OhioHealth

Transcription Report

[redacted]
DOB: [redacted]
Report Type: Emergency Dept Physician Note
Status: Final
Location: not available

MRN/PAN: [redacted]
Attending: [redacted]
Date: 7/16/2010 1:58:00 PM
Accn #: [redacted]

OHIOHEALTH
[redacted]
COLUMBUS, OHIO [redacted]

[redacted]
ATTENDING [redacted] MD

ACCT # [redacted]
DOB [redacted]
DATE 07/16/2010

EMERGENCY DEPARTMENT

This report is to be considered preliminary and subject to revision until electronically signed by the originator. Please refer to the electronic medical record for the final report.

CHIEF COMPLAINT
Vaginal bleeding.

HISTORY OF PRESENT ILLNESS
The patient is a 19-year-old female who was pregnant, states 13 weeks along, G2 P1, that had an elective abortion today. The appointment was around 6:15 in the morning. She was discharged around 8:15. She said she was nauseated and lightheaded while she was in the facility, and she even vomited there, but they still discharged her. When she got outside, she was so weak she fell to her knees and was vomiting. When she was advised that her family worked here at OhioHealth, they brought her to the hospital for evaluation. She is complaining of some pain in the suprapubic area and now it is in the midline lumbar back. Did not hit her head; was not actually passed out. No vision change. No speech change. No numbness or weakness in her extremities. No chest pain or shortness of breath. She still has a little nausea, but it is getting better. No urinary complaints. She said she was soaking through her pad and her sweat pants initially, put 2 more pads on and was still having a fair amount of bleeding. She denies any fever or chills. No urinary complaints.

PAST MEDICAL HISTORY
No significant medical problems.

ALLERGIES
She has no allergies to medications.

MEDICATIONS
In ORB and reviewed.

FAMILY HISTORY
Reviewed and noncontributory.

SOCIAL HISTORY
The patient smokes a half pack a day. Does not drink alcohol.

[redacted]

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REVIEW OF SYMPTOMS

Name: [redacted] MRN: [redacted] Account: [redacted]

See HPI, otherwise all other systems reviewed and negative.

PHYSICAL EXAM
Vital signs are in EmSTAT and reviewed. Initial blood pressure 88/59, repeat was 91/48, pulse in the 60s. Exam: Patient seen by ER physician and PA with findings as noted. A well developed female lying in bed alert and cooperative. Head is NCAT. Eyes are PERRL, EOMI, anicteric. Nose patent without discharge. Mouth: Good occlusions. No exudate or lesions. Neck is supple, nontender, full range of motion without adenopathy. Her lungs are clear to auscultation without wheeze, rales or rhonchi. Good air exchange bilaterally. Heart is RRR. Normal S1, S2. No gallop or rub. Abdomen is soft, flat, nondistended with mild suprapubic tenderness. There is no rebound, guarding, mass, organomegaly. No CVA or spinal tenderness. Skin is warm and dry, good turgor without rash, no cyanosis or edema. Neurologically: The patient is alert and orientedx3, nonfocal exam. Pelvic Exam: Shows normal female external genitalia. BUS within normal limits. On speculum exam, initially she had about half a cup of blood coming from the vault. After I suctioned that dry with [redacted] suction, there was only a small trickle of blood coming from her os with no tissue visible in the vault or the os. Bimanual shows no cervical motion tenderness. She had an enlarged uterus about 8-10 weeks in size with mild tenderness. There were no adnexal tenderness or masses appreciated.

DIAGNOSTIC STUDIES
White count 11,900, hemoglobin is 12.8, platelets are 197,000 with 89% neutrophils. The patient had a type and screen, which is A+. She had a pelvic ultrasound, which shows a small amount of heterogeneous fluid in the endometrial canal without a vascular mass lesion identified. No gestational sac or fetal pole identified. Normal evaluation of the ovaries.

ED COURSE
The patient had an IV normal saline given 1 L wide open. OB/GYN came to evaluate the patient. They felt that her bleeding had stopped when they saw her and seemed medically stable. From their standpoint, she was safe to go home. Dr. Yamarick spoke to Dr. Samuels, OB, who also felt she was safe to go home. We are going to send her home with Phenergan 25 mg tablets 1 by mouth q.4-6 hours as needed for nausea and vomiting, #12. She was given vomiting and GI antiemetic instructions.

IMPRESSION
1. Pelvic pain.
2. Postop bleeding.
3. Nausea and vomiting.

PLAN
Again, she is to use the medicine as directed. Bedrest for 12 hours.

[redacted]

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Follow up with Dr. Samuels in a week. Call sooner if any further problems.

Name: [redacted] MRN: [redacted] Account: [redacted]

Dictated by: [redacted] PA

[redacted] MD

DD: 07/16/2010 13:58:07
DT: 07/16/2010 14:40:23
TL: 9164634/JOB: d:/CIG/51554/reports/work/Dn54377_426877966_1
Authenticated by [redacted] MD On 07/18/2010 05:12:24 PM