Date of visit: 2/13/2026

Chief complaint: “My headaches won’t go away.”

HPI: S.A is a 55 YOF with PMHx of HTN and HLD who presents to the clinic for her annual physical exam and reports chronic headaches for over a year. They are located in the back of her head bilaterally, occur 3-4x a week, and typically last several hours at a time. They are described as dull, pressure-like, and non throbbing. There are no specific triggers and are not exacerbated with exertion or positional changes. She takes Tylenol and Ibuprofen with relief of symptoms. Rated 9/10. Pt was previously referred for an MRI last year but never followed up with imaging. She denies any recent or previous trauma to the head, travel, or stressors. Denies nausea, vomiting, dizziness, lightheadedness, room spinning sensation, photophobia or phonophobia, visual disturbances, aura, numbness, tingling, weakness, confusion, fever, chills, weight loss, neck stiffness, back pain, or jaw/scalp tenderness.

Past Medical History
- Hypertension x current
- Hyperlipidemia x current
- Cholelithiasis (2015)

OBGYN History
Menarche: 14 years old
Pregnancies: G5P1041
LMP: 01/10/2026

Immunizations:
- Pzifer COVID-19 vaccine administered 2021; no booster received
- Last Flu vaccine 2025

Past Surgical History
- C-section (2012)

Medications
- Amlodipine Besylate 10 MG Tablet; take 1 tablet by mouth 1 time daily for high blood pressure
- Aspirin 81 MG Oral Tablet Delayed Release; take 1 tablet by mouth daily for ASCVD risk reduction
- Atorvastatin Calcium 20 MG Oral Tablet; take 1 tablet by mouth 1 time daily
- Hyzaar 100–25 MG Oral Tablet; take 1 tablet by mouth 1 time daily
- Metoprolol Succinate ER 25 MG Oral Tablet; take 1 tablet by mouth daily for high blood pressure
- Vitamin D3 1.25 MG (50,000 UT) Capsule; take 1 capsule by mouth weekly

Allergies
No known medication, food, or environmental allergies

Family History
- Mother 76 years of age, alive & in good health
- Maternal aunt with hx of stroke
- Father deceased at age 60 of stomach cancer

Social History
Habits: denies smoking, drinking alcohol, or illicit drug use.
Diet: endorses healthy diet of eggs, meats, vegetables, fruits.
Occupation: unemployed.
Exercise: does not exercise.

Travel: no recent travel.
Sleep habits: endorses healthy sleeping habits; about 8 hours per night.
Marital status/living situation: married; lives with husband and 2 children

Screenings:
PHQ 2 & PHQ9 Depression screening negative in office today
Audit C screening negative in office today
Dast 10 screening negative in office today
Social needs screening negative in office today
UTD with breast cancer screening via mammogram; last in 2025
UTD with colon cancer screening via colonoscopy; last in 2020
UTD with cervical cancer screening via pap smear; last in 2024
Ophthalmology: last visit in 2025
Dental: last visit was 2025

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: denies rash, itching, excessive sweating or dry skin
HEENT: reports headache; denies visual changes, double vision or blurriness, tinnitus, discharge from ears, nose bleed or discharge, congestion, sore throat, mouth ulcers or bleeding gums
Neck: denies localized swelling, lumps, stiffness or decreased ROM
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, jaw pain, palpitations, or swelling of legs or feet
Gastrointestinal: denies nausea, vomiting, diarrhea, constipation, abdominal pain, decreased appetite, or pain with swallowing
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, flank pain or vaginal discharge
Neurological: denies numbness, weakness, tingling, seizures, facial droop or slurred speech
Musculoskeletal: denies pain, swelling, redness, deformity, or trauma
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Psychiatric: denies depression, anxiety, mood changes, new difficulty sleeping, difficulty concentrating or suicidal ideations

Physical Exam
General: 55 year old obese female, well developed and well groomed. Pt appears stated age and is in no acute distress.

Vital Signs:
Blood pressure: 136/86 mmHg
Respiratory rate: 16 breaths per minute
Pulse: 80 BPM
Temperature: 98.6 F
SpO2: 99%
Height: 5 feet 3 inches
Weight: 265 pounds
BMI: 46.94

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Head: normocephalic, atraumatic. No tenderness. No palpable masses. Even hair distribution.
Eyes: normal pink conjunctiva; white sclera. PERRL, EOMI. Anicteric. No discharge or exudates.
Ears: normal hearing. External canal is intact, no discharge. TM intact with no bulging, fluid, or blood collection noted.

Nose: symmetrical, patent nares. No nasal flaring/grunting/discharge.
Mouth/oropharynx: good dentition. Moist mucus membranes. No oropharyngeal exudates or ulcers. No oral or gum erythema, swelling, or bleeding. No FBs.
Neck: symmetric and supple. Trachea midline. Full ROM. No JVD. Non tender. No palpable lymphadenopathy, masses, or goiter. No bruits.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rules, wheezes, or rhonchi auscultated. No fremitus.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Abdomen: soft and non distended. No tenderness or guarding. No palpable masses or organomegaly. No inguinal hernia. No palpable lymphadenopathy.
Extremities/MSK: no obvious deformities, clubbing, cyanosis, or edema noted. No visible joint swelling or erythema. Normal ROM. Bilateral upper and lower pulses present.
Mental status/neuro exam: Patient is well appearing, good hygiene and neatly groomed. Patient is alert and oriented to person, place, and time. Speech and language ability intact, with normal quantity, fluency, and articulation. Patient denies changes to mood. Conversation progresses logically. Strength and sensation intact.

Assessment:
Pt is a 55 YOF with PMHx of obesity, HTN and HLD who presents with chronic headaches, located in the occipital region which occur 3-4x a week, for over a year. She describes them as a dull, pressure-like, non-throbbing sensation. Headaches are relieved with Tylenol/Ibuprofen. She was previously referred for MRI which she never completed. She denies associated symptoms such as neurological deficits, visual disturbances, nausea, vomiting, jaw claudication, scalp tenderness, constitutional symptoms or positional worsening. Physical exam, including neuro exam, is unremarkable. Vitals are stable.

Presentation is most consistent with chronic tension-type headaches, but given age over 50 and incomplete prior imaging work up, secondary causes should be considered and ruled out.

Differential Diagnoses
1. Chronic tension-type headache
    A. Tension headaches are the most common type of headaches and are more common in females. They cause non-throbbing pain described as a “tight band” or pressure sensation around the forehead, temples, and back of the head. Pt does not have associated symptoms such as visual disturbances, nausea, or vomiting, which is typical of a tension-type headache (compared to, for example, migraines). Her headaches last several hours at a time and she experiences the headaches 3-4x a week, which (when calculated) may be greater than or equal to 15 times a month, which is diagnostic of chronic tension-type headaches.
2. Medication overuse headache
    A. Medication overuse headaches, also called rebound headaches, are due to long term use of medications (such as analgesics) to treat headaches. Pt has been taking Tylenol/Ibuprofen every time she gets a headache, which is about 3-4x a week, for over a year. These types of headaches are relieved with the medication, but return as the medication wears off. They are described as dull and pressure-like, which can affect the whole head or specific areas (such as occipital), which is consistent with this pt’s presentation.
3. Occipital neuralgia
    A. Occipital neuralgia is a headache disorder that affects the occipital nerves which run through the scalp. They can be due to pinched nerves or muscle tightness in the neck, but many can be attributed to chronic neck tension or unknown origins. While the location of the pt’s headache fits this diagnosis, they are generally described as a severe pinching, or shock-like pain in the back of the head, which is inconsistent with the pt’s headache characteristics, making this diagnosis less likely (but should still be ruled out).

4. Intracranial mass
    A. Pt's age of 55 and new onset, persistent headaches should raise concern for an intracranial mass or lesion. An intracranial mass increases intracranial pressure, causing symptoms that often include headaches. Although she has no neurological deficits or red flag symptoms such as vomiting, worsening headaches in the morning, seizures, or visual disturbances, intracranial mass should still be ruled out. Further, she was referred for an MRI which was never completed. Age and chronicity warrant imaging to rule out secondary causes of her headaches.

5. Idiopathic intracranial hypertension (pseudotumor cerebri)
    A. Pseudotumor cerebri is a disorder characterized by high pressure in the skull from increased cerebrospinal fluid due to unknown cause, primarily affecting overweight women of child bearing age. Key symptoms include headache, visual disturbances, nausea, and ringing in the ears. Although pt lacks associated symptoms, her history of obesity, HTN, and chronic headaches raise suspicion for this diagnosis and should be ruled out with MRI.

Plan/Workup

Labs:
- Routine labs including CBC, CMP, lipid panel, and A1C

Imaging:
- MRI brain with and without contrast

Medications:
- Continue current medications including Amlodipine and Metoprolol for HTN
    - Will give BP log for pt to monitor readings at home, ensuring <130/80 consistently
- Limit analgesics to <2-3x a week to prevent medication overuse
- If symptoms persist, will consider preventative therapy with low does Amitriptyline

Patient education:

Pt was advised to avoid foods high in saturated fat, sugar/sweetened foods, and foods with high sodium. She was advised to eat more whole grains and vegetables such as kale, spinach, sweet potatoes, and tomatoes. She was educated on the benefits of exercise on high blood pressure, cholesterol, weight loss, and overall mental and physical health, as it releases chemicals that help improve mood and also increases the flow of oxygen in the blood to working muscles and the heart (advised 30 minutes of daily exercise).

She was educated on the importance of completing the MRI brain to rule out secondary causes of headache. She expressed understanding and stated she will make an appointment to get the MRI. She will follow up with lab results in one week.