

PROGRESS NOTE - HISTORY

Name Sykes, Romale P
Gender M
Facility Lexington Health Care Center of Chicago
Ridge
Room # 115
Admission 11/27/19
Date
Date Form Opened 12/14/2019

MR # 143065
Birth Date 02/09/1979
Marital Married
Status
Reason For Visit tibial plateau fx, pain management

Chief Complaint

History of Present Illness:

Patient is a 40 year old male who presented to the hospital after a MVC on the expressway. Patient was found to have a right eyebrow and lip lac, left open tib/fib fx, b/l, tibial plateau fx, abrasion to right tibia. He underwent a L tibia plateau ORIF, tibial, shaft I&D, IMN left tibia, left pilon ORIF with left calcaneus ORIF and left distal ORIF and right tibial plateau and pilon. PMH of HTN, TBI.

Patient seen today for tibial plateau fx, pain management. Patient denies any pain. Patient states pain is controlled at this time, he is NWB to b/l LE, working with therapy. Wound care consult for healing injuries. Denies HA, CP, SOB, N/V/D/C.

Past Medical History Reviewed

Past Medical/Surgical History:

HTN, TBI

Health Status

Advanced Directives:

Full Code/Attempt
Resuscitation/CPR, Full
Code/Attempt Resuscitation/CPR,

Additional Notes Regarding Advanced Directives:

Select dropdown arrow to see all diagnoses. Admitting diagnosis is at the top.

S82.142D — Displaced bicondylar fracture of left tibia, subsequent encounter for closed fracture with routine healing

Recent Physician Progress Notes (Click links to view):

Recent Laboratory and Diagnostic Tests (Click Link to Access Laboratory Attachments):

Reviewed Laboratory Results

Labs/Radiology (List reviewed labs with dates)
11/29/19: WBC-9.22, Hgb-11.1, Plt-687
Na-141, K-4.9, BUN-21, Cr-0.78

Jaqueline Kimball
H R D -

01-11-20 16:18 FROM-
1/11/2020 2:09 PM (CST)

T-022 P0035/0039 F-268
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Health Status (Continued)

Allergy List: No Known Allergies

Medication List (Click link to view all orders):

Reviewed Medications

Review of Systems

CONST	Y	N	RESP	Y	N	GU	Y	N	MS	Y	N
WNL to ALL Constitution			WNL to ALL RESP			WNL to ALL GU			WNL to ALL MS		
Fever			SOB	No		Dysuria			Joint Pain		
Δ Mental Status			Cough	No		Hematuria			Swelling		
Δ Function			Wheezing			Frequency			Myalgia		
Δ Weight			Phlegm			Urgency			Arthralgia		
Pain	No		Hx Smoking			Nocturia			Fall last 30 days		
						Foley			Hx of Falls		
									Gait D/O		

HEENT	Y	N	GI	Y	N	NEURO	Y	N	PSYCH	Y	N
WNL to ALL HEENT			WNL to ALL GI			WNL to ALL NEURO			WNL to ALL PSYCH		
Eye Discharge			Nausea			Syncope			Anxiety		
Δ Visual			Vomiting			Aphasia			Depression		
HOH			Obesity			HA			Sleep Disturbance		
Epistaxis			Abd Pain			Vertigo			Agitation		
Rhinitis			Diarrhea			Focal Weakness			Combative		
Tinnitus			Constipation			Paraesthesia			Hallucination		
Sore Throat			Melena			Seizures			Psychosis		
			Hemoccult			Confused	No		Δ Mood		
			Dysphagia								
			Dyspepsia								
			Δ Appetite								
			Δ Stools								
			G tube								

CV/PV	Y	N	DERM	Y	N	Other:
WNL to ALL CV/PV			WNL to ALL DERM			
Chest Pain	No		Rash			
Palpitation	No		Pruritus			
Dizzy	No		Bruising			
DOE						
Edema						

Urinary:	Clear	Comments
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Psych	Normal Mood	Comments
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Pain: Scale 0 - 10	0 = No pain	Change from baseline?	Comments - Sites
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Other:	
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Physical Examination**Latest Vitals:**

Weight: 145.00

Temperature: 97.50 [Temporal]

Blood Pressure: 135 / 87 [R Arm Sitting]

Pulse: 102.00 [Brachial]

Respiration: 20.00

Pulse Ox: 97.00 [Room Air]

Past Vitals (Click link to view all vitals)**Physical Examination:**

LOC:	Alert	Change from baseline?	Comments
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Orientation:	Time Person	Change from baseline?	Comments
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Neuro		Comments
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HEENT:	Normocephalic	Comments
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Apical/Radial Pulse:	Regular		Change from baseline?	Comments
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Murmur?	No	If Yes, describe Murmur
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Edema:	N/A	Pitting Edema, scale +	Change from baseline?	Comments
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Peripheral Pulses:	Right:WNL	Right Capillary refill <3 seconds:	Comments
	Left:WNL	Left Capillary refill <3 seconds:	

Skin:	Warm Dry	Turgor:	Change from Baseline
			Skin Comments

Skin Color:	WNL	Abnormal:
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Respiration:	WNL	Abnormal:	Respiratory Comments
Breath Sounds:	Right:	Clear	
	Left:	Clear	
			Change from baseline?

Cough:	No	Describe:	Change from baseline?
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Abdomen:	Soft	Change from baseline?	Abdomen/Bowel Comments
Bowel Sounds:	Normoactive	Change from baseline?	

Assessment/Plan

Problem 1Select Problem

Encounter of orthopedic aftercare (Z47.89), left tibial fx (S82.142D) right tibial fx (S82.141D) Pain (89.11)

Pain management

Cont oxy, pain controlled with current regimen, script signed for refill

Cont gabapentin

Cont docusate

Cont Lovenox

Ortho f/u

PT/OT

wound care consult staple removal 12/4 and cover with steri strips per d/c notes from hospital

Problem 2Select Problem

HTN (I10)

Monitor BPO

Cont Coreg

Cont Losartan

Problem 3Select Problem Z87.820 — Personal history of traumatic brain injury

h/o TBI (Z87.820)

No seizures

Cont to monitor

Cont levetiracetam

Problem 4Select Problem M62.81 — Muscle weakness (generalized)

continue PT,OT

fall/safety precautions

Problem 5Select Problem **Problem 6**Select Problem **Problem 7**Select Problem **Problem 8**Select Problem **Signature (Click on the check box to sign)**

Jackie Kimball, NP

(12/14/2019 04:10 PM
(CST))