Patient Medical History Report

1. Patient Information

* **Patient Unit Stay ID:** 425870 * **Patient Health System Stay ID:** 363090 * **Unique Patient ID:** 005-10445 * **Gender:** Male * **Age:** 76 * **Ethnicity:** Hispanic * **Hospital ID:** 141 * **Ward ID:** 307 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 04:01:00 * **Unit Admit Source:** Emergency Department * **Hospital Admit Time:** 02:00:00 (Hospital Admit Offset: -121 minutes from unit admit) * **Hospital Discharge Time:** 19:23:00 (Hospital Discharge Offset: 18202 minutes from unit admit) * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Unit Discharge Time:** 04:26:00 (Unit Discharge Offset: 4345 minutes from unit admit) * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Admission Weight:** 66.7 kg * **Admission Height:** 162.6 cm * **Discharge Weight:** NULL

2. History

The provided data does not include a detailed patient history. Further information is needed to complete this section. This section would typically include information on presenting complaints, relevant past medical history (including previous hospitalizations, surgeries, and significant illnesses), family history of relevant conditions, social history (including smoking, alcohol, and drug use), and medication history. NULL

3. Diagnoses

The patient received multiple diagnoses during their ICU stay. The diagnoses, listed in order of priority, are:

* **Primary:** Septic shock (ICD-9 codes: 785.59, R65.21) * **Major:** Diabetic foot infection without gangrene (ICD-9 codes: NULL) * **Major:** Anemia (ICD-9 codes: NULL) * **Major:** Leukocytosis (ICD-9 codes: 288.8, D72.829) * **Major:** Diabetes Mellitus (ICD-9 codes: NULL) * **Major:** Wound infection (ICD-9 codes: NULL)

Multiple entries for each diagnosis suggest repeated assessments and reassessments over the course of the ICU stay. The temporal aspect of these diagnoses, indicated by the `diagnosisoffset`, could reveal important information regarding the progression of the patient's condition and the effectiveness of treatment interventions. For example, it would be useful to determine whether the diabetic foot infection was present on admission or developed during the hospital stay. Similarly, the timing of septic shock diagnosis in relation to other diagnoses is clinically relevant.

4. Treatments

The patient received several treatments during their ICU stay. Some treatments were active upon discharge, others were not. The treatment details include:

* **Therapeutic Antibacterials:** Administered to address the infectious diseases diagnoses (wound infection and diabetic foot infection). The timing and type of antibacterials are not specified in this dataset and would be important in a more comprehensive report. * **Conventional Heparin Therapy (Subcutaneous):** Used for VTE prophylaxis (Venous Thromboembolism). This suggests a potential risk assessment for blood clots. * **Analgesics (Narcotic and Bolus Parenteral):** Used to manage pain and possibly agitation, suggesting a level of discomfort or distress experienced by the patient. * **Antiemetic:** Used to address nausea and vomiting that may be present in patients with infections or other illnesses. * **Beta-blocker (Metoprolol):** Prescribed for hypertension, indicating a pre-existing condition. * **Insulin (Subcutaneous and Sliding Scale):** Used to manage diabetes mellitus, confirming a pre-existing condition. * **Oxygen Therapy (Nasal Cannula):** Indicates respiratory support provided, potentially due to the septic shock or other respiratory complications. * **Consultations:** Consultations with specialists (Infectious Disease, Surgery, and Pulmonary/CCM) were indicated and some active at discharge.

5. Vital Trends

The physical examination data provides limited vital sign information, including several measurements of heart rate (HR), blood pressure (BP), respiratory rate (RR), and oxygen saturation (O2 Sat) at different time points. To generate comprehensive vital trends, further data points are required to construct a time series analysis. NULL

6. Lab Trends

The laboratory data includes various blood tests (hemoglobin, hematocrit, white blood cell count, platelet count, etc.) and chemistry panels (glucose, BUN, creatinine, etc.) performed at different time points. Again, a time series analysis is needed to fully assess lab trends. The available data shows some lab results for different times. To complete this section, more lab results over time are needed. NULL

7. Microbiology Tests

The provided data does not contain information on microbiology tests such as blood cultures, wound cultures, or urine cultures. These tests are crucial in diagnosing and managing infectious diseases. NULL

8. Physical Examination Results

Physical examination data is limited, but the initial exam (at 32 minutes) recorded a heart rate of 85 (current), 84 (lowest), and 85 (highest). Blood pressure was recorded as 99/57. Respiratory rate was 22 (current), 21 (lowest), and 22 (highest). Oxygen saturation was 99 (current), 98 (lowest), and 99 (highest). A later exam (at 3562 minutes) indicates a GCS score of 14, with motor, verbal and eye scores of 6, 4, and 4, respectively. This suggests neurological improvement. Additional physical exam results are available at 146 and 3512 minutes, showing changes in vital signs. More comprehensive data is needed for a thorough analysis. NULL