Georgetown University Hospital
3800 Reservoir Road
Washington, DC 20007-

(202) 444-2000

Patient: **YOSHIMOTO, AYAE**
MRN: GUH-000002380268
FIN: GUH-07732455709
DOB/Age/Sex: 10/26/1994 31 years Female

Date of Service: 5/1/2025
Attending Provider: Layman,MD,Kerri L.

Patient Viewable Documents

DOCUMENT NAME: ED Note-Clinician
PERFORM INFORMATION: Kane,MD,Cary Anne (5/2/2025 05:36 EDT)
RESULT STATUS: Auth (Verified)
SERVICE DATE/TIME: 5/2/2025 05:34 EDT
SIGN INFORMATION: Burrows,MD,Eliese Friedel (5/6/2025 14:43 EDT); Kane,MD, Cary Anne (5/2/2025 08:02 EDT)

Clinician Assign
Time Seen:
Kane, MD, Cary Anne / 05/02/2025 02:30 - ED Resident
Preferred Language/Interpretation Services
Preferred Language Discussing Healthcare: English
Interpreter Used: N/A

Sources reviewed: Chart review, pt interview

Initial nursing notes reviewed.

Chief Complaint

As per Triage RN:
Burning of L side of face (cheek) x 6 hrs. Cough, sore throat, nasal congestion x 2 weeks. Denies fevers, CP, SOB. Airway intact. Denies PMH.
Arrived From for ED: Home
Lines or Tubes Present on Admission: None

History of Present Illness
Patient is a 30 year old with no PMH presents with left sided burning of her face.

Patient has had URI symptoms for about 1 week. Symptoms include cough, sore throat, runny nose, fatigue. She has not had fever, nausea vomiting, diarrhea. She has not needed any meds to take care of her symptoms. Today patient developed tingling in her left cheek. Denies vision changes, eye tearing, headache, fever. Has had increased acne on her face for past couple weeks but no rash on her cheek since sx started. No difficulty w/ facial movements (has received botox so has decreased mobility of eye brows at baseline).

PMH: None
Meds: Birth control, Mg, Vit B, Vit D
Allergy: None
Substance use: pollen

Relevant Social Determinants of Health
none

Problem List/Past Medical History
Ongoing
No chronic problems

Allergies
aspirin
ibuprofen

Home Medications
Home
acetaminophen(Tylenol), PO
drospirenone-ethinyl estradiol(Yaz 3 mg-0.02 mg oral tablet), 1 tab, PO, Daily, 4 refills, start first tablet today

Social History
Smoking Status
Never smoker

Alcohol
Alcohol Use:Denies

Substance Use
Use:Denies

Tobacco/Nicotine
Use:Past
Smoking Status
Tobacco Use: Never Used (05/02/25)

Family History

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Review of Systems
10 point ROS negative except as per HPI.

Physical Exam

Vitals:
Initial Vitals
T: 36.9 degC (Oral) **HR:** 69 (Peripheral) **RR:** 15 **BP:** 103/70 (Automated) **SpO2:** 99%
Constitution: well developed, well nourished, in no acute distress;
Head/ENT: Normocephalic / atraumatic; no nasal deformities, moist mucus membranes, no erythema or lesions in oropharynx, good dentition
Eyes: conjunctiva and sclera clear; Normal Lids, PERRLA
Neck: supple
Respiratory: clear to auscultation, no increased work of breathing
CVS/Pulses: regular rate and rhythm, S1, S2, good pulses bilaterally
GI/Abdomen: soft/nontender; no guarding or rebound
Msk: normal gait and station
Extremities: no edema
Neurologic: no focal deficits; CN II-XII grossly intact except for reported numbness over L cheek (normal sensation forehead and jaw) - with normal sensation; strength
Skin: no rashes or atypical lesions
Psych: alert and oriented x 3; mood appears normal

Assessment and Plan/Medical Decision Making
Patient is a 30 year old with no PMH presents with left sided burning of her face in setting of viral illness. Hemodynamically stable, appears comfortable, only notable physical exam finding was numbness over left cheek. Decreased ability to raise eyebrows due to Botox. Etiology of burning unclear, possibly due to viral syndrome vs. start of shingles (tenderness w/ palpation along dermatome, but no rash) vs. less likely peripheral nerve palsy/bell's palsy. Otherwise normal neuro exam, low concern for intracranial mass, no indication for imaging at this time. Low concern for stroke.

- Tylenol for discomfort
- Follow up with PCP

Impression/Disposition

ED Diagnosis:
Left facial pain| (R51.9)
Patient Disposition
Discharge Patient (Discharge Patient MGUH) - Ordered
-- 05/02/25 6:11:00 EDT, Home, Improved/Stable

Discharge Prescriptions:
No documented discharge medications

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Attending Physician Note:
Case discussed with the Resident. I have interviewed and examined the patient and agree with the plan of care unless otherwise noted.

Electronically signed by:

Kane, MD, Cary Anne on: 05.02.2025 08:02 EDT

Electronically signed by:

Burrows, MD, Eliese Friedel on: 05.06.2025 14:43 EDT