Patient Medical History Report

1. Patient Information

* **Patient Unit Stay ID:** 384028 * **Patient Health System Stay ID:** 328853 * **Unique Patient ID:** 004-10063 * **Gender:** Female * **Age:** 69 * **Ethnicity:** Caucasian * **Hospital ID:** 122 * **Ward ID:** 236 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:13:00 * **Unit Admit Source:** Emergency Department * **Unit Discharge Time:** 19:19:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 20:45:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 15:14:00 * **Hospital Discharge Location:** Other * **Hospital Discharge Status:** Alive * **Admission Height:** 162.6 cm * **Admission Weight:** 74.8 kg * **Discharge Weight:** NULL

2. History

The provided data does not contain a detailed patient history. This section requires additional information from the patient's chart, including presenting complaints, relevant past medical history (e.g., prior hospitalizations, surgeries, allergies), family history, social history (e.g., smoking, alcohol use, drug use), and medication history. Without this information, a comprehensive history cannot be generated. The admission diagnosis was Pneumonia, bacterial. This suggests the patient presented with symptoms consistent with a bacterial lung infection, potentially requiring intensive care due to respiratory compromise.

3. Diagnoses

Multiple diagnoses were recorded during the patient's ICU stay. The primary diagnosis upon admission was pneumonia (ICD-9 codes 486, J18.9). Major diagnoses included generalized abdominal pain/tenderness (ICD-9 codes 789.07, R10.84), dehydration (ICD-9 codes 276.51, E86.0), and hypoxemia (ICD-9 codes 799.02, R09.02). These diagnoses were recorded at various times during the stay, indicating the evolution of the patient's condition. Note that the dehydration and abdominal pain/tenderness diagnoses were active upon discharge, suggesting ongoing issues. The multiplicity of diagnoses hints at a potentially complex clinical picture requiring multi-system management.

4. Treatments

A wide range of treatments were administered. These included multiple medications: antibiotics (vancomycin, cefepime, levofloxacin), analgesics (acetaminophen, bolus parenteral analgesics, oral analgesics), bronchodilators, antiemetics (serotonin antagonist, promethazine), and a vasopressor (phenylephrine). The patient also received aggressive volume resuscitation and electrolyte administration (calcium). Respiratory support consisted of oxygen therapy, CPAP/PEEP therapy, mechanical ventilation, tracheal suctioning and ventilator weaning. Consultations were performed by cardiology, gastroenterology, and pulmonary/CCM specialists. The use of multiple treatment modalities reflects a multifaceted approach to managing the patient's condition.

5. Vital Trends

NULL. The provided data lacks time-series vital sign data (heart rate, blood pressure, respiratory rate, oxygen saturation, temperature, etc.). This information is crucial for assessing the patient's hemodynamic stability and respiratory status over time. This data is essential for generating vital trends.

6. Lab Trends

The lab data includes serial measurements of various blood chemistries and hematologic parameters. The trends of these parameters over time need to be analyzed to evaluate the patient’s response to treatment and overall clinical course. Specific values are available for glucose, chloride, BUN, creatinine, calcium, bicarbonate, potassium, sodium, MCV, MCHC, Hgb, Hct, WBC, platelets, and other blood parameters. These values are available at various points in time, allowing for a trend analysis. Further analysis is needed to identify trends.

7. Microbiology Tests

The patient underwent testing for C. difficile toxin and stool cultures. Results are needed to determine if these tests were positive and the relevant implications for the patient's clinical course. This section requires the results of the microbiology tests to be complete.

8. Physical Examination Results

The physical examination documented a Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6), indicating normal neurological function. Heart rate measurements were recorded, with a current rate of 105 bpm, a lowest rate of 105 bpm, and a highest rate of 125 bpm. Blood pressure readings show a current systolic pressure of 87 mmHg, a lowest of 87 mmHg and a highest of 100 mmHg. Respiratory rate was recorded at 18 breaths per minute, with a lowest of 17 and a highest of 20. Oxygen saturation was 93%, with a lowest of 92% and a highest of 95%. The admission weight was 74.8 kg. Respiratory mode was spontaneous. This information was recorded at 81 minutes post-unit admission. Further information is needed for a complete physical examination result.