ED Provider Notes

History

Chief Complaint

Patient presents with

- Fever-9 Weeks To 74 Years

  Patient noted to have fever for approx 2 1/2 weeks. Patient noted to have increased weakness, decreased appetite, not feeling well. Multiple ed visits per family. Patient shaking at time of triage.

Patient is a 67 y.o. male presenting with fever. The history is provided by the patient and a relative.

Fever

Primary symptoms of the febrile illness include fever, fatigue, cough (dry) and abdominal pain (Rt flank pain). Primary symptoms do not include visual change, headaches, wheezing, shortness of breath, nausea, vomiting, diarrhea, dysuria, altered mental status, myalgias, arthralgias or rash. The current episode started more than 1 week ago. This is a new problem. The problem has not changed since onset.

Associated with: nothing. Risk factors: neck fusion, hernia repair.

Past Medical History

Elevated PSA

Osteoporosis 2/2014

Comment: Dexa L femoral neck -2.8

Acromioclavicular joint arthritis

Comment: L sided

Kidney stone

Comment: s/p lithotripsy

H. pylori infection

Comment: s/p triple therapy July 2015

Past Surgical History

NECK SURGERY

HERNIA REPAIR

URETEROSCOPY

History reviewed. No pertinent family history.

History

Social History

- Marital Status: Married
  - Spouse Name: N/A
  - Number of Children: N/A
- Years of Education: N/A

Social History Main Topics

- Smoking status: Former Smoker
  - Types: Cigarettes

- Smokeless tobacco: None
- Alcohol Use: 0.0 oz/week
- Drug Use: None
- Sexual Activity: None

Other Topics	Concern
• None	

Social History Narrative

Review of Systems
Constitutional: Positive for fever, chills and fatigue.
HENT: Negative for congestion.
Respiratory: Positive for cough (dry). Negative for chest tightness, shortness of breath and wheezing.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Positive for abdominal pain (Rt flank pain). Negative for nausea, vomiting and diarrhea.
Genitourinary: Positive for flank pain. Negative for dysuria.
Musculoskeletal: Negative for myalgias, arthralgias, neck pain and neck stiffness.
Skin: Negative for rash.
Neurological: Negative for headaches.
All other systems reviewed and are negative.

Physical Exam
ED Triage Vitals:
BP: 138/95 mmHg [08/29/15 1926]
Pulse: 97 [08/29/15 1926]
Resp: 16 [08/29/15 1926]
Temp: 101.6 °F (38.7 °C) [08/29/15 1926]
Temp src: Temporal [08/29/15 1926]
SpO2: 98 % [08/29/15 1926]

BP 129/66 mmHg | Pulse 94 | Temp(Src) 100.5 °F (38.1 °C) (Oral) | Resp 18 | Wt 70.308 kg | SpO2 96%

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Eyes: EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion and full passive range of motion without pain. Neck supple. No Brudzinski's sign and no Kernig's sign noted.
Cardiovascular: Normal rate and regular rhythm.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. He has no wheezes. He has no rales. He exhibits no tenderness.
Abdominal: Soft. Bowel sounds are normal. There is no tenderness.
Musculoskeletal: Normal range of motion. He exhibits no edema or tenderness.
Neurological: He is alert and oriented to person, place, and time. He exhibits normal muscle tone.
Speech clear, gait steady
Skin: Skin is warm and dry.
Psychiatric: He has a normal mood and affect. His behavior is normal.
Nursing note and vitals reviewed.

Procedures
Procedures

ED Course

ED COURSE

Reviewed previous: previous chart
Interpreted by ED Provider: pulse oximetry and labs

Patient Reevaluation: 67 yo with renal colic presents with over 1 week fever and Rt flank pain, febrile in ED, mild rt side abd pain, non-focal neuro exam, will recheck lab, get abd CT r/o renal colic, r/o pyelonephritis

11:30 PM radiology states no utility in getting U/S because GB looks fine on CT, bilirubin most likely secondary to hep A

Patient progress: stable

Labs Reviewed

CBC AND DIFFERENTIAL - Abnormal; Notable for the following:

RBC	3.9 (*)
Hemoglobin	11.4 (*)
Hematocrit	32.1 (*)
Platelets	96 (*)
Lymphocytes	12 (*)
Monocytes	23 (*)
Basophils	3 (*)

All other components within normal limits

BASIC METABOLIC PANEL - Abnormal; Notable for the following:

Glucose	112 (*)
CO2	19.0 (*)
Sodium	132 (*)
Calcium	8.2 (*)

All other components within normal limits

HEPATIC FUNCTION PANEL - Abnormal; Notable for the following:

Albumin	3.2 (*)
Globulin	3.7 (*)
A/G Ratio	0.9 (*)
Aspartate Aminotransferase (AST)	59 (*)
Alanine Aminotransferase (ALT)	53 (*)
Total Bilirubin	1.7 (*)
Bilirubin, Direct	0.6 (*)

All other components within normal limits

PROTIME AND INR - Abnormal; Notable for the following:

INR	1.15 (*)

All other components within normal limits

PARTIAL THROMBOPLASTIN TIME (BH GH Q YH) - Abnormal; Notable for the following:

PTT	31.6 (*)

All other components within normal limits

POCT URINALYSIS DIPSTICK - Abnormal; Notable for the following:

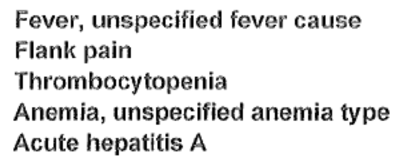
POC Blood, UA	Moderate (2+) (*)
POC Protein, UA	1+ (30 mg/dL) (*)

All other components within normal limits

URINE CULTURE
CA/MG/PHOS (YH)
LIPASE
LACTIC ACID, WHOLE BLOOD (YH)
EGFR (GH L YH)
EGFR (AFR AMER) (GH YH)

ED Clinical Impression(s)

Final diagnoses:



Fever, unspecified fever cause
Flank pain
Thrombocytopenia
Anemia, unspecified anemia type
Acute hepatitis A

ED Disposition
Admit