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Patient Discharge Summary

Not-A Real Hospital, Department of Family Medicine

Patient

Patient Name:	John Doe
Patient ID:	NARH-36640
Gender:	Male

Visit

Attending Physician:	Mateo Jackson, PhD
Admit Date:	07-Sep-2020
Discharge Date:	08-Sep-2020
Discharge Disposition:	Home with Support Services

Diagnosis

Pre-existing / Developed Conditions Impacting Hospital Stay:	35 yo M c/o stomach problems since 2 montsh ago. Patient reports epigastric abdominal pain non-radiating. Pain is described as gnawing and burning, intermitent lasting 1-2 hours, and gotten progressively worse. Antacids used to alleviate pain but not anymore; nothing exhacerbates pain. Pain unrelated to daytime or to meals. Patient denies constipation or diarrhea. Patient denies blood in stool but have noticed them darker. Patient also reports nausea. Denies recent illness or fever. He also reports fatigue since 2 weeks ago and bloating after eating. ROS: Negative except for above findings Meds: Motrin once/week. Tums previously. PMHx: Back pain and muscle spasms. No Hx of surgery. NKDA. FHx: Uncle has a bleeding ulcer. Social Hx: Smokes since 15 yo, 1/2-1 PPD. No recent EtOH use. Denies illicit drug use. Works on high elevation construction. Fast food diet. Exercises 3-4 times/week but stopped 2 weeks ago.

Discharge:

Summary:	some activity restrictions suggested, full course of antibiotics, check back with physican in case of relapse, strict diet

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