

Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

12452



4 - ER URGENT

000001

ASSESSMENT FORM

TEMPORARY NUMBER		REF. #	W-C CF PP PR																																																														
		PRIVATE PHYSICIAN		PCP NOTIFIED BY PT PTA																																																													
		W-C PHYSICIAN		ER NOTIFIED BY PCP PTA																																																													
		ALLERGIES <u>NONE</u> <u>KNOWN LATEX</u>		PREVIOUS TESTS/TX IN 72 HR																																																													
TETANUS/IMMUNIZATION		WEIGHT	LMP	TRAUMA ACUITY																																																													
		168#		C E U N																																																													
PERTINENT MEDICAL HISTORY				MODE OF TRANSPORT																																																													
Hypertension				W/C CARRY CART																																																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th rowspan="2">VITALS</th> <th>TIME</th> <th>BP</th> <th>P</th> <th>R</th> <th>T</th> <th>SAO2</th> <th>TIME</th> <th>BP</th> <th>P</th> <th>R</th> <th>T</th> <th>SAO2</th> </tr> <tr> <td>1935</td> <td>176/110</td> <td>107</td> <td>20</td> <td>98</td> <td>99%</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>						VITALS	TIME	BP	P	R	T	SAO2	TIME	BP	P	R	T	SAO2	1935	176/110	107	20	98	99%																																									
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<p>INITIAL ASSESSMENT: 1300 intermittent substernal pain radiating into jaw & numbness in N. arm & hand last pm.</p>																																																																	
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<p>CURRENT MEDS: Captopril 150 mg/day (50 mg tid) Omeprazole 40 mg/day</p>																																																																	
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CLOCK IN		IMPRESSION																																																															
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REFER TO DR. CF PP PR PR REQ IL		CLOCK OUT		17:45 MAR 61																																																													
		PRESCRIPTIONS		[Redacted]																																																													
		PHYSICIAN SIGNATURE		[Redacted]																																																													

Name: [REDACTED]
DOB: [REDACTED]
No.: [REDACTED]
Date: 06/19/97

HISTORY OF PRESENT ILLNESS: The patient is a 59-year-old white female complaining of some intermittent substernal chest pain yesterday that was dull in nature and radiated to the left neck and jaw associated with some diaphoresis. She has had no further radiation of the pain in the neck or jaw today but she has had a continuous, dull chest pressure all day today. She says it does not change with exertion.

She denies any significant shortness of breath and no nausea or vomiting. Denies a prior history of similar symptoms.

REVIEW OF SYSTEMS:

GENERAL: No fever or chills.

CARDIOVASCULAR: Positive for the above chest pain.

RESPIRATORY: No cough or sputum production. No shortness of breath.

GASTROINTESTINAL: No nausea, vomiting or diarrhea.

No other positive review of systems.

SOCIAL HISTORY: She does smoke a pack of cigarettes a day.

PAST MEDICAL HISTORY: She has a history of hypertension. Denies a personal history of diabetes or heart disease.

CURRENT MEDICATIONS: Capoten and Omnitrim.

ALLERGIES: No known medical allergies.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.8 degrees orally. Respirations 20. Pulse 107. Blood pressure 176/91. Pulse oximetry 95% on room air.

GENERAL APPEARANCE: Well-developed, well-nourished white female in no acute distress. Alert and cooperative.

LUNGS: Clear to auscultation and equal.

HEART: Regular rate and rhythm with a 2/6 systolic murmur, best heard at the right upper sternal border.

CONTINUED

[REDACTED] -- ADMITTED

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[REDACTED]

[REDACTED]

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PHYSICAL EXAMINATION: Continued

ABDOMEN: Bowel sounds are positive. Soft and nontender. No mass or splenomegaly.

EXTREMITIES: No clubbing, cyanosis or edema.

COURSE IN THE EMERGENCY DEPARTMENT: The patient was given aspirin 325 mg p.o., two nitroglycerin sublingually with total relief of her discomfort. She then had an inch of Nitro-Paste placed. She was placed on heparin high-dose protocol.

She had an electrocardiogram that showed a normal sinus rhythm with poor R wave progression anteriorly, some small Q waves in V2 and V3 and 1 mm ST segment elevations in V2 and V3. No old electrocardiograms for comparison. She had an elevated CK total of 517, CK/MB of 93.6, index 18.1, elevated troponin I of 6.2. Hemoglobin 13.6, hematocrit 40.1, platelets 233,000, white count 11.8. She had sodium 142, potassium 4.9, chloride 109, CO2 19, glucose 105, BUN 20, creatinine 2.1, cholesterol elevated at 294, triglycerides elevated at 549. She also had an elevated LDH of 248, SGOT of 71. When her enzymes came back elevated, she was changed from Nitro-Paste to a nitroglycerin drip.

I discussed the case with Dr. [REDACTED], on call for Dr. [REDACTED]. He came and evaluated the patient and wrote admitting orders.

CLINICAL IMPRESSION:

1. Acute myocardial infarction.

CONDITION ON ADMISSION: Fair.

[REDACTED]

D: 03/19/97

T: 03/20/97 [REDACTED]

[REDACTED] -- ADMITTED

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