EMR Narrative Generated Markdown

Emergency Room Visit Report

HPI

Arrival

Arrival

Date/Time: 05/01/2025 02:28
Source: Emergency Room Visit Report
Mode of Arrival: Ambulance
Accompanied by: Spouse

Chief Complaint (CC): Fever, chills, diarrhea

History of Present Illness (HPI):
65 y/o female presents to the ER with a 2-day hx of fever (Tmax 102°F), chills, and profuse watery diarrhea. Pt reports 6-8 episodes of diarrhea per day, associated with abdominal cramping. No hematochezia or melena noted. Pt c/o generalized weakness and fatigue. Denies nausea or vomiting. Recent abx use for UTI 3 weeks ago. Hx of recurrent C. difficile infection. No recent travel or sick contacts.

Past Medical History (PMH):
- Obstructive Sleep Apnea
- Anxiety Disorder
- Hx of C. difficile infection
- Hx of breast cancer, in remission

Past Surgical History (PSH):
- Partial colectomy
- Mastectomy with reconstruction

Social History (SHx):
- Tobacco: Former smoker
- Alcohol: Occasional, social
- Drugs: Denies illicit drug use
- Occupation: Retired teacher
- Living situation: Lives at home with spouse

Family History (FHx): Non-contributory

Allergies: NKDA

Review of Systems (ROS):
- Constitutional: Positive for fever, chills, fatigue
- GI: Positive for diarrhea, abdominal cramping
- Respiratory: Negative for cough, dyspnea

- Cardiovascular: Negative for chest pain, palpitations
- Neurological: Negative for headache, dizziness

Physical Examination (PE):
- General: Alert, NAD, appears fatigued
- Vitals: T 101.8°F, HR 110, BP 98/60, RR 20, SpO2 96% RA
- HEENT: WNL
- Cardiovascular: Tachycardic, regular rhythm, no murmurs
- Respiratory: Clear to auscultation bilaterally
- Abdomen: Soft, diffusely tender, hyperactive bowel sounds
- Extremities: No edema
- Neurological: A&O x3, no focal deficits

Assessment & Plan (A&P):
- Sepsis, unspecified organism: Initiate sepsis protocol, blood cultures x2, lactate, CBC, CMP
- R/O recurrent C. difficile infection: Stool studies for C. difficile toxin, start empiric oral vancomycin
- Dehydration: IV fluids, monitor electrolytes
- Continue home CPAP for OSA

Disposition: Admit to hospital for further management and monitoring.

Travel/Ebola Screening

Travel/Ebola Screening

Screening Tool	Result	Risk Category	Interventions
Travel History	No recent travel	Low	None
Ebola Exposure Risk	No known exposure	Low	None

- Travel History: No travel outside the country in the past 21 days. No travel to Ebola-endemic regions.
- Ebola Exposure: No contact with individuals diagnosed with or suspected of having Ebola. No participation in funeral rites or healthcare settings in affected areas.

Patient presents with s/s concerning for sepsis; however, no epidemiological risk factors for Ebola identified. Continue with standard sepsis protocol.

COVID Screening

COVID Screening

Screening Tool	Result	Risk Category	Interventions
COVID-19 PCR Test	Pending	N/A	Isolation precautions
COVID-19 Antigen Test	Negative	Low	Standard precautions
COVID-19 Symptom Check	Fever, Cough	High	Isolation precautions

- COVID-19 exposure: Denied
- Recent travel: Denied
- Vaccination status: Fully vaccinated, booster received 11/2024

History of Present Illness

HPI

65 y/o female, Sarah Johnson, p/w fever, chills, malaise x 2 days. T 102.3°F, HR 110, BP 90/60. Reports diarrhea x 5 days, watery, non-bloody, 6-8 episodes/day, assoc. with crampy abd pain. H/o C. difficile infection, s/p partial colectomy. Recent Abx: Amoxicillin for sinusitis 2 weeks ago. No recent hospital admissions. Risk factors for C. diff include h/o infection, recent Abx use. Initial interventions: IVF initiated, blood and stool cultures obtained, empiric Abx started. Initial impression: infectious etiology, sepsis vs C. diff colitis.

Provider HPI Details

Provider HPI Details

65 y/o F presents to ED c/o fever, chills, and diarrhea x 2 days. Reports generalized weakness, decreased oral intake, and confusion. Denies recent travel, new medications, or known sick contacts. PMH significant for OSA, anxiety, h/o C. difficile infection, and breast CA in remission. PSH includes partial colectomy and mastectomy with reconstruction. SHx: former smoker, occasional alcohol use, denies illicit drugs. Lives with spouse. FHx noncontributory.

Vitals: T 101.8°F, HR 112, BP 98/60, RR 22, SpO2 94% RA. Appears ill, NAD. Initial labs: WBC 18.5, neutrophilic predominance. Lactate 3.2. CMP: hyponatremia, mild AKI. Blood cultures pending. Stool studies ordered to R/O recurrent C. difficile. Imaging deferred at this time.

Assessment: Suspected sepsis, likely infectious etiology. Differential includes recurrent C. difficile enterocolitis. Initial sepsis protocol initiated.

Pain Assessment

Pain Assessment

- **Location:** Generalized abdominal pain
- **Onset:** Acute, began 2 days prior to presentation
- **Duration:** Persistent, worsening over 48 hrs
- **Quality:** Cramping, diffuse
- **Severity:** 7/10 on pain scale
- **Radiation:** No radiation
- **Aggravating Factors:** Movement, palpation
- **Alleviating Factors:** None noted
- **Associated Symptoms:** Nausea, diarrhea, fever
- **Previous Episodes:** Similar pain during prior C. difficile infection
- **Impact on Function:** Limited mobility, difficulty sleeping
- **Patient's Pain Goal:** 3/10
- **Current Pain Management:** Acetaminophen, limited relief

Pain assessment consistent with potential infectious process, c/w Hx of recurrent C. difficile infection. Further evaluation and management required.

Immunizations

Immunizations

- Influenza vaccine: Administered annually, last dose 10/2024
- Pneumococcal vaccine: PCV13 and PPSV23 completed, last dose 11/2023
- Tdap: Booster given 08/2023
- Shingles vaccine: Shingrix series completed, last dose 06/2023
- COVID-19 vaccine: Fully vaccinated, booster received 12/2024
- Hepatitis B vaccine: Completed series, last dose 09/2023
- Hepatitis A vaccine: Deferred
- MMR: Immunity confirmed, no booster required
- Varicella: Immunity confirmed, no booster required

NKDA.

Allergies/Home Meds

Allergies

Allergen	Reaction	Severity	Notes
Penicillin	Rash, pruritus	Moderate	Avoid all penicillins
Sulfa drugs	Anaphylaxis	Severe	Avoid all sulfa medications
NKDA			

Home Medications

Medication	Dose	Route	Frequency	Indication
Lorazepam	0.5 mg	PO	BID	Anxiety
Omeprazole	20 mg	PO	QD	GERD
Metoprolol	50 mg	PO	BID	HTN
Levothyroxine	75 mcg	PO	QD	Hypothyroidism
Albuterol HFA	90 mcg/act	INH	Q4-6H PRN	SOB/Respiratory Sx
ASA	81 mg	PO	QD	Cardioprotection
Multivitamin	1 tab	PO	QD	Supplementation
Calcium + Vit D	500 mg/400 IU	PO	BID	Osteoporosis prevention
Acetaminophen	500 mg	PO	Q6H PRN	Pain/Fever

NKDA.

Last Intake

Last Intake

- Date/Time: 05/01/2025 01:45
- Type: Oral
- Contents: Clear liquids (water, apple juice)
- Tolerance: Tolerated well, no N/V
- NPO Status: Initiated post-intake for further evaluation and management
- Additional Notes: Patient instructed to remain NPO pending further diagnostic testing and potential intervention.

Reproductive History

Reproductive History

- G3P3 (Gravida 3, Para 3)
- Menarche: Age 13
- Menopause: Age 50
- LMP: N/A (post-menopausal)
- Contraceptive Hx: None post-menopausal
- OB Hx:
  - Full-term deliveries: 3
  - No history of miscarriages or abortions
- Gynecological Hx:
  - Pap smears: Regular, last Pap 1 year ago, WNL
  - Mammograms: Annual, last mammogram 6 months ago, WNL
- HRT: None
- No history of gynecological surgeries beyond mastectomy for breast cancer