Patient Name:	SANDERS, TRACI EUGENIA	Financial #:	A2329500011
Medical Record #:	1183599	Date of Birth:	9/29/1983 40 years
Location:	SVI ED; Waitroom (SVI)	Gender:	Female
Attending Physician:	SCARBROUGH,DEWEY,PA Emergency Medicine	Discharge Date:	10/22/2023
Admission Date:	10/22/2023		

Emergency

DOCUMENT TYPE: ED Physician Notes
RESULT STATUS: Modified
SIGNED INFORMATION: WILBUR,LEE,MD Emergency Medicine (10/24/2023 16:06 CDT); SCARBROUGH,DEWEY,PA Emergency Medicine (10/22/2023 05:24 CDT); SCARBROUGH,DEWEY,PA Emergency Medicine (10/22/2023 05:13 CDT)
SERVICE DATE/TIME 10/22/2023 03:48 CDT

Headache *ED

Patient: **SANDERS, TRACI EUGENIA** **MRN: 1183599** **FIN: A2329500011**
Age: **40 years** Sex: **Female** DOB: **9/29/1983**
Associated Diagnoses: **Migraine headache**
Author: **SCARBROUGH, DEWEY, PA Emergency Medicine**

Basic Information

Time seen: Date & time 10/22/2023 03:48:00.
History source: Patient, significant other.
Arrival mode: Private vehicle.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint

10/22/2023 3:42 CDT Chief Complaint reports headache/ photophobia weakness and vomiting. husband states she felt better after getting treatment in this ED last night but symptoms returned. actively vomting in triage
10/21/2023 0:16 CDT Chief Complaint Pt c/o migraine since this afternoon, has her feeling weak, nauseous, and sensitive to light. PMHx: seizures .

History of Present Illness

The patient presents with headache. The onset was chronic. The course/duration of symptoms is constant. Location: Bilateral frontal retro-orbital. Radiating pain: none. The character of symptoms is throbbing. The degree at onset was moderate. The degree at maximum was moderate. The degree at present is moderate. There are exacerbating factors including light, noise and exertion. There are relieving factors including light avoidance, noise avoidance, rest, lying down and medications(s). Risk factors consist of none. Prior episodes: frequent and migraine. Therapy today: none. Preceding symptoms: visual disturbance. Associated symptoms: nausea, vomiting, photophobia, denies dizziness, denies altered vision, denies fever, denies chills, denies neck pain, denies syncope, denies rash, denies altered speech, denies altered level of consciousness and denies seizure.

Review of Systems

Constitutional symptoms: Negative except as documented in HPI.
Skin symptoms: Negative except as documented in HPI.
Eye symptoms: Negative except as documented in HPI.
ENMT symptoms: Negative except as documented in HPI.
Respiratory symptoms: Negative except as documented in HPI.
Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Musculoskeletal symptoms: Negative except as documented in HPI.
Neurologic symptoms: Negative except as documented in HPI.
Psychiatric symptoms: Negative except as documented in HPI.

Emergency

Endocrine symptoms: Negative except as documented in HPI.
Hematologic/Lymphatic symptoms: Negative except as documented in HPI.
Allergy/immunologic symptoms: Negative except as documented in HPI.

Health Status

Allergies:

Allergic Reactions (Selected)

Severe

Geodon- Swelling.

Moderate

Codeine- Hives.

Unknown

Morphine- No reactions were documented..

Medications: (Selected)

Inpatient Medications

Ordered

droPERidol 2.5 mg/mL injectable solution: 2.5 mg, 1 mL, IntraMuscular, 1-Time

Documented Medications

Documented

OXcarbazepine 300 mg oral tablet: 600 mg, 2 Tab, Oral, BID, 120 Tab, 0 Refill(s)
Vistaril 25 mg oral capsule: mg, Cap, Oral, At Bedtime, 0 Refill(s)
divalproex sodium 500 mg oral tablet, extended release: mg, Tab, Oral, BID, 0 Refill(s)
famotidine 20 mg oral tablet: 20 mg, 1 Tab, Oral, Daily, 30 Tab, 0 Refill(s)

sertraline 50 mg oral tablet: 100 mg, 2 Tab, Oral, BID, 0 Refill(s), per nurse's notes.

Immunizations: Per nurse's notes.

Past Medical/ Family/ Social History

Medical history:

No active or resolved past medical history items have been selected or recorded., Reviewed as documented in chart.

Surgical history:

No active procedure history items have been selected or recorded., Reviewed as documented in chart.

Family history:

No family history items have been selected or recorded., Reviewed as documented in chart.

Social history:

Social & Psychosocial Habits

No Data Available
, Reviewed as documented in chart.

Problem list:

Active Problems (2)
Acute head injury
Post-concussion syndrome
, per nurse's notes.

Physical Examination

Vital Signs

Vital Signs/Vital Measures

10/22/2023 3:42 CDT	Blood Pressure Location	Arm, left upper
	Blood Pressure Source	Non-Invasive BP Device
	Systolic Blood Pressure	139 mmHg
	Diastolic Blood Pressure	78 mmHg
	Mean Arterial Pressure (MAP)	98 mmHg
	Temperature Source	Temporal artery scanning
	Temperature Mode	Fahrenheit
	Temperature, Fahrenheit	97.8 Deg F
	Clinical Temperature, C	36.6 Deg C

Emergency

	Pulse Rate	**103 bpm HI**	
	Respiratory Rate	**22 Breaths/Min HI**	
	Oxygen Saturation	94 %	
	Oxygen Therapy Mode	Room air	
10/21/2023 2:19 CDT	Systolic Blood Pressure	113 mmHg	
	Diastolic Blood Pressure	**58 mmHg LOW**	
	Mean Arterial Pressure (MAP)		76 mmHg
	Heart Rate Monitored	**58 bpm LOW**	
	Oxygen Saturation	96 %	
10/21/2023 1:35 CDT	Heart Rate Monitored	72 bpm	
	Oxygen Saturation	94 %	
10/21/2023 1:30 CDT	Systolic Blood Pressure	105 mmHg	
	Diastolic Blood Pressure	**54 mmHg LOW**	
	Mean Arterial Pressure (MAP)		71 mmHg
	Heart Rate Monitored	74 bpm	
	Oxygen Saturation	**89 % LOW**	
10/21/2023 1:00 CDT	**Systolic Blood Pressure**	**142 mmHg HI**	
	Diastolic Blood Pressure	69 mmHg	
	Mean Arterial Pressure (MAP)		93 mmHg
	Heart Rate Monitored	72 bpm	
	Oxygen Saturation	95 %	
10/21/2023 0:16 CDT	**Systolic Blood Pressure**	**165 mmHg HI**	
	Diastolic Blood Pressure	**102 mmHg HI**	
	Mean Arterial Pressure (MAP)		123 mmHg
	Temperature Source	Oral	
	Temperature Mode	Fahrenheit	
	Temperature, Fahrenheit	97.8 Deg F	
	Clinical Temperature, C	36.6 Deg C	
	Pulse Rate	90 bpm	
	Respiratory Rate	20 Breaths/Min	
	Oxygen Saturation	95 %	
	Oxygen Therapy Mode	Room air .	

Measurements

10/22/2023 3:42 CDT	Height Source	Stated	
	Height Entry Format	Imperial	
	Height/Length ENGLISH (in)		62 Inch
	CLINICALHEIGHT	157.48 cm	
	Weight Source, ED	Standing scale	
	Weight Entry Format	Imperial	
	Weight English lb	140 lb	
	CLINICALWEIGHT	63.64 kg	
	Body Surface Area (BSA)	1.67 m2	
	Body Mass Index	**25.7 kg/m2 HI**	
	Ideal Body Weight	50 kg	
10/21/2023 0:16 CDT	Height Source	Stated	
	Height Entry Format	Imperial	
	Height/Length, ENGLISH (ft)		5 ft
	Height/Length ENGLISH (in)		4 Inch
	CLINICALHEIGHT	162.56 cm	

Emergency

	Weight Source, ED	Critical estimated dosing weight
	Weight Entry Format	Imperial
	Weight English lb	130 lb
	CLINICALWEIGHT	59.09 kg
	Body Surface Area (BSA)	1.63 m2
	Body Mass Index	22.4 kg/m2
	Ideal Body Weight	54 kg .

Oxygen Saturation

10/22/2023 3:42 CDT	Oxygen Saturation	94 %
10/21/2023 2:19 CDT	Oxygen Saturation	96 %
10/21/2023 1:35 CDT	Oxygen Saturation	94 %
10/21/2023 1:30 CDT	**Oxygen Saturation**	**89 % LOW**
10/21/2023 1:00 CDT	Oxygen Saturation	95 %
10/21/2023 0:16 CDT	Oxygen Saturation	95 % .

General: Alert, grimacing, groaning, grunting.
Skin: Warm, dry.
Head: Normocephalic, atraumatic.
Neck: Supple, trachea midline, no tenderness.
Eye: Pupils are equal, round and reactive to light, extraocular movements are intact, normal conjunctiva.
Ears, nose, mouth and throat: Oral mucosa moist.
Cardiovascular: Regular rate and rhythm, No murmur.
Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal.
Gastrointestinal: Soft, Nontender, Non distended.
Neurological: No focal neurological deficit observed.
Psychiatric: Cooperative, appropriate mood & affect.

Medical Decision Making

Differential Diagnosis: Migraine, tension headache, sinusitis, subarachnoid hemorrhage, cerebral vascular accident, transient ischemic attack, intracranial hemorrhage, vomiting, dehydration, anxiety, depression, viral syndrome.

Rationale: 12:49 AM this patient is a 40-year-old female comes in the ER today complaining of migraine headache. Will obtain CT of head and Droperidol 2.5mg IM.

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Orders Include Previous Orders (Selected)

Inpatient Orders

Ordered

droPERidol 2.5 mg/mL injectable solution: 2.5 mg, 1 mL, IntraMuscular, 1-Time

Ordered (Exam Ordered)

CT Head WO:

.

Radiology results: **Radiology Results (Last 48 hours)**

A2329500011 -- 10/22/2023 03:36

CT Head WO (10/22/2023 04:38)

Result: EXAMINATION: CT Head Without Contrast DATE: 10/22/2023 4:42 AMINDICATION: Headache.TECHNIQUE: CT of the head was performed without IV contrast.COMPARISON: None.FINDINGS:Gray-white matter differentiation is maintained without evidence of alarge acute territorial infarction. Brain volume is appropriate for thepatient's stated age. No intraparenchymal hemorrhage or extra-axial fluid collection. No mass, mass effect, or midline shift of structures. No ventricularoutflow obstruction. Basal cisterns are patent.No acute osseous abnormality. The visualized paranasal sinuses andmastoid air cells are clear.IMPRESSION:1. No acute intracranial abnormality. Signed by Gregory M Morris, MD 10/22/2023 5:05 AMAll CT scans are performed using dose optimization techniques asappropriate to a performed exam including automated exposurecontrol and/or standardized protocols for targeted exams wheredose is matched to indication/reason for exam/patient size.

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Emergency

Reexamination/ Reevaluation
Time: 10/22/2023 05:11:00 .
Vital signs
per nurse's notes
Course: improving.
Pain status: decreased.
Assessment: exam improved.
Interventions: Include Previous Orders (Selected)
Inpatient Orders
Completed
droPERidol 2.5 mg/mL injectable solution: 2.5 mg, 1 mL, IntraMuscular, 1-Time
.

Impression and Plan
Diagnosis
Migraine headache - Discharge-MD
Plan
Condition: Improved, Stable.
Disposition: Discharged
Admit/Transfer/Discharge:
Discharge (Order): 10/22/2023 5:11 CDT, Discharge to: Home
.
Prescriptions: Prescription Writer
Pharmacy:
Zofran ODT 4 mg oral tablet, disintegrating (Prescribe): 4 mg, 1 Tab, Oral, Q8H, 10 Tab, 0 Refill(s)
, Prescription Writer
Pharmacy:
Zofran ODT 4 mg oral tablet, disintegrating (Prescribe): 4 mg, 1 Tab, Oral, Q8H, 10 Tab, 0 Refill(s)
.
Patient was given the following educational materials: Migraine Headache, Easy-to-Read.
Follow up with: Follow up with primary care provider Within 1-2 days call for follow up appointment, Follow up with primary care provider Within 1-2 days call for follow up appointment.
Counseled: Patient, Family, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions, family understood.

Addendum

Teaching-Supervisory Addendum-Brief
The case was discussed with: Midlevel provider.
Evaluation and management service: I agree with the evaluation and management decisions made in this patient's care.
Results interpretation: I agree with the study interpretation in this patient's care.

Request for Electronic Authentication By:

SCARBROUGH, DEWEY, PA Emergenc Electronically Authenticated On: 10/22/2023 05:13 AM

CoSigner: SCARBROUGH, DEWEY, PA Emergenc 10/22/2023 05:24 AM
10/22/2023 05:24 AM

CoSigner: WILBUR, LEE, MD Emergency Medi 10/24/2023 04:06 PM
10/24/2023 04:06 PM