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North Alicia

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Department: Neurology / Internal Med

Document Type: ED NOTE + CONSULT + DISCHARGE

Generated: 03-21-38 ********

Printed by: Carter (unit clerk) ext 608.263.5849

PATIENT INFORMATION

Name: Rory

AKA: Rory Rory

DOB: 06-19-94

Age: 29 y/o

Sex: F

Preferred Language: English

Race/ethnicity (self-reported): Korean-American

MRN: 13769177

Acct#: *******

Encounter ID: **********

Home Address:

East Matthew

Apt# 3B

West Sarah *****

CURRENT ADDRESS (per patient, moved recently):

Lake Michelle West Jordanmouth Apt #3B

Thomasshire 39905

Phone: 968.867.3937

Alt/cell: 648.266.2568

Email: ****** @ **********

Emergency contact:

Dylan (spouse) 986.683.3245

relationship: wife

Secondary contact:

Avery (sister) 989.703.1474

Primary care provider (outside):

Micah

Lauraside Pulmonology

Fax: 855.955.7347

CHIEF COMPLAINT

"migraine flare" + dizziness + chest tightness intermittently

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HISTORY OF PRESENT ILLNESS

Pt is a 29 yo F presenting on 05/04/2024 with headache for 2 days.
Pain begins behind R eye, throbbing, +photophobia.
She states she ran out of topiramate "a few wks ago" due to insurance issues.
Reports dizziness at work yesterday while lifting boxes.

She works at ********** ********* shift). Reports high stress.
Denies syncope. No focal weakness or speech changes.
One episode N/V this AM 05-04-24

Pt also notes intermittent chest pressure for ~2 weeks, worse w/ exertion.
She denies palpitations. No LE swelling. No known hx DVT/PE.

She notes she lived in East Pennymouth until 06-19-39 and previously received care at:
South Melvinton Neurology Center
North Ernest Angelaville
(Old records list this address; patient unsure if still correct.)

Pt traveled internationally recently (reports "Spain + Netherlands") for vacation, returned approx 04/12/24 Also mentions family background includes Czech ancestry on father's side. (Father immigrated from Poland in early 01-22-65

REVIEW OF SYSTEMS

+ headache
+ nausea/vomiting
+ photophobia
- fever/chills
- cough
- SOB at rest
- dysuria
- rash

PAST MEDICAL HISTORY

Migraine disorder
Asthma (mild intermittent)
HTN (borderline)
Hyperlipidemia
Anxiety

Prior hospitalizations: none known
Surgical hx: appendectomy 03-05-00

ALLERGIES: NKDA per pt
MEDS (per pt; inconsistent compliance):
- topiramate 25mg BID (ran out)
- albuterol inhaler PRN
- lisinopril 10mg daily
- atorvastatin 20mg qhs

SOCIAL HISTORY

Lives w/ spouse. Denies tobacco. Occ ETOH.
No illicit substances.
Employment: ********** *********
Insurance: ********** (pt unsure of policy #)

Pt prefers morning appts; works nights occasionally.

FAMILY HISTORY

Mother: Rory (contact in chart: 731.500.9806 [note: pt unsure if current]
Father: deceased, hx "stroke" per pt
Sibling: sister Avery (see contact above)

PHYSICAL EXAM

Vitals:
T 98.2 HR 102 BP 151/92 RR 18 SpO2 99% RA
GEN: alert, anxious
HEENT: PERRL, mild photophobia
CV: tachycardic, reg rhythm
RESP: CTA bilat

NEURO: AOx3, CN2-12 intact, no drift, gait slightly unsteady

ED COURSE / MEDICAL DECISION MAKING

Given migraine cocktail: fluids + metoclopramide + ketorolac.
Pt improved significantly after tx.

EKG: sinus tachy, no ST elevation.
CXR: negative.
Troponin: negative.

Consider PE given travel hx; D-dimer obtained.

LAB RESULTS

Specimen ID: ********
Collection date: 01-22-05 *****
Result date: 2024-05-05

CBC: WNL
BMP: WNL
D-dimer: 0.42 (neg)
hCG: negative

IMAGING

CT Head w/o contrast
Study date: 2024-04-01 (outside prior) — stable
Today's study date: 05/04/24
IMPRESSION: no acute intracranial hemorrhage. chronic microvascular changes.

NEUROLOGY CONSULT NOTE

Consult requested by ED provider at 23:40.

Consultant: Blake
Assistant: Carter

Assessment:
Chronic migraine w/ medication nonadherence.

No red flags. Normal neuro exam.

Plan:
1. Restart topiramate 25mg BID; increase to 50mg BID in 7 days if tolerated.
2. Add sumatriptan 50mg PRN for severe headaches (max 2 doses/24h).
3. Encourage hydration, sleep hygiene.
4. Follow up in clinic.

Follow-up arranged:
Thompsonshire Care / Neurology clinic
Call 246.381.7870 for scheduling

Pt requests Markton paperwork; advise PCP.

DISCHARGE SUMMARY

Discharge date: 05-05-24
Disposition: home

DIAGNOSES:
- Migraine exacerbation
- Anxiety
- Chest tightness, likely non-cardiac

FOLLOW UP:
PCP: Micah Lauraside Pulmonology listed in chart; verify PCP)
Neurology in 4-6 weeks

DISCHARGE CONTACT INFO:
Return precautions given. Patient understands.

Signed:
Micah (electronically signed)
Faxed summary to: 855.955.7347

NOTES / ADDENDUM

Pt requested results be emailed due to difficulty accessing portal:
****** @ **********

Spouse requested call for updates:
986.683.3245

Case mgr note:
Pt has outstanding balance; referred to billing office.

END OF DOCUMENT
