Medical Report
Patient Information:
- Name: John Doe
- Age: 35
- Gender: Male
- Patient ID: 123456
- Date of Examination: October 5, 2023
Chief Complaint:
- The patient presents with a fever persisting for 3 days, characterized by chills and night sweats.
History of Present Illness:
- The patient experienced the onset of fever 3 days ago, with temperatures reaching up to 102degF (38.9degC). Associated symptoms include fatigue, body aches, and sore throat. No significant cough or shortness of breath reported.
Past Medical History:
- No significant past medical history. No known drug allergies.
Medications:
- Ibuprofen as needed for fever.
Vital Signs:
- Temperature: 102degF (38.9degC)
- Pulse: 88 bpm
- Blood Pressure: 120/80 mmHg
- Respiratory Rate: 16 breaths/min
Physical Examination:
- General: Patient appears fatigued but in no acute distress.
- HEENT: Erythematous throat, no exudate.
- Lungs: Clear to auscultation bilaterally.
- Heart: Regular rate and rhythm, no murmurs.
- Abdomen: Soft, non-tender, no hepatosplenomegaly.
- Skin: Warm to touch, with no rash.
Laboratory Tests:
- Complete Blood Count (CBC): Elevated white blood cell count.
- Basic Metabolic Panel: Within normal limits.
- Rapid Strep Test: Negative.
- Infectious Disease Panel: Pending.
Assessment:
- Pyrexia of unknown origin, likely viral etiology, given the negative rapid strep test and the presence of upper respiratory symptoms.
Plan:
- Symptomatic treatment with antipyretics for fever management.
- Advise hydration and rest.
- Follow up in 48 hours or sooner if symptoms worsen.
- Educate patient on signs of complications that require immediate medical attention.
Physician's Name: Dr. Jane Smith
Signature: _____
Date: October 5, 2023