Patient Medical History Report

1. Patient Information

* **PatientUnitStayID:** 349322 * **PatientHealthSystemStayID:** 300342 * **Gender:** Male * **Age:** 70 * **Ethnicity:** Caucasian * **HospitalID:** 125 * **WardID:** 174 * **APACHEAdmissionDx:** Sepsis, renal/UTI (including bladder) * **Admission Height:** 170.2 cm * **Hospital Admit Time:** 2014-XX-XX 18:18:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2014 * **Hospital Discharge Time:** 2014-XX-XX 02:16:00 * **Hospital Discharge Location:** Other * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 2014-XX-XX 20:59:00 * **Unit Admit Source:** Emergency Department * **Unit Visit Number:** 1 * **Unit Stay Type:** admit * **Admission Weight:** 139.2 kg * **Discharge Weight:** NULL * **Unit Discharge Time:** 2014-XX-XX 02:11:00 * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive * **UniquePID:** 004-1262

2. History

NULL (Insufficient information provided in the JSON data to create a detailed patient history section.)

3. Diagnoses

The patient presented with multiple diagnoses during their ICU stay. The primary diagnosis upon discharge was sepsis with single organ dysfunction (acute renal failure), with other major diagnoses including cellulitis of the extremity, acute renal failure, and intracranial injury with subdural hematoma. Secondary diagnoses included diabetes mellitus, hypertension, and hypothyroidism. The diagnoses were entered at various times throughout the ICU stay, reflecting the evolving clinical picture. Specific details regarding the onset and progression of each condition are not available from the provided data.

* **Primary Diagnosis:** Sepsis with single organ dysfunction – acute renal failure (ICD-9 codes: 038.9, 584.9, R65.20, N17) * **Major Diagnoses:** * Cellulitis, extremity (ICD-9 codes: 682.9, L03.119) * Acute Renal Failure (ICD-9 codes: 584.9, N17.9) * Intracranial Injury with Subdural Hematoma (ICD-9 codes: 852.20, S06.5) * Diabetes Mellitus * **Other Diagnoses:** * Hypertension (ICD-9 codes: 401.9, I10) * Coronary Artery Disease, s/p CABG (ICD-9 codes: 414.00, I25.10) * Hypothyroidism (ICD-9 codes: 244.9, E03.9) * Lower Urinary Tract Infection (ICD-9 codes: 595.9, N30.9)

4. Treatments

The patient received a comprehensive range of treatments during their ICU stay. These included medications for various conditions, such as insulin for diabetes management (both regular and longer-acting preparations), antihypertensives (labetalol, clonidine), antiplatelet agents (aspirin), antibiotics (piperacillin/tazobactam, vancomycin), antiemetics (promethazine, diphenhydramine, ondansetron), analgesics (oral and parenteral), laxatives (bisacodyl, milk of magnesia), and thyroid hormone replacement. The patient also received oxygen therapy via nasal cannula, vascular catheter placement, and VTE prophylaxis with compression stockings. The duration and effectiveness of each treatment are unavailable from this data. Note that several treatments were administered at multiple time points, indicating ongoing management of the patient's conditions.

5. Vital Trends

NULL (No vital sign data was provided.)

6. Lab Trends

The provided lab data includes hematology and chemistry results obtained at multiple time points. The data shows some fluctuations in several lab values. Specifically, Hemoglobin (Hgb) levels decreased from 10.2 g/dL to 8.5 g/dL between initial and final measurements. White blood cell (WBC) count decreased from 9.4 K/mcL to 3.4 K/mcL over the same period, suggesting a possible response to treatment. Creatinine levels increased from 2.1 mg/dL to 3.1 mg/dL, indicating

worsening renal function. Blood glucose levels remained relatively high, ranging from 143 mg/dL to 197 mg/dL, consistent with the diagnosis of diabetes mellitus. Further analysis is needed to fully interpret these trends.

7. Microbiology Tests

Blood cultures were obtained during the patient's ICU stay. The results of these cultures are not available in the provided data.

8. Physical Examination Results

The physical exam documented the patient as obese and ill-appearing but not in acute distress. Vital signs recorded include a heart rate of 105 bpm, systolic blood pressure of 140 mmHg, diastolic blood pressure of 49 mmHg, and oxygen saturation of 94%. A Glasgow Coma Scale (GCS) score of 14 was recorded. The details of the physical examination are limited, and more comprehensive information would be needed for a thorough assessment.