CITY GENERAL HOSPITAL

123 Medical Center Blvd, Metropolis, NY 10012
Department of Infectious Diseases

MEDICAL RECORD: ENCOUNTER SUMMARY

PATIENT DEMOGRAPHICS

Name:	John A. DOE	**MRN:**	8493-2024-XJ
DOB:	12-May-1989 (Age: 35)	**Gender:**	Male
Encounter Date:	November 20, 2025	**Provider:**	Dr. Sarah Bennett, MD

TRIAGE VITALS

Temp: 39.4°C (102.9°F) **HR:** 112 bpm **BP:** 105/65 mmHg **RR:** 22/min **SpO_2:** 98% RA

SUBJECTIVE / HISTORY OF PRESENT ILLNESS (HPI)

Chief Complaint: High grade fever, shaking chills, and headache.

History: The patient is a 35-year-old male presenting to the ED with a 3-day history of cyclical high-grade fevers associated with rigors and profuse sweating. He reports severe frontal headache, generalized myalgia (muscle pain), and nausea. He had one episode of non-bilious vomiting this morning.

Travel History: Patient returned 12 days ago from a 3-week business trip to Lagos, Nigeria. He reports taking Malaria prophylaxis (Doxycycline) strictly for the first week but admits to missing doses during the latter half of the trip. He recalls multiple mosquito bites.

Review of Systems:

- **General:** Positive for fatigue, fever, chills.
- **HEENT:** Positive for headache. No photophobia or neck stiffness. Scleral icterus noted.
- **GI:** Positive for nausea. Mild abdominal discomfort.
- **Resp:** Negative for cough or shortness of breath.

OBJECTIVE / PHYSICAL EXAM

General Appearance: Patient appears ill, diaphoretic, and uncomfortable. Alert and oriented x3.

HEENT: Mucous membranes are dry. Mild scleral icterus (yellowing of eyes) present. Conjunctival pallor noted. **Cardiovascular:** Tachycardic, regular rhythm. No murmurs, rubs, or

gallops. **Lungs:** Clear to auscultation bilaterally. **Abdomen:** Soft, non-distended. **Palpable splenomegaly** (spleen tip felt 2cm below costal margin). Mild hepatomegaly. No rebound tenderness. **Skin:** Hot to touch. No rashes or petechiae.

DIAGNOSTIC RESULTS

Hematology (CBC)

Test	Result	Reference Range
Hemoglobin	**10.2 g/dL (L)**	13.5–17.5 g/dL
Hematocrit	31%	41–50%
White Blood Cell (WBC)	4.2 x 10^9/L	4.5–11.0 x 10^9/L
Platelets	**85 x 10^9/L (L)**	150–450 x 10^9/L

Chemistry Panel

- **Glucose:** 85 mg/dL
- **Creatinine:** 1.1 mg/dL
- **AST/ALT:** Mildly elevated (55/62 U/L)
- **Total Bilirubin:** 2.1 mg/dL (Indirect dominance)

Microbiology

Giemsa Stained Blood Smear (Thick and Thin):

- **Result: POSITIVE for Malaria parasites.**
- **Species Identification:** *Plasmodium falciparum*.
- **Parasitemia:** Estimated at 2.5%. Ring forms and occasional gametocytes observed.

Rapid Diagnostic Test (RDT): Positive for *P. falciparum* (HRP2 antigen).

ASSESSMENT AND DIAGNOSIS

1. **Acute Uncomplicated Malaria** (*Plasmodium falciparum*)
2. Thrombocytopenia (secondary to malaria)
3. Mild Anemia

TREATMENT PLAN

Medications Administered/Prescribed

1. **Artemether-Lumefantrine (Coartem):** Standard 3-day course. Initial dose (4 tablets) taken under direct observation in clinic. *Instructions:* Take second dose 8 hours after the first. Then twice daily (morning and evening) for the next 2 days. Take with fatty food (e.g., milk) for absorption.
2. **Acetaminophen (Tylenol):** 1000mg PO q6h PRN for fever > 38.5°C.

Patient Education & Follow-up

- Patient advised to return immediately if symptoms worsen, if unable to tolerate oral medication (vomiting), or if confusion/lethargy develops (signs of severe malaria).
- Hydration encouraged.
- Follow-up appointment scheduled in 3 days for repeat smear and CBC check.

Electronically Signed by:
Dr. Sarah Bennett, MD
License #: 992-441-NY
Date/Time: November 20, 2025 14:30 EST