Diagnosis Form

Patient information	
Name: Kate Evatt	**Date of birth:** March 29, 1974
Gender: Female	**Patient ID:** 5826800
Contact information: 0273486373, kate.evatt@gmail.com	
Emergency contact details: Tim Evatt, 0226249000	
Date of visit: January 22, 2025	
I. Clinical history	
Presenting/chief complaint:	**History of present illness:**
Patient reports persistent fatigue, frequent headaches, and dizziness for the past three weeks.	Symptoms began three weeks ago with mild headaches and fatigue, which have progressively worsened. The patient has also been experiencing occasional dizziness, particularly when standing up quickly. No significant relief from over-the-counter pain medications. Patient has noted difficulty concentrating at work and a general feeling of exhaustion.
Past medical history:	**Family history:**
No known chronic conditions. History of mild asthma during childhood, no recent flare-ups. Previous surgeries include an appendectomy at age 20. No history of significant hospitalizations.	Father has hypertension and hyperlipidemia. Mother has a history of rheumatoid arthritis. No known family history of cardiovascular diseases or diabetes.
Social history:	**Medications and allergies:**
Non-smoker, occasional alcohol use (1-2 drinks per week). Works as a graphic designer, sitting at a desk for long hours. Occasionally exercises (walking and yoga), but not regularly. Lives with a partner in a city apartment. Diet is fairly balanced, but patient reports consuming high amounts of caffeine during workdays.	Currently taking ibuprofen as needed for headaches. No known drug allergies. Allergic to cats (experienced mild sneezing and eye irritation around cats).

II. Physical examination

General appearance:

Patient appears alert and oriented but shows signs of fatigue. No acute distress observed. Slight pallor noted, especially around the eyes. Patient appears slightly underweight but is otherwise well-groomed.

Vital signs:

Temperature: 98.2°F (36.8°C), within normal range.	Blood pressure: 120/80 mmHg, normal.
Heart rate: 82 bpm, regular.	Respiratory rate: 16 breaths per minute, normal.

Physical findings:

Cardiovascular examination normal with no murmurs or irregularities. Respiratory examination clear, no wheezing or crackles. Abdomen soft and non-tender. No peripheral edema. Neurological examination unremarkable, reflexes within normal limits. No signs of visual disturbances or nystagmus. Patient reports mild tenderness to palpation around the temples.

III. Diagnostic testing

Test(s) ordered	Preliminary results
Complete blood count to check for anemia or infection.	Normal; no signs of anemia or infection.
Thyroid function tests to assess for hypothyroidism.	TSH within normal range, T3 and T4 normal.
Electrolyte panel to rule out imbalances.	Normal
Vitamin D and B12 levels to investigate deficiencies.	Vitamin D low (serum level of 15 ng/mL).

IV. Diagnosis

Primary diagnosis:	Secondary diagnosis (if applicable):
Fatigue and headaches secondary to Vitamin D deficiency.	Occasional dizziness, likely related to fatigue and vitamin deficiency.

V. Referrals and consultations

N/a

Clinician information

Name: Patty Smith	License ID/number: 345123
Date: January 22, 2025	Signature: P.R.Smith