Medical Report for Patient 004-11364

1. Patient Information

* **Patient Unit Stay ID:** 348873 * **Unique Patient ID:** 004-11364 * **Gender:** Male * **Age:** 71 * **Ethnicity:** Caucasian * **Admission Height:** 175.3 cm * **Admission Weight:** 93.3 kg * **Hospital Admission Time:** 2014-XX-XX 11:14:00 * **Hospital Admission Source:** Emergency Department * **Hospital Discharge Time:** 2014-XX-XX 19:50:00 * **Hospital Discharge Location:** Other Hospital * **Hospital Discharge Status:** Alive * **Unit Type:** Med-Surg ICU * **Unit Admission Time:** 2014-XX-XX 15:03:00 * **Unit Admission Source:** Emergency Department * **Unit Discharge Time:** 2014-XX-XX 19:45:00 * **Unit Discharge Location:** Other Hospital * **Unit Discharge Status:** Alive

2. History

Admission diagnosis was Angina, unstable (angina interferes w/quality of life or meds are tolerated poorly). The patient presented to the Emergency Department and was subsequently admitted to the Med-Surg ICU. Further details regarding the patient's medical history prior to this ICU stay are not available in the provided data. More comprehensive information would be needed to provide a complete patient history. This section would benefit from detailed information about prior medical conditions, surgeries, allergies, and family history.

3. Diagnoses

* **Primary Diagnosis:** cardiovascular|chest pain / ASHD|chest pain|r/o myocardial ischemia (ICD-9 code not provided) * **Major Diagnosis:** endocrine|glucose metabolism|diabetes mellitus|Type II (ICD-9 code not provided)

The lack of ICD-9 codes limits the precision of this diagnostic information. A complete diagnostic picture requires more detailed information about the extent and severity of both conditions. Further diagnostic studies and their results would be crucial to a comprehensive report.

4. Treatments

The patient received the following treatments during their ICU stay:

* Enoxaparin (low molecular weight heparin) * Levothyroxine (T4) * Aspirin * Non-narcotic analgesic * Diltiazem (class IV antiarrhythmic) * Pneumococcal vaccine * Glucose management (insulin sliding scale) * Metoprolol (beta blocker) * Esomeprazole (stress ulcer prophylaxis) * Atorvastatin (HMG-CoA reductase inhibitor) * Oral analgesics

The specific dosages and administration routes of these medications are not provided and are necessary for a complete treatment record. Furthermore, the rationale behind each treatment choice and their effectiveness would enhance this section.

5. Vital Trends

The following vital signs were recorded:

* **Heart Rate (HR):** Current 57 bpm, Lowest 55 bpm, Highest 57 bpm * **Respiratory Rate (RR):** Current 15 breaths/min, Lowest 15 breaths/min, Highest 16 breaths/min * **Oxygen Saturation (O2 Sat%):** Current 94%, Lowest 91%, Highest 95%

This data represents only a snapshot of vital signs at a single point in time. A time-series analysis of vital signs would be far more informative, revealing trends and patterns in the patient's condition over their ICU stay.

6. Lab Trends

The following lab results were obtained:

* **Creatinine:** 1.9 mg/dL * **Albumin:** 3.6 g/dL * **Sodium:** 139 mEq/L * **Glucose:** 271 mg/dL * **WBC x 1000:** 9.9 K/mcL * **Hct:** 36.8% * **BUN:** 32 mg/dL * **Respiratory Rate (from labs):** 16 /min * **LPM O2:** 0 L/min * **FiO2:** 21%

Similar to the vital signs, these lab values represent a single time point. Serial lab results are needed to assess trends and identify changes in the patient's condition. The absence of multiple measurements prevents the identification of crucial trends or abnormalities.

7. Microbiology Tests

NULL. No microbiology test data was provided.

8. Physical Examination Results

A structured physical exam was performed. Specific details of the exam are limited to the vital signs already mentioned above, and the Glasgow Coma Scale (GCS) score of 15 (Eyes 4, Verbal 5, Motor 6). A comprehensive physical examination report would include a detailed assessment of all body systems.

This report is incomplete due to missing data. Additional information is required to provide a thorough and accurate medical record.