Chief complaint: “He has cough and fever x 1 week”
HPI
A 9-year-old male with no significant PMHx presents with his mother, complaining of a dry cough and fever for the past week. According to the mother, the fever has been low-grade, ranging from 99°F to 100°F, and has improved with ibuprofen. The child also reports a sensation of something stuck in his throat. Additional symptoms include a runny nose, nasal congestion, mild shortness of breath, and disturbed sleep. His oral intake is slightly decreased, but he remains well-hydrated with normal urine output. The mother denies chills, chest pain, nausea, vomiting, diarrhea, headache, recent travel, or known sick contacts at home. The child is reportedly missing three vaccines, though the mother is unsure which ones.

Past Medical History:
No significant PMHx

Past Surgical History:
No significant past surgical history

Immunization History:
Immunizations records
Influenza, Hep B (2/3), HIB (4), Pneumococcal (4),Polio (2/4), MMR (1/2), Varicella (2), Hep A (2), MenACWY (1), HPV (2) DTP (3)

Medications:
None

Allergies:
No known drug allergies
No known food allergies
No known environmental allergies

Family History:
-Mother is alive, Age 31,No sig PMHx
-Father is alive, Age 35,No sig PMHx

Social History:
Living situation – Currently lives with parents
Travel – No recent travel
Diet – Home cooked meals, school lunch or occasional fast foods.
Exercise – Admits exercises
Sleep – admits disturbed sleep in past week
Occupation – middle school,
Pharmacy – CVS.

Review of Systems (ROS)
General: **Admits fever and weakness**, Denies chills weight changes, night sweats, body aches,

• Skin: denies rash, sores, lumps, itching, color changes, hair, nails
• Head: denies headache, trauma, nausea, vomiting, dizziness
• Eyes: denies pain, redness, tearing, vision loss, discharge, double/blurred vision,
• Ears: denies hearing loss/aid, tinnitus, vertigo, earache, discharge
• Mouth/Throat: Denies hoarseness, voice change and sore throat bleeding gums, dentures, cavities,, dry mouth, difficult/painful
• Nose/Sinuses: **admits stuffiness, rhinorrhea, sneezing.** Denies itching, epistaxis, allergies (perennial, seasonal)
• Neck: denies lumps/masses, goiter, pain, stiffness, swelling
• Respiratory: **Admits dry cough, mild shortness of breath**. Denies wheezing, hemoptysis, pleurisy, snoring
Cardiac: Denies palpitations, chest pain, DOE, orthopnea, paroxysmal nocturnal dyspnea, syncope, lower extremity edema
• Gl: **Admits abdominal discomfort, and decreased appetite**. Denies nausea, vomiting, bloating, dysphagia, regurgitation, indigestion, bowel movement frequency/color/size/caliber, changes in bowel habits, diarrhea, constipation, bleeding (hemorrhoids, melena, hematemesis, hematochezia)
Musculoskeletal: muscle or joint pain, stiffness, arthritis, gout, weakness, swelling, redness, instability
• Neurological: seizures, numbness, tingling, paralysis, paresthesias, fainting, blackouts, burning, tremors
• Hematological: anemia, easy bruising/bleeding, petechiae, purpura, ecchymosis, transfusions
• Endocrine: heat/cold intolerance, sweating/thirst/hunger
• Psychiatric: nervousness, mood, anxiety, depression or suicidal ideation.

Physical Exam:
Vital Sign
BP 110/72 (BP Location: Left arm)
Pulse 112
Temp 97.8 °F (36.6 °C) (Oral)
Resp 23, unlabored
Wt 53.4 kg (117 lb 12.8 oz)
Height 5”4
BMI: 20.1
SpO2 96%

Constitutional:
General: AO x 3. He is not in acute distress. Dressed appropriately for the weather, appear stated age.
HENT:
Head: Normocephalic and atraumatic.
Ears: B/L TMs were intact, non-bulging. Mild cerumen in both ears. No lesions, discharge or foreign bodies.
Nose: **Congestion and rhinorrhea present.** Septum was midline. No signs of erythema, edema, foreign bodies.
Mouth: Mucous membranes are moist with uvula midline. No signs of lesions. Good dentition.

Pharynx: No signs of tonsillar enlargement or exudates.
Eyes:
General: Vision grossly intact. No visual field deficit. Visual acuity was 20/20 OD OS, OU
No foreign body or discharge. Extraocular movements intact, No conjunctivae injection
Pupils are equal, round, and reactive to light. PERRLA
Cardiovascular:
Rate and Rhythm: Regular rate and rhythm, S1 and S2 appreciated. No Murmur No gallop.
Pulmonary:
Breath sounds: **Rhonchi present on left lung field. No accessory muscle use**. No wheezes.
Abdominal: Bowel sounds present. Soft, non-distended, non-tender to palpation, no rebound tenderness, no guarding.
Musculoskeletal:
General: Normal range of motion. No evidence of spinal deformities.
Cervical back: Neck supple. No ecchymosis.
Skin:
General: Skin is warm.
Capillary Refill: Capillary refill takes less than 2 seconds.
Neurological:
General: No focal deficit present.
Mental Status: He is alert and oriented to person, place, and time. Mental status is at baseline.
Cranial Nerves: No cranial nerve deficit.

Differential Diagnoses

Community-Acquired Pneumonia (CAP)
Rhonchi on pulmonary exam and mild SOB could indicate a bacterial or viral pneumonia, especially if findings are localized on imaging.

Acute Bronchitis
Prolonged dry cough and rhonchi can suggest bronchitis, often viral in children, particularly without significant systemic findings. Fever>5 days.

Viral Upper Respiratory Infection (URI)
Most common cause of fever, nasal congestion, cough, and rhinorrhea in children. Mild SOB may be due to nasal obstruction or postnasal drip.

Labs and imaging:
POC Liat RSV and Flu A/B: negative
POC Liat COVID-19 Flu A/B RT-PCR: Negative
DX Chest 2 Views: PA and lateral view
Left midlung infiltrate. No pneumothorax. No evidence of pulmonary edema. No free air under the hemidiaphragm.
Impression: Pneumonia/infection involving the left lung.

Assessment

A 9-year-old male with no significant PMHx presents with a 1-week history of dry cough, low-grade fever, runny nose, nasal congestion, and mild shortness of breath. Physical exam reveals rhinorrhea, nasal congestion, and rhonchi on pulmonary auscultation. No wheezing, tonsillar exudates, or significant constitutional symptoms such as chills or night sweats are present. C Xray reveal left midlung infiltrate. Pneumonia/infection involving the left lung, lower respiratory tract infections.

Plan
Antibiotics
Amoxicillin: 800 mg oral 2x daily and
azithromycin 250 mg oral daily

Symptomatic Treatment
Prescribed ibuprofen 300 mg every 6 hrs PRN for fever and pain.
Encouraged hydration and rest.
Saline nasal drops and suction for nasal congestion.
Advised return to the clinic or ED for worsening symptoms, including high fever, increasing SOB, or lethargy.
Discharged home