

The Miriam Hospital - A Lifespan Partner

**Patient Information**

Patient Name	Account	ID #	Sex	DOB	Age
Andrade, Ana G	2005399996	10009861030	Female	05/29/1930	88 yrs

**ED Provider Notes by Kenneth C Baris Jr. at 10/28/2018 9:05 AM**

Author: Kenneth C Baris Jr.      Service: Emergency Medicine      Author Type: Resource  
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**History****Chief Complaint**

Patient presents with

- Fall

*Mechanical fall with right knee pain.*

The patient is a 88 y.o. female with a Hx of CHF, DM, HLD who presents to ED following a fall at home. Per the patient's family, the patient went to the bathroom yesterday and slid off the side of the toilet landing on her B/L knees. The fall was unwitnessed, but the patient denies any head trauma as she landed against the bathtub. She was able to call for her daughter who was able to help her to her feet. The patient declined evaluation following at that time and went to bed. She was able to get up and go to the bathroom this morning but was C/O increased pain to the left knee and right foot which prompted ED visit. Does endorse some dysuria but denies any fevers, cough, vomiting. The patient currently lives at home with family and ambulates with a walker. She was recently discharged from the hospital after an admission for failure to thrive. It was recommended at that time the patient go to a SNF, but she declined services at that time. The patient is allergic to ciprofloxacin. The patient reports that she has never smoked.

PCP: Pcp No, MD

HPI

**Past Medical History:**

Diagnosis	Date
<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• CHF (congestive heart failure)</li> <li>• Diabetes mellitus</li> <li>• Hyperlipidemia</li> <li>• Migraine</li> </ul>	

**Past Surgical History:**

Procedure	Laterality	Date
<ul style="list-style-type: none"> <li>• APPENDECTOMY</li> <li>• CHOLECYSTECTOMY</li> </ul>		

**Patient's Medications****New Prescriptions**

No medications on file

#### **Previous Medications**

ACETAMINOPHEN (TYLENOL) 325 MG TABLET	Take 2 tablets (650 mg total) by mouth every 6 (six) hours as needed.
ASPIRIN 81 MG ENTERIC COATED TABLET	Take 81 mg by mouth once daily.
CARVEDILOL (COREG) 3.125 MG TABLET	Take 1 tablet (3.125 mg total) by mouth 2 (two) times a day for 30 days.
DICYCLOMINE (BENTYL) 10 MG CAPSULE	Take 2 capsules (20 mg total) by mouth 3 (three) times a day for 30 days.
FUROSEMIDE (LASIX) 40 MG TABLET	Take 1 tablet (40 mg total) by mouth once daily for 30 days.
GABAPENTIN (NEURONTIN) 100 MG CAPSULE	Take 1 capsule (100 mg total) by mouth 2 (two) times a day for 30 days.
LOPERAMIDE (IMODIUM) 2 MG CAPSULE	Take 1 capsule (2 mg total) by mouth 4 (four) times a day as needed (diarrhea).
PANTOPRAZOLE (PROTONIX) 40 MG DELAYED RELEASE TABLET	Take 1 tablet (40 mg total) by mouth daily at 6:30 am.
QUETIAPINE (SEROQUEL) 25 MG TABLET	Take 0.5 tablets (12.5 mg total) by mouth bedtime for 30 days.

#### **Modified Medications**

No medications on file

#### **Discontinued Medications**

No medications on file

The patient's family history is not on file.

The patient reports that she has never smoked. She has never used smokeless tobacco. She reports that she does not drink alcohol or use drugs.

#### **Review of Systems**

Constitutional: Negative for fever.

Respiratory: Negative for cough and shortness of breath.

Cardiovascular: Negative for chest pain.

Gastrointestinal: Negative for vomiting.

Genitourinary: Positive for dysuria.

Musculoskeletal:

**+Left knee pain, right foot pain**

#### **Physical Exam**

BP 122/83 (BP Location: Right upper arm, Patient Position: Lying) | Pulse 72 | Temp 98.3 °F (36.8 °C) (Temporal) | Resp 19 | SpO2 98%

### Physical Exam

Constitutional: She is oriented to person, place, and time. She appears well-developed. No distress.

HENT:

Head: Atraumatic.

Mouth/Throat: Oropharynx is clear and moist. No oropharyngeal exudate.

Eyes: Pupils are equal, round, and reactive to light. Conjunctivae are normal. No scleral icterus.

### **Pink conjunctiva**

Neck: Normal range of motion.

Cardiovascular: Normal rate and regular rhythm.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. There is no tenderness.

Musculoskeletal: She exhibits edema (**2+ Pitting edema to the midshin B/L**).

**Left knee: TTP to the lateral joint line. No palpable effusion. Pain with active flexion to 30 degrees. Stable to stress testing.**

**Right knee: No TTP or effusion**

**Left foot: TTP diffusely over the dorsum predominantly over the 1st-3rd metatarsals. No external signs of trauma.**

Lymphadenopathy:

She has no cervical adenopathy.

Neurological: She is alert and oriented to person, place, and time.

### **Moving all four extremities**

Skin: Skin is warm and dry. No rash noted.

**Cap refill less than 2 seconds B/L LE**

Psychiatric: She has a normal mood and affect.

Nursing note and vitals reviewed.

## **ED Course**

Procedures

### **MDM**

**Number of Diagnoses or Management Options**

**Amount and/or Complexity of Data Reviewed**

Clinical lab tests: ordered and reviewed

Tests in the radiology section of CPT®: reviewed and ordered

I, Kenneth C. Baris Jr, scribed for Rachel L Fowler, MD

Electronically signed by Kenneth C. Baris Jr, Scribe at 9:08 AM on 10/28/18

{Attestation Choices:1600011}