Chief Complaint: Fever

Encounter Type: Initial

Acuity: E Green

NO DICTATION FOUND

CHART:

Physicians caring for patient:

Diagnosis
Stomatitis
Fever
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. .

Medications: use ibuprofen for pain or fever and use Tylenol (acetaminophen) for pain or fever . Return if you feel you are becoming dehydrated . Aftercare: Hand-foot-mouth . Adult (English)

Private Physician(s)

LOCAL PHYSICIAN: FPMC/SLR

Chief Complaint

Chief complaint/quote: 2 - 3 days of fussiness and fever. Mother denies particular GI or URI symptoms. Concerned about dehydration but patient is wetting diapers and making tears.

History of Present Illness

HPI text: This is a 15-month-old male who presents to the emergency department with fever, decreased oral import, fussiness and nasal congestion. The mother states that all the symptoms started a couple of days ago. The child does go to daycare and there has been other children with still her symptoms. The mother states that the child has tympanostomy tubes and has had some drainage of his right ear. The child continues to make wet diapers and has continued to tear.

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: No known allergies.

Past Medical/Surgical History

NO SIGNIFICANT PAST MEDICAL OR SURGICAL HISTORY.

Vaccinations are up to date.

Social History

There are no smokers in the patient's home.

The patient attends a daycare.

VITAL SIGNS

| Initials/Date/Time | Temp(C) | Rt. | Pulse | Resp | Syst | Diast | Pos. | O2 Sat | O2 Del | Pain Sc |
|---|---|---|---|---|---|---|---|---|---|---|
| CXG 5/18/2008 02:05 | 37.9 | R | | | | | | | | |
| MD1 5/18/2008 02:11 | | | 160 | 26 | | | | 97 | .R/A | |

Height and Weight

Weight: 10.4 kg. (22.9 lbs.)

Physical Exam

GENERAL: well appearing child; no acute distress; cries during exam and he has large, instantaneous tearing

HEAD: normocephalic; atraumatic

EYES: sclera clear; child looks in various directions; pupils are equal, round and reactive to light; conjunctiva pink and moist; no exudates

EARS: normal appearing ear canals; tympanic membranes are clear; normal light reflex

NOSE: no discharge; nares patent

OROPHARYNX: posterior pharynx, soft palate and uvula have multiple small 1-2 mm, round ulcerations consistent with viral stomatitis

NECK: supple without tenderness; no cervical adenopathy; no meningismus

PULMONARY: lungs clear to auscultation bilaterally; no retractions; no paradoxical respirations

CARDIOVASCULAR: heart with regular rate and rhythm; no murmurs; no gallops; capillary refill is 2-3 seconds in extremities; no peripheral edema

GASTROINTESTINAL: abdomen soft; no tenderness to palpation; no guarding; no rebound tenderness; normal bowel sounds; no masses or hepatosplenomegaly

GENITOURINARY: normal appearing external genitalia; no suprapubic tenderness; no costovertebral angle tenderness to percussion

MUSC/SKEL: no focal bony tenderness; no apparent deformity; no soft tissue swelling; no tenderness to palpation of extremities; joints with normal range of motion

NEURO: alert and awake; easily consolable; normal suck reflex

SKIN: warm, dry; normal turgor; no rash; no petechia or purpura

## Procedures

## Progress Notes

## Medical Decision-Making

Medical Decision-making:
On my examination the patient had multiple ulcerations in the posterior pharynx consistent with viral stomatitis and this also makes sense when the child is eating and drinking less and having high fevers. I have recommended foods low in salt and acidic content and soft foods. I have told them to avoid hard textured foods or spicy foods as well. I've recommended popsicles, juices, yogurt, ice cream to keep the child well-hydrated. I have recommended ibuprofen and Tylenol for fever and discomfort. I have told her to come back if the child is dehydrated. On my examination, at this time, the child does not appear dehydrated to the extent of needing IV hydration.

## 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: