EPIC Encounter Summary

Patient Name: John Doe

MRN: 12345678

Date of Service: 2025-11-17

Provider: Dr. Alicia Mendel, MD – Orthopedics

Department: Ambulatory Care – Spine Clinic

Chief Complaint:

Patient presents with persistent lower back pain radiating into the left posterior thigh. Symptoms ongoing for 3.5 months. Denies recent trauma. Pain intensity reported as 7/10 at worst, 4/10 baseline.

History of Present Illness:

John Doe is a 43-year-old male with no significant past surgical history who presents for evaluation of subacute to chronic lower lumbar pain.

Pain began insidiously after lifting boxes during a household move. Since onset, pain has fluctuated but gradually worsened, particularly with prolonged sitting (>45 minutes), standing (>20 minutes), and lumbar flexion. Patient reports intermittent tingling in the left foot (digits 3–5). No bowel/bladder incontinence. Occasional nocturnal discomfort requiring positional changes.

Patient reports trial of NSAIDs (ibuprofen 400 mg PRN), heat therapy, and two chiropractic sessions with minimal relief. Denies fevers, weight loss, gait instability, or saddle anesthesia.

Review of Systems:

— Constitutional: Denies fevers, chills, unintentional weight loss.

— Musculoskeletal: Reports back pain, stiffness in the morning for ~20 minutes.

— Neurological: Reports intermittent tingling in left foot; denies weakness, dizziness, headaches.

— GI/GU: Denies bowel/bladder dysfunction.

Past Medical History:

— Hypertension (diagnosed 2021)

— Mild seasonal allergies

Medications:

— Lisinopril 10 mg daily

— Ibuprofen 400 mg PRN (self-administered)

Allergies:

— No known drug allergies

Family History:

— Father: HTN, Type 2 DM

— Mother: Osteoarthritis

— No family history of spinal disorders

Social History:

— Occupation: Accountant (sedentary, sits ~8–10 hours/day)

— Tobacco: Never smoker

— Alcohol: ~2 drinks/week

— Physical activity: Minimal; occasional weekend tennis

Physical Exam:

Vitals (11/17/2025 09:32):

— BP: 132/84

— HR: 74

— Temp: 98.1°F

— RR: 16

— SpO2: 98% on room air

General: Alert and oriented, mild discomfort noted when transitioning from sitting.

Back: No deformities, normal lumbar lordosis. Palpation reveals tenderness at L4–L5 midline and left paraspinals. Mild spasm of left quadratus lumborum.

ROM: Flexion limited to 40° due to pain; extension to 15°.

Neurologic: Motor strength 5/5 BLE except left plantarflexion 4+/5. Sensation intact except decreased sensation over left lateral foot. Reflexes: Patellar 2+ bilaterally, Achilles 1+ left, 2+ right.

Special Tests: Straight-leg raise positive on left at 42°. FABER negative. Gait normal.

Imaging:

MRI Lumbar Spine (11/11/2025):

— Mild disc bulge at L4–L5

— Left paracentral disc protrusion at L5–S1 contacting left S1 nerve root

— No canal stenosis; mild foraminal narrowing on left at L5–S1

Assessment:

1. Lumbar radiculopathy – left S1 distribution secondary to disc protrusion

2. Subacute low back pain exacerbated by mechanical strain

3. Myofascial component contributing to paraspinal spasm

Plan:

— Begin physical therapy 2×/week for 6 weeks focusing on core stabilization, lumbar traction, and nerve glides.

— Prescribed naproxen 500 mg BID with food, 14-day course.

— Consider gabapentin if neuropathic symptoms worsen.

— Discussed red flag symptoms requiring immediate ED visit.

— Follow-up in 4 weeks; earlier if worsening.

Provider Notes:

Patient verbalized understanding of plan and medication risks. All questions addressed. Encouraged lifestyle adjustments including workstation ergonomics, scheduled breaks, and low-impact cardio.

Electronic Signature:

Alicia Mendel, MD

Electronically signed: 2025-11-17 10:04 AM