Diagnosis
Cephalgia
Anxiety
Prescriptions
Xanax (alprazolam) 0.25mg; Sixteen (16); Take one by mouth every eight hours CAUTION: may cause sedation. - Refills: None Ordering phys: <
, SCRIB 6/13/2008 19:06>
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 , next week . Return if
any new concerns develop or you are feeling worse

Medication instructions: No changes
Private Physician(s)
Chief Complaint

Chief complaint/quote: spoke with nurse practitioner wanting her to have
an CT of head. had an episode of "brain freeze" that consumes her head,
taking 24 hours to resolve intermittent for 1 week. occurs with "bad news"

History of Present Illness

HPI text: This is a 60 yo female who presents to the ED with complaints of
one week of intermittent headache-like symptoms. Pt reports that the pain
is like a "brain freeze when you eat too much ice cream" that is
occipitally located and usually triggered by stressful situations. Pt
reports that one week ago she received news that her brother had a hear
attack, and since, has been having these episodes. Pt reports that the
pain will start and stop suddenly and occurs several times daily. She
states that these episodes last for 2-3 minutes and then resolves. Pt
reports that the HA sometimes radiates throughout her head and at this
time has radiated somewhat to the left head. She states that the HA's for
the past week are similar to what she has been experiencing for the past 7
years except that it is lasting longer than usual and she has had some
slight dizziness that she characterizes as if the room is spinning. She
has taken Ibuprofen for her symptoms without relief. She states that she
spoke with a nurse practitioner who advised her to come to the ED for a CT
scan of the head. She reports Hx of HTN for which she takes medications.
At this time, Pt denies any head injury, syncope, neck pain/stiffness, CP,
SOB, pleuritic pain, abdominal pain, N/V/D, constipation, hematemesis,

melena, hematochezia, flank pain, hematuria, dysuria, fever, chills, cough, congestion, sore throat, rash, focal weakness, or any other concerning symptoms.

Review of Systems

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

Medications

Home medications: Atenolol (Tenormin) PO 50 mg every day
Motrin IB PO PRN
Multivitamin(s) PO every day

Allergies

Patient allergies: Penicillins (Skin reactions) (Mild)

Past Medical/Surgical History

PAST MEDICAL/SURGICAL HISTORY Hypertension Knee surgery Pulmonary embolus
Hysterectomy Tonsillectomy

Patient has not been diagnosed with antibiotic resistant infection.

Social History

Living arrangement: Patient lives with spouse/significant other

Family History

There is no significant family history of any medical condition pertinent to the patient's current presentation

VITAL SIGNS

Initials/Date/Time	Temp(C)	Rt.	Pulse	Resp	Syst	Diast	Pos.	O2 Sat	O2 Del	Pain Sc
MR 6/13/2008 15:24	36.6	O	74	16	138	90	S	95	.R/A	4
SZR 6/13/2008 17:11			75	16	180	93	S			
SZR 6/13/2008 17:55			78	16	168	92	S			
SZR 6/13/2008 19:07			75	16	132	63	S			

Physical Exam

GENERAL: well appearing; in no acute distress

HEAD: normocephalic; atraumatic

EYES: sclera clear; extra-ocular muscle movement intact; pupils are equal, round and reactive to light; conjunctiva pink and moist; no photophobia; no nystagmus; funduscopic examination shows no hemorrhages or papilledema

OROPHARYNX: oral mucosa pink and moist; no tonsillar swelling or exudate

NECK: supple without meningismus; no cervical adenopathy; no tenderness to palpation; thyroid normal

PULMONARY: lungs clear to auscultation bilaterally; no retractions

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

GASTROINTESTINAL: abdomen soft; no tenderness to light or deep palpation; no guarding or rebound tenderness; normal bowel sounds; no abdominal distension or tympany; no masses or hepatosplenomegaly

GENITOURINARY: no suprapubic tenderness; no costovertebral angle tenderness to percussion

MUSC/SKEL: no focal bony tenderness; no apparent deformity; no soft tissue swelling or tenderness to extremities

BACK: no midline spine tenderness; no peri-spinal muscle tenderness or spasm

NEURO: alert and awake; oriented to person, place and date; cranial nerves 2 through 12 intact; normal motor function in all muscle groups; sensory exam normal to touch and light painful stimulus; deep tendon reflexes are normal; no focal motor or sensory deficits

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

RESULTS

Lab

CSF Cell Count; Specimen: CSF Tube #1
Result 6/13/2008 19:03

CSF Cell Count; Specimen: CSF Tube #1

Test	Flag	Value	Units	Ref. Range	Status
NEUTROPHILS		0	%	0-6	F
LYMPHOCYTES		0	%	0-80	F
LARGE MONONUCLEAR		0	%	0-45	F
EOSINOPHILS		0	%	0	F
BASOPHILS		0	%	0	F
UNCLASSIFIED		0	%	0	F
NRBC		0	#/100 WBC	0	F
		CELL DIFFERENTIAL DONE ON CONCENTRATED SPECIMEN.			F

Result 6/13/2008 19:01

CSF Cell Count; Specimen: CSF Tube #1

Test	Flag	Value	Units	Ref. Range	Status
COUNT DONE ON TUBE#:		1			F
TOTAL VOLUME		4.0	ML		F

Test	Flag	Value	Units	Ref. Range	Status
TUBE 1, VOLUME:		1.0	ML		F
TUBE 1, APPEARANCE:		CLEAR			F
TUBE 2, VOLUME:		1.0	ML		F
TUBE 2, APPEARANCE:		CLEAR			F
TUBE 3, VOLUME:		1.0	ML		F
TUBE 3, APPEARANCE:		CLEAR			F
TUBE 4, VOLUME:		1.0	ML		F
TUBE 4, APPEARANCE:		CLEAR			F
RBC	H	38	/UL	0	F
WBC		0	/UL	0-5	F

CSF Cell Count; Specimen: CSF Tube #3
Result 6/13/2008 19:27

CSF Cell Count; Specimen: CSF Tube #3

Test	Flag	Value	Units	Ref. Range	Status
NEUTROPHILS		0	%	0-6	F
LYMPHOCYTES	H	100	%	0-80	F
LARGE MONONUCLEAR		0	%	0-45	F
EOSINOPHILS		0	%	0	F
BASOPHILS		0	%	0	F
UNCLASSIFIED		0	%	0	F
NRBC		0	#/100 WBC	0	F
		CELL DIFFERENTIAL DONE ON CONCENTRATED SPECIMEN.			F

CSF Cell Count; Specimen: CSF Tube #3

Test	Flag	Value	Units	Ref. Range	Status
COUNT DONE ON TUBE#:		3			F
TOTAL VOLUME		4.0	ML		F
TUBE 1, VOLUME:		1.0	ML		F
TUBE 1, APPEARANCE:		CLEAR			F
TUBE 2, VOLUME:		1.0	ML		F
TUBE 2, APPEARANCE:		CLEAR			F
TUBE 3, VOLUME:		1.0	ML		F
TUBE 3, APPEARANCE:		CLEAR			F
TUBE 4, VOLUME:		1.0	ML		F
TUBE 4, APPEARANCE:		CLEAR			F
RBC		0	/UL	0	F
WBC		3	/UL	0-5	F

Reviewed By:, MD 6/13/2008 19:04

CSF Glucose; Specimen: CSF Tube #2
Result 6/13/2008 19:24

CSF Glucose; Specimen: CSF Tube #2

Test	Flag	Value	Units	Ref. Range	Status
SPINAL FLUID GLUCOSE		50	MG/DL	40-70	F

CSF Protein; Specimen: CSF Tube #2
Result 6/13/2008 19:24

CSF Protein; Specimen: CSF Tube #2

Test	Flag	Value	Units	Ref. Range	Status
SPINAL FLUID PROTEIN	H	51.7	MG/DL	15-45	

Radiology

CT; Head WO/IV Cntrst CT; Modifier: None; Indications: headache
Result 6/13/2008 17:29

CT; Head WO/IV Cntrst CT; Modifier: None; Indications: headache
*** PRELIMINARY REPORT ***

DATE: 06/13/2008
CT HEAD WITHOUT CONTRAST

CLINICAL DATA: Headache.

COMPARISON: None.

FINDINGS: Images were performed from the foramen magnum through the vertex without contrast. Thin-section coronal and sagittal reformations performed at no additional charge to the patient.
Ventricles are of normal size and configuration. Gray-white differentiation is normal. No intracranial hemorrhage, infarction, mass effect or midline shift. No abnormal extraaxial fluid collections present. Basilar cisterns are normal in appearance. Paranasal sinuses and mastoid air cells are clear.

CONCLUSION: Normal unenhanced CT scan of the head.
***Preliminary Report**

Procedures

Lumbar puncture: After discussing risks, benefits, alternatives and indications, the patient/guardian consented to the procedure. The patient was placed in a sitting position. The area was cleansed and prepped in a sterile manner. 1% lidocaine without epinephrine was used for local anesthesia. The tap was a diagnostic tap. A(n) 20 gauge adult spinal needle was placed in the 4th lumbar intervert space. The opening pressure was not obtained . The CSF was clear. A total of 4 ml extracted. The labs ordered are Cell Count, Protein, Glucose and Sample sent to lab. 1.There were no complications. The patient tolerated the procedure well. SNW 06/13/08 18:42

Progress Notes

Progress Note: The CT scan results are negative. The patient wishes to proceed to the lumbar puncture.

Progress Note: The lumbar puncture was completed without incident. All but

much results are unremarkable and subarachnoid bleed is not suspected at this time.

Consults

Medical Decision-Making

INITIAL ASSESSMENT AND PLAN:
The patient was referred to the ED for evaluation of episodic headaches that have been occurring for the past seven years. The headaches which are always localized to the left occipital region only occur when the patient is under stress or when anxious. They have never occurred at random. The patient learned that her brother had a heart attack this week was brought on her typical headache, but it has continued to recur intermittently which is unusual. She has also experienced some associated vertigo and nausea. Although a benign cause is suspected her symptoms could also be consistent with intermittent subarachnoid bleeding. After careful discussion with the patient we've elected to proceed to a noncontrast head CT to exclude this condition and possibly a lumbar puncture if the CT is normal.

Pulse Ox: 95%
Oxygen: Room air
Interpretation: Normal
Intervention: None

Medical Decision-making:
Diagnosis is chronic recurrent cephalgia. It did not suspect sinusitis, temporal arteritis, subarachnoid bleed, pseudotumor's retry or intracerebral mass. Patient will be given Xanax for anxiety and referred for follow up with her primary care physician. She is advised to return for fevers, neck stiffness, focal numbness of weakness, bowel or bladder incontinence or any other concerns.

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.