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University of Chicago Medical Center 5841 S Maryland Chicago, IL 60637

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Author: [redacted] Service: (none) Author Type: [redacted]

Filed: [redacted] Note Time: [redacted] Note Type: ED Provider Notes

Reason for Visit

Chief Complaint
Patient presents with
- Abdominal Pain

ER Notes

History of Present Illness
HPI

47 yo F with DM, HTN presenting with acute onset of n/v/abd pain

Pt has had three similar episodes in the past few years. She has undergone a thorough evaluation at multiple hospitals, including MRIs, scopes, and ex-lap 7/12. No etiology of her symptoms were found, although she was told that her bowels were "inflamed". SHe was referred to U of C for further evaluation.

She attended a luncheon today with her children. She went home, and approx 3 hours after she had eaten her symptoms began. Nausea started first, followed by emesis and then followed by diarrhea. Emesis is NBNB. Diarrhea is loose, but not watery. She reports mucus. No blood. No recent travel or abx.

She has spent about a week for each episode as an inpt receiving IVF, antiemetics, and pain control.

She has no other infectious symptoms. Last A1C was 10, last checked yesterday by her endocrinologist at UIC. Does not have a PCP.

Past Medical History
Past Medical History

Diagnosis	Date
• HTN (hypertension)	
• Diabetes	

Past Surgical History
Past Surgical History

Procedure	Date
• Abdominal surgery	

Family History
No family history on file.

Social History
History
Substance Use Topics
- Smoking status: Never Smoker

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- Smokeless tobacco: Not on file
- Alcohol Use: No

Current Medications

Outpatient Prescriptions Marked as Taking for the 6/22/13 encounter (Hospital Encounter)

Medication	Sig	Dispense	Refill
• glimepiride (AMARYL) 4 mg Oral Tab	4 mg by Oral route every morning.		
• lisinopril (PRINIVIL) 40 mg Oral Tab tablet	40 mg by Oral route daily.		
• metFORMIN (GLUCOPHAGE) 1,000 mg Oral Tab tablet	1,000 mg by Oral route twice daily.		

Allergies

Allergies

Allergen	Reactions
• Penicillins	

Review of Systems

Review of Systems
Constitutional: Negative for fever and chills.
Eyes: Negative for blurred vision.
Respiratory: Negative for cough.
Cardiovascular: Negative for chest pain.
Gastrointestinal: Positive for nausea, vomiting, abdominal pain and diarrhea. Negative for heartburn, constipation and blood in stool.
Genitourinary: Positive for dysuria.
Musculoskeletal: Negative for myalgias.
Skin: Negative for rash.
Neurological: Negative for headaches.
All other systems reviewed and are negative.

Physical Exam

Physical Exam
Nursing note and vitals reviewed.
Constitutional: She is oriented to person, place, and time and well-developed, well-nourished, and in no distress.
Appears in pain
HENT:
Head: Normocephalic and atraumatic.
Eyes: Conjunctivae normal are normal. Pupils are equal, round, and reactive to light.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no gallop and no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal. No respiratory distress. She has no wheezes. She has no rales. She exhibits no tenderness.
Abdominal: Soft.
Diffusely tender to palpation. No rebound, but guarding. +BS
Musculoskeletal: Normal range of motion. She exhibits no edema and no tenderness.
Neurological: She is alert and oriented to person, place, and time.
Skin: Skin is warm and dry. No rash noted. She is not diaphoretic. No erythema.

Assessment/Plan: 47 yo F with DM, HTN presenting with acute onset of n/v/abd pain

Nausea, vomiting, abdominal paln: unclear etiology. Thorough workup at OSH, including complete imaging, scopes, and ex-lap without etiology determined.
- Symptomatic management with IVF, antiemetics, pain control
- EKG
- CBC, BMP, LFTs, lipase

Dispo pending

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