METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat23, Stat23
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 22:17

Patient No: Stat23
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Patient Complaint: Female presented to the Emergency Physician with chest pain.

CHIEF COMPLAINT(s)

Chief Complaints	(1)Chest Pain

History of Present Illness

Timing:	Symptom was abrupt, time of occurrence was 20:09.
Context:	Patient was resting.
Location:	Sternal Area, Substernal Area.
Modifying Factors:	Patient reported no relief with rest, taking nitroglycerin x 2,.
Quality, Description:	Problem is acute.
Severity:	Positive for moderate ache.
Associated Signs and Symptoms:	Positive for diaphoresis, weakness, current chest pain, diaphoresis, history of heart attack, dyspnea on exertion, shortness of breath, nausea, diaphoresis,

Review of Systems

Constitutional Symptoms:	Positive for diaphoresis, weakness. No fever or chills, No LOC, No dizziness.
Ears, Nose, Mouth, Throat:	Reviewed and no significant abnormalities.
Eyes:	No blurry vision, No double vision.
Cardiovascular:	Positive for current chest pain, diaphoresis, history of heart attack. No radiation.
Respiratory:	Positive for dyspnea on exertion, shortness of breath. No cough.
Gastrointestinal:	Positive for nausea. Denies abdominal pain, No melena, Not vomiting.
Genitourinary:	Reviewed and no significant abnormalities.
Musculoskeletal:	Reviewed and no significant abnormalities.
Neurological:	No dizziness, No LOC.
Integumentary:	Positive for diaphoresis. No bruising.

Histories

Family History:	Heart disease, Diabetes,.
Social History:	Patient is a social drinker, Patient uses tobacco,.
Medication:	Patient currently taking Accupril.
Allergies:	Patient is allergic to following medications: Penicillin,.
Past Surgical History:	CARDIOVASCULAR: CABG, occurrence (years) ago= 10, Angioplasty, occurrence (years) ago= 3,.
Past Medical History:	CARDIAC RISK FACTORS: Uses alcohol, Hyperlipidemia, Hypertension, Obese, Smokes, Smokes, Strong family history,, CARDIOVASCULAR: Myocardial infarction, Hypertension,.

Physical Exam

General Impression:	Anxious, Appears in moderate distress.
Respiratory Pattern:	Normal.
Constitutional Symptoms:	Positive for weakness. No fever.
Ears, Nose, Mouth, Throat:	Neck/Back exam= No thyroid enlargement, No JVD.

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat23, Stat23 **Patient No:** Stat23
Medical Record: **Sex:**
Date of Birth: /_/_//__ **Race:**
Date Seen: 01/02/19 **Age:** 0 Days
Time Seen: 20:44 **Arrival By:** Car
Discharge Time: 22:17 **Physician:** Fox

Female presented to the Emergency Physician with chest pain.

Eyes: Pupils are equal, round, regular and react to light. Extra occular muscles intact, and patient exhibits no nystagmus.

Cardiovascular: Positive for pedal edema, pitting pedal edema, tachycardia. No heaves, No JVD, Murmurs = 2/6, MURMUR LOCATION: ,, No rubs, No thrills.

Respiratory: Positive for breath sounds equal bilaterally. No breathing difficulty.

Gastrointestinal: Abdomen exam= Abdomen soft, Abdomen not tender, No guarding noted,, Rectal exam= No masses, Not melanotic,.

Genitourinary: The genitalia are unremarkable.

Musculoskeletal: Pulses equal, no cyanosis, no edema. Neurovascular intact. Range of motion normal.

Neurological: Patient is oriented X 3, active, exhibits no focal deficits, alert, affect is appropriate with memory intact.

Integumentary: Positive for diaphoresis, pitting edema. No cyanosis.

Medications Ordered in E.D.

Meds in E.D. Meds: Nitro Ointment = 1 inch to chest wall @21:16:26 02/25/2001 Ordered By: Fox

Meds in E.D. Meds: Aspirin = 325 mg TAB @21:16:36 02/25/2001 Ordered By: Fox

Meds in E.D. Meds: Nitroglycerin = Nitroglycerin drip 300 mcg/minute IV @21:16:53 02/25/2001 Ordered By: Fox

Meds in E.D. Meds: Heparin = Per Protocol @21:17:44 02/25/2001 Ordered By: Fox

Vital Signs:

Feb 25, 2001 21:12:38 BP: 190/100 Pulse: 100 Resp: 20 User: Fox Temp: 99.0 Weight: 100 Kg.. BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 98% Room

Medical Decision Making

Orders: Cardiac Monitor ordered 21:14:33 21:14:46, 12-lead EKG ordered 21:14:39, Laboratory Orders= ABG, CBC with differential, Chem- 12, PT/PTT, Troponin I, Pulse Oximetry= 98 %, Room Air, Normal,, Radiology Orders= CXR- AP Portable,.

Results: EKG Results= Sinus Tachycardia, ST and T Wave Changes= Inferior leads, Consistent with infarction, Ectopic Beats= PVCs,, Laboratory Results= CHEMISTRIES: Troponin +, Normal PT/PTT, CBC normal, ABG: pH normal = 7.35-7.45 mmHg, pCO2 normal = 35-45 mmHg, pO2 normal = 80-90 mmHg,, Radiology Results= CHEST X-RAY: Normal, Interpretation of X-Ray by Radiologist,.

Dr. Interval Exam, Time: First re-evaluation: Symptoms improved 21:17:57. No respiratory distress 21:18:05..

Consultants: Consultant called at 21:19:04.

Review Records: Obtained and reviewed old records.

Disposition: Patient admitted 21:19:00..

Differential / Diagnosis

Differential Diagnosis: (1) ANGINA-UNSTABLE (2) ATYPICAL CHEST PAIN (3) MI-MYOCARDIAL INFARCTION-ACUTE (4) HYPERTESIVE URGENCY

Diagnosis: MI-MYOCARDIAL INFARCTION-ACUTE

House Staff / P.A. / Private Dr.

Physician: Fox

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat24, Stat24
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:01

Patient No: Stat24
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Patient Complaint: Female presented to the Emergency Physician with multiple trauma.

CHIEF COMPLAINT(s)

Chief Complaints	(1)Multiple Trauma

History of Present Illness

Timing:	Symptom was abrupt, time of occurrence was 21:18.
Duration:	Patient was unconscious 5 minutes.
Context:	MVA= Patient was a passenger in the front seat and unrestrained, Vehicle rolled over, Patient was ejected from vehicle,.
Location:	Abdomen= all quadrants,, Chest= Left side, Lateral,, Head= Left side, Frontal,.
Modifying Factors:	Patient on IV fluids= 0.9% Sodium Chloride, 1.0 L,.
Quality, Description:	Problem is acute.
Severity:	Patient in critical condition, patient lost consciousness.

Review of Systems

Constitutional Symptoms:	Unable to obtain due to patient being unable to speak.
Ears, Nose, Mouth, Throat:	Unable to obtain due to patient being unable to speak.
Eyes:	Unable to obtain due to patient being unable to speak.
Cardiovascular:	Unable to obtain due to patient being unable to speak.
Respiratory:	Unable to obtain due to patient being unable to speak.
Gastrointestinal:	Unable to obtain due to patient being unable to speak.
Genitourinary:	Unable to obtain due to patient being unable to speak.
Musculoskeletal:	Unable to obtain due to patient being unable to speak.
Neurological:	Unable to obtain due to patient being unable to speak.
Psychiatric:	Unable to obtain due to patient being unable to speak.
Endocrine:	Unable to obtain due to patient being unable to speak.
Integumentary:	Unable to obtain due to patient being unable to speak.
Hematologic, Lymphatic:	Unable to obtain due to patient being unable to speak.
Allergic, Immunologic:	Unable to obtain due to patient being unable to speak.

Histories

Family History:	Unable to obtain due to patient being unable to speak.
Social History:	Unable to obtain due to patient being unable to speak.
Medication:	Unable to obtain due to patient being unable to speak.
Allergies:	Unable to obtain due to patient being unable to speak.
Past Surgical History:	Unable to obtain due to patient being unable to speak.
Past Medical History:	Unable to obtain due to patient being unable to speak.

Physical Exam

General Impression:	Combative, Moaning.
Respiratory Pattern:	Labored, Tachypneic.
Constitutional	Positive for lethargic.

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat24, Stat24
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:01

Patient No: Stat24
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Female presented to the Emergency Physician with multiple trauma.

Symptoms:

Ears, Nose, Mouth, Throat:	Both ears exam= No hemotympanum, External auditory canal is clear, TMs clear,, Head/Face exam= Positive for abrasion, No Battle's sign, No bony step-off, Positive for ecchymosis, Forehead swelling,, Mouth exam= No broken teeth, No swelling to tongue,, Neck/Back exam= No crepitus, Trachea is midline, Neck is supple,, Nose exam= No active bleeding,, Throat exam= Uvula midline,.
Eyes:	Left eye exam= Pupil reaction normal,, Periorbital= Left eye, Positive for ecchymosis,, Right eye exam= Pupil reaction normal,.
Cardiovascular:	Positive for JVD cm= 4,, muffled heart tones, tachycardia. No rubs.
Respiratory:	Positive for diminished breath sounds left. Chest location= Left side, Lateral, Rib= 5, 6, 7,, Chest exam= Positive for abrasions, Asymmetrical chest, Positive for crepitation, Positive for ecchymosis, Positive for signs of trauma,, No wheezes.
Gastrointestinal:	Abdomen exam= Firm abdomen, Abdomen distended, Patient has an abrasion,, Rectal exam= Good sphincter tone, Not melanotic, No rectal heme,.
Genitourinary:	Positive for urethral bleeding, suprapubic tenderness. The genitalia are unremarkable.
Musculoskeletal:	Back/Neck exam= Neck is immobilized, No bony step-off, No midline cervical tenderness, No midline dorsal tenderness, No midline lumbar tenderness,, Pelvis exam= No pelvic tenderness, No ecchymosis, Positive for abrasion,.
Neurological:	Positive for obtunded.
Integumentary:	Positive for abrasion, ecchymosis. No cyanosis, No diaphoresis.

Vital Signs:

Feb 25, 2001 22:20:28 BP: 90/50 Pulse: 120 Resp: 24 User: Fox Temp: 96.9 Weight: . BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 90% 100%

Medical Decision Making

Orders:	Cardiac Monitor ordered 22:27:16, Laboratory Orders= CBC with differential, Chem- 12, ETOH, PT/PTT, Serum Drug Screen, Urinalysis, Radiology Orders= Trauma Series,.
Results:	Laboratory Results= URINALYSIS: Hematuria, TOXICOLOGY: THC/Presumptive +, Amphetamines/Presumptive +, HEMATOLOGY: COMPLETE BLOOD COUNT: Leukocytosis, ANEMIA: Normocytic, Hypochromic, Normal PT/PTT, CHEMISTRIES: Bun-Normal, Creatinine-Normal, Hemocult -,, Radiology Results= CHEST X-RAY: Pulmonary Collapse= Hemopneumothorax: 50%,.
Consultants:	Consultant called at 22:29:16.
Procedures:	Foley cath= Placement by Nurse, Urine obtained - 100 cc, return bloody,, Intubation= Size=7.5, Orotracheal/Rapid Sequence placement successful on 1st attempt, By ER Physician, Verified by Chest x-ray, Verified by ET CO2 Level, Verified by tube check,, NG Tube Placement= Placed by nurse, Return clear,, Surgical Procedures= Thoracostomy with waterseal, blood obtained= 400 cc, L chest. DPL +
Disposition:	Patient sent to OR Patient was in critical condition,.

Differential / Diagnosis

Diagnosis: HEMOTHORAX CLOSED HEAD INJURY BLUNT ABDOMINAL TRAUMA

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat25, Stat25
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:09

Patient No: Stat25
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Patient Complaint: Female presented to the Emergency Physician with asthma attack.

CHIEF COMPLAINT(s)

Chief Complaints	(1)Asthma Attack

History of Present Illness

Timing:	Symptom came on gradually.
Duration:	The duration of this episode was 3 hours.
Context:	Sporting Activity= Patient was playing basketball,.
Modifying Factors:	Patient reported no relief with prescribed meds, rest,.
Quality, Description:	Problem is acute.
Severity:	Patient was in acute distress.
Associated Signs and Symptoms:	Positive for diaphoresis, breathing with difficulty, cough, wheezing, diaphoresis,

Review of Systems

Constitutional Symptoms:	Positive for diaphoresis. No fever or chills.
Ears, Nose, Mouth, Throat:	No difficulty swallowing, No sore throat.
Eyes:	Reviewed and no significant abnormalities.
Cardiovascular:	No current chest pain.
Respiratory:	Positive for breathing with difficulty, cough, wheezing.
Gastrointestinal:	Denies abdominal pain, Not vomiting.
Genitourinary:	Reviewed and no significant abnormalities.
Neurological:	Reviewed and no significant abnormalities.
Integumentary:	Positive for diaphoresis.

Histories

Social History:	Patient denies using tobacco.
Medication:	Patient currently taking Albuterol.
Allergies:	Reviewed nursing notes and concur, Patient is allergic to following medications: Penicillin,.
Past Surgical History:	No previous history.
Past Medical History:	RESPIRATORY: Asthma,.

Physical Exam

General Impression:	Appears in acute distress.
Respiratory Pattern:	Severe distress.
Constitutional Symptoms:	No fever, No lethargy.
Ears, Nose, Mouth, Throat:	TMI and clear bilaterally. No nasal discharge. Throat / Mouth without exudate or asymmetry. Oral mucosa moist. Phonation normal, and no cervical adenopathy palpable.
Eyes:	Pupils are equal, round, regular and react to light. Extra occular muscles intact, and patient exhibits no nystagmus.
Cardiovascular:	Positive for tachycardia. No heaves, No JVD, No gallops, murmurs, or rubs, No rubs, No thrills.

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat25, Stat25
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:09

Patient No: Stat25
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Respiratory: Female presented to the Emergency Physician with asthma attack.
Gastrointestinal: Positive for breathing difficulty, expiratory wheezing. No rhonchi, No stridor.
Neurological: Abdomen exam= Abdomen soft, Abdomen not tender, No guarding noted,.
Integumentary: Patient is oriented X 3, active, exhibits no focal deficits, alert, affect is appropriate with memory intact.
Positive for diaphoresis. No cyanosis, No pitting edema.

Medications Ordered in E.D.

Meds in E.D. Meds: Albuterol = 2.5 mg via nebulizer @23:07:20 02/25/2001 Ordered By: Fox
Meds in E.D. Meds: Atrovent = 1 vial nebulizer @23:07:28 02/25/2001 Ordered By: Fox
Meds in E.D. Meds: Brethine = 1 mg/ml unit dose, give 0.25 mg sq @23:07:41 02/25/2001 Ordered By: Fox

Vital Signs:

Feb 25, 2001 23:04:39 BP: 150/90 Pulse: 118 Resp: 28 User: Fox Temp: 98.8 Weight: . BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 88% 100%

Medical Decision Making

Orders: Cardiac Monitor ordered 23:06:11, Pulse Oximetry= 88%, Obtained on FiO2 of= 100 %, Pulse oximetry consistent with hypoxia,, Radiology Orders= CXR- AP Portable,.

Results: Radiology Results= Interpretation of X-Ray by ER Physician, CHEST X-RAY: Normal,.

Dr. Interval Exam, Time: Condition was improving 23:06:42, Evaluation of nebulizer therapy 23:06:22, Post nebulizer peak flow results= 350-400,, Post nebulizer pulse ox evaluation= 98 %,, First re-evaluation: Symptoms improved 23:06:26. Vital signs stable 23:06:28., Second re-evaluation: No respiratory distress 23:07:49. Symptoms resolved 23:07:51..

Disposition: Condition at Discharge= Patient was in stable condition,, Disposition Information= Follow up with private medical doctor in 24 hours, Follow up with emergency department immediately, If symptoms worsen,, Instructed to rest, Instructed to take medications as directed. Patient discharged on Ventolin, Flovent, Prednisone.

Differential / Diagnosis

Differential Diagnosis: (1) ASTHMA (2) STATUS ASTHMATICUS (3) PNEUMONIA
Diagnosis: ASTHMA

House Staff / P.A. / Private Dr.

Physician: Fox

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat26, Stat26
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:26

Patient No: Stat26
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Patient Complaint: Female presented to the Emergency Physician with facial droop.

CHIEF COMPLAINT(s)

Chief Complaints: (1)Facial Droop (2)POPTA

History of Present Illness

Timing: Symptom was abrupt, time of occurrence was 22:09.
Duration: This complaint has been going on for 1 hours.
Context: Patient was resting, Mechanism= None,.
Modifying Factors: Patient recently treated by physician for similar- 5 days ago, for Hypertension, Patient reported no relief with rest,.
Quality, Description: Problem is acute.
Severity: Patient was in acute distress.
Associated Signs and Symptoms: Positive for loss of consciousness, dizzy spells, dyspnea on exertion, nausea, dizziness, current headache, patient had LOC, weakness in an extremity, left facial droop, speaking problem, weakness,

Review of Systems

Constitutional Symptoms: Positive for loss of consciousness. No diaphoresis, No fever or chills.
Ears, Nose, Mouth, Throat: No difficulty swallowing.
Eyes: No blurry vision, No photophobia, No double vision.
Cardiovascular: Positive for dizzy spells. No current chest pain, No diaphoresis, No palpitations.
Respiratory: Positive for dyspnea on exertion. No breathing difficulty, No cough.
Gastrointestinal: Positive for nausea. Denies abdominal pain, No diarrhea, No melena, Not vomiting.
Genitourinary: No blood in urine, No difficulty or pain during urination.
Musculoskeletal: Reviewed and no significant abnormalities.
Neurological: Positive for dizziness, current headache, patient had LOC, weakness in an extremity, left facial droop, speaking problem, weakness. No seizure, No vision loss.
Integumentary: No diaphoresis.

Histories

Family History: Heart disease, Hypertension, Diabetes,.
Social History: Patient uses tobacco,.
Medication: Patient currently taking Norvasc.
Allergies: Patient is allergic to following medications: Bactrim DS,.
Past Surgical History: GASTROINTESTINAL: Cholecystectomy, occurrence (years) ago= 10,.
Past Medical History: CARDIAC RISK FACTORS: Smokes, Obese, Hypertension, Strong family history,,
CARDIOVASCULAR: No heart attack,, NEURO/PSYCHIATRIC: No previous history of CVA.

Physical Exam

General Impression: Appears in acute distress.
Respiratory Pattern: Normal.
Constitutional Symptoms: No fever, No lethargy.

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat26, Stat26
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:26

Patient No: Stat26
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Female presented to the Emergency Physician with facial droop.

Ears, Nose, Mouth, Throat:	Neck/Back exam= No carotid bruits, No JVD, Phonation= Speech Status= Aphasic, Throat exam= No redness, swelling or masses,.
Eyes:	Both eyes exam= PERRL, EOMI,, Fundi= No hemorrhage, No papilledema, No AV nicking,.
Cardiovascular:	Positive for irregular rate & rhythm. Murmurs = 1/6, Systolic ejection murmur, MURMUR LOCATION: LLSB.
Respiratory:	Positive for breath sounds equal bilaterally. No breathing difficulty.
Gastrointestinal:	Positive for femoral pulses 2+ bilateral and symmetrical. Abdomen exam= Abdomen soft, Abdomen not tender, No guarding noted,, No solid masses, Rectal exam= No masses, Not melanotic,.
Genitourinary:	The genitalia are unremarkable.
Musculoskeletal:	Pulses equal, no cyanosis, no edema. Neurovascular intact. Range of motion normal.
Neurological:	Positive for patient alert, patient awake, toes downgoing. grips unequal, Does not move all extremities- R upper extremity weakness. Decrease strength R dorsal-pedal flex/extension.. Face symetrical, no droop identified.
Psychiatric:	AFFECT= Flat,.
Integumentary:	No cyanosis, No diaphoresis, No pitting edema, No ecchymosis.
Hematologic, Lymp, Immun:	No enlarged lymph nodes.

Medications Ordered in E.D.

Meds in E.D.	Meds: Nipride = 100 mcg/ml conc.: 3 mcg/kg/min @23:25:30 02/25/2001 Ordered By: Fox
Meds in E.D.	Meds: Heparin = Per Protocol @23:25:53 02/25/2001 Ordered By: Fox

Vital Signs:

Feb 25, 2001 23:14:53 BP: 200/100 Pulse: 100 Resp: 16 User: Fox Temp: 99.0 Weight: 100 Kg.. BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 98% Room

Medical Decision Making

Orders:	Cardiac Monitor ordered 23:21:47, 12-lead EKG ordered 23:21:45, Laboratory Orders= CBC with differential, Chem- 12, PT/PTT, Pulse Oximetry= 98 %, Room Air, Normal,, Radiology Orders= CT-Head without contrast, CXR- AP Portable,.
Results:	EKG Results= Atrial Fibrillation= With rapid ventricular response, Ectopic Beats= occasional unifocal PVCs, Laboratory Results= CHEMISTRIES: Bun-Elevated, Creatinine-Normal, Hyperkalemia-K+, Hemocult -, HEMATOLOGY: Normal PT/PTT, COMPLETE BLOOD COUNT: Leukocytosis, WBC DIFFERENTIAL: Polys Predominant,, Radiology Results= CHEST X-RAY: Normal, Interpretation of X-Ray by ER Physician, CT Scan of the Head: No contrast-enhancement of lesion, Nonhemorrhagic, Lesion Density: Low density with adjacent edema,.
Dr. Interval Exam, Time:	First re-evaluation: No respiratory distress 23:25:16. No change in symptoms 23:25:17..
Consultants:	Consultant called at 23:24:57.
Review Records:	Obtained and reviewed old records.
Disposition:	Patient admitted 23:25:42..

Differential / Diagnosis

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat26, Stat26
Medical Record:
Date of Birth: /_/_//__
Date Seen: 01/02/19
Time Seen: 20:44
Discharge Time: 23:26

Patient No: Stat26
Sex:
Race:
Age: 0 Days
Arrival By: Car
Physician: Fox

Female presented to the Emergency Physician with facial droop.

Differential Diagnosis: (1) CVA-CEREBROVASCULAR ACCIDENT (2) HYPERTENSIVE CRISIS (3) NEOPLASM
Diagnosis: CVA-CEREBROVASCULAR ACCIDENT

House Staff / P.A. / Private Dr.

Physician: Fox

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat5, Stat5
Medical Record:
Date of Birth: /_/_//__
Date Seen: 00/06/19
Time Seen: 05:51
Discharge Time: 00:21

Patient No: Stat5
Sex:
Race:
Age: 16 Months
Arrival By: Car
Physician: Fox

Patient Complaint: Female presented to the Emergency Physician with back pain.

CHIEF COMPLAINT(s)

Chief Complaints	(1)Back Pain

History of Present Illness

Timing:	Symptom was abrupt, time of occurrence was 00:29.
Context:	MVA= Patient was the driver and restrained, Rear-ended while stopped, Restraints= Shoulder/lap restraints used, Speed= 30 miles/hour,, Pre-Hospital Course= Patient arrived in full spinal immobilization,.
Location:	Cervical: C6, C5,, Lumbar region of back.
Quality, Description:	Problem is acute.
Severity:	Patient was in moderate distress.
Associated Signs and Symptoms:	Positive for back pain, neck pain,

Review of Systems

Constitutional Symptoms:	No LOC.
Ears, Nose, Mouth, Throat:	Reviewed and no significant abnormalities.
Respiratory:	No breathing difficulty, No shortness of breath.
Gastrointestinal:	Denies abdominal pain, No nausea.
Genitourinary:	Reviewed and no significant abnormalities.
Musculoskeletal:	Positive for back pain, neck pain. Denies numbness, Denies arm pain, Denies leg pain, Denies pelvic pain, Denies shoulder pain, Denies wrist pain, Denies radiculopathy.
Neurological:	No current headache, No LOC.
Integumentary:	No diaphoresis, No bruising.

Histories

Social History:	Positive for Patient smokes tobacco.
Medication:	Patient states no use of any medications.
Allergies:	None.
Past Surgical History:	No previous history.
Past Medical History:	No previous history.

Physical Exam

General Impression:	Awake, alert, and oriented, Appears in moderate distress.
Respiratory Pattern:	Normal.
Constitutional Symptoms:	No fever, No lethargy.
Ears, Nose, Mouth, Throat:	Both ears exam= No hemotympanum,, Head/Face exam= No abrasions, Atraumatic,, Neck/Back exam= Trachea is midline, Neck is supple,.
Eyes:	Pupils are equal, round, regular and react to light. Extra occular muscles intact, and patient exhibits no nystagmus.

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat5, Stat5
Medical Record:
Date of Birth: /_/_//__
Date Seen: 00/06/19
Time Seen: 05:51
Discharge Time: 00:21

Patient No: Stat5
Sex:
Race:
Age: 16 Months
Arrival By: Car
Physician: Fox

Female presented to the Emergency Physician with back pain.

Cardiovascular: There is a regular rate and rhythm without murmurs, rubs, clicks, gallops, or heaves. No jugular venous distension. Patient exhibits no peripheral edema.

Respiratory: Positive for breath sounds equal bilaterally. No breathing difficulty, Chest exam= No crepitation, Atraumatic, Symmetrical bilaterally, No tenderness,.

Gastrointestinal: Abdomen exam= Abdomen soft, Abdomen not tender, No guarding noted,.

Musculoskeletal: Back/Neck exam= No midline cervical tenderness, No midline dorsal tenderness, No midline lumbar tenderness, No midline tenderness, No bony step-off, No numbness, Pain on movement, Patient has paraspinous lumbar tenderness, Patient has paraspinous cervical tenderness,, Pelvis exam= No pelvic tenderness, No pelvic rock,.

Neurological: Patient is oriented X 3, active, exhibits no focal deficits, alert, affect is appropriate with memory intact.

Integumentary: No cyanosis, No diaphoresis, No ecchymosis.

Vital Signs:

Tetanus Status: Up to Date. Feb 26, 2001 00:17:52 BP: 134/72 Pulse: 100 Resp: 18 User: Fox Temp: 99.0 Weight: . BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 98% Room

Medical Decision Making

Orders: Laboratory Orders= Urinalysis, Radiology Orders= C-Spine, LS-Spine,.

Results: Laboratory Results= UA normal,, Radiology Results= CERVICAL SPINE: Negative for fracture or abnormality, LUMBOSACRAL SPINE: Negative for fracture or abnormality, Interpretation of X-Ray by ER Physician,.

Dr. Interval Exam, Time: First re-evaluation: Vital signs stable 00:20:27. No change in symptoms 00:20:31..

Disposition: Disposition Information= Follow up with private medical doctor in 3 days, Follow up with emergency department immediately, If symptoms worsen,, Instructed to rest, Instructed to return to the Emergency Department if symptoms should worsen before follow-up.

Differential / Diagnosis

Differential Diagnosis: (1) CERVICAL STRAIN (2) LUMBAR STRAIN

Diagnosis: CERVICAL STRAIN LUMBAR STRAIN

Prescriptions

Prescription 1: Drug:Vicodin Dosage: 1 p.o. q.4h. p.r.n. take p.o.(no driving on medication) Dispense: 15 Refill: 0
Drug:Soma Dosage: 350 mg 1 p.o. q.6h. p.r.n. Dispense: 15 Refill: 0

Discharge Instructions

Discharge Instructions: Discharge Instructions given for: BACK STRAIN-THORACIC, BACK STRAIN, FRACTURE, BACK STRAIN, BACK STRAIN, LUMBAR STRAIN, LUMBAR STRAIN.

House Staff / P.A. / Private Dr.

Physician: Fox

METHODIST HOSPITALS OF DALLAS

Emergency Department Medical Record

Patient Name: Stat5, Stat5
Medical Record:
Date of Birth: /_/_//__
Date Seen: 00/06/19
Time Seen: 05:51
Discharge Time: 00:21

Patient No: Stat5
Sex:
Race:
Age: 16 Months
Arrival By: Car
Physician: Fox

Female presented to the Emergency Physician with back pain.

Cardiovascular: There is a regular rate and rhythm without murmurs, rubs, clicks, gallops, or heaves. No jugular venous distension. Patient exhibits no peripheral edema.

Respiratory: Positive for breath sounds equal bilaterally. No breathing difficulty, Chest exam= No crepitation, Atraumatic, Symmetrical bilaterally, No tenderness,.

Gastrointestinal: Abdomen exam= Abdomen soft, Abdomen not tender, No guarding noted,.

Musculoskeletal: Back/Neck exam= No midline cervical tenderness, No midline dorsal tenderness, No midline lumbar tenderness, No midline tenderness, No bony step-off, No numbness, Pain on movement, Patient has paraspinous lumbar tenderness, Patient has paraspinous cervical tenderness,, Pelvis exam= No pelvic tenderness, No pelvic rock,.

Neurological: Patient is oriented X 3, active, exhibits no focal deficits, alert, affect is appropriate with memory intact.

Integumentary: No cyanosis, No diaphoresis, No ecchymosis.

Vital Signs:

Tetanus Status: Up to Date. Feb 26, 2001 00:17:52 BP: 134/72 Pulse: 100 Resp: 18 User: Fox Temp: 99.0 Weight: . BP Orthostatic: BP Method: BP Site: Pulse Site: Temp. Site: Pulse Ox: 98% Room

Medical Decision Making

Orders: Laboratory Orders= Urinalysis, Radiology Orders= C-Spine, LS-Spine,.

Results: Laboratory Results= UA normal,, Radiology Results= CERVICAL SPINE: Negative for fracture or abnormality, LUMBOSACRAL SPINE: Negative for fracture or abnormality, Interpretation of X-Ray by ER Physician,.

Dr. Interval Exam, Time: First re-evaluation: Vital signs stable 00:20:27. No change in symptoms 00:20:31..

Disposition: Disposition Information= Follow up with private medical doctor in 3 days, Follow up with emergency department immediately, If symptoms worsen,, Instructed to rest, Instructed to return to the Emergency Department if symptoms should worsen before follow-up.

Differential / Diagnosis

Differential Diagnosis: (1) CERVICAL STRAIN (2) LUMBAR STRAIN

Diagnosis: CERVICAL STRAIN LUMBAR STRAIN

Prescriptions

Prescription 1

Drug:Vicodin Dosage: 1 p.o. q.4h. p.r.n. take p.o.(no driving on medication) Dispense: 15 Refill: 0

Drug:Soma Dosage: 350 mg 1 p.o. q.6h. p.r.n. Dispense: 15 Refill: 0

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