

Chief Complaint: Headache

Encounter Type: Initial

Acuity: D Blue

NO DICTATION FOUND

CHART:

Physicians caring for patient:

MD

Diagnosis

Headache (HA) - migraine

Disposition

Provider documentation to be completed on HMED.

Disposition - Discharge from ED: home . Condition: stable . The patient

is to follow up with his or her private physician , as needed. .

Recheck

immediately for new or worsening symptoms. . Wound/injury: you may resume

normal activity as tolerated . Return if you are feeling worse or you develop a fever . Aftercare: Migraine headache . Adult (English)

Medication instructions: No changes

Private Physician(s)

OTHER PCP :

Chief Complaint

Chief complaint/quote: Frontal headache since last night. Nausea and vomiting as well.

History of Present Illness

CC: headache

ONSET: Last evening \R\23:00

TIME COURSE: This is a 31 year old female who presents to the Emergency

Department with a female companion for evaluation of a headache. Last night, the patient gradually developed a headache that has become worse.

The patient has a history of migraine headaches and states that this feels

similar to her previous headaches.

QUALITY: Constant achey throb

LOCATION: Diffuse

SEVERITY: She rates her pain a 8/10.

ASSOCIATED POSITIVE SYMPTOMS: Phonophobia, photophobia, vomiting, nausea

PERTINENT NEGATIVE SYMPTOMS: At this time, patient denies cough or cold symptoms, fever, diarrhea, chills, chest pain, SOB, abdominal pain, constipation, dysuria, flank pain, bowel or bladder symptoms, or any other acute concerns

TREATMENT AT HOME: Tramadol with minimal relief

PRIOR HISTORY OF HEADACHE: Positive

FAMILY HISTORY OF INTRACRANIAL ANEURYSM: Patient is unsure.

Review of Systems

Review of systems is as indicated in the HPI. All other systems were reviewed and were negative.

Medications

Home medications: Patient not currently taking any medications.

Allergies

Patient allergies: Penicillins Codeine

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Back problems Attention deficit/Hyperactivity disorder Breast surgery

Patient has not been diagnosed with antibiotic resistant infection.

Social History

Living arrangement: Patient states that she lives with 13 other women.

Occupation: accountant

Family History

The patient does not know his/her family medical history.

VITAL SIGNS

| Initials/Date/Time | Temp(C) | Rt. | Pulse | Resp | Syst | Diast | Pos. | O2 | O2 |
|--------------------|---------|-----|-------|------|------|-------|------|----|----|
|--------------------|---------|-----|-------|------|------|-------|------|----|----|

DelPain

Sat

Sc

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Physical Exam

GENERAL: alert; in moderate distress

HEAD: normocephalic; atraumatic; no otorrhea, rhinorrhea, hemotympanum, Battle's sign, or raccoon eyes.

EYES: sclera clear; extra-ocular muscle movement intact; the disks are sharp.

EARS: normal ear canals; normal right and left tympanic membranes.

OROPHARYNX: oral mucosa moderately dry and pink, no edema or exudate;  
able  
to handle saliva without difficulty.

NECK: supple without meningismus; no cervical adenopathy; no  
tenderness to  
palpation; there is no stridor with auscultation

CHEST: good chest wall movement without crepitus or subcutaneous  
emphysema

PULMONARY: lungs clear to auscultation bilaterally

CARDIOVASCULAR: heart with regular rate and rhythm; no murmurs; no  
gallops; strong peripheral pulses

GASTROINTESTINAL: abdomen soft and non-tender; no abdominal distension  
or  
masses; bowel sounds present throughout; no guarding, rebound, or  
other  
peritoneal signs.

BACK: no paraspinal or midline pain; no significant muscle spasms.

GENITOURINARY: no costovertebral angle tenderness to percussion; no  
discomfort in the suprapubic region with deep palpation.

MUSC/SKEL: no focal bony tenderness; no apparent deformity; no  
peripheral  
edema

NEURO: normal mental status; no focal motor or sensory deficits;  
cerebellar function and cranial nerves are intact without focality

SKIN: normal color; warm; dry; no rashes; no petechiae

Procedures

Medications Administered

: Benadryl Intravenous 50mg IV MD 5/18/2008 21:42

Given: Yes IVP. Diluted in 10 mls NS. Infused over Slow IVP Dose: 50  
mg(s)

RN 5/18/2008 22:01

: Compazine Intravenous 10mg IV MD 5/18/2008 21:42

Given: Yes IVP. Diluted in 10 mls NS. Infused over Slow IVP Dose: 10  
mg(s)

RN 5/18/2008 22:01

: D.H.E. 45 Intravenous 1mg/ml IV MD 5/18/2008 21:42

Given: Yes RN 5/18/2008 22:02

: Toradol Intravenous 30mg IV MD 5/18/2008 21:42

Given: Yes IVP. Diluted in 10 mls NS. Infused over Slow IVP Dose: 30  
mg(s)

RN 5/18/2008 22:02

Progress Notes

Progress Note: because of the patient's symptoms, I ordered an IV, gave her normal saline "wide-open", Benadryl, Compazine, DHE 45, and Toradol intravenously. The patient had significant improvement in her symptoms and then desired to go home.

Progress Note: The patient was reevaluated. At this point, the patient reports subjective improvement in all symptoms. The patient has been stable throughout the stay in the Emergency Department. A repeat exam shows marked improvement. At this time, the patient will be discharged.

Consults  
Medical Decision-Making

Pulse oximeter measurement: 100%

Oxygen: Room air

Interpretation: No evidence for hypoxemia

Intervention: No supplemental oxygen given

Medical Decision-making: This patient presented with a headache that started as a smaller one yesterday and gradually increased in intensity and severity. She complained of nausea and intermittent vomiting as well.

The patient reports a prior history of migraine headaches, but has not had one in several years.

The patient had an IV established, received normal saline wide open, Benadryl, Compazine, DHE 45, and Toradol with complete resolution of her symptoms.

The patient was discharged to home, is to follow-up with her primary care

physician as needed, but to return to the emergency department for fever,

increased pain, worsening or symptoms or change in her condition.

No clear evidence for leaking or ruptured aneurysm, subdural hematoma, meningitis, trauma, skull fracture, increased intracranial pressure, or sinusitis.

Patient Discussion

The diagnosis was discussed with the patient and/or the patient's family.

The treatment plan, as specified under disposition documentation, was discussed with the patient and/or the patient's family. The patient and/or

the patient's family have expressed understanding and comprehension of the plan.

Resident Supervision

Signatures:

