**Chief Complaints**

Abscess:

Patient is a [] year old [fe]male who presents with complaints of tooth pain. There is pain around tooth number [], pain is [non]-radiating, and has lasted for [duration]. Pain is [severity], [provoking/palliating factors] include []. [denies] fever, purulent drainage from the mouth, and [denies] swelling or new lesions of the mouth. [Denies] sore throat, difficulty breathing, or stridor. [Denies] any facial swelling or skin changes.

Allergy

The patient is a [AGE] year old [fe]male with a past medical history of [allergies?] presenting to the ED complaining of [COMPLAINT] that occurred [ONSET] after [CONTEXT]. Patient [denies] similar symptoms in the past. Patient [denies] tongue swelling, throat swelling, shortness of breath or wheezing, or rash. [Patient denies exposure to new soaps, detergents, foods, pets or new environments.] [Patient denies exposure to new medications.] [Patient denies nausea, vomiting, diarrhea, chest pain, fevers or chills.]

CP

Patient is a [AGE] yo [fe]male presenting with [left-sided] [chest pain] since [ONSET]. The symptoms started when the patient was [at rest] with [no] associated [shortness of breath,] [diaphoresis,] [nausea,] [lightheadedness]. The pain feels like [sharpness] and [non-radiating]. Pain is [?]/10 in severity, with [no] provoking factors [] and [no] palliating factors []. The onset of the pain was [sudden]. The pain was [not] reproducible to palpation. The patient reported [no] shortness of breath with activity at baseline. The patient [denies] a history of [hypertension], [DM, smoking cigarettes, previous history of MI, FMH of MI, obesity/bariatric surgery]. Patient has [not] taken an aspirin since the symptoms started. [Patient denies hemoptysis.] [Patient denies a history of clots or malignancy, estrogen supplements, or recent surgery or being bed bound.] [Patient denies any leg swelling or pain.]

Hyperglycemia

The patient is a [AGE] year old [fe]male who presents to the ED [sent by PCP for hyperglycemia]. Patient's usual regimen is [SCHEDULE] and reports [non-]compliance with their regimen. [details]. Patient [denies] recent cold-like symptoms, cough, fever, SOB, dysuria, or diarrhea. Associated symptoms include [polyuria], [polydipsia], [ vomiting,][ abdominal pain,], [chest pain], [headache], [blurry vision]. Patient [has adequate refills of their medication and a reliable PCP].

Palpitations

The patient is a [AGE] year old [fe]male presenting to the ED complaining of [#] episodes palpitations since [TIME]. [Patient denies an associated prodrome with episode.]. The episode started when the patient was []. Patient reports having [no episodes of vomiting or diarrhea] prior to palpitations episode. [Patient denies chest pain, back pain, shortness of breath, or syncope associated with the palpitations.] [Patient denies feeling short of breath on exertion.] [Patient denies having a history of dysrhythmia or myocardial infarction,] [and denies family members whom have died suddenly of a medical cause at a young age.]

Seizure

The patient is a [AGE] year old [fe]male with [no] prior history of a seizure disorder who presents to the ED for [one] episode of seizure [ONSET] that lasted [TIME]. The episode was [un]witnessed [and included]. The patient [was not engaging in any particular activity] immediately prior to the episode. Patient reported [not] having an aura or premonition prior to the event. There was [no] associated tongue biting. There was [no] incontinence of urine. There was [no] associated post-ictal period. Patient [denies] regular alcohol use. Patient [denies] illicit drug use. [Patient admits non-compliance with prescribed anti-epileptic medication.] [Denies chest pain, sob, headache, or N/V].

SOB

The patient is a [AGE] [fe]male who presents to the ED complaining of worsening shortness of breath that began [gradually] since [ONSET]. Patient [denies] a history of intubation or ICU admission. Patient [denies] having a history of heart failure. Patient [denies] having a history of asthma. Patient [denies] having a history of COPD. Patient [denies] having a history of murmurs or valvular dysfunction. Symptoms are [unchanged] when the patient lies down. Patient [denies] worsening ankle swelling. [The patient denies any history of heart disease, blood clots or cancer.] [Patient denies any history of surgery or trauma in the last month.] [Patient denies being mostly bed-bound over the last few days and denies any recent travel.]

Toothache

Patient is a [] year old [fe]male who presents with complaints of tooth pain. There is pain around tooth number [], pain is [non]-radiating, and has lasted for [duration]. Pain is [severity], [provoking/palliating factors] include []. [denies] fever, purulent drainage from the mouth, and [denies] swelling or new lesions of the mouth. [Denies] sore throat, difficulty breathing, or stridor. [Denies] any facial swelling or skin changes.

URI

The patient is a [AGE] year old [fe]male who presents to the ED complaining of [COMPLAINT] that began [ONSET]. Associated symptoms include [subjective fever] [, nausea] [, sore throat] [, rhinorrhea] [, cough] []. Patient [denies] dysphagia or odynophagia. Patient [denies] history of asthma. Patient [denies] history of COPD. Patient denies chest pain, shortness of breath or hemoptysis. Patient has tried [over-the-counter cough syrup] without substantial relief.

Abd pain

The patient is a [AGE] [fe]male who presents to the ED complaining of [sharp] abdominal pain located [diffusely] that began [suddenly] [TIME OF ONSET]. Patient reports that the pain [does not] radiate to [back, flank or groin]. Patient had a [normal] bowel movement [today]. [The pain is not relieved by vomiting or having a bowel movement.] Patient report [no] vomiting. Patient report [no] diarrhea. [Patient denies having a cough, dyspnea, or chest pain.] [Patient denies dysuria, increased frequency or urgency in voiding, and hematuria.] [Patient denies experiencing similar pains in the past.] [Patient denies prior abdominal surgeries.] [PATIENT ADDS…]

[Patient denies vaginal discharge, bleeding, and dyspareunia.] Patient reports her last menstrual period was [TIME] and was [normal].

Ankle pain

Patient is a [AGE] year old [fe]male presenting to the ED with [left] ankle pain after [inverting on weight bearing] [ONSET]. [There was no associated loss of consciousness.] [There was no associated head trauma.] [There was no associated blood loss.]

Anxiety

Patient is a [AGE] [fe]male presenting with [#] episode [COMPLAINT] with associated [shortness of breath] since [ONSET]. [Patient has a history of anxiety attacks and this feels similar to prior episodes.] The current episode have lasted [TIME] and have [not] resolved. [Patient is concerned about having another attack.] Patient has a history of [psychiatric disorders]. Patient reports [no] family history of panic attacks.

Back pain

Patient is a [AGE] year old [fe]male that presents to the ED with [lower] back pain that since [TIME]. [Patient has a long history of chronic back pain.] [There has been no new trauma.] [The patient reports no unexpected weight loss or fevers.] [There is no history of IV drug use.] [The patient reports no paresthesias in a saddle distribution and although bending over and lifting anything heavy exacerbates the pain, they report no new focal lower extremity weakness.] [No incontinence or difficulty with defecation or urination.] [The patient also denies hematuria or flank pain and denies any history of nephrolithiasis.]

Constipation

The patient is a [AGE] [fe]male who presents to the ED complaining of constipation. At baseline, the patient has [#] bowel movements a day but there have been no bowel movements since [TIME]. Patient has tried [REMEDY] with [little effect]. Patient report [not] having a long-term problem with constipation. Associated symptoms include [ASSOCIATED SYMPTOMS]. Patient report [no] associated vomiting. Patient report [no] unintentional weight loss. Patient denies having a history of hypothyroidism, diverticulitis, or nephrolithiasis. Patient [denies] daily use of narcotic medication. [Patient's describes limited intake of fiber and water in diet.]Patient has presented [#] times to the DMC system for this complaint in the last [TIME].

HTN

The patient is a [AGE] [fe]male who presents to the ED [sent by PCP] for elevated blood pressure of [#] measured at [the office]. [The patient deny any headache, speech or gait abnormalities, focal sensory or motor deficit, or mental status changes.] [The patient denies any visual disturbances or loss of vision.] [The patient denies any dyspnea or chest pain.] [The patient denies abdominal or back pain.] [The patient denies any hematuria or anuria.] Pertinent past medical history is significant for chronic hypertension that is [BEING TREATED WITH... COMPLIANT?].

Hypogly

The patient is a [AGE] year old [fe]male who presents to the ED as a medical code. The patient was brought in by [EMS] for [being unresponsive]. Accu-Chek was done on the scene that was noted to be ["low"]. [There is no reports of trauma or seizure.] [No more information to be obtained from patient.]

REVIEW OF SYSTEMS:

Unable to provide secondary to mental status

PMD: [Unable to provide due to clinical condition]

PAST MEDICAL/SURGICAL HISTORY: [Unable to provide due to clinical condition]

MEDICATIONS: [Unable to provide due to clinical condition]

ALLERGIES: [Unable to provide due to clinical condition]

SOCIAL HISTORY: [Unable to provide due to clinical condition]

FAMILY HISTORY: [Unable to provide due to clinical condition]

MVC

Patient is a [AGE] year old [fe]male whom came to the ED [via EMS] as a victim of a motor vehicle accident. The patient was a [un]restrained [driver] traveling at [SPEED] when the vehicle [was] struck [from behind]. There was [no] deployment of airbags. There was [no] associated loss of consciousness. There was [no] associated head trauma. There was [no] report of blood loss at the scene. Patient [denies] associated alcohol use. [Patient report to be [non]ambulatory after the accident.

Leaky penis

The patient is a [AGE] male presenting to the ED with penile discharge since [TIME]. Patient reports the discharge as [clear]. Patient [denies] subjective fever. [Patient denies dysuria, increased frequency or urgency in voiding, and hematuria.] He is currently [sexually active] and [does not use condoms]. He [denies] having a history of [STIs].

Red eye

Patient is a [AGE] year old [fe]male presenting to the ED with [red eye] that was first noticed [TIME] in [both] eyes. Patient reports [no] pain. Patient reports [no] purulent discharge. [Patient reports no changes or loss of vision.] Patient [denies] wearing contacts. [Patient denies a gritty feeling or sensation of foreign body in the eye.] [Patient denies seeing flashes, floaters, spiderwebs, or curtains.] [Patient denies experiencing associated headache.] Patient have [no] history of allergy, atopy, and nasal symptoms. Associated symptoms include [no] rhinorrhea and [no] other signs of upper respiratory infection. [Patient denies any exposure to any noxious stimuli.] [Patient denies having any ill contacts.]

SOB

The patient is a [AGE] [fe]male who presents to the ED complaining of worsening shortness of breath that began [gradually] since [ONSET]. Patient [denies] a history of intubation or ICU admission. Patient [denies] having a history of heart failure. Patient [denies] having a history of asthma. Patient [denies] having a history of COPD. Patient [denies] having a history of murmurs or valvular dysfunction. Symptoms are [unchanged] when the patient lies down. Patient [denies] worsening ankle swelling. [The patient denies any history of heart disease, blood clots or cancer.] [Patient denies any history of surgery or trauma in the last month.] [Patient denies being mostly bed-bound over the last few days and denies any recent travel.] Patient has had [CHF] exacerbations in the past that feels the same as the current presenting symptoms.

SCC

Patient is a [AGE] year old [fe]male presenting with pain in [LOCATION] since [TIME]. The patient has a history of sickle cell disease with acute pain episodes and reports that the current pain episodes is similar to those in the past. Patient reports that the pain has worsened since onset. In the last 24 hours, the patient have used [NARCS] for pain relief. [The patient has presented multiple times in the last year to this ED with similar presentation]. The patient's pain regimen at home is [HOME MEDS]

**DISPOSITIONS/MDM**

Ankle sprain dc

The patient presents with soft tissue swelling and pain upon twisting their [left] ankle. I applied the Ottawa ankle rules on this patient, which are as follows: 1. bone tenderness along the distal 6 cm of the posterior edge of the tibia or tip of the medial malleolus. 2. Bone tenderness along the distal 6 cm of the posterior edge of the fibula or tip of the lateral malleolus. 3. Bone tenderness at the base of the fifth metatarsal (for foot injuries). 4. Bone tenderness at the navicular bone (for foot injuries). 5. An ability to bear weight both immediately and in the emergency department for four steps.

Since the patient have features that violate the Ottawa ankle rules, namely [RULES], we obtained an ankle X-ray. The patient has no proximal fibular pain to suggest a Maissoneuve injury and no knee or hip pain. The patient was given [600mg of ibuprofen PO] for pain. The ankle X-ray show [no acute fracture or subluxation].

We applied an [ACE/SPLINT] on the patient's ankle and gave them crutches and told them to weight-bear as tolerated and apply ice to the affected area, rest and elevate the leg. They are told to follow-up with orthopedic clinic.

I have explained to the patient in appropriate terminology their diagnosis and provided anticipatory guidance for further management as an outpatient. The patient has verbalized their understanding and at this time I feel they are stable for discharge home.

Asthma admit

Based on the history, PE, and considering the patient's presenting signs and symptoms, I believe the patient has a asthma exacerbation. Clinically, the patient does not have signs consistent with congestive heart failure. I have also considered the diagnosis of a pulmonary embolism, but as the patient's Well's score is [#], they are below the testing threshold for further evaluation.

The patient was given [#] nebulized breathing treatments with albuterol and ipratroprium [as well as 60mg of oral prednisone]. [Due to the severity of the patient's symptoms, 1g of magnesium sulfate was given IV over 30 minutes.]

Chest X-Ray was done and showed [no acute cardiopulmonary process.] This is the radiology read which I agree with.

After the treatment, the patient still report persistent dyspnea. [NPPV was intiated with BiPAP as an alternative to intubation.]

[At this point, given the patient's abnormal vital signs and co-morbidities, inpatient management is required for further management.]

I have admitted the patient to the [floor] for further evaluation, diagnostic testing, and management. I have explained to the patient the necessity of their admission to undergo continued treatment for their asthma. The patient is amenable to admission at this point. The patient's repeat vital signs are stable.

Asthma dc

Based on the history, PE, and considering the patient's presenting signs and symptoms, I believe the patient has a asthma exacerbation. Clinically, the patient does not have signs consistent with congestive heart failure. [I have also considered the diagnosis of a pulmonary embolism, but as the patient's Well's score is [#], they are below the testing threshold for further evaluation.]

The patient was given [#] nebulized breathing treatments with albuterol and ipratroprium [as well as 60 mg of oral prednisone]. [The patient responded well to the treatment.]

Chest X-Ray was done and showed [no acute cardiopulmonary process.] This is the radiology read which I agree with.

Due to the fact the patient does not have persistent or worsening dyspnea or hypoxia after treatment, have normal mentation, and lack comorbidities, I am comfortable to have the patient undergo further management as an outpatient.

I have explained to the patient in appropriate terminology their diagnosis and provided anticipatory guidance for further management as an outpatient. I have reviewed the asthma-related medications with the patient, inhaler technique, counseled the patient on avoidace of noxious stimuli, and the importance of follow-up as part of my anticipatory guidance. The patient has verbalized their understanding and at this time I feel they are stable for discharge home. [I have written a prescription for an albuterol inhaler as well as a Medrol-pack for symptomatic relief.]

Alcohol

The accucheck is [#] and pulse-ox reading is [#], the patient was placed in the transition care unit pending sobriety. The patient has no signs of head trauma. They will be assessed periodically to ensure stability.

[Patient was signed out to the incoming physician pending disposition.]

[After allowing the patient to sleep, with the guard-rails raised, for several hours, the patient appeared clinically sober. The patient was then fed a meal with complex carbohydrates to prevent alcohol-induced hypoglycemia since these patients have a propensity to develop sudden hypoglycemic events secondary to depleted glycogen stores. The patient was given oral thiamine to prevent Wernicke's encephalopathy since their nutritional status is unknown. Repeat neuro exam is non-focal, the patient answers questions appropriately and has intact judgment and decision-making capacity. The patient has a stable gait in the ED upon re-assessment. They have been counseled regarding alcohol cessation. Repeat vitals are stable and the patient is stable for discharge.]

Alcohol withdrawal

Patient presented to the ED with [SYMPTOMS] consistent with acute alcohol withdrawal. [The patient does not have any hemodynamic instability that suggest imminent progression into delirium tremens.] [The patient is neurologically normal and does not appear to be internally stimulated.]

IV access was established in the patient and the patient was given 1L of [normal saline]. [Given the patient's history of alcohol abuse and concern for Wernicke's encephalopathy, I administered 100mg of thiamine and 1mg of folic acid.] [I have also chosen to obtain a complete blood count and basic metabolic panel as patient's with a history of alcohol abuse are susceptible to electrolyte abnormalities.] [I have obtained an ammonia level to rule out uremic encephalopathy.] [I have also obtained a serum alcohol level.] [A urine drug screen was sent.]

The patient's electrolyte was notable for [FINDINGS]. [The patient ammonia level was normal.] [The patient's serum alcohol level is below detection limits.]

[I have administered 2mg of IV Ativan to treat the patient's withdrawal symptoms.]

[Patient was signed out to the incoming physician pending disposition.]

STEMI

Based on the history, PE, and considering the patient's presenting signs and symptoms, I believe the patient has a clinical presentation concerning for a cardiopulmonary etiology and justify further evaluation that includes an acute coronary syndrome rule out. Therefore, we have obtained an ECG, [aspirin was given,] the patient was placed on a monitor, provided supplemental oxygen to maintain pulse-oximetry above 95%, and IV access was established by the nursing staff. Basic labs, cardiac enzymes, and coagulation studies were drawn.

A 12-lead EKG was performed which showed a rate of [#] beats per minute. A rhythm which is [regular]. Axis is [non-deviated]. Intervals show a PR-interval of [#] milliseconds, QRS-duration of [#] milliseconds, QT-corrected of [#] milliseconds. There are ST elevations in leads [LEADS] with reciprocal changes in leads [#]. [OTHER FINDINGS]. My final interpretation of this EKG is []. [A prior ECG from][There is no prior ECG in the EMR for comparison].

Chest X-Ray was done and showed [no acute cardiopulmonary process.] This is the radiology read which I agree with.

[The patient has symmetrical pulses over the radial or carotid arteries and a normal X-ray. Based on this, the patient has a very low probability of having an aortic dissection and does not warrant further testing.]

[The patient's has a calculated Well's score of <2. Based on this, the patient has a very low probability of having a diagnosis of PE and does not warrant further testing.]

I have activated the Code STEMI and consulted Cardio Team One regarding the patient's [abnormal ECG]. Per cardiology's recommendation, I have administered [Plavix] and admitted the patient to [cath lab] for further management.

I have explained to the patient the necessity of their admission to undergo urgent treatment for STEMI. The patient is amenable to admission at this point. The patient's repeat vital signs are stable.

Allergy

Based on the history, physical exam, and considering the patient's presenting signs and symptoms, I believe the patient presents with what clinically appears to be an allergic reaction. There are no signs of impending respiratory failure or anaphylaxis. There is no sign of lip or tongue swelling that may suggest angioedema.

[The patient had a I.V. placed by the nursing staff and was given a bolus of normal saline, Benadryl 50 mg IV push, Zantac 50 mg IV piggyback, Decadron 10 mg IV push. ] [I have also given the patient Donnatal, Maalox and 60 mg dose of prednisone by mouth to relieve her GI symptoms.]

[Patient felt subjectively better with resolution of symptoms after treatment.]

I have explained to the patient in appropriate terminology their diagnosis and provided anticipatory guidance for further management as an outpatient as per my custom. The patient has verbalized their understanding and at this time I feel they are stable for discharge home.

Copd

Based on the history, PE, and considering the patient's presenting signs and symptoms, I believe the patient has a COPD exacerbation. Clinically, the patient does not have signs consistent with congestive heart failure. I have also considered the diagnosis of a pulmonary embolism, but as the patient's Well's score is [#], they are below the testing threshold for further evaluation.

[Supplemental oxygen was given to maintain O2Sat above 90%.]

The patient was given nebulized breathing treatments with albuterol and ipratroprium as well as oral prednisone. [Due to the severity of the patient's symptoms, 2g of magnesium sulfate was given IV over 20 minutes.]

Chest X-Ray was done and showed [no acute cardiopulmonary process.] This is the radiology read which I agree with.

After the treatment, the patient still report persistent dyspnea. [NPPV was intiated with BiPAP.]

After treatment, the patient's symptoms [improved] on re-evaluation.

[At this point, given the patient's abnormal vital signs and co-morbidities, inpatient management is required for further management.]

I have admitted the patient to the [floor] for further evaluation, diagnostic testing, and management. I have explained to [the patient] the necessity of their admission to undergo continued treatment for their COPD exacerbation. The patient is amenable to admission at this point. The patient's repeat vital signs are stable.

AMA

The patient was apprised of the potential risks of leaving the hospital AGAINST MEDICAL ADVICE. They include serious complications, permanent disability, death. At the time of my interview with the patient, the patient was alert, oriented, and capable. I urged the patient to return to the hospital as soon as possible to complete their evaluation and treatment.

Discharge

I have explained to the patient in appropriate terminology their diagnosis and provided anticipatory guidance for further management as an outpatient, and that they are to follow-up with [their PCP] to further assess them for [ their symptoms]. [For symptomatic control at home I have provided them with a prescription for] []. If the patient cannot follow-up as an outpatient, they should return to the ED so that we could help facilitate follow-up. I have explained to the patient appropriate return precautions prior to discharge. The patient has verbalized their understanding of this plan and at this time I feel they are stable for discharge home.

Laceration

The patient presents with a laceration on [ ]. It is [a clean wound]. [We have updated the patient's tetanus.]

[I have sent the patient for an X-ray to rule-out a retained foreign body. The X-ray shows no evidence of a retained foreign body or fracture by my interpretation.]

The patient's laceration was copiously irrigated under high-pressure irrigation with [clean tap water]. The wound was carefully inspected and explored for the possible retained foreign body and none was found. The wound was anesthetized with [1% lidocaine with epinephrine and bupivicaine mixed at at 50/50 ratio.] Using aseptic technique, the laceration was repaired using [#]-0 [nylon] [sutures] and [# sutures] were placed in [simple interrupted] fashion with good approximation and without strangulation of the involved tissue. The patient was appropriately counseled regarding proper wound care and infection avoidance.

 I have instructed the patient to return to the ED or visit their PCP to have the stitches removed in [10] days.

I have explained to the patient in appropriate terminology the appropriate manner of wound care and provided anticipatory guidance for further management as an outpatient as per my custom. The patient has verbalized their understanding and at this time I feel they are stable for discharge home.

Signout

This patient was signed out to the oncoming emergency medicine physician. The oncoming emergency medicine physician was updated fully on this patient's history, physical examination, and pertinent diagnostic studies. They were updated on the plan moving forward, and will take over care for this patient, who is currently in [] condition. [the patient is currently pending] [], with the expectation that they will be [discharged home in stable condition]

Toothache

Patient is a [] year old with a [non-significant] PMH [] who presents with []. I feel the patient's symptoms are consistent with toothache. I recommend analgesia with Naproxen and breaththrough treatment of pain with Norco. [The patient will also be started on Penicillin.] The patient was given first doses of each medication in the ED today.

The patient was given prescriptions for Naproxen 500mg BID, Norco 5 Q6H, and Penicillin 500mg QID. The patient was told to follow up with their dentist or follow up in our oral surgery clinic in the next few days.

UTI

Based on the history, PE, and considering the patient's presenting signs and symptoms, I believe the patient has symptoms suggestive of an [UTI]. An [urine pregnancy test,] urinalysis was sent. [Zofran was administered as an anti-emetic.]

Urinalysis showed [FINDINGS]. [Urine pregnancy test was negative.]

The diagnosis of urinary tract infection is made given the clinical presentation and lab findings. The patient appear otherwise well, have stable vitals, no CVA tenderness, or fever that might suggest pyelonephritis or a systemic infection. Therefore, the patient can be discharged safely with follow-up within 48 hours and instructions to return immediately for increased pain, vomiting, fever, or failure of symptoms to resolve. I have written a prescription for [TMP/SMX DS160/800mg BID for 3 days] [Nitrofurantoin 100mg ER for 5 days]. [A dose is given here in the ED.] [I am also prescribing phenazopyridine 200mg tid for bladder analgesia.]

[I have explained to the patient in appropriate terminology their diagnosis and provided anticipatory guidance for further management as an outpatient. I have encourage the patient to maintain ample fluids and void frequently. The patient has verbalized their understanding and at this time I feel they are stable for discharge home.]

Vaginal discharge

The patient is a [ ] year old who presents with concerns for sexually transmitted infection. Therefore, we have obtained [urine pregnancy test, and urinalysis].

A pelvic examination was done by myself with a female chaperone. External examination revealed [no lesions, vesicles, or papules]. Speculum examination revealed [no] discharge in the vaginal canal. There was [no] erythema of the cervix. [Cultures were taken from the cervix.] Bimanual examination revealed [no] cervical motion tenderness and [no] adnexal tenderness. A wet mount was done that showed [no] trichomonads and [no] clue cells.

The urine pregnancy test was negative.

My clinical impression is that the patient has cervicitis concerning for [yeast, bacterial vaginosis,] [gonorrhea and chlamydia]. I have sent labs off for GC/CT DNA amplification and have placed her name in the contact book to be notified of her results. I have empirically treated the patient with a dose of [metronidazole,] [ceftriaxone, and azithromycin.]

I have explained to the patient in appropriate terminology her diagnosis and provided anticipatory guidance for further management as an outpatient. I have instructed the patient to refrain from sexual activity for the next two weeks [or until she finds out her GC/CT amplification result is negative]. The patient has verbalized her understanding and at this time I feel she is stable for discharge home.

Syncope

The patient is a [AGE] [fe]male presenting to the ED complaining of [#] episode of syncope that occurred [ONSET] [CONTEXT]. [Patient denies an associated prodrome with episode.] [The syncopal episode lasted seconds and the patient was not confused immediately after recovering from the episode.] Patient [denies] reproduction of symptoms on postural changes. Patient [denies] episodes of vomiting or diarrhea prior to syncopal episode. Patient [denies] having poor PO intake prior to syncopal episode. [Patient denies family members have died suddenly.] [Patient denies chest pain, back pain, shortness of breath, or palpitations associated with the syncopal episode.] [Patient denies feeling short of breath on exertion.] [Patient denies having a history of dysrhythmia or myocardial infarction.]

Vag bleed

The patient is a [AGE] year old female presenting to the ED with [PAINFUL/PAINLESS] vaginal bleeding that began [TIME]. Patient is currently [not] pregnant. Since the bleeding started, the patient has [passed clots]. Pateint reports [no] vomiting and abdominal pain. [Patient denies changes in bowel movement.] [Patient denies dysuria, increased frequency or urgency in voiding, and hematuria.] Patient reports her last menstrual period was [TIME] and was [normal]. [OB Hx] She is currently [SEXUAL ACTIVITY] and [does not use] contraception. She [denies] having a history of [STIs].

**EXAMS**

Hand

Regarding the [affected] hand: [No] swelling or deformity noted []. [No] redness or muscular atrophy noted []. [No] nodules over the joints []. Palpation of the distal interphalangeal, proximal interphalangeal, and metacarpophalngeal joints without swelling, bogginess, tenderness, or bony enlargement. [No] tenderness in the anatomical snuffbox. +2 radial pulses bilaterally, <2second capillary refill bilaterally

Motor: [Full] passive and [full] active flexion and extension of fingers of both hands at the MCP/PIP/DIP joints. [no] difficulty of making a fist with thumbs across the knuckles. [no] difficulty giving thumbs up, OK sign, or thumb opposition. [5/5] strength in wrist flexion, FDP/FDS of digits 2-5 and at MCP/IP joint of thumb bilaterally, finger abduction and adduction of digits 2-5, as well as extension of wrist and digits1-5 at MCP/IP joints bilaterally

Sensory: full sensation to touch along distal radial aspect of 2nd digit, ulnar aspect of 5th digit, or dorsal web between 1st-2nd digit.

Ortho Extremities

RUE 5/5 motor shoulder abduction, arm flex/ext, wrist flex/ext, intact AIN/PIN/U SILT M/R/U, Hand warm and well perfused with +2 radial pulse

LUE 5/5 motor shoulder abduction, arm flex/ext, wrist flex/ext, intact AIN/PIN/U, SILT M/R/U, Hand warm and well perfused with +2 radial pulse

RLE 5/5 motor hip flexion/knee flex/extension, df/pf, intact FHL/EHL/GSC/TA, SILT DP/SPN/Saph/Sural, +2 DP/PT pulse

LLE 5/5 motor hip flexion/knee flex/extension, df/pf, intact FHL/EHL/GSC/TA, SILT DP/SPN/Saph/Sural, +2 DP/PT pulse

Eye

OD

External: There are [no visible external lesions around the eyes.] [no ptosis]

Globe: [There are no signs of proptosis], [no] conjunctival injection, []

Acuity: Vision is 20/[#] to near vision

Pupils: are [3mm] [and reactive to light]. There is [no] teardrop pupil.

Extraocular movements are [intact and normal]. There is [no] upward gaze inhibition

Fuorescein stain was [] performed: [There are no abrasions on the corneal surface visible] There is [no] Seidel's sign.

IOP: [not performed]

OS:

External: There are [no visible external lesions around the eyes.] [no ptosis]

Globe: [There are no signs of proptosis], [no] conjunctival injection, []

Acuity: Vision is 20/[#] to near vision

Pupils: are [3mm] [and reactive to light]. There is [no] teardrop pupil.

Extraocular movements are [intact and normal]. There is [no] upward gaze inhibition

Fuorescein stain was [] performed: [There are no abrasions on the corneal surface visible] There is [no] Seidel's sign.

IOP: [not performed]

Pelvic

A pelvic examination was done by myself with a female chaperone. External examination revealed [no] lesions, vesicles, or papules. Speculum examination revealed [no] discharge in the vaginal canal. There was [no] erythema of the cervix, cervical os was [closed], there was [no] blood in the vaginal canal. [Cultures were taken from the cervix.] Bimanual examination revealed [no] cervical motion tenderness and [no] adnexal tenderness. A wet mount was done that showed [no trichomonads] and [no] clue cells.

Rectal

Rectal exam performed by myself with a chaperone. There are [no] protruding hemorrhoids on rectal exam, [no] fissures, skin tags, lesions or abscess. There is good anal sphicter tone without palpable masses or areas of tenderness in the anorectum. [No] gross blood. Stool is guaiac [negative].

Spine

MUSCULOSKELETAL: gait pattern is [normal with symmetric stride length].

 Toe walking [], heel walking []

 Tone and bulk are normal.

 palpation to midline lumbar spine shows [no tenderness], lumbar paraspinal musculature palpation shows [no tenderness].

 No palpable step-off over the thoracolumbar spinous processes.

 Motor strength [5/5 for the bilateral] EHL, []FHL, []GSC, []TA, []Q, []H, []iliopsoas

 Straight leg raise is [negative] in the supine position [bilaterally].

 [No] groin pain with AROM of the hip joints bilaterally.

 NEURO:

Patient is [alert and conversational, speaking in full sentences]

CN: I [not tested], II [vision grossly intact], III/IV/VI [EOMI in all cardinal directions], V [sensation intact to light touch to the face bilaterally], VII [symmetric facies], VIII [hearing grossly intact], IX/X [symmetric uvula and elevation of posterior pharynx], XI [symmetric shoulder shrug], XII [tongue protrudes midline]

Sensory/Strength:[sensation intact to light touch throughout bilateral lower extremities], [strength is grossly intact and equal in all four extremities]

 Cerebellar/reflex: [Normoactive patellar DTR's bilaterally], [No] spasticity or sustained ankle clonus. [negative] babinski bilaterally, [negative] FNF exam

Macro oooweeeee

This little poopypants is HUNGRY

FAST

A FAST exam was conducted that was [negative] for intraabdominal and [] pericardial fluid.

**PROCEDURE**

IC

I have discussed the proposed procedure with the patient. I have informed the patient regarding the risks, benefits, side effects and expected outcomes and likelihood of achieving the goals for the procedure. I have also discussed alternatives of the procedure, the risks and benefits of the alternatives, and the possible results of not receiving this treatment. After discussion, the patient has agreed to undergo the procedure.

LP

Procedure Note: Universal precautions were taken. The area was prepped with povidone and the skin was locally anesthetized with 1% lidocaine. A spinal needle with stylette was inserted between L4 and L5 spinous processes. CSF was obtained and sent to the lab. The patient is instructed to remain for the next hour.

ID

Incision and drainage was performed by myself []. The area was prepped with povidone and the skin was locally anesthetized with 1% lidocaine. An incision was made with an 11 blade. Approximately [5] mL of purulent material was removed. The wound was irrigated, and loculations were broken with hemostats. [The wound was packed with gauze.] A dressing was placed.

Intubation

Procedure note: [Rapid sequence] intubation was conducted by me under the direct supervision of the attending physician. After adequate preoxygenation [and induction with] [20 milligrams of IV etomidate] [and neuromuscular blockade with] [70 mg of rocuronium,] and a [7.5] endotracheal tube was passed through the vocal cords in one attempt under my direct vision with [a Mac 3 blade] using [glidescope]. Tube placement was verified by bilateral breath sounds, endotracheal tube fogging, and colormetric CO2 color change. [Patient was placed on continuous waveform capnography]. Initial ventillator settings of [AC 500, 10, 100%, 5 PEEP]. The patient was [unable to consent directly due to critical clinical condition, and consent was implied.] [2 mg of Ativan] [was given for post intubation.] [placement was confirmed with chest radiograph]

Procedural sedation

Procedural sedation and [what procedure] were performed by myself under the guidance of the attending emergency medicine physician

The risks and benefits of the procedure and of moderate sedation were discussed with the patient and the patient agreed to undergo both. Written consent [was obtained] for both procedural sedation and [].

A Time Out was performed before either sedation or the procedure were initiated. The patient´s identity, procedure type, and body location including side where the procedure was to be performed were confirmed.

This Time Out was documented at the bottom of the informed consent form.

The procedure began at [default value] and ended at [default value].

The result of the procedure was [default value].

The sedating drug(s) used were[default value]. The doses used were [default value].

The patient's response to sedation was [adequate].

The patient was observed until full recovery from sedation.

The patient will be given a Logicare discharge instruction for procedural sedation in addition to other instructions.

Stitches

Procedure Note: Repair of the wound was done by [myself] under the direct supervision of the attending physician with the patient's verbal consent. The patient's laceration was [anesthetized locally with 2% lidocaine and 0.5% bupivicaine]. It was thoroughly explored with no evidence of foreign bodies. The wound was irrigated with copious amount of [clean water]. It was then sutured with a total of [3] [4-0] [nylon sutures]. Bacitracin ointment and a sterile dressing were applied. [Patient was given bacitracin ointment to take home.] Wound edges were well approximated. The patient was told to keep the area clean, given wound care instructions and told to keep a dressing on the wound. The patient was told return to emergency department if there is any evidence of infection such as increased erythema, increased warmth, pain or swelling or purulent drainage. Otherwise, the patient is to return to the emergency department in [7 days] for suture removal and wound check. The patient verbalized their understanding and agrees with the plan.

**Decision Making Tools/Calculators**

PERC Rule for Pulmonary Embolism: r/o PE if no critera present and pre-test probability ≤15%

Age ≥50: [No 0] [Yes +1]

HR ≥100: [No 0] [Yes +1]

SaO₂ on room air <95%: [No 0] [Yes +1]

Unilateral leg swelling: [No 0] [Yes +1]

Hemoptysis: [No 0] [Yes +1]

Recent surgery or trauma (<4weeks w/ GA): [No 0] [Yes +1]

Prior PE or DVT: [No 0] [Yes +1]

Hormone use: [No 0] [Yes +1]

Score: [NUMBER]

If 0: no need for further workup if pre-test probability ≤15%,, as <2% chance of PE.

If ≥1: PERC Rule cannot be used to rule out PE.

Wells' Criteria for DVT

Active cancer

Treatment or palliation within 6 months

[No 0] [Yes 1]

Bedridden recently >3 days or major surgery within four weeks

[No 0] [Yes 1]

Calf swelling >3 cm compared to the other leg

Measured 10cm below tibial tuberosity

[No 0] [Yes 1]

Collateral (nonvaricose) superficial veins present

[No 0] [Yes 1]

Entire leg swollen

[No 0] [Yes 1]

Localized tenderness along the deep venous system

[No 0] [Yes 1]

Pitting edema, confined to symptomatic leg

[No 0] [Yes 1]

Paralysis, paresis, or recent plaster immobilization of the lower extremity

[No 0] [Yes 1]

Previously documented DVT

[No 0] [Yes 1]

Alternative diagnosis to DVT as likely or more likely

[No 0] [Yes -2]

Total Wells Score: [0]

[A score of 0 or lower is associated with DVT unlikely with a prevalence of DVT of 5%.

A score of 1-2 is considered moderate risk with a pretest probability of 17%.

A score of 3 or higher suggests DVT is likely. Pretest probability 17-53%.]

PERC Rule for Pulmonary Embolism: r/o PE if no critera present and pre-test probability ≤15%

Age ≥50: [No 0] [Yes +1]

HR ≥100: [No 0] [Yes +1]

SaO₂ on room air <95%: [No 0] [Yes +1]

Unilateral leg swelling: [No 0] [Yes +1]

Hemoptysis: [No 0] [Yes +1]

Recent surgery or trauma (<4weeks w/ GA): [No 0] [Yes +1]

Prior PE or DVT: [No 0] [Yes +1]

Hormone use: [No 0] [Yes +1]

Score: [NUMBER]

If 0: no need for further workup if pre-test probability ≤15%,, as <2% chance of PE.

If ≥1: PERC Rule cannot be used to rule out PE.

Centor Criteria for Acute Pharyngitis

1. Temperature: >38C [yes 1] [no 0]

2. Absence of cough: [yes 1] [no 0]

3. Swollen, tender anterior cervical nodes: [yes 1] [no 0]

4. Tonsillar swelling or exudate: [yes 1] [no 0]

5. Age:

    -3-14 years: +1 point

    -15-44 years: 0 points

    ->=45 years: -1 point

Score:

<2 points: no further testing or antibiotics recommended

>= 2 points: additional testing recommended