## Patient Medical Report

**1. Patient Information**

* **Patient Unit Stay ID:** 219982 * **Unique Patient ID:** 002-11976 * **Patient Health System Stay ID:** 190098 * **Gender:** Female * **Age:** 58 * **Ethnicity:** Caucasian * **Hospital ID:** 56 * **Ward ID:** 82 * **Unit Type:** Med-Surg ICU * **Unit Admit Time:** 01:42:00 * **Unit Admit Source:** ICU to SDU * **Unit Discharge Time:** 00:08:00 * **Unit Discharge Location:** Floor * **Unit Discharge Status:** Alive * **Hospital Admit Time:** 09:34:00 * **Hospital Admit Source:** Emergency Department * **Hospital Discharge Year:** 2015 * **Hospital Discharge Time:** 16:19:00 * **Hospital Discharge Location:** Home * **Hospital Discharge Status:** Alive * **Admission Height (cm):** 152.4 * **Admission Weight (kg):** NULL * **Discharge Weight (kg):** 107.3 * **Admission Diagnosis:** NULL

**2. History**

Insufficient data provided to generate a detailed patient history. The available data only provides admission and discharge times and locations, but lacks information regarding presenting complaints, past medical history, family history, social history, and medication history. A comprehensive history is crucial for understanding the patient's condition and would ideally include details of the events leading up to admission, any prior hospitalizations, relevant family medical history (e.g., heart disease, diabetes), lifestyle factors (e.g., smoking, alcohol consumption), and a complete list of current and past medications, allergies, and significant surgical history. Without this information, a complete assessment of the patient's clinical picture is not possible.

**3. Diagnoses**

NULL. No diagnoses are recorded in the provided data. A complete diagnosis section would list all diagnoses made during the patient's stay, including principal and secondary diagnoses, with corresponding ICD codes if available.

**4. Treatments**

NULL. The provided data does not contain information about the treatments administered. A complete treatment section should detail all medical interventions, including medications (dosage, route, frequency), procedures performed, and any other therapies received.

**5. Vital Trends**

NULL. No vital sign data (heart rate, blood pressure, respiratory rate, temperature, oxygen saturation) is included in the dataset. Vital sign trends are essential for monitoring patient stability and response to treatment. A graphical representation of these trends over time would be very informative.

**6. Lab Trends**

The provided laboratory data includes results for various blood tests, including glucose, BUN (blood urea nitrogen), creatinine, electrolytes (sodium, potassium, chloride, bicarbonate), liver enzymes (AST, ALT), total and direct bilirubin, albumin, total protein, complete blood count (CBC) components (Hgb, Hct, MCH, MCV, MCHC, RBC, WBC, platelets, RDW), and Vancomycin levels. These lab results are presented at various time points during the patient's stay. Detailed analysis of these trends over time is essential for assessing the patient's response to treatments and identifying any potential complications.

**7. Microbiology Tests**

NULL. No microbiology test results are available in the dataset. This section would include culture results (e.g., blood cultures, urine cultures) and sensitivity testing if performed.

**8. Physical Examination Results**

NULL. The dataset lacks any information concerning the physical examination findings. A comprehensive physical exam would assess various systems (e.g., cardiovascular, respiratory, neurological, abdominal) and document any abnormalities. This would provide a crucial aspect of the patient's clinical evaluation.