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CL-10313173

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INFORMATION Redacted PURSUANT TO THE FREEDOM OF INFORMATION ACT (FOIA), 5 U.S.C. 552(B)(6)

April 4, 2008

RE: [redacted]
MRN: 1654
DOB: 11/22/1961

Mr. [redacted] stated that on April 2, 2008 his motor vehicle when he pressed on the accelerator accelerated way too fast and causing him to bolt forward striking a concrete barrier. He subsequently struck the steering wheel with his head and chest. He stated at the time he felt dazed but he did not lose consciousness. He has had no subsequent vomiting, unusual discharge from his ear or nose other than a nosebleed at the time. He has not lost his balance nor has he vomited. He had anterior chest pain at the time of the accident and that pain has persisted until this point. He states that he most likely struck his knees against the dashboard because he had subsequent inferior patella pain in both legs.

The patients past history indicates that he has had no peptic ulcer disease but does suffer from diabetes.

Physical examination reveals a well-nourished black male in mild distress. Examination of the head revealed mild frontal tenderness but no soft tissue swelling or ecchymosis noted. Neurological examination revealed cranial nerves II through XII grossly intact. There was no loss of coordination and there was normal proprioception. His hearing was unremarkable. There was no unusual discharge from his eyes or nose. Deep tendon reflexes were 2+ and symmetrical throughout. There was no motor weakness or sensory examination changes noted. Cervical spine revealed minimal tenderness in the anterior cleidomastoid muscles and minimal tenderness of the trapezia muscles. There was full range of motion of the cervical spine. There was full range of motion of the thoracic spine and minimal tenderness noted. There was minimal trapezium tenderness noted. Lumbosacral spine revealed full range of motion and negative straight leg raising. Examination of both knees revealed mild inferopatella tenderness, no soft tissue swelling or ecchymosis noted. His chest revealed normal percussion to auscultation yet there was mild sternal tenderness with compression. Heart sounds were unremarkable.

EKG revealed no changes with a normal sinus rhythm.

ASSESSMENT: Head contusion, chest wall contusion, cervical sprain and bilateral knee contusions.

PLAN: The patient was given a prescription for Ultram because he stated that Tylenol with codeine would not work. He requested Vicodin but I did not offer to prescribe any for him. Flexeril 10 mg to be used at bedtime was also suggested. He was advised to use extra strength Tylenol two at a time breakfast, lunch and dinner. He will return in one week in follow up. This case will be reviewed with Dr. Edward Prior who recommended we see this patient.

Charles R. Park, P.A.- C.

CRP/tlb

D: 04/04/2008
T: 04/08/2008

2010 APR -6 AM 11:22

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