

Chief Complaint: Nosebleed/epistaxis, non-traumatic

Encounter Type: Initial

Acuity: D Blue

NO DICTATION FOUND

CHART:

Physicians caring for patient:

MD

Diagnosis

Epistaxis

Tobacco use disorder

Disposition

Provider documentation to be completed on HMED.

Copy to:

Patient is pending discharge.

Provider to recheck patient. Discharge to: home . Condition: stable .  
The

patient is to follow up with: the Emergency Department . in 1-2 days  
.

Diet: drink plenty of fluids . Return if any new concerns develop, if  
bleeding worsens or you are feeling worse

Private Physician(s)

CARDIOLOGIST GENERAL

INTERNIST

Chief Complaint

Chief complaint/quote: Couple of hours ago nose started bleeding when  
bent

over forward.

History of Present Illness

HPI text: 64yo male presents with his wife for evaluation of epistaxis  
stating "I need you to stop the bleeding." The patient reports that he  
bent forward tonight at \R\ 1800 when he had a sudden onset of  
epistaxis. He

notes that he has been unable to stanch the bleeding. He notes that he  
is

bleeding out of his left nostril. There has not been any dizziness,  
light

headedness, nausea, vomiting, weakness or any additional acute  
concerns.

The patient is presently on Coumadin.

Review of Systems

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

Medications

Home medications: Coumadin PO -

Lopid PO -

Sular PO -

Aspirin PO 81 mg every day

Allergies

Patient allergies: No known allergies.

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Aortic valve replacement Harrington Rod placement

Patient has not been diagnosed with antibiotic resistant infection.

Social History

Tobacco use: (+)

Tobacco use: 1 pack cigarettes per day

Alcohol use: (+)

Living arrangement: Patient lives with spouse/significant other

Occupation: Retired , truck driver

VITAL SIGNS

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

Sat

Sc

LXB 11/25/2007 20:43	37.1	0	84	18	160	89	S	97	.R/A
MXH 11/25/2007 21:51			76	18	120	85	S	95	.R/A

Physical Exam

GENERAL: 64 year-old male, pleasant, conversant, accompanied by spouse. In good spirits, jovial, laughing, generally well appearing, in no acute distress.

HEAD: Head normocephalic, atraumatic.

EYES: Pupils equal, round, reactive to light and accommodation. Extraocular movements intact. No conjunctival injection; no scleral icterus.

NOSE: Notable for bleeding from the right nare. No evidence of trauma. No gross evidence of foreign body or debris.

OROPHARYNX: Clear with moist mucous membranes. Uvula midline. No sores, lesions, or exudates.

NECK: Supple, without lymphadenopathy. Trachea midline.

PULMONARY: Clear to auscultation bilaterally without crackles or rales. No chest wall tenderness. No wheezes.

HEART: Regular rate and rhythm. No murmur. Normal S1 and S2. No rubs or gallops.

NEUROLOGIC: Awake, alert, oriented times three. Moving all four extremities in a purposeful fashion. Normal reflexes, symmetric.

RESULTS

Lab

CBC; Specimen: blood ; Location: Not applicable Nathan Andrew, MD  
Result 11/25/2007 21:14

CBC; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
NEUTROPHIL %		70	%	40-76	F
LYMPHOCYTE %	L	20	%	24-44	F
MONOCYTE %		7	%	1.0-10.0	F
EOSINOPHIL %		3	%	0.0-3.0	F
BASOPHIL %		0	%	0.0-1.0	F
NEUTROPHIL #		4.7	K/UL	1.90-8.80	F
LYMPHOCYTE #		1.3	K/UL	1.00-4.80	F
MONOCYTE #		0.5	K/UL	0.10-0.80	F
EOSINOPHIL #		0.2	K/UL	0.00-0.50	F
BASOPHIL #		0.0	K/UL	0.00-0.10	F

Reviewed By: Nathan Andrew, MD 11/25/2007 21:19  
Result 11/25/2007 21:14

CBC; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
WBC COUNT		6.7	K/UL	4.5-11.0	F
RBC COUNT	L	4.24	MIL/UL	4.30-5.90	F
HEMOGLOBIN	L	13.5	G/DL	13.9-16.3	F
HEMATOCRIT	L	38.4	%	39.0-55.0	F
MCV		90.6	FL	80.0-100.0	F
MCH		31.9	PG	25.0-35.0	F
MCHC		35.2	%	31.0-37.0	F
RDW-CV		12.9	FL	11.0-16.0	F
PLATELET COUNT		249	K/UL	130-350	F
MPV	L	6.4	FL	7-10	F

Reviewed By: MD 11/25/2007 21:19

Prottime-INR; Specimen: blood ; Location: Not applicable Nathan Andrew, MD

Result 11/25/2007 21:33

Prottime-INR; Specimen: blood ; Location: Not applicable

Test	Flag	Value	Units	Ref. Range	Status
PROTHROMBIN TIME	H	19.2	SEC	9.1-11.9	F
INR	H	2.03		0.82-1.18	F
INR	H	RECOMMENDED REFERENCE RANGES VENOUS		0.82-1.18	
		THROMBOEMBOLISM: 2.0-3.0			
		MECHANICAL			
INR		HEART VALVES-ARTERIAL			
		EMBOLISM: 2.5-3.5			

Reviewed By: MD 11/25/2007 21:41  
Procedures

Nasal tamponade: The right nare was anesthetized with 4% cocaine .  
Nostril  
packed anteriorly with Merocel nasal dressing with epistaxis  
controlled NA  
11/25/07 23:33

Medications Administered  
: Afrin Nasal spray MD 11/25/2007 20:53

Given: Yes RN 11/25/2007 21:24

Notes:  
Provided to MD, MD administered.  
: Cocaine HCl Topical 4% soln topically MD 11/25/2007 20:53

Given: Yes RN 11/25/2007 21:22

Notes:  
Provided to MD, MD gave to patient.  
: Cocaine HCl Topical 4% soln topically MD 11/25/2007 21:56

Given: RN 11/25/2007 22:05

Notes:  
Provided to MD, MD administered.  
Progress Notes  
Medical Decision-Making

Medical Decision-making:  
64-year-old male presents for evaluation of right nose bleed,  
indicating  
that he had these frequent as a child but these are not frequent now  
as an  
adult. He is on Coumadin for valve repair, and has his bleeding time  
checked once monthly.  
With respect to his nosebleed, he denies any blunt trauma, denies any  
chest pain, dizziness, weakness, shortness of breath or  
lightheadedness.  
He has otherwise been in his usual state of good health.  
Blood work reveals no evidence of significant anemia, and INR is 2.0.  
The  
patient is advised to blow his nose, then is given Afrin, followed by  
cocaine solution. The site of bleeding is easily identified, to the  
right  
side of the nasal septum without evidence of nasoseptal hematoma. A  
Miracil packing is put in place, tolerated well, and patient is to  
return  
in two days for removal. He agrees to return immediately if any signs  
of  
infection, if having pain, or if having rebleeding. I have also  
advised  
him to hold off on taking blood thinners for the next two days. He and  
his  
wife express understanding of his condition, treatment, and follow-up  
plans, and his questions are answered.

Patient Discussion

Test results were discussed with the patient and/or the patient's family.

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: