New Mexico Foot and Ankle, receiving treatments that included orthotics, physical therapy, cryotherapy, and rest.

From 2011 until 2022, her plantar fasciitis had been effectively managed following a diagnosis in 2017. Prior to this period, in 2011, she underwent injections that provided significant symptomatic relief for neuropathic sensations described as stepping on a hot object under the balls of her feet.

Approximately 12 years ago, the patient sustained a fall while walking her dog, leading to torn tendons and ligaments that required surgical repair. After surgery, she developed neuropathic complications in her feet, marked by persistent discomfort and abnormal sensations.

Her history of lower extremity issues dates to an ankle injury at age 10, when a fall caused a growth plate fracture. Since then, she has experienced chronic ankle weakness and recurrent falls.

Her medical background is further notable for frequent falls and multiple toe fractures.

The patient has a history of knee pathology, with an eventual need for knee replacement surgery, although she is currently considered too young for the procedure. She has been receiving cortisone injections for the past year, with the most recent injection administered yesterday, resulting in an 80% improvement. She anticipates being able to perform a deep squat by tomorrow.

Podiatry: Physical Examination

General Medical Model

PHYSICAL EXAM
Tenderness is noted over the ATF and slightly over the CF ligaments of the ankle. There is a slight anterior drawer with some guarding. Localized 1+ edema is present with slight ecchymosis. No erythema or open lesions are observed.

Specific Specialty Model

PHYSICAL EXAM
Musculoskeletal
Left Ankle: Tenderness noted over the anterior talofibular (ATF) and slightly over the calcaneofibular (CF) ligaments. Slight anterior drawer present with some guarding. Localized 1+ edema observed alongside slight ecchymosis.

Skin: No erythema or open lesions detected.

Podiatry: Assessment and Plan

General Medical Model

1. Left ankle pain.
She reports significant tenderness and a burning sensation on the left lateral ankle and calf, which started gradually 2 months ago. Physical examination reveals exquisite tenderness and local swelling along the left peroneal tendons, with increased pain during specific movements. An MRI of the left ankle will be ordered to evaluate for potential tendon tears. She will be provided with an immobilizer boot and an Ace wrap for compression. She is advised to limit activity tolerance and apply ice or heat as needed. If the MRI confirms tendon tears, further treatment options will be discussed.

2. Rheumatoid arthritis (RA).
She reports generalized joint pain and is currently taking Enbrel for RA. No changes to her RA management were discussed during this visit.

Follow-up
The patient will follow up after the MRI.

Specific Specialty Model

1. Left ankle pain.
Significant tenderness and a burning sensation noted on the left lateral ankle and calf, which began gradually 2 months ago. Physical examination reveals exquisite tenderness and local swelling along the left peroneal tendons, with increased pain during specific movements.

Order an MRI of the left ankle to evaluate for potential tendon tears. Provide an immobilizer boot and an Ace wrap for compression. Advise limiting activity tolerance and applying ice or heat as needed. If the MRI confirms tendon tears, discuss further treatment options.

2. Rheumatoid arthritis (RA).
Generalized joint pain reported; Enbrel currently prescribed for RA.

No changes to RA management discussed at this visit.

Follow-up: Follow-up after the MRI.

Psych/Neuropsychology

Targeted Improvements:

This model is tailored for use across the lifespan, from early childhood to older adulthood, and incorporates age-relevant considerations such as developmental milestones, educational status, and social functioning. It also emphasizes the integration of conversational content from patient and informant interactions, including memory for current events, interests like favorite TV shows or video games, and social behaviors such as empathy, bullying experiences, and conflict resolution strategies. These elements are considered clinically meaningful and must be woven into the appropriate sections of the note.

Updates clarify expectations for documenting behavioral observations, test results, and treatment recommendations. Overall, the model supports accurate diagnosis, treatment planning, and interdisciplinary communication.

Psych/Neuropsych: HPI with Specialty-Specific Content

The patient presents for memory issues, sleep apnea, depression, and situational anxiety.

She reports experiencing memory lapses, such as misplacing items and struggling to recall specific words or recent events. These symptoms have been present for approximately a year, with a noticeable increase over the past 8 months. She has noticed increased distractibility over the past 6 months, particularly when reading, but maintains focus on tasks. She has a history of sleep apnea and was prescribed a CPAP machine 6 years ago, which she used for about a year before discontinuing due to discomfort. She typically sleeps for 6 hours per night but often wakes up around 4:00 AM and remains awake until 6:00 AM. She occasionally takes a 45-minute to 1-hour nap during the day.

Functional Status: She reports experiencing memory lapses, such as misplacing items and struggling to recall specific words or recent events. These symptoms have been present for approximately a year, with a noticeable increase over the past 8 months. She does not experience disorientation in familiar environments or forgets significant dates or events. She has not had any instances of forgetting to take her medications. She has been using a pill box for years and has not had any increased difficulty filling it or remembering to take her medications. She has noticed increased distractibility over the past 6 months, particularly when reading, but maintains focus on tasks. She has not had any changes in her ability to complete tasks that she used to be able to finish quickly. She has not had any visual-spatial issues like feeling clumsy, running into things, or missing things while driving. She engages in strength training twice a week and reports no other language difficulties. She has not had any changes in her ability to follow recipes or cook meals. She continues to handle her finances without issue.

Past Medical History: She has not had any major medical conditions, cancer, or chemotherapy. She has not been tested for breast cancer. She has not had any migraines, headaches, or chronic pain.

Mental/Psychiatric History: She has seen a counselor for situational anxiety and depression but is not currently seeing anyone. She is taking sertraline 2 tablets daily for several years. She reports feeling depressed and angry about political issues and the state of the world but also experiences periods of happiness and joy.

Family Medical History: Her mother had Parkinson's disease. Her father had prostate cancer. Her sister has chronic lymphoid leukemia and basal cell carcinoma.

Developmental and Educational History: She met all developmental milestones on time. She was a good student, attended Catholic school, and obtained a master's degree in education. English is her first language, and she learned French academically. She lived in Paris for a year and is comfortable with French. She also knows a little Spanish.

Social and Occupational History: She is married and lives with her husband. They have one daughter and one grandchild. She worked primarily in financial services as a writer and corporate television producer. She retired in 2011 but freelanced until 2022. She has adequate social support from family and friends

Psych/Neuropsych: PE with Specialty-Specific Content

Mental Status Exam:
Mood and Affect: The patient exhibits significant mood instability, characterized by extreme emotional reactivity and irritability. She has frequent mood swings and displays heightened emotional responses to minor provocations.
Thought Processes: The patient's thought processes appear to be organized but are often driven by impulsivity and manipulation. She is capable of fabricating stories and manipulating situations to her advantage.
Thought Content: The patient demonstrates a preoccupation with obtaining what she desires, often through deceitful means. There is no evidence of delusions or obsessions.
Harmful Thoughts: There is no mention of suicidal ideation, homicidal ideation, or other harmful intentions.
Sensorium and Cognitive Functions: The patient is described as highly intelligent, achieving high academic performance. There are no concerns about her attention or focus when engaged in activities of interest, such as using her cell phone.
Insight and Judgment: The patient shows limited insight into the impact of her behavior on others. She often does not express remorse or regret when caught in deceitful actions.
Motivation: The patient exhibits a lack of motivation to engage in therapy, often viewing it as a personal attack and not giving it the necessary time and energy.

Psych/Neuropsych: Assessment and Plan with Specialty-Specific Content

Clinical Impression:
The patient presents with a gradual onset of memory issues over the past year, characterized by misplacing items, occasional word-finding difficulties, and foggy recall for dates. These symptoms have mildly progressed but have not significantly impacted her activities of daily living or medication management. Cognitive testing will be conducted today to further evaluate these concerns. Additionally, she has a history of sleep apnea, for which she was prescribed a CPAP machine 6 years ago but discontinued use due to discomfort and lack of perceived benefit. She reports getting at least 6 hours of sleep per night but occasionally wakes up in the middle of the night. The patient also experiences situational depression and anxiety related to current events and family stressors, for which she is taking sertraline.

Recommendations:
Cognitive testing will be performed today to assess the extent of memory issues. Continued use of sertraline for depression is advised, and the patient should monitor for any changes in mood or anxiety levels. It is recommended to revisit the use of the CPAP machine or explore alternative treatments for sleep apnea to improve sleep quality. Patient education on the importance of consistent CPAP use and potential benefits should be provided. Non-pharmacological strategies such as cognitive behavioral therapy (CBT) for managing situational anxiety and depression may be beneficial. Encouraging regular physical activity, such as her current strength training routine, and maintaining a healthy diet can also support overall well-being. Referral to a sleep specialist for further evaluation of sleep apnea and potential adjustments to CPAP therapy may be considered. Additionally, discussing the impact of current events on mental health and exploring stress management techniques can help alleviate situational anxiety and depression.

Notes & Risk Factors:
- History of sleep apnea
- Situational depression and anxiety related to current events and family stressors
- Protective factors include regular physical activity, social support from family and friends, and ongoing use of sertraline for depression management.
- No risk factors for harm to self or others were identified.

Psychiatry

Targeted Improvements:

HPI: Model to include social, family, and psychiatric histories, substance use, pertinent negatives, and results (when applicable).

PE: Will be abbreviated to general appearance and skin. Focus is on Mental Status Exam to include information listed below.

Mental Status Examination
General Behavior:
Speech Characteristics:
Mood and Affect:
Thought Processes:
Thought Content:
Harmful Thoughts:
Perceptual Disturbances:
Sensorium and Cognitive Function:
Insight and Judgment:
Motivation:

Assessment and Plan: Model to include problems, content of therapy, clinical impressions, therapeutic intervention, plan, follow-up and risk factors.

Psychiatry: History of Present Illness with Specialty-Specific Content

The patient is a 15-year-old girl who presents for medication management for ADHD and generalized anxiety disorder. She is accompanied by her mother.

She has been living independently for the past 3 to 4 months, with minimal contact with her parents. This decision was prompted by an incident where her brother physically assaulted her, leading to feelings of discomfort and insecurity at home. Additionally, she experienced stress due to her parents' frequent arguments, which often involved her. These stressful situations led to an increase in stomach acid production, causing her to vomit blood. She recently returned to live with her mother after her parents separated. Her father visits on weekends, and she spends weekdays at his house. She is currently attending online school and finds it challenging to manage all these changes. She feels embarrassed when her parents argue in public. She reports no suicidal thoughts or safety concerns. She believes that getting out of the house more might improve her mood. She is uncomfortable around her brother, even on his good days. She has been taking one tablet of lamotrigine daily instead of the prescribed two and reports satisfaction with this regimen. She is also taking sertraline but is considering switching to another medication.

She has been experiencing auditory and visual hallucinations since childhood, which have worsened recently, and she finds disturbing. She is concerned about how others perceive her because of these hallucinations.

Social History:
- Currently attending online school
- Recently lived independently for 3 to 4 months
- Lives with her mother; father visits on weekends

Family History:
- Father has a history of alcohol use and has been involved in physical altercations
- Parents recently separated

Psychiatric History:
- Currently taking lamotrigine and sertraline
- Reports satisfaction with lamotrigine regimen
- Considering switching from sertraline to another medication

Substance Use:
- Father has a history of alcohol use

Pertinent Negatives:
- Reports no suicidal thoughts or safety concerns

Psychiatry: Physical Examination

General Content

General: Well-developed, well-nourished patient.
Vital Signs: Blood pressure, heart rate, respiratory rate, and temperature are within normal limits.
Mental Status: The patient presents with a depressed mood, flat affect, and diminished concentration. He demonstrates a negative self-perception and feelings of hopelessness.
Skin: No abnormalities or lesions are observed.
Neurological: Cranial nerves are intact, and there are no signs of focal neurological deficits.

Specialty-specific Content

General Physical Appearance: She maintains good eye contact and is appropriately dressed for the appointment.
Skin: No visible signs of self-harm or physical abuse.

General Behavior: The patient appears cooperative and engaged during the session.
Speech Characteristics: The patient's speech is clear, coherent, and of normal rate and volume.
Mood and Affect: The patient reports feeling depressed at times but denies any current suicidal ideation. Her affect appears congruent with her mood.
Thought Processes: The patient's thought processes are logical and goal-directed.
Thought Content: The patient reports experiencing visual and auditory hallucinations, which have increased in frequency recently.
Harmful Thoughts: The patient denies any current suicidal or homicidal ideation.
Perceptual Disturbances: The patient reports seeing and hearing things that are not there, including seeing her mother on the couch when she was actually in bed.
Sensorium and Cognitive Functions: The patient is oriented to person, place, and time. No cognitive deficits are noted.
Insight and Judgment: The patient demonstrates good insight into her condition and the need for treatment. Her judgment appears intact. Motivation: The patient is motivated to continue her current medication regimen and is open to adjustments as needed.

Psychiatry: Assessment and Plan with Specialty-Specific Content

Problems:
- Attention Deficit Hyperactivity Disorder (ADHD)
- Generalized Anxiety Disorder
- Psychotic Features

Content of Therapy:
During the session, the patient discussed significant changes in her living situation, including moving out of her parents' house due to physical violence from her brother and returning recently. She described ongoing family conflicts, her father's alcoholism, and the impact on her mental health. The patient also shared her experiences with online schooling, feelings of depression, and coping strategies. Additionally, she reported visual and auditory hallucinations that have worsened recently.

Clinical Impression: The patient appears to be experiencing increased stress due to family dynamics and her father's alcoholism. She has shown resilience by moving out to protect herself from physical violence and has returned with a more confident demeanor. Her ADHD and generalized anxiety disorder are being managed with medication, though adjustments are needed. The recent onset of psychotic features, including visual and auditory hallucinations, is concerning and requires further monitoring.

Therapeutic Intervention:
Specific therapeutic techniques discussed include reframing thoughts around family conflicts, exploring feelings of safety and self-worth, and addressing the impact of her father's alcoholism on her mental health. The patient was encouraged to focus on her education and personal well-being rather than taking responsibility for her parents' issues.

Plan:
- Continue lamotrigine 25 mg once daily.
- Resume Vyvanse capsules as needed.
- Discontinue sertraline and start Wellbutrin XL 150 mg once daily.
- Maintain a log of hallucinations and other psychotic symptoms over the next 2 to 3 weeks.
- Mother to provide an update on the patient's progress via message.

Follow-up:
- Next appointment scheduled in 2 to 3 weeks to review the symptom log and assess the need for further intervention.
- Goals include monitoring the effectiveness of Wellbutrin XL and evaluating the necessity of antipsychotic medication.

Notes & Risk Factors:
- No current suicidal thoughts or safety concerns reported.
- Protective factors include the patient's proactive steps to ensure her safety and her supportive relationship with her mother.

Pulmonology

Targeted Improvements:

HPI
- HPI will start with a description of the reason for visit.
- Content in the HPI will be documented by problem in chronological order.
- Content will be formatted one problem per paragraph, and large paragraphs will be separated.
- HPI will not include plan content.

Physical Exam
- Updated to include only findings that were verbalized.
- Updated to replace vague terms such as “examined” or “palpitated” with concrete normal findings.

Assessment and Plan
- Comprehensive documentation of all relevant details regarding risks, benefits, and alternatives.
- Updated to eliminate redundancy.
- Amount of subjective information reported by the patient will be limited in the plan.

Pulmonology: History of Present Illness

General Content

The patient presents for evaluation of COPD.
She reports experiencing urinary urgency, necessitating her to cross her legs to prevent urination. This symptom is not consistent daily but appears to be associated with the use of albuterol inhaler. She has been adhering to the prescribed antibiotic and steroid regimen, with one dose remaining. She has found relief from these medications and has been utilizing her nebulizer as directed, limiting each session to 30 seconds. She has attended three pulmonary sessions, during which her oxygen saturation levels were monitored. Initially, her levels were around 90, but they dropped to 88 during physical activity. During the third session, her oxygen saturation unexpectedly decreased to 75, even without exertion, prompting concern from the medical team. A slight bluish discoloration was noted in her nails, but she did not experience any respiratory distress or chest pain. Despite the recommendation to visit the emergency room, she declined and was subsequently administered oxygen. However, her oxygen saturation continued to fluctuate between 90 and 75. She underwent a CT scan and x-ray to rule out pulmonary embolism, both of which were negative. Blood work was also conducted, yielding normal results. She was informed that her breathing issues were due to oxygenation problems. She does not have an oxygen supply at home and does not wish to have one. She notes that her oxygen saturation is satisfactory when she is at rest, such as when sitting on the couch, but decreases during physical activity. She is considering using oxygen during sleep and is interested in obtaining a small portable oxygen concentrator for use during the day. She is requesting a refill of Trelegy through Optum.

Specialty-specific Content

The patient presents for evaluation of COPD.

She reports experiencing urinary urgency, necessitating her to cross her legs to prevent urination. This symptom is not consistent daily but appears to be associated with the use of her albuterol inhaler. She has been adhering to the prescribed antibiotic and steroid regimen, with one dose remaining. She has found relief from these medications and has been utilizing her nebulizer as directed, limiting each session to 30 seconds.

She has attended three pulmonary sessions, during which her oxygen saturation levels were monitored. Initially, her levels were around 90, but they dropped to 88 during physical activity. During the third session on 05/13/2025, her oxygen saturation unexpectedly decreased to 75, even without exertion, prompting concern from the medical team. A slight bluish discoloration was noted in her nails, but she did not experience any respiratory distress or chest pain. Despite the recommendation to visit the emergency room, she declined and was subsequently administered oxygen. However, her oxygen saturation continued to fluctuate between 90 and 75.

She underwent a CT scan and x-ray to rule out pulmonary embolism, both of which were negative. Blood work was also conducted, yielding normal results. She was informed that her breathing issues were due to oxygenation problems. She does not have an oxygen supply at home and does not wish to have one. She notes that her oxygen saturation is satisfactory when she is at rest, such as when sitting on the couch, but decreases during physical activity. She is considering using oxygen during sleep and is interested in obtaining a small portable oxygen concentrator for use during the day.

She is requesting a refill of Trelegy through Optum.

Pulmonology: Physical Exam

General Content

Oral exam was performed.
Neck was examined.
Lungs sound normal.
Abdomen was examined.
Lower extremities were examined.

Specialty-specific Content

Vital Signs: Oxygen saturation is at 96%
HEENT: Oral exam reveals dentures in good condition.
Neck: Neck examination is normal.
Lungs: Lung sounds are clear.
Abdomen: Abdomen is non-tender upon palpation.
Extremities: Lower extremities show normal range of motion.

Pulmonology: Assessment and Plan

General Content

1. Chronic Obstructive Pulmonary Disease (COPD).
She has a history of severe COPD with moderate diffusion impairment, as indicated by previous PFTs done during her TAVR workup. At that time, she had significant edema and pulmonary congestion, which likely affected the results. A CT scan showed no lung nodules. She has a smoking history of about 30 years, quitting in 1986. Currently, she is on 2 L of supplemental oxygen more than 18 hours a day. She was started on Breztri but has not used it due to insurance coverage issues and lack of severe shortness of breath. A 6-minute walk test and comprehensive PFTs, including total lung capacity and residual volume, will be conducted to assess her current lung function. She is advised to try Breztri and nebulizers to see if they improve her symptoms. A sample of Breztri will be provided.
2. Congestive Heart Failure with Preserved Ejection Fraction.S
he has a history of congestive heart failure with an ejection fraction of 55% to 60%. She reports significant improvement in symptoms, including reduced lower extremity edema. On physical exam, there is no pitting edema, and lung sounds are clear though distant. She is currently on spironolactone and Farxiga. Lasix has been discontinued.
3. Nonobstructive Coronary Artery Disease.
She has a history of nonobstructive coronary artery disease.
4. Hypertension.
She has a history of hypertension.
5. Hyperlipidemia.
She has a history of hyperlipidemia.

Specialty-specific Content

1. Chronic Obstructive Pulmonary Disease (COPD).

She has a history of severe COPD with moderate diffusion impairment, as indicated by previous PFTs done during her TAVR workup. At that time, she had significant edema and pulmonary congestion, which likely affected the results. A CT scan showed no lung nodules. She has a smoking history of about 30 years, quitting in 1986. Currently, she is on 2 L of supplemental oxygen more than 18 hours a day. She was started on Breztri but has not used it due to insurance coverage issues and lack of severe shortness of breath. A 6-minute walk test and comprehensive PFTs, including total lung capacity and residual volume, will be conducted to assess her current lung function. She is advised to try Breztri and nebulizers to see if they improve her symptoms. A sample of Breztri will be provided.

2. Congestive Heart Failure with Preserved Ejection Fraction.

She has a history of congestive heart failure with an ejection fraction of 55% to 60%. She reports significant improvement in symptoms, including reduced lower extremity edema. On physical exam, there is no pitting edema, and lung sounds are clear though distant. She is currently on spironolactone and Farxiga. Lasix has been discontinued.

Rheumatology

Targeted Improvements:

The current medical documentation system needs improvements to align with CMS guidelines. Key areas for enhancement include:

- **HPI**: Reduce pronouns and "the patient," and organize information into multiple paragraphs.
- **Physical Exam**: Improve formatting and organization.
- **Assessment and Plan:** Enhance layout and format, with the option for clinicians to use a list format.

These changes aim to improve clarity, efficiency, and compliance with CMS guidelines.

Rheumatology: History of Present Illness

General Content

HISTORY OF PRESENT ILLNESS
The patient presents for evaluation of neck pain.

She reports a significant improvement in her neck pain, attributing it to increased home-based stretching exercises. She has not been attending physical therapy sessions due to her perceived progress with the home exercises. She also engages in wall stretches at work and incorporates more walking and stair climbing into her routine. She does not experience any pain during sleep but notes occasional swelling. Despite these improvements, her sleep quality remains poor, which she attributes to high stress levels related to her mother's health condition. Her mother has cirrhosis of the liver, stage 3 kidney disease, C. difficile infection, and diabetes.

Specialty-specific Content

HISTORY OF PRESENT ILLNESS
The patient presents for evaluation of neck pain.

She reports a significant improvement in her neck pain, attributing it to increased home-based stretching exercises. She has not been attending physical therapy sessions due to her perceived progress with the home exercises. Wall stretches are engaged at work and incorporates more walking and stair climbing into her routine. No pain has been experienced during any sleep but notes occasional swelling.

Current medication regimen includes baclofen, which is taken intermittently, and cyclobenzaprine, which she uses sparingly due to its sedative effects. She is currently on a 4-weekly Simponi regimen, which is being tolerated well without any adverse effects.

Despite these improvements, her sleep quality remains poor, which is attributed to high stress levels related to her mother's health condition.

FAMILY HISTORY
Mother has cirrhosis of the liver, stage 3 kidney disease, C. difficile infection, and diabetes.

Rheumatology: Physical Examination

General Content

PHYSICAL EXAM

Vital Signs
Blood pressure is under 140.

Specialty-specific Content

PHYSICAL EXAM
Blood pressure, heart rate and temperature reviewed.
Vital Signs
Blood pressure is under 140.
General: Well-developed well-nourished, comfortably seated in no acute distress.
HEENT: Normocephalic, atraumatic. Pupils are equal round and reactive to light with external ocular movements intact. No conjunctival injection, sclera anicteric. Normal oral mucosa. No oral lesions. Neck supple. No thyromegaly.
Lymphatic: No submandibular, parotid, cervical lymphadenopathy bilaterally.
Lungs: Clear to auscultation without wheezes, rales or rhonchi. Normal respiratory effort.
Heart: Regular rate and rhythm. No murmurs, rubs, gallops. Normal PMI.
Joint Examination:
Spine: Normal dorsal kyphosis and lumbar lordosis without midline tenderness.
Hands: No synovitis of PIPs, MCPs. Good grip strength and the squeeze test is negative at both the MCP and PIP levels.
Wrists: No swelling.
Elbows: Normal range of motion. No synovitis.
Shoulders: Normal ROM without discomfort.
Hips: No pain on IR or ER. No lateral tenderness B.
Knees: Without discomfort on ROM. No synovitis or effusion.
Ankles: Without swelling. Feet: No swelling or metatarsalgia. No dactylitis, no enthesitis.
Skin: No rash or Raynauds. No nail pitting.
Tender Points: 0/18

Rheumatology: Assessment and Plan

General Content

1. Bilateral iritis.
She has been experiencing iritis in both eyes and has been using prednisone drops. Long-term use of steroid drops is not ideal, so an alternative medication is needed to reduce steroid dependency. Methotrexate is recommended as a weekly medication to control inflammation. Begin with 4 tablets (2.5 mg each) for the first 2 weeks, then increase to 6 tablets weekly. Folic acid supplementation is advised due to methotrexate's effect on folic acid levels. She is instructed to abstain from alcohol for the first 6 weeks of treatment to avoid liver irritation. Labs will be checked in 6 weeks to monitor liver function. Potential side effects, including fatigue and hair loss, have been discussed. If fatigue occurs, Mucinex may be considered. If hair loss is observed, she should report it for further evaluation.

2. Health maintenance. She is advised to get the influenza vaccine annually and to wear a mask around individuals who are actively ill.

Follow-up
The patient will follow up in 6 weeks with labs done beforehand.

Specialty-specific Content

1. Bilateral iritis.

She has been experiencing iritis in both eyes and has been using prednisone drops. Long-term use of steroid drops is not ideal, so an alternative medication is needed to reduce steroid dependency.

Methotrexate is recommended as a once-a-week medication to control inflammation. She will start with 4 tablets (2.5 mg each) for the first 2 weeks, then increase to 6 tablets weekly. Folic acid supplementation is advised due to methotrexate's effect on folic acid levels.

Instructed to abstain from alcohol for the first 6 weeks of treatment to avoid liver irritation. Labs will be checked in 6 weeks to monitor liver function.

Potential side effects, including fatigue and hair loss, have been discussed. If fatigue occurs, Mucinex may be considered. If hair loss is observed, she should report it for further evaluation.

2. Health maintenance.

Advised to get the influenza vaccine annually and to wear a mask around individuals who are actively ill.

Follow-up

The patient will follow up in 6 weeks with labs done beforehand.

Speech-Language Pathology

Targeted Improvements:

Speech-Language Pathologists often face challenges in documenting consultation and progress notes due to delays in entry, incomplete or vague descriptions, inconsistent adherence to documentation standards, overuse of generic templates, and poor integration with electronic health record systems. These issues compromise the accuracy, clarity, and compliance of clinical records, potentially affecting patient care continuity, legal defensibility, and reimbursement.

Speech-Language Pathology: HPI

General Content

The patient is a 4-year-old child who presents for feeding difficulties. He is accompanied by his mother. The patient's mother reports that he continues to exhibit resistance towards new foods, often physically rejecting them. He has not shown any interest in novel food items. His diet primarily consists of fried rice, which he consumes without any apparent discomfort. The mother has attempted to limit his access to the refrigerator, but he remains persistent in his attempts to open it. He does not consume pudding or yogurt, although he previously included yogurt in his diet. He has no known food allergies. He is currently undergoing speech therapy, which appears to be yielding positive results as evidenced by an increase in his verbal communication.

Specialty-specific Content

The patient is a 4-year-old child who presents for feeding difficulties. He is accompanied by his mother. The patient's mother reports that he continues to exhibit resistance towards new foods, often physically rejecting them. He has not shown any interest in novel food items. His diet primarily consists of fried rice, which he consumes without any apparent discomfort. The mother has attempted to limit his access to the refrigerator, but he remains persistent in his attempts to open it. He does not consume pudding or yogurt, although he previously included yogurt in his diet. He has no known food allergies. *The mother is currently awaiting an Applied Behavior Analysis (ABA)evaluation. He is scheduled to start kindergarten in the fall and will have an Individualized Education Program (IEP) in place. The mother is also exploring the possibility of acquiring an Augmentative and Alternative Communication (AAC) device for him.* He is currently undergoing speech therapy, which appears to be yielding positive results as evidenced by an increase in his verbal communication.

Speech-Language Pathology: Physical Examination

General Content

Neurological: Awake, alert, oriented x4, no focal deficit
Head: Normocephalic, atraumatic
Ears: External ear canals and tympanic membranes intact
Eyes: Pupils equal and round, conjunctivae clear
Nose: Septum midline, nares patent, mucosa normal
Mouth/Throat: Mucous membranes moist, no erythema, no exudate
Neck: Supple, no abnormalities
Respiratory: Clear to auscultation, no wheezing, rales or rhonchi
Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops
Gastrointestinal: Soft, no tenderness, no distention, no masses
Extremities: No edema, no cyanosis
Musculoskeletal: No joint or muscular abnormalities noted
Skin: No abnormalities, no rashes or lesions

Specialty-specific Content

General: Well-nourished, well-developed infant in no acute distress.
Neurological: Alert and interactive, making eye contact and responding to stimuli appropriately.
Head: Normocephalic, atraumatic.
Mouth/Throat: Drooling noted, shirt is wet.
Musculoskeletal: Demonstrates good muscle tone and coordination, good head control observed, able to sit up with support, reaching for objects and transferring them between hands.

Speech-Language Pathology: Assessment and Plan

General Content

1. Feeding difficulties. He continues to have challenges with feeding, particularly with nonpreferred foods. Despite efforts to present nonpreferred foods first, he still pushes them away. He is growing and making progress in other areas, such as communication. A variety of preferred and nonpreferred foods will be offered during the visit to encourage participation. The mother is advised to continue working on his comfort with different foods and to limit his access to the refrigerator and freezer to manage his eating habits.
2. Speech delay. He is currently in speech therapy and is making improvements. He has been speaking more and trying to think more. The mother is working on getting him an AAC device to aid in communication. He will start kindergarten in the fall and will have an Individualized Education Program (IEP) in place.
3. Awaiting ABA evaluation. The mother is waiting for an Applied Behavior Analysis (ABA) evaluation to further assess and support his needs.

Specialty-specific Content

1. Feeding difficulties.
- Continues to have challenges with feeding, particularly with nonpreferred foods.
- Despite efforts to present nonpreferred foods first, he still pushes them away.
- Growing and making progress in other areas, such as communication.
- A variety of preferred and nonpreferred foods will be offered during the visit to encourage participation. The mother is advised to continue working on his comfort with different foods and to limit his access to the refrigerator and freezer to manage his eating habits.

2. Speech delay.
- Currently in speech therapy and making improvements.
-Speaking more and trying to think more.
- The mother is working on getting him an AAC device to aid in communication.
- Will start kindergarten in the fall and will have an Individualized Education Program (IEP) in place.

3. Awaiting ABA evaluation.
- The mother is waiting for an Applied Behavior Analysis(ABA) evaluation to further assess and support his needs.

Sports Medicine

Targeted Improvements:

HPI:
- CMS Guidelines for documentation.
- HPI will be more organized with additional paragraphs to allow visibility of information.
- HPI will also include verbalized past procedures rather than in the procedure section.

Physical Exam:
- Exam will include an improved format and organization.

Assessment/Plan:
- Enhanced capture of visit findings, recommendations and education provided during the visit.

Sports Medicine: HPI

General Content

The patient presents for evaluation of ankle pain.

He reports a significant improvement in his ankle condition, although it has not fully recovered to the same extent as his left ankle. Mild discomfort is experienced on the medial aspect of the ankle, but the Achilles tendon is in good condition. Running activities are performed without issues. He continues to engage in physical therapy exercises. A snapping and crackling sensation in the ankle is noted, which is not associated with severe pain. This discomfort is particularly noticeable during sprinting activities.
He has been experiencing an increase in the frequency of migraines, with the most recent episode occurring 3 weeks ago. He is currently in the recovery phase from this episode. He was awakened at 1:30 AM due to severe headache and nausea, which led to vomiting. Headaches are predominantly localized to the right side of the head and are accompanied by a sensation of pressure. No visual disturbances are reported, but pixelation is experienced prior to the onset of a migraine. An optometrist consultation found no abnormalities. The last headache occurred approximately a month ago. He has not taken any ibuprofen or Tylenol since 1:30 AM. Symptoms have been managed with ibuprofen and Tylenol, which have been effective in alleviating the pain. An ice pack is applied to the head and sleep is attempted, which has been beneficial.

Specialty-specific Content

The patient presents for evaluation of ankle pain.

The patient reports a significant improvement in his ankle condition, although it has not fully recovered to the same extent as his left ankle. He experiences mild discomfort on the medial aspect of the ankle, but the Achilles tendon remains in good condition.

Running activities are performed without issues, and he continues to engage in physical therapy exercises. However, he notes a snapping and crackling sensation in the ankle, particularly during sprinting activities, which is not associated with severe pain.

He has been experiencing an increase in the frequency of migraines, with the most recent episode occurring three weeks ago. He is currently in the recovery phase from this episode. During the most recent migraine, he was awakened at 1:30 AM due to severe headache and nausea, which led to vomiting. The headaches are predominantly localized to the right side of the head and are accompanied by a sensation of pressure.

He does not report any visual disturbances, but pixelation is experienced prior to the onset of a migraine. A recent consultation with an optometrist found no abnormalities. The last migraine occurred approximately a month ago.

To manage symptoms during a migraine, he uses ibuprofen and Tylenol, which have been effective in alleviating the pain. He also applies an ice pack to the head and tries to sleep, which has been beneficial. No ibuprofen or Tylenol has been taken since the episode at 1:30 AM.

Sports Medicine: Physical Exam

General Content

Examination revealed normal strength and range of motion in both the left and right thighs. The left calf exhibited increased sensitivity, whereas the right calf had normal sensitivity. The hips were level and showed no pain upon palpation, while tenderness was observed in the gluteus medius and piriformis muscles of the lower back.

Specialty-specific Content

Thigh bilaterally: Normal strength and range of motion
Left calf: Increased sensitivity
Right calf: Normal sensitivity
Hips: Level, no pain on palpation
Lower Back: Tenderness in the gluteus medius and piriformis muscles

Sports Medicine: Assessment and Plan

General Content

1. Left knee pain.
Persistent pain has been reported, particularly exacerbated by activities such as bowling and yard work. The patient has been advised to take meloxicam daily until the completion of national events and then as needed. Additionally, there is a plan to drain the left knee and administer a steroid injection to alleviate pain. During the consultation, the importance of taking meloxicam with food to minimize gastrointestinal side effects was discussed thoroughly.

2. Left shoulder pain.
The patient mentioned that the left shoulder pain is generally manageable and less concerning compared to the knee pain. No specific treatment was discussed for the shoulder during this visit, and no immediate intervention is required at this time.

Specialty-specific Content

1. Left knee pain.
- Persistent pain reported, exacerbated by activities such as bowling and yard work.
- Advised to take meloxicam daily until the completion of national events, then as needed.
- Plan to drain the left knee and administer a steroid injection to alleviate pain.
- Discussed the importance of taking meloxicam with food to minimize gastrointestinal side effects.

2. Left shoulder pain.
- Reports that the left shoulder is generally manageable.
- No specific treatment discussed for the shoulder during this visit.
- Patient mentioned the shoulder pain is less concerning compared to the knee pain.
- No immediate intervention required for the shoulder at this time.

PROCEDURE
The left knee was drained, and a steroid injection was administered today.

Surgical Oncology

Targeted Improvements:

History of Present Illness

•Oncologic History – An opening statement that identifies the cancer diagnosis and any relevant data such as staging, markers, and a brief timeline of prior treatments.

•Interval History – The history of present illness as reported by the patient, containing subjective reporting on symptoms, side effects, hospitalizations, etc., since the last visit.

•Social History – The optimized social history documents a robust and organized set of data pertinent to decision making and determining procedure eligibility.

Physical Exam

•Optimization includes functional assessments such as the ECOG or Karnofsky performance status, in addition to the standard body systems.

Assessment and Plan:

•Discussion of risks, benefits, and alternatives of treatment options will be captured in detail and avoid the use of umbrella statements such as “Risks and benefits were discussed”.

•Goals of care, treatment preferences, and advanced care planning are incorporated in the assessment and plan, documenting how the patient’s preferences may influence decision making.

•The multidisciplinary aspect of surgical oncology has been addressed, and the optimization should incorporate and attribute decision making and how it affects the surgical oncology plan to the appropriate team.

Surgical Oncology: History of Present Illness

General Content

The patient presents for evaluation of breast cancer.

She reports a general sense of well-being, although she experiences mild soreness today. She has been able to perform some household chores, such as laundry, without exacerbating her discomfort. She expresses concern about a red area near her nipple. She has been adhering to her prescribed exercise regimen, performing the exercises 3 times daily. She also reports occasional sharp, stabbing pains in her breast. She has an appointment with Dr. ___, radiologist on ___ at 9:15 AM. She has been experiencing hot flashes, with a particularly severe episode occurring yesterday.

Specialty-specific Content

The patient is a ___-year-old female with a history of stage IA, grade 1, ER+/PR+/HER2- invasive ductal carcinoma of the right breast, initially diagnosed in ___ following a routine mammogram. A lumpectomy was performed, removing a 5 mm tumor with clear margins, and three lymph nodes were excised, all of which were benign.

She presents today for evaluation of her breast cancer. Post-surgery, she reports a general sense of well-being, although she experiences mild soreness today. She has been able to perform some household chores, such as laundry, without exacerbating her discomfort. She expresses concern about a red area near her nipple. She has been adhering to her prescribed exercise regimen, performing the exercises three times daily. She also reports occasional sharp, stabbing pains in her breast. She has an appointment with Dr. ___, radiologist, on ___ at 9:15 AM. She has been experiencing hot flashes, with a particularly severe episode occurring yesterday.

Surgical Oncology: Assessment and Plan

General Content

1. Post-surgical follow-up.
Her Oncotype score is low, indicating no need for chemotherapy. The recurrent score is 5, which is well below the threshold of 25, and the percentage benefit from chemotherapy is less than 1%. The chance of cancer recurrence is 1% if she takes the prescribed pills for 5 years. The surgical site is healing well. She was advised to use adhesive remover to clean the remaining glue on her skin before showering. She can transition to any comfortable sports bra that provides lift and compression. If significant asymmetry between the breasts is noted, a referral to ___ Clinic for a partial prosthetic breast will be considered after healing and radiation therapy. No additional surgery is recommended at this time. Radiation therapy and oral medication are recommended. The medical oncologist will provide further details. Her case will be presented at a conference for additional input, and the results will be communicated.

Specialty-specific Content

1. Post-surgical follow-up for breast cancer.
The Oncotype score is low, with a recurrent score of 5, indicating no need for chemotherapy. The benefit from chemotherapy is <1%, and the chance of cancer recurrence is 1% with 5 years of prescribed oral medication. The surgical site is healing well. Adhesive remover was provided to clean the remaining glue on the skin before showering. Transition to any comfortable sports bra that provides lift and compression is advised. If significant asymmetry between the breasts is noted, a referral to ___ Clinic for a partial prosthetic breast will be considered after healing and radiation therapy. No additional surgery is recommended at this time. Radiation therapy and oral medication are recommended. The medical oncologist will provide further details. The case will be presented at a conference for additional input, and the results will be communicated.

Risks, benefits, and alternatives of treatment were discussed. Additional surgery would involve removing all lymph nodes under the armpits, with a 20% risk of irreversible lymphedema. Given the favorable pathology results and the absence of cancer in the other nodes, additional surgery is not recommended. Radiation and oral medication are preferred, with the option to address any recurrence if it occurs.

Urgent Care

Targeted Improvements:

- Adjust the opening statement to include various pertinent medical histories that are discussed during the visit, e.g. "This is a ___-year-old ___ with a history of ___, ___, and ___, presenting today with ___"
- Adjust the history and note if the patient was not the primary historian, in cases where the patient is altered, unconscious, or otherwise unable to verbalize, and also note who provided the history (family, EMS, bystander, etc.).
- Focus on the chronological capture of the history in the order it occurred, instead of the information as it was reported by the patient.
- Note any factors that limit the patient's access to medical care or to follow through with care plans.
- Document GPA status for patients with OB or gyn related complaints.
- Avoids the use of pejorative or judgmental language like "admits to".
- The physical exam now notes if a chaperone was present during sensitive portions of the exam.
- The A&P is a modified version of the current ED optimization, containing an initial assessment, differential diagnosis, ED course, final assessment, clinical impression, disposition, and patient education, and critical care.
- The DDx is modified to avoid stating that a condition was completely ruled out, instead, the model should state that various observations and test results should result in a condition not being considered.
- The disposition has been updated to capture specific return precaution details, and additional detail about what care team the patient will be admitted to, or if the patient has been signed out to an oncoming clinician.

Urgent Care: HPI

General Content

The patient is a ___-year-old male who presents for back pain.

He has a history of right-sided back issues, which have been managed through the VA. However, he now reports left-sided back pain, which he describes as different from his previous condition. He occasionally seeks chiropractic adjustments for relief, which typically last for 2 to 3 weeks. The current episode of pain began 2 days ago following an incident at work where he experienced a sharp pain while lifting floor panels. This pain was severe enough to prevent him from getting out of bed the following day. He also reports occasional leg symptoms, such as difficulty tying his shoes or rising from a chair, depending on his movements. He has not had an MRI of his lower back in several years. He reports no gastrointestinal symptoms such as nausea, vomiting, or diarrhea. Despite maintaining an active lifestyle, he continues to experience back pain. He attempted to manage the pain with half a dose of muscle relaxer, which provided temporary relief, but the pain returned upon waking up.

Specialty-specific Content

This is a ___-year-old male presenting with left-sided back pain.

The patient reports that the current episode of pain began 2 weeks ago after lifting rocks on his property, which caused soreness. This past weekend, he performed additional physical labor involving wheelbarrow loads. On 05/12/2021, while at work, he experienced a sharp pain in his lower back while attempting to lift floor panels. The pain was severe enough to prevent him from getting out of bed the following day. He describes the pain as sharp and severe, making it difficult to get out of bed and perform daily activities. The pain is constant and worsens with movement. He has tried chiropractic adjustments in the past, which provide relief for 2 to 3 weeks, but this episode feels different and more severe. He took half a muscle relaxer prescribed for his previous right-sided pain, which provided temporary relief, but the pain returned upon waking up. He reports occasional leg symptoms, such as difficulty tying his shoes or rising from a chair, depending on his movements. He has not had an MRI of his lower back in several years. He reports a history of right-sided back issues that has been managed through the VA. He denies any gastrointestinal symptoms such as nausea, vomiting, or diarrhea. Despite maintaining an active lifestyle, he continues to experience significant back pain.

Urgent Care: Assessment and Plan

General Content

1. Left foot injury.
The patient sustained the injury 3 days ago after kicking an elbow during Taekwondo practice. He reports immediate sharp pain followed by radiating pain up the leg and back of the calf. Physical examination reveals visible swelling on the dorsal surface of the left foot with tenderness over the cuboid bone and Lisfranc joint space. The x-ray did not show any obvious fractures. Differential diagnoses include Lisfranc injury, cuboid injury, or a vascular injury causing significant swelling. A walking boot will be provided for support. A referral to sports medicine has been made for further evaluation. If symptoms persist or worsen, a CT scan may be considered to rule out a midfoot fracture.

Specialty-specific Content

___-year-old male with left foot injury 3 days ago after kicking an elbow during Taekwondo practice. Immediate sharp pain followed by radiating pain up the leg and back of the calf. Visible swelling on the dorsal surface of the left foot with tenderness over the cuboid bone and Lisfranc joint space. X-ray did not show any obvious fractures.

Differential Diagnosis:
- Lisfranc injury: Tenderness over Lisfranc joint space. Weightbearing images to isolate Lisfranc joint. Referral to sports medicine.
- Cuboid injury: Tenderness over cuboid bone.
- Vascular injury: Significant swelling. Possible rupture of a vessel.

Urgent Care Course:
- X-ray obtained. No obvious fractures.

Final Assessment:
Left foot injury with visible swelling and tenderness over cuboid bone and Lisfranc joint space. X-ray did not show any obvious fractures. Walking boot provided for support. Referral to sports medicine for further evaluation.

Clinical Impression:
- Left foot injury
- Lisfranc injury
- Cuboid injury
- Vascular injury

Disposition:
- Discharge: Home. Referral to sports medicine. Return if symptoms persist or worsen.

Patient Education:
- Discussed potential diagnoses and management options. Advised on use of walking boot and follow-up with sports medicine.

Urology

Targeted Improvements:

Overall Note:
Style enhancements specific to urology documentation

HPI:
Inclusion of more robust discussion of urologic symptoms, prostate and urologic cancer, urology risk assessments, and PSA surveillance.

PHYSICAL EXAM:
More accurately captures relevant content with greater clinical specificity in a logical and concise format.

ASSESSMENT & PLAN:
- More accurately captures urologic relevant content with greater clinical specificity.
- Capture of discussion of risks, benefits, and alternatives of treatment
- Capture of differential diagnoses if discussed.

Urology: HPI

General Content

The patient presents for evaluation of urinary incontinence, solitary kidney, and sleep apnea.

She was born with a solitary kidney and a small perforation in her anus, necessitating the use of a colostomy bag until the age of 4. She also had an imperforate hymen, which required surgical intervention. Despite these challenges, she has been managing well. She continues to wear pull-ups due to persistent urinary leakage, which does not cause her discomfort. A recent concern is the onset of sleep apnea symptoms approximately one month ago, characterized by a sore throat. The mother reported a metallic odor in her urine a few days prior to the visit. She expresses a desire to transition to regular underwear and is considering surgical options to improve her comfort.

She was hospitalized in 2022 due to a kidney infection but has not experienced any recurrent urinary tract infections since then. She has a scheduled appointment with nephrology on 04/04/2025. She has not yet exhibited signs of puberty. She has developed pubic hair and breast buds over the past 4 to 5 months. She still has her appendix.

She has a tethered cord and is under the care of neurosurgery. She reports no new back pain. She has no issues with ambulation.

Specialty-specific Content

The patient presents for evaluation of urinary incontinence, solitary kidney, and sleep apnea. She is accompanied by her mother.

She was born with a solitary kidney, a small perforation in her anus, and an imperforate hymen, all of which required surgical intervention. Colostomy bag was used until the age of 4. Despite these challenges, she has been managing well. She continues to wear pull-ups due to persistent urinary leakage, which does not cause her discomfort. There is a desire to transition to regular underwear and consideration of surgical options to improve comfort. She maintains good personal hygiene.

She was hospitalized in 2022 due to a kidney infection but has not experienced any recurrent urinary tract infections since then. Her mother reports a metallic odor in her urine for a few days. She has a scheduled appointment with nephrology on 04/04/2025.

She has not yet exhibited signs of puberty, although she has developed pubic hair and breast buds over the past 4 to 5 months.

She occasionally experiences constipation, which is managed with MiraLAX.

She has a tethered cord and is under the care of neurosurgery. There are no new reports of back pain, and she has no issues with ambulation.

A recent concern is the onset of sleep apnea symptoms approximately one month ago, characterized by a sore throat.

Urology: Exam

General Content

No output

Specialty-specific Content

Genitourinary: Bladder appears normal except for a small raised area on the left lateral wall, likely a small bladder tumor.

Urology: Assessment & Plan

General Content

1. Prostate cancer.
His PSA levels have significantly decreased. However, his testosterone levels remain suboptimal, which may be contributing to his persistent fatigue and decreased libido. The goal is to maintain low PSA levels as testosterone levels normalize.

2. Erectile dysfunction.
He is currently taking Viagra 100 mg but reports it is not effective enough.

Follow-up
The patient will follow up in 4 months.

Specialty-specific Content

1. Prostate cancer.

PSA levels have significantly decreased to 0.04, indicating a positive response to treatment. Testosterone levels remain suboptimal, contributing to persistent fatigue and decreased libido. The goal is to maintain low PSA levels as testosterone levels normalize. Follow-up appointments with Dr. Patel will continue, and a subsequent appointment will be scheduled post-consultation with Dr. Patel. The patient is advised to provide a copy of his lab results for further review.

2. Erectile dysfunction.

Currently taking Viagra 100 mg but reports it is not effective. Alternative treatment options such as tadalafil, vacuum devices, and injection medications were discussed. The patient will consider these options and communicate his decision prior to the next visit.

Follow-up

Follow-up in 4 months.

Thank you