

Chief Complaint: Migraine

Encounter Type: Initial

Acuity: D Blue

NO DICTATION FOUND

CHART:

Physicians caring for patient:

MD

Diagnosis

Migraine

Prescriptions

Phenergan 25mg; Ten (10) tablets; Take one every six hours as needed for

nausea. May cause drowsiness and on rare occasions muscle spasms reversed

by Benadryl. - Refills: None Ordering phys: < SCRIB

6/8/2008 03:16>

Phenergan 25mg suppositories; Twelve (12); Insert one rectally every six

hours as needed for nausea and vomiting. This medication will make you sleepy. Take appropriate precautions. - Refills: None Ordering phys:

<

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Disposition

Provider documentation to be completed on HMED.

Copy to:

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

is to follow up with Obstetrics \T\ Gynecology, his or her private physician , call

the office to schedule your appointment . Medications: As prescribed

Return if any new concerns develop, headache worsens or changes characteristics, if changes in level of alertness develop, if difficulty

with strength or sensation develops or you are feeling worse

Medication instructions: No changes

Private Physician(s)

OBSTETRICIAN/GYNECOL

Chief Complaint

Chief complaint/quote: Pt states, "I am having a migraine. I called my Dr.

to see what to do because I can't take my med's. I am 14 weeks pregnant.

They said to come here."

History of Present Illness

CC: headache

ONSET: Yesterday

TIME COURSE: This is a 29 year old female who presents to the Emergency Department for evaluation of migraine headache that began yesterday morning. The patient states that she woke with a mild headache, then began vomiting at 1030. She was able to sleep at that time, but woke with a severe migraine at 1130 which has continued without resolve since onset.

QUALITY: Throbbing sensation

LOCATION: Frontal and bilateral temporal

SEVERITY: 7/10

ASSOCIATED POSITIVE SYMPTOMS: Nausea, vomiting, and photophobia

PERTINENT NEGATIVE SYMPTOMS: No visual distortion, focal weakness, numbness/tingling in the extremities,

TREATMENT AT HOME: Tylenol without relief

PRIOR HISTORY OF HEADACHE: The patient reports a Hx of migraine headaches and states that her symptoms today are similar to those she has experienced in the past. While she usually treats her headaches with Imitrex, the patient has not taken this medication secondary to her pregnancy (see below).

FAMILY HISTORY OF INTRACRANIAL ANEURYSM: None

OTHER COMMENTS: The patient, G1P0AB0, is 14 weeks pregnant and denies any complications associated with the pregnancy including hypertension.

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

PAST MEDICAL/SURGICAL HISTORY Migraine headaches Tonsillectomy  
Patient has not been diagnosed with antibiotic resistant infection.

Social History

Tobacco use: (-)

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	O2
DelPain									
								Sat	
Sc									
JB5 6/8/2008 01:42			92	18				96	.R/A 7
JB5 6/8/2008 01:44	36.4	0			123	85	S		
JB5 6/8/2008 02:28									4
JB5 6/8/2008 03:11			82	16	112	64	S		2

Physical Exam

GENERAL: well nourished appearing; uncomfortable because of headache but in no acute respiratory distress

HEAD: normocephalic; atraumatic

EYES: sclera clear; extra-ocular muscle movement intact; pupils are equal, round and reactive to light; conjunctiva without exudates

OROPHARYNX: oral mucosa moist and pink; tonsillar pillars without erythema; no tonsillar swelling; no exudate

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

PULMONARY: lungs with good air movement bilaterally; no retractions; breath sounds normal; no wheezes; no rales; no rhonchi

CARDIOVASCULAR: heart with regular rate; regular rhythm; normal S1S2; no murmurs; no gallops; no rubs; strong peripheral pulses

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

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

BACK: no midline spine tenderness; no paraspinal muscle tenderness or spas

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; deep tendon reflexes are normal bilaterally in arms and legs; no focal motor or sensory deficits; gait normal

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

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

Procedures  
Medications Administered

IV's: Normal Saline IV 1 L bolus MD 6/8/2008 02:03

Given: Yes RN 6/8/2008 02:09  
: Compazine Intravenous 10mg IV MD 6/8/2008 02:03

Given: Yes IVP. Diluted in 10 mls NS. Infused over 2 minutes RN 6/8/2008 02:14

: Benadryl Intravenous 25mg IV MD 6/8/2008 02:03

Given: Yes IVP. Diluted in 10 mls NS. Infused over Slow IVP RN 6/8/2008 02:14

: Tylenol Oral 650mg PO MD 6/8/2008 02:03

Given: Yes PO RN 6/8/2008 02:27

Progress Notes

Progress Note: After the initial assessment and treatment, the patient was

reassessed and the patient had improvement in their symptoms with the treatment rendered. The repeat physical examination was reassuring. No new

complaints were elicited

Medical Decision-Making

Pulse Ox: 96%

Oxygen: Room air

Interpretation: Normal

Intervention: None

Medical Decision-making:

This patient's medical evaluation was consistent with migraine headache.

She had no suggestion on physical examination or presentation a subarachnoid hemorrhage or meningitis. Patient had complete relief of her

headache with the medications administered. Patient is pregnant and we chose medications that can be given during pregnancy. There is no suggestion of hypertension or peripheral edema.

We did not identify any dangerous medical/surgical conditions requiring

hospitalization. They understand that if their medical condition worsens,

or they develop new symptoms or other concerns, they need to be reevaluated in the ER promptly. The patient understands their medical condition, agreed with the medical plan, and thanked us for care given in

the ED.

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.