

NR603

Week 6 post

Step 1: Select a chief complaint that meets the following criteria:

- Related to the body system from your lowest scoring CEA content area- which was integumentary
- Commonly seen in clients in primary care settings.
- Not covered in this term's iHuman virtual patient encounter.

Step 2: Create an original case study using the criteria outlined below, focus on a Chief Complaint, NOT an individual diagnosis.

Include the following sections:

Application of Course Knowledge: Answer all questions/criteria with explanations and detail.

Include the following elements in your initial case study post:

- a. **Client Information and Social History:** Include the client's name or initials, date of birth, chief complaint, demographics, any client allergies, and at least three social history elements (e.g., substance use, marital status, living conditions, social support, etc.).
- b. **Assessment Data:** Include the chief complaint, history of present illness, and associated physical exam findings.
- c. **Past Medical and Surgical History:** Include at least three significant pieces of the client's past medical and/or surgical history.
- d. **Risk Factor Analysis:** Analyze associated risk factors and demographics contributing to the chief complaint.

Patient information

Initials: C.C.

DOB: 6/17/95

CC: headache

Demographics: 30 y/o male, African American, army veteran, police officer, married

Allergies: NKA

Social history: Patient is in a monogamous relationship, has been married for six years. Patient is a home owner. Patient is an army veteran, served two tours in Afghanistan. Patient currently employed as a police officer. Patient is an amputee, had a left BKA following an MVA two years ago. Patient denies alcohol, drug or tobacco use. Has a strong social support network and large family. Patient exercises regularly 4-5 times a week and maintains a healthy diet.

Assessment Data

CC: headache

HPI: C.C. is a 30-year-old male presenting to the office today with complaints of recurring headaches for the past two months. Patient reports two-month history of episodic throbbing headaches, localized to temporal or frontal region. Headaches have been increasing in frequency, occurring up to three times a week. Patient describes pain as pulsating, moderate to severe (7-8/10), and lasting for 12-24 hours. Patient states that pain is worse with activity and that associated symptoms include nausea, photophobia, phonophobia, and blurry vision. Patient denies fever, neck stiffness, flashes of light, visual disturbances, slurred speech or focal weakness. Pertinent history includes left below the knee amputation after a motor vehicle accident, diagnosis of anxiety and PTSD related to time served in the army. Patient believes headaches are triggered by vigorous physical activity, stating that he can no longer participate in his normal exercise regimen. Additional triggers include stress and lack of sleep, especially if the patient works an overnight shift. Relief is partially achieved by resting in a dark room and taking ibuprofen helps "take the edge off." Denies recent head trauma, history of hypertension,