S Subjective

1 PATIENT IDENTIFICATION

Name:	Michael R. Thompson	**DOB / Age:**	08/14/1982 / 43 years
Sex:	Male	**MRN:**	45823917
Date of Visit:	03/28/2026	**Referring Provider:**	Dr. Karen Mitchell, PCP
Neurologist:	Dr. Andrew L. Carter, MD	**Accompanied by:**	Wife (collateral history)

2 CHIEF COMPLAINT

Primary concern: Recurrent episodes of severe unilateral headache with visual disturbances and nausea

Duration of symptoms: Approximately 6 months, worsening over the past 8 weeks

3 HISTORY OF PRESENT ILLNESS

ONSET & COURSE

Onset:	Gradual	**Progression:**	Worsening
Duration / Frequency:	6–12 hrs/episode; 3–4x/week	**Severity (0–10):**	8–9/10 at peak

EVENT DESCRIPTION

No preceding trauma or infection. Symptoms triggered by prolonged screen exposure and sleep deprivation. Increased work-related stress. Occasional episodes following moderate alcohol intake.

SYMPTOM CHARACTERIZATION

Location / distribution: Right temporal and retro-orbital region

Pattern: Episodic

Throbbing, pulsatile quality. Visual aura ("zig-zag flashing lights") lasting ~20 min before headache. Photophobia and phonophobia present. Occasional mild dizziness, no true vertigo. No focal weakness or persistent sensory deficits.

ASSOCIATED SYMPTOMS

Nausea during most episodes, occasional vomiting. Visual aura consistently precedes headache. No loss of consciousness. Mild cognitive slowing during severe attacks. Increased fatigue post-episode.

AGGRAVATING & ALLEVIATING FACTORS

Aggravating: Bright lights, loud environments, physical exertion

Alleviating: Rest in dark quiet room; ibuprofen (partial relief)

FUNCTIONAL IMPACT

Missed ~5 workdays in past month. Reduced productivity. Avoids driving during episodes due to visual disturbances. Difficulty maintaining concentration during attacks.

PRIOR EVALUATION & TESTING

No prior neurology consultation. One ED visit 2 months ago for severe headache — CT head reportedly normal. No prior MRI, EEG, or EMG.

PRIOR TREATMENTS & RESPONSE

Ibuprofen 400–600mg PRN with partial relief. Acetaminophen trial ineffective. No preventive migraine therapy initiated. No prior physical or behavioral therapy.

4 PAST MEDICAL HISTORY

Migraine (undiagnosed prior to this evaluation). Hypertension (diagnosed 3 years ago, moderately controlled). Hyperlipidemia. No history of stroke, seizures, or demyelinating disease. No history of TBI.

5 PAST SURGICAL HISTORY

Appendectomy at age 25. No neurosurgical procedures.

6 MEDICATIONS

Lisinopril 10mg daily · Atorvastatin 20mg nightly · Ibuprofen 400–600mg PRN headaches (3–4x/week) · Multivitamin daily

7 ALLERGIES

Drug allergies: Penicillin – rash (non-anaphylactic)

Contrast dye allergy: None

Latex allergy: None

8 SOCIAL HISTORY

Occupation:	Software engineer	**Living situation:**	With spouse and two children
Smoking:	Denies	**Alcohol use:**	1–2 drinks/week (social)
Recreational drugs:	Denies	**Sleep (hrs/quality):**	5–6 hrs/night, poor quality
Driving status:	Active; avoids during headaches	**Exercise habits:**	Minimal, occasional weekend walking

Psychosocial stressors: High occupational stress, recent project deadlines

9 FAMILY HISTORY

Mother: Migraine history. Father: Hypertension and ischemic stroke at age 62. No family history of seizures or neurodegenerative disease.

10 REVIEW OF SYSTEMS

NEUROLOGICAL

Recurrent unilateral headaches with aura, photophobia, nausea. No persistent weakness, numbness, or seizures.

COGNITIVE / PSYCHIATRIC

Mild anxiety related to symptom frequency. No depression or hallucinations.

SYSTEMS

General: fatigue, no fever or weight loss. Cardiovascular: no chest pain or palpitations. Endocrine: no thyroid or glucose symptoms. GI/GU: nausea during headaches; no bowel/bladder dysfunction.

11 FUNCTIONAL STATUS & SAFETY

ADL independence: Independent in all ADLs

Fall history / risk: No falls reported

Mobility / assistive device: None required

Driving safety: Limited during symptomatic periods

Seizure precautions: None required at this time

O Objective

12 VITAL SIGNS

BP:	138/86 mmHg	**HR:**	78 bpm	**RR:**	16 breaths/min
Temp:	98.4°F (36.9°C)	**O_2 Sat:**	98% on room air		

13 GENERAL PHYSICAL EXAMINATION

General appearance: Well-appearing male in no acute distress between episodes

Level of distress: None (between episodes)

Mental alertness: Alert and cooperative

Gait observation: Normal

14 NEUROLOGICAL EXAMINATION

MENTAL STATUS

DOMAIN	FINDINGS
Orientation (person / place / time)	Fully oriented

Attention & concentration	Intact (serial 7s performed accurately)
Short-term memory	Intact
Long-term memory	Intact
Language (comprehension / expression)	Fluent, normal comprehension
Mood & affect	Mildly anxious, affect appropriate
MMSE score (if performed)	Not performed
MoCA score (if performed)	28/30 (minor points lost on delayed recall)

CRANIAL NERVES (I–XII)

CN II: Visual fields full. CN III/IV/VI: EOMs intact. Pupils equal, round, reactive to light. CN V: Facial sensation intact. CN VII: Symmetric facial movements. CN VIII: Hearing intact bilaterally. CN IX/X: Palate elevates symmetrically. CN XI: Shoulder shrug 5/5. CN XII: Tongue midline.

MOTOR EXAMINATION (0–5 SCALE)

MUSCLE GROUP	RIGHT	LEFT
Shoulder	5/5	5/5
Elbow	5/5	5/5
Wrist	5/5	5/5
Hand	5/5	5/5
Hip	5/5	5/5
Knee	5/5	5/5
Ankle	5/5	5/5
Foot	5/5	5/5

Tone / other findings: Normal tone. No atrophy, fasciculations, or pronator drift.

SENSORY EXAMINATION

MODALITY	RIGHT	LEFT
Light touch	Intact	Intact
Pain	Intact	Intact
Temperature	Intact	Intact
Vibration	Intact	Intact
Proprioception	Intact	Intact

Dermatomal distribution: No dermatomal deficits

REFLEXES

REFLEX	RIGHT	LEFT
Biceps	2+	2+
Triceps	2+	2+
Brachioradialis	2+	2+
Patellar	2+	2+
Achilles	2+	2+
Babinski	Absent	Absent
Hoffmann	Absent	Absent
Clonus	Absent	Absent

COORDINATION & GAIT

TEST	FINDINGS
Finger-to-nose	Intact, no dysmetria
Heel-to-shin	Intact
Rapid alternating movements	Normal
Normal gait	Normal
Tandem walking	Intact
Heel / toe walking	Normal
Romberg test	Negative

15 NEUROLOGICAL SEVERITY SCALES

GCS:	15/15	**NIH Stroke Scale:**	Not indicated
Modified Rankin Scale:	Not indicated	**MMSE / MoCA:**	MoCA 28/30

16 DIAGNOSTIC STUDIES

NEUROIMAGING

CT brain (2 months prior, ED visit): No acute pathology identified.

ELECTROPHYSIOLOGIC STUDIES

None performed.

LABORATORY STUDIES

Basic metabolic panel: Within normal limits. Lipid panel: Elevated LDL (consistent with known hyperlipidemia).

OTHER TESTING

None performed.

A Assessment

17 CLINICAL SUMMARY

43-year-old male with a 6-month history of progressively worsening episodic unilateral throbbing headaches associated with visual aura, photophobia, and nausea. Neurological examination is normal. Clinical presentation is consistent with migraine with aura, exacerbated by stress, sleep deprivation, and screen exposure.

18 PROBLEM LIST

1. Migraine with aura (increasing frequency) 2. Hypertension 3. Hyperlipidemia 4. Sleep disturbance 5. Occupational stress

19 PRIMARY NEUROLOGICAL DIAGNOSIS

Diagnosis: Migraine with aura (episodic, progressing toward chronic pattern)

20 SECONDARY DIAGNOSES

Hypertension · Hyperlipidemia · Sleep deprivation contributing to headache frequency

21 DIFFERENTIAL DIAGNOSIS

1. Tension-type headache 2. Cluster headache (less likely due to duration and aura) 3. Secondary headache — intracranial lesion (unlikely given normal CT but MRI warranted) 4. Medication overuse headache

P Plan

22 MEDICAL MANAGEMENT

Initiate Sumatriptan 50mg PRN at onset of migraine. Start preventive therapy: Propranolol 40mg BID. Limit NSAID use to avoid medication overuse headache. Consider magnesium supplementation.

23 DIAGNOSTIC PLAN

MRI brain with and without contrast to rule out structural causes. Headache diary tracking frequency, triggers, and severity.

24 REHABILITATION & THERAPY

Referral to behavioral therapy for stress management. Sleep hygiene counseling.

25 PROCEDURAL / SURGICAL CONSIDERATIONS

No surgical indication at this time.

26 CARE COORDINATION

Communicate plan with primary care provider (Dr. Karen Mitchell). Consider psychiatry referral if anxiety worsens.

27 PATIENT EDUCATION

Discussed migraine pathophysiology and triggers. Advised on sleep optimization and screen breaks. Educated on proper use of abortive medications. Reviewed red flags: sudden severe headache, neurological deficits, vision loss.

28 FOLLOW-UP

Return in: 6 weeks (neurology clinic)

Instructions: Earlier if headaches worsen, change in pattern, or new neurological symptoms

Notes: Headache diary to be brought to next visit

PROVIDER SIGNATURE

Provider name: Dr. Andrew L. Carter, MD

Date & Time: 03/28/2026

Credentials / NPI: MD, Neurology

Signature: