Complete Emergency Care
10628 Culebra Rd Suite 200, San Antonio, TX 78251
(210) 579-9707

Patient: Clark, Rene G
DOB: 01/13/1961 64 year/F Wt: Ht:
MRN: CLARE000 PROVIDER: Edggar Frausto, MD
Acct #: 96016 Generated: 04/09/2025 04:41
DOS: 01/29/2025 10:14

PHYSICIAN CHART

CHIEF COMPLAINT:
Influenza-like illness

VITALS HISTORY:
Weight: Height: BMI:0

01/29/2025
11:10 BP: 100/64 Arm Supine (Automatic) MAP: 76 mmHG, Temp: 97.9 ºF Oral, HR: 57 Supine Awake , RR: 18, O2 Sat: 97% , Pain: 4

CURRENT MEDICATIONS:
CEVIMELINE HCL Dose: 25 mg Route: Orally Frequency: Daily
CHLORTHALIDONE Dose: Unknown Route: Orally Frequency: Daily
CYCLOBENZAPRINE HCL Dose: 10 mg Route: Orally Frequency: Daily
OZEMPIC Dose: Unknown Route: Subcutaneous Frequency: Once a week
SUPER B COMPLEX Dose: Unknown Route: Unknown Frequency: Daily
TRAMADOL HCL-ACETAMINOPHEN Dose: Unknown Route: Orally Frequency: Daily at bedtime
VALSARTAN Dose: Unknown Route: Unknown Frequency: Daily
Medication Reconciliation Completed and Signed by K. King, RN @ 01/29/2025 11:18:45

ALLERGIES:
Ace Inhibitors causes severe shortness of breath.

MODE OF ARRIVAL:
The patient arrived by walk in. Patient arrived unaccompanied.

HISTORY OF PRESENT ILLNESS:
This patient is a 64 year old female who presents with a chief complaint of Influenza-like illness. Provider assessment time was 01/29/2025 11:32. I reviewed the vital signs, the oxygen saturation result and the nursing/ treatment notes. I agree with the chief complaint selected for this patient's chart. The onset was 2 day(s) prior to arrival. There has been a cough which was described as nonproductive. The nasal discharge has been clear. The cough was described as mild. The shortness of breath was noted to be mild. There has been mild sore throat. The patient had a known contact exposure. The patient's symptoms include cough, nasal symptoms and sore throat. There is no history of asthma, immunosuppression, COPD or sinusitis. There was suspected exposure to Influenza A, Influenza B and COVID-19. The patient has not traveled outside of the United States. The patient has not had contact with anyone who has traveled outside of the United States within the last 30 days. Travel inside the US within the last 30 days? No. Patient meets criteria for potential additional screening criteria for: COVID-19. Positive Travel Screen Interventions initiated: patient wearing a surgical mask. There was associated facial pain.

ROS
CONSTITUTIONAL: Positive for fatigue.
EYES: Denies any eye problems.
ENT: Denies any ear problems. Positive for nasal congestion. Nasal discharge noted to be clear. Positive for throat pain and sore throat. Denies any mouth problems.
RESPIRATORY: Positive for cough and shortness of breath.
CV: Denies any cardiovascular problems.
GI: Denies any GI problems.

GU: Positive for dysuria and frequency.
NEUROLOGICAL: Denies any neurological problems.
MUSCULOSKELETAL: Denies any musculoskeletal problems.
INTEGUMENTARY: Denies any skin problems.
PSYCHIATRIC: Denies any psychiatric problems.

PAST MEDICAL HISTORY (PHYS):
No significant Past Medical History.
Recent hospitalizations: The patient has had no recent hospitalizations.
Medical: SYSTEMIC: History of anemia and fibromyalgia. No history of HIV, high lipids or cancer. Known carrier of PMH includes: Sjogren's Syndrome -[KK@06/02/2020 17:12]. Other Systemic Sjogrens DZ -[EN@10/10/2023 11:05]. ENT: No history of ENT problems. NEUROLOGICAL: No history of neurological problems. CARDIOVASCULAR: No history of abdominal aortic aneurysm or hypertension. PULMONARY: No history of pulmonary problems. PULMONARY: No history of asthma, chronic lung disease (COPD) or pneumonia. GI: No history of pancreatitis. GU: History of recurrent UTI. No history of ectopic or urolithiasis. PMH includes: only 1 kidney -[KK@06/02/2020 17:16]. MUSCULOSKELETAL: History of chronic back pain, osteoarthritis and scoliosis. PSYCHIATRIC: History of anxiety.
Surgical: The patient has a history of hysterectomy (Complete). The patient has no history of back surgery or neuro surgery.

FAMILY HISTORY (PHYS):
No significant Family History and aneurysm. Maternal history is positive for: aneurysm. Paternal history is positive for: aneurysm. Sibling history is positive for: aneurysm.

SOCIAL HISTORY (PHYS):
No significant Social History.
Habits: Tobacco use: Never smoker. Denies abusing alcohol (ETOH). No reported illegal drug use.
Lives: The patient lives at home.

INITIAL VITALS AT PRESENTATION:
01/29/2025
11:10 BP: 100/64 Arm Supine (Automatic) MAP: 76 mmHG, Temp: 97.9 ºF Oral, HR: 57 Supine Awake , RR: 18, O2 Sat: 97% , Pain: 4

PHYSICAL EXAMINATION
Constitutional: The patient was alert and ill-appearing. The patient was in mild distress.
Neck: The neck does not have meningeal signs. Negative for anterior and posterior cervical adenopathy.
Eyes: Negative for discharge and redness.
ENT: The airway was patent. Right tympanic membrane negative for redness, bulging, dullness, retraction and perforation. Left tympanic membrane negative for redness, bulging, dullness, retraction and perforation. The nose was positive for discharge. The nose was negative for bleeding and injection. Sinus exam was negative for tenderness. The oropharynx was positive for moist and redness. The oropharynx was negative for exudate and tonsillar hypertrophy.
Respiratory: The pulse oximeter reading was within a normal range. The lung sounds were clear, and breath sounds were equal bilaterally.
Chest: Negative for accessory muscle use and retractions.
CV: Heart rate was normal and the rhythm was regular. There was no systolic murmur or diastolic murmur.
GI: Palpation negative for hepatomegaly, splenomegaly and a non-pulsatile mass. There was no

abdominal tenderness.
Skin: No rash was present.
Neurological: The patient was oriented to person, place and time.
Psychiatric: Affect was appropriate.

DIAGNOSTIC CONSIDERATIONS FOR INFLUENZA-LIKE ILLNESS:
DIAGNOSTIC CONSIDERATIONS: Allergic rhinitis, COVID -19, Influenza, Pharyngitis, viral and URI.
(I have considered the above as the potential cause of the patient's condition. I have based my consideration on a limited patient encounter, and my considerations may not be all-inclusive. History, physical examination, and/or diagnostic studies, in combination with medical judgment, have been used in determining the final diagnosis)

MDM:
Problems Addressed: The patient has no chronic disease processes affecting care.
Reviewed and Analyzed Data: Information regarding the patient was obtained from no other sources. Review of external records included none. No independent study interpretation was performed.
Risk of Morbidity: No additional treatments considered.
Disposition Management: Patient care management was discussed with The patient management was not discussed with any outside entities. The patient was not considered for hospitalization or escalation of level of care. The patient and I, along with available family/guardian/friends, had a discussion in layman's terms which included SHARED DECISION MAKING. All parties indicated they understood the condition, diagnosis, treatment, and agreed with the plan. STRONG PRECAUTIONS were discussed, including study limitations, and the patientwas advised toreturn to the emergency department if any changes occur or concerns ariseregarding their condition. I have also informed thepatient/family that if needed they would beable to call the emergency department and discuss any concerns with nurses and or doctors. I have counseled the patient about ongoing non-emergent medical problems and have recommended close follow-up with their PMD. This includes incidental findings on labs and/or radiologic studies done in ED. Patient comes in presenting with signs and symptoms of COVID-19. Patient recently had family member/close contact who tested positive for corona virus. History and PE c/w viral syndrome, POSSIBLE covid-19. Influenza negative and covid swab negative. No clinical evidence of SERIOUS BACTERIAL INFECTION to include PTA, RPA, PPA, epiglottitis, or pneumonia. Antibiotics not indicated at this time but will treat symptomatically. Discussed return indications, prognosis and need for follow up. Patient expressed full understanding.
Of note pt c/o of frequency and dysuria. UA was done that showed nitrites positive. will start abx for uti and send out urine cx. pt understood and agreed with plan. -[EF@01/29/2025 17:04].

SOCIAL DETERMINANTS:
ECONOMIC STABILITY: Income / Employment: The patient has no income or employment issues. Housing: The patient has no housing issues. The patient has no housing concerns. Food: The patient has no Food Issues. Transportation: The patient has no Transportation Issues. HEALTHCARE:The patient has full access to healthcare. EDUCATION: The patient has no literacy or language issues. SOCIETAL DETERMINATES: Community: The patient has no community issues.

PROVIDER TREATMENT NOTES:

COVID NOTES:
COVID Counseling Preventive medicine counseling and/or risk factor reduction intervention(s) were provided the patient.

CONSULTATION(S):

ADDITIONAL NOTES:

Prudent Layperson: Prudent Layperson Standard: The patient has presented with significant concern that an emergency condition exists. The patient is a prudent layperson. The patient is protected under the Prudent Layperson Standard see Diffferential Diagnosis.

ORDERS AND RESULTS:

ED Orders:

Placed Orders:

COVID-19 Antigen & Influenza A/B - (Verbal from E. Frausto MD) Placed at 01/29/2025 11:19, ; Completed at 01/29/2025 11:28, ; Reviewed at 01/29/2025 11:38, EF, MD; E. Frausto at 01/29/2025 11:38 Interpretation WNL.

COVID Rapid Antigen:	Negative	(Negative)
Influenza A:	Negative	(Negative)
Influenza B:	Negative	(Negative)
Controls Reacted Appropriately:	Yes	(Yes)
Note:		

Urinalysis Placed at 01/29/2025 11:37, EF, MD; Completed at 01/29/2025 11:43, ; Reviewed at 01/29/2025 11:45, EF, MD; E. Frausto at 01/29/2025 11:45 Interpretation ABNL.

DEXAMETHASONE SOD (Decadron) 10mg/ml INJ - 10 mg IM Placed at 01/29/2025 11:43, EF, MD; Completed at 01/29/2025 11:43,

KETOROLAC TROMETHAMINE (Toradol) 30mg/ml - 30 mg IM Placed at 01/29/2025 11:43, EF, MD; Completed at 01/29/2025 11:43,

UA Culture (SO) Placed at 01/29/2025 11:45, EF, MD; Completed at 01/29/2025 11:43, ; Reviewed at 01/29/2025 11:45, EF, MD; E. Frausto at 01/29/2025 11:45 Results Pending.

PROCEDURES:

IMPRESSION:

CONTACT WITH AND (SUSPECTED) EXPOSURE TO OTHER VIRAL COMMUNICABLE DISEASES INCLUDING COVID-19 - [Z20.828]
URINARY TRACT INFECTION, SITE NOT SPECIFIED - [N39.0]
ACUTE COUGH - [R05.1]
ILLNESS, UNSPECIFIED - [R69]
NASAL CONGESTION - [R09.81]
ACUTE BRONCHITIS, UNSPECIFIED - [J20.9]
MYALGIA, UNSPECIFIED SITE - [M79.10]
COUNSELING, UNSPECIFIED - [Z71.9]
WORRIES - [R45.82]

DISPOSITION (PHYS):

The disposition time decision was 01/29/2025 11:46.
Discharge.

Discharge: The patient was discharged to home. The patient's condition upon discharge was good and stable. Education was provided to the patient in reference to the final impressions, prognosis and need for follow up. Based on the medications I am prescribing, I have made any necessary changes to the patients medications.

Instructions given to the patient: Bronchitis, Urinary Tract Infection.

Follow up provider: Your Doctor (Primary Care Physician) , ,.

Follow up: If symptoms are not Better in Within 2 days.
Prescriptions: AZELASTINE 0.1% (137 MCG) SPRY Spray 1-2 spray(s) 2 times a day (BID) Nasal Dispense: 1 spray(s) Generic allowed No refills Rx Num 1293463
BROMFED DM COUGH SYRUP Apply 10 milliliters every 6 hours Oral Dispense: 410 milliliters Generic allowed No refills Rx Num 1293464
CEFDINIR 300 MG CAPSULE Take 1 capsule(s) 2 times a day (BID) Oral Dispense: 14 capsule(s) Generic allowed No refills Rx Num 1293466
PREDNISONE 20 MG TABLET Take 2 tablet(s) once a day (QD) Oral Dispense: 6 tablet(s) Generic allowed No refills Rx Num 1293465
Excuse:
No work starting 1/29/2025. Return on 1/30/2025.

CALL BACK:
Call Back - Closed
Disposition Type Discharged

SIGN OFF:
E. Frausto, MD
Chart electronically signed by E. Frausto, MD @ 01/29/2025 17:04:48
Verbal orders signed by Edggar Frausto, MD on 01/29/2025 17:04:48

ADDENDUM

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PHYSICIAN CHART

PHYSICIAN CHART CALLBACK
01/31/2025 06:40 - Randal Seriel
Results reviewed, no changes to plan of care