89TH MEDICAL GROUP DIVISION: MALCOLM GROW
Personal Data - Privacy Act of 1974 (PL 93-579) Automated Version of SF600
Printed: 29 May 2001@0808

ORTHO CLINIC MG SCHROEDER,MICHAEL H 29 May 2001 0808 SDA BEAA
REF: CMT:
RSN:
INSURANCE YES/NO:

BP: PULSE: RESP: TEMP: HT: WT: AGE:

ALLERGIES:

S/ 48 yo ♂ seen in ED yesterday for pain + swelling left calf. Pt noticed a pull during run. one week ago. Rested leg for one week. Tried running again Saturday + had pain + swelling on Sunday. Rested + iced with minimal improvement. Seen in ED - concerned about compartment syndrome - given crutches / no weight bearing

ADDITIONAL COMMENTS: feels slightly better w/ NWB.

O/

	R	L
calf →	42.5cm	44.5cm

(L) mm Pain w/ dorsiflexion, ↓pain w/ eversion or inversion
TTP lateral calf muscles - peroneal tendon distribution
achilles tendon NT
+ pedal pulse
sensation intact P/PL/S/S/D
paresthesias
lateral calf pain with heel elevation in sitting position
Swelling peroneal sheath

A/ Peroneal/Soleus muscle Tear

P/ 1. Walking boot
2. Min → no weight bearing
3. RTC ASAP if pain worsens
4. FU 8 June

S. Rest/Ice/Elevation

MICHAEL SCHROEDER, Capt, USAF, BS
AFSC 42G3A
Staff Orthopedic Physician Assistant

20/256-88-7864 SMITH,ROBBIE LEE
20 Oct 1952 MALE
Spon: SMITH,ROBBIE LEE
CS:
Unit: SENSOR RETIRED

A31
W:202-442-6398 H:301 805-8310
CIC:
Rank: MAJ D:202-442-6398
RR: HAND CARRY RECORDS

SF600

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Ortho

FROM: (Requesting physician or activity) ED

DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

48 y/o ♂ runner ran 1 mile ... (L) leg. Kept running. Ran again ... in leg.

HEALTH RECORDS (ROBBIE SMITH)

PROVISIONAL DIAGNOSIS

Gastroc / Peroneal [illegible]

DOCTOR'S SIGNATURE | APPROVED | PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL | ☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO | PATIENT EXAMINED ☐ YES ☐ NO | TELEMEDICINE ☐ YES ☐ NO

S: Pt. resting comfortably (asleep)
No C/O today [illegible] — Pt. not taking any pain meds
Sx improved today over yes[terday]

O: alert, NAD ♂
(L) LE c tight palpable lateral leg (+)TTP.
(−) Tender c PROM of ankle + toes.
5/5 strength to DF/PF, EV/INV. (+) [illegible] c resisted eversion
X-ray (−). 2+ pulses DP/PT.

A: Probable Gastroc/Peroneal muscle pull

P: (1) Rest, Ice, Elevation of (L) LE, F/U [illegible] c me ER if [illegible]

(Continue on reverse side)

SIGNATURE AND TITLE

MICHAEL SCHROEDER, Capt, USAF, BSC
AFSC 42G3A
Staff Orthopedic Physician Assistant

DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (Last, first, middle) | SPONSOR'S ID NUMBER (SSN or Other)

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

Smith, Robbie
20/256-88-7864

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

EMERGENCY DEPARTMENT FLOW CHART

(This form is subject to the Privacy Act of 1974)

ED LOG #	DATE	TIME SIGNED IN
34	5/28/01	1046

ARRIVED BY (Circle Appropriate Item): POV MTF AMB EMS BOLLING AMB

CHIEF COMPLAINT: (L) leg swelling

TIME: 1044 **COMPREHENSIVE TRIAGE ASSESSMENT** Int

S/O - Running 1 week ago + felt (L) leg pull + hurt A-Alt~ comfort W-5/26/01 W-AT None A-Eval by ER Phy~ Pt ambulatory but c̄ pain to (L) lower extremity outer aspect (L) calf

PSYCHOSOCIAL EVAL

- EYE CONTACT: ☑ Yes ☐ No
- SPEECH: ☑ Normal/Clear ☐ Abnormal
- AFFECT: ☑ Normal ☐ Flat
- LANGUAGE BARRIER: ☐ Yes ☑ No
- MOTOR BEHAVIOR: ☑ Cooperative ☐ Restless ☐ Agitated
- IDEATIONS: ☑ N/A ☐ None ☐ Suicidal/Homicidal

VITAL SIGNS

TEMPERATURE: (Circle One) Oral Rectal Other — Visual Acuity: OS 20/___ OD 20/___ OU 20/___

TIME	B/P	P	R	T	POx	RHY	Int
1044	140/83	58	18	97.7	100%	—	[illegible]

INITIAL PAIN ASSESSMENT (Circle One)

Adults: (None) 0 1 2 3 4 5 6 7 8 9 10 (Worst)

Children: (None/Happy) 0 1 2 3 4 5 (Worst/Sad) *Used for children 3 yrs old and up*

Refer to Triage Pain Assessment Tool

PREGNANT

- ☑ N/A
- ☐ Denies
- ☐ Yes
- ☐ LMP:______
- ☐ G:___ P:___ AB:___
- ☐ Fetal Heart Rate:______

TRIAGE NURSE NAME/SIGNATURE/INT: [illegible signature] Int

PATIENT PLACED ON (Circle Appropriate Items): CARDIAC MONITOR EKG COMPLETE ROOM AIR PULSE Ox_____% Int

AIRWAY/OXYGEN DELIVERY

TIME	DEVICE	RATE	POx
	NC		
	Simple Face Mask		
	Non-Rebreather		
	BVM		
	ETT #		

☐ Breath Sounds Auscultated Bilaterally Int
☐ Inserted By:

QUICK TESTS

Test	Time	Value	Int
Dextrose Stick			
Peak Flow			
HCG			
Stool Guiac			
Other:			

RADIOLOGY

STUDY	Time Left	Time Returned	Int
X-RAY			
CT			
US/VQ			
Other:			

IV INSERTION

Time	LOT #	Cath Size	Site	Int	Time D/C'd	Int

INTRAVENOUS FLUIDS

Time Up	Sol Type	Rate	Site	Amt In	Time Down	Int

TOTAL IV FLUIDS ______

TOTAL I & O

Time		Int
PO Intake		
IV Intake		
Urine Output		
NGT Output		
Other		
Total In		
Total Out		

NEBULIZER THERAPY

MEDICATION	TIME Started	TIME Finished	TIME Re-Assessed	P	R	POx	Peak Flow	Breath Sounds	Respiratory Effort	RESPONSE Improved	RESPONSE Not Improved	Int
PRE-NEB ASSESSMENT												
☐ ALBUTEROL ☐ ATROVENT										☐	☐	
☐ ALBUTEROL ☐ Other:										☐	☐	
☐ ALBUTEROL ☐ Other:										☐	☐	
☐ ALBUTEROL ☐ Other:										☐	☐	

PATIENT NAME	FMP/SSN	AGE	SEX
SMITH, ROBBIE L	20/256-88-2864	46	M

MGMC PT Interview Form

Name: Smith, Robbie

Age:	48	Height:	6'2"
Gender:	M (F)	Weight:	215
Occupation:	Network Engineer	Smoker?	Y (N)
Pregnant?	Y (N)	Hand dominance?	(R) L

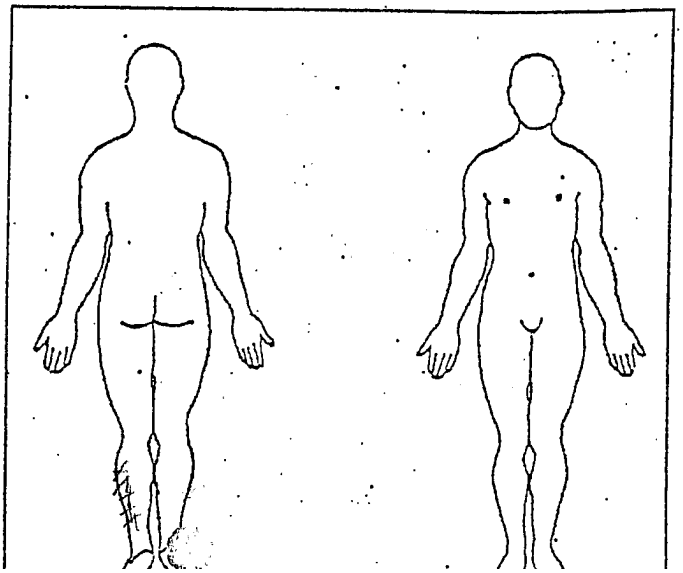
1. Where is your injury? Left calf muscle
2. When did it start? 1 June 2011
3. Has it been getting: Worse Same (Better)
4. Do you have any Numbness, pins and needles, etc.? YES (NO)
5. If Yes, where? _____
6. What makes your pain worse? Running
7. What, if anything, makes it better? not running
8. Does this injury prevent you from working? YES (NO)
9. This injury prevents me from Running
10. Please list any prior medical conditions you have been told you have:
None
11. Please list any prior surgeries you have had:
None
12. Please list any medications you are on:
None
13. Please circle how bad your pain has been in the last 24 hours:

(0) 1 2 3 4 5 6 7 8 9 10

No Pain — Worst Pain

Draw your Sx on the chart to the Right:

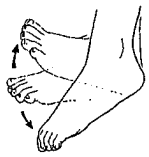
XXXX = Other
****** = Sharp Pain
^^^^^ = Ache
000000 = Numbness or Pins/Needles
////////// = Throbbing



Provided for :

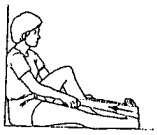
Provided by : Beverly Coker

Date : 7/2/2001

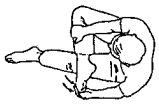


1. Bend ankle up toward your body as far as possible
2. Hold _____ seconds
3. Now point toe away from your body
4. Hold _____ seconds
5. _____ repetitions, _____ times per day

1. Move your ankle around slowly in a large circle
2. Repeat in the opposite direction
3. _____ repetitions, _____ times per day



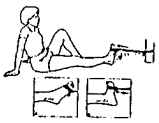
1. Sit on floor with towel or strap around _____ foot as shown
2. Pull top of foot toward your body so that you feel a stretch
3. Hold _____ seconds
4. _____ repetitions, _____ times per day



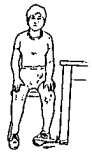
1. Assume position shown, pulling the _____ toes toward your body so that you feel a stretch
2. Hold _____ seconds
3. _____ repetitions, _____ times per day

1. Sit with _____ leg crossed over and grasp _____ foot as shown
2. Turn foot (forefoot and heel) upward so that you feel a stretch
3. Hold _____ seconds
4. _____ repetitions, _____ times per day

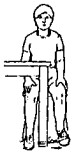
1. Sit with leg crossed over and grasp _____ foot as shown
2. Turn foot (forefoot and heel) downward so that you feel a stretch
3. Hold _____ seconds
4. _____ repetitions, _____ times per day



1. Tie one end of elastic tubing to a solid object and the other end to your foot as shown
2. Pull foot up toward yourself slowly
3. Hold _____ seconds
4. _____ repetitions, _____ times per day



1. Sitting in a chair, assemble elastic tubing to table and your foot as shown
2. Without moving your hip or knee, turn the bottom of your foot inward toward your body
3. Hold _____ seconds
4. _____ repetitions, _____ times per day

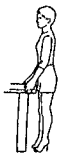


1. Sitting in a chair, assemble elastic tubing to table and your foot as shown
2. Without moving your hip or knee, tip the bottom of your foot outward away from your body
3. Hold _____ seconds
4. _____ repetitions, _____ times per day

1. Sit with leg propped as shown
2. Relax, letting the leg straighten
3. Lean forward, keeping the back straight
4. Hold _____ seconds
5. _____ repetitions, _____ times per day

1. Stand holding the _____ ankle as shown
2. Bend the knee upward so that you feel a stretch
3. As you bend the knee, make sure the thigh stays in line with your body as shown (don't let it point forward)
4. Hold _____ seconds
5. _____ repetitions, _____ times per day

1. Position your body against a wall as shown with _____ foot behind
2. Point toes directly toward wall and hold heel down
3. Lean into wall as shown so that you feel a stretch
4. Hold _____ seconds
5. _____ repetitions, _____ times per day



1. Stand with feet 12 inches apart
2. Raise up slowly onto your toes as high as you can
3. Hold _____ seconds
4. _____ repetitions, _____ times per day

89TH MEDICAL GROUP
Personal Data - Privacy Act of 1974 (PL 93-579)
Printed: 12 Mar 2003@1024

DIVISION: MALCOLM GROU
Automated Version of SF60

ORTHO CLINIC MG   SCHROEDER,MICHAEL H   12 Mar 2003 1023 ACUT 15   BEA
REF:
RSN: CMT:
Detail Codes:
INSURANCE YES/NO:

BP: PULSE: RESP: TEMP: HT: WT: AGE:

==

ALLERGIES:

DOI 26 Jan 03

S: 50 y/o ♂ fell 2 months ago @ home, slipped on ice (FOOSH) Pt. still some swelling. No prior inj (R) HD

O: Alert, NAD [illegible]
RLW/Motor M/S

ADDITIONAL COMMENTS:

PMHx
Migraine HA.

NKDA.
Non-Smoker

Flex/ext. nl
(+) mild swelling ulnodorsal wrist
(+) TTP over Triquetrum
X-ray - avulsion Triquetrum

A: Triquetral fx (R) hand

P: (1) Volar splint x3/d
(2) F/U 2-3 weeks repeat (R) wrist films

[signature]
Schroeder, Michael, MAJ, USAF, BSC
[illegible] PA-C
[illegible] Physician Assistant
[illegible]
Andrews AFB, MD 20762

==

20/256-88-7864   SMITH,ROBBIE LEE   A31
20 Oct 1952 MALE   W:2027270922   H:3018058310
Spon: SMITH,ROBBIE LEE   CIC:
CS: Rank: MAJ   D:2027270922
SF600   Unit: SPONSOR RETIRED   RR: MG FAMILY PRACTICE FILE ROOM

EMERGENCY DEPARTMENT SIGN IN SLIP

DATE: 3 JAN 04 | TIME: 7:07 | PHONE: (301) 805-8310

NAME: Robbie L. Smith | AGE: 52

SPONSOR SSN: 256-88-7864

REASON FOR VISIT: My left leg is swollen from the knee to the tips of my toes

VISIT INFORMATION | **PLEASE ANSWER ALL QUESTIONS**

1. Have you been seen in the Emergency Department in last 72 hours? NO YES
2. Have you called the ADVICE NURSE? NO YES
3. Have you called your PRIMARY CARE MANAGER (PCM)? NO YES
4. Are you having CHEST PAIN? NO YES MILD MODERATE SEVERE
5. Do you have a HISTORY OF HEALTH PROBLEMS? NO YES
6. Are you having SHORTNESS OF BREATH? NO YES MILD MODERATE SEVERE
7. Do you have a HISTORY OF ASTHMA? NO YES
8. Are you having PAIN TODAY? NO YES
9. What is your current LEVEL OF PAIN? NONE 1 2 3 4 5 6 7 8 9 10 WORSE
10. Are you BLEEDING? NO YES SMALL MODERATE SEVERE
11. Do you have a FEVER? NO YES HIGHEST TEMP _____
12. Have you been VOMITING? NO YES How many times today? _____
13. How LONG have you had this problem? TODAY 2 DAYS 3-5 DAYS More than 6 days
14. Is this the first time you have sought treatment for this? NO YES
15. Have you suffered an INJURY? IF yes, put How/When/Where on Back of this sheet. NO YES
16. Are you PREGNANT or is there a possibility you could be PREGNANT? NO YES
17. Are you enrolled in TRICARE PRIME? NO YES What Team? Gold
18. Do you have OTHER HEALTH INSURANCE? NO YES

EMERGENCY STATEMENT

Triage is a process whereby a highly trained emergency care nurse will determine the urgency of the care you need. If the problem you have is not an immediate threat to your life, limb or eyesight you may be asked to contact the nurse advice line and/or your primary care manager for guidance. We are concerned about the health and well-being of all our patients and ask your cooperation.

Patient Signature: Robbie L Smith

SMITH,ROBBIE L
03 Jan 2005@1943

PATIENT INFO
FMP/LAST 4 SS
NAME:
OUTPATIENT RECORD: **PCM:**

EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS

Your DIAGNOSIS is: Calf pain - need repeat US

You should follow up with: your primary care manager ___ (other) _____
Within 24 hours ___ 72 hours ___ routine ___ (other) _____
Specific appointment Date: Fam prac Time: 1100 Location: Family practice
You should be seen before, or return to the emergency department if: Dr Perron
shortness of breath, chest pain, coughing up blood
Other instructions: - elevate leg

You will receive the following new medications: as needed
1. Name: motrin, 800 mg, take 1 tablet/tsp, 3 time(s) per day, for ___ day(s)
2. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
3. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
4. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
5. Others: - normal us up through popliteal

Your emergency department evaluation was focused and based on your presenting chief complaint. Your evaluation was limited to delineating urgent and emergent causes of these symptoms. It is therefore important for you to follow up with your doctor in a timely manner for further evaluation if your symptoms persist, and for recommended screening and preventative healthcare. Should you have new symptoms or concerns, you may return to the emergency department if you feel it necessary.

I understand the above discharge instructions: Robbie L Smith Date: 3 Jan 04
Patient (or guardian) SIGNATURE

(ED personnel)
1. Have patient (or guardian) sign after reading above
Discharge with:
2. Photocopy of this discharge instruction sheet
3. ___ Aftercare sheet: _____
4. ___ Follow up sheet: _____
5. ___ Quarters ___ 24 hrs ___ 48 hrs ___ 72 hrs
6. Medications ___ will be given to patient
___ are at (main) satellite ___ other pharmacy: _____

_____ Date/Time: 2310
ED Personnel Completing Discharge
3 Jan 2005

RADIOLOGIC EXAMINATION REPORT

Patient: SMITH,ROBBIE L FMP/SSN: 20/256-88-7864

MALCOLM GROW
Procedure: US, EXTREMITY VENOUS BI-LAT LOWER
Requested by: PERRON,GREGORY A
Ward/Clinic: FAM PRACTICE MG

MG ULTRASOUND
Exam Date: 04 Jan 2005É1143
Status: COMPLETE
Exam #: 05003483
Pregnant:

Reason for Order:
52 yo male with 3-4 day hx of unilateral calf swelling. Had u/s negative per report in ED 1/3/5. No recent travel, surgeries, no past/fhx of VTE. However, clinically has unilateral swelling (47cm vs 43cm), homan's, calf tenderness. please rescreen for DVT - d/w Dr. Hunn

Order Comment:
PERRON 1635327

Result Code: SEE RADIOLOGIST'S REPORT

Report:

LEFT LOWER EXTREMITY VENOUS DOPPLER ULTRASOUND EXAMINATION 4 JAN 05

Correlative studies: 1/3/05.

FINDINGS:
LEFT DVT SONOGRAM: Multiple images were obtained in the transverse and longitudinal planes of the left common femoral vein, superficial femoral vein, and popliteal vein. These structures were examined with the use of color flow doppler imaging techniques. All deep venous structures compress in a normal fashion and none contain echogenic material within their lumens. These structures respond as expected to respiratory variation and augmentation.

IMPRESSION:
NO EVIDENCE OF A DEEP VENOUS THROMBOSIS INVOLVING THE EXAMINED VENOUS STRUCTURES. IF THIS PATIENT'S SYMPTOMS PERSIST FOR GREATER THAN 48 HOURS AFTER THE PERFORMANCE OF THIS EXAMINATION, CONSIDERATION SHOULD BE GIVEN TO REPEATING THE STUDY IN 3-5 DAYS IN ORDER TO ASSESS FOR POSSIBLE PROXIMAL PROPAGATION OF A CALF THROMBUS.

RADIOLOGIC EXAMINATION REPORT

Patient: SMITH,ROBBIE L FMP/SSN: 20/256-88-7864

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kjf

Transcription Date/Time: 05 Jan 2005É1047

Interpreted by: Jonathan S. Hunn, M.D.
Supervised by:

Approved by: Jonathan S. Hunn, M.D. 06 Jan 2005É0920
Supervised by:

20/256-88-7864 SMITH,ROBBIE L USA RET LOS OFFICER
20 Oct 1952 / MALE H:3018058310 W:2024427030
Loc:
Spon: SMITH,ROBBIE L Rank: MAJOR D:2024427030
SF519-B Unit: RR: OUTPATIENT RECORDS KI
O/Site Rec Loc: DD2569 081612AB, 080312M HAND CARRY RECORDS-MALCOLM GROW

EMERGENCY DEPARTMENT FLOW CHART

(This form is subject to the Privacy Act of 1974)

ED LOG #	DATE	TIME SIGNED IN
83	3 Jan 05	1941

ARRIVED BY (Circle Appropriate Item): POV (circled) MTF AMB ~~EMS~~ BOLLING AMB

CHIEF COMPLAINT: (L) leg pain

COMPREHENSIVE TRIAGE ASSESSMENT — Int

TIME: 2004

Sx started c achy on Friday – followed by swelling Sun – c pain – swelling from knee down – no recent flight – no long trips – no injury – (+) Hoffmans sign – pain to calf. No SOB

PSYCHOSOCIAL EVAL

- EYE CONTACT: ☒ Yes ☐ No
- SPEECH: ☒ Normal/Clear ☐ Abnormal
- AFFECT: ☒ Normal ☐ Flat
- LANGUAGE BARRIER: ☐ Yes ☒ No
- MOTOR BEHAVIOR: ☒ Cooperative ☐ Restless ☐ Agitated
- IDEATIONS: ☒ N/A ☐ None ☐ Suicidal/Homicidal

VITAL SIGNS

TEMPERATURE: (Circle One) Oral (circled) Rectal Other____

Visual Acuity: OS 20/____ OD 20/____ OU 20/____

TIME	B/P	P	R	T	POx	RHY	Int
2004	141/97	72	18	97.9	97%		[illegible]

INITIAL PAIN ASSESSMENT (Circle One)

Adults: (None) 0 1 2 3 4 (circled) 5 6 7 8 9 10 (Worst)

Children: (None/Happy) 0 1 2 3 4 5 (Worst/Sad) *Used for children 3 yrs old and up*

Refer to Triage Pain Assessment Tool

PREGNANT

- ☐ N/A
- ☐ Denies
- ☐ Yes
- ☐ LMP:______
- ☐ G:____ P:____ AB:____
- ☐ Fetal Heart Rate:______

TRIAGE NURSE NAME/SIGNATURE/INT: [signature] — Int [illegible]

PATIENT PLACED ON (Circle Appropriate Items): CARDIAC MONITOR   EKG COMPLETE   ROOM AIR PULSE Ox____%   Int

AIRWAY/OXYGEN DELIVERY

TIME	DEVICE	RATE	POx
	NC		
	Simple Face Mask		
	Non-Rebreather		
	BVM		
	ETT #		

☐ Breath Sounds Auscultated Bilaterally   Int

☐ Inserted By:

QUICK TESTS

Test	Time	Value	Int
Dextrose Stick			
Peak Flow			
HCG			
Stool Guiac			
Other:			

RADIOLOGY

STUDY	Time Left	Time Returned	Int
X-RAY			
CT			
US/VQ			
Other:			

IV INSERTION

Time	LOT #	Cath Size	Site	Int	Time D/C'd	Int

INTRAVENOUS FLUIDS

Time Up	Sol Type	Rate	Site	Amt In	Time Down	Int

TOTAL IV FLUIDS ________

TOTAL I & O

Time		Int
PO Intake		
IV Intake		
Urine Output		
NGT Output		
Other		
Total In		
Total Out		

NEBULIZER THERAPY

MEDICATION	TIME Started	Finished	Re-Assessed	P	R	POx	Peak Flow	Breath Sounds	Respiratory Effort	RESPONSE Improved	Not Improved	Int
PRE-NEB ASSESSMENT												
☐ ALBUTEROL ☐ ATROVENT										☐	☐	
☐ ALBUTEROL Other:										☐	☐	
☐ ALBUTEROL ☐ Other:										☐	☐	
☐ ALBUTEROL ☐ Other:										☐	☐	

SMITH,ROBBIE L
03 Jan 2005@1943

20/256-88-7864

FMP/SSN

AGE: 52   SEX: M

MEDICATIONS

PO/Sub Q/IM/IV Push

Time	Med	Dose	Route	Site	Response	Int
0150	Tramadol	50mg	IM	Rt	Tolerated	(B2)

IV Drip

Time	Med	Dose	Rate	Vol	Response

MEDICATION ADMINISTRATION REFERENCE KEY

VG - Ventrogluteal	DG - Dorsogluteal	dt – Deltoid	QF – Quadriceps Femoris	UP – Upper Back	pa – Posterior Upper Arm	abd - Abdomen
ot - Otic	OP - Ophthalmic	p.r. – Per Rectum	PO – By Mouth	SL – Sublingual	SQ – Subcutaneous	IM - Intramuscular
IV - Intravenous	IVPB – IV Piggyback	IVP – IV Push	☐ Side rails up X 2	☐ Call bell in reach	☐ Drug effects discussed	☐ No reaction in 20 min; pt D/C'd without complication

NURSING NARRATIVE

Time		Int

PROCEDURE NOTES (e.g. Foley Cath, NGT, ET, Suturing, ABG, Splinting, etc

Time		Int

ADMISSION/TRANSFER NOTE

TIME OF REPORT:	AMDMITTED/TRANSFERRED TO:	TRANSPORTED WITH:
REPORT GIVEN TO:		☐ FOLEY ☐ IV FLUIDS/MEDS ☐ ACLS/PALS PROTOCOL ☐ NG TUBE ☐ OTHER:

NURSE/TECH SIGNATURES

PRINT NAME	SIGNATURE	Int	PRINT NAME	SIGNATURE	Int

PATIENT NAME	FMP/SSN	AGE	SEX

Personal Data - Privacy Act of 1974 (PL 93-579)

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE/SF600E SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION

Date : 04 Jan 05
Provider: PERRON,GREGORY A

Clinic : FAM PRACTICE MG
Division: MALCOLM GROW

FH (-) VTE

T ∅
E socially
H Vit E

Allergies:
NKDA
Rx: tylenol

Medical Record Available? (Y) N

AGE: Have you or a family member been deployed recently? Yes (No)

IMMUNIZATIONS CURRENT? (Y) N IN PAIN TODAY? N (Y) (0/10): 4

BP: 155/101 P: 64 RESP: SpO2: TEMP: HT: 6'1 WT: 114 BMI:

Prevention: Advanced Directives / Regular Exercise / Healthy Diet / Safety

[ ] 2766 Rev'd/Updated. PIMR Check: [ ]NA [ ]OK [ ]Needs:

Clinic Notes:
52 year old Male c swollen lower (L) calf x 4 days

Approved By: Pt reports he pulled a muscle 3-4 yrs ago and had similar symptoms → but this episode Date/Time:

not associated w/ known muscle pull. Sx started Friday T-4 w/ tingling in toes; then noted calf swelling which worsened over weekend. He notes pain unrelieved by tylenol. Walking exacerbates pain. No SOB, No CP, no DOE. Pt reported to ED last night and was evaluated to include an U/S → (-) for DVT. Pt notes he went running ~ week ago, felt ~ muscle pull (L) calf → but no activity/trauma since. Was discharged from ED w/ motrin 800 and instruction to f/u. Denies recent travel, no planes car rides. No recent surgeries. With elevation, his swelling does decrease.

O) Vsnoted, WDWN, in NAD. Pulm CTA Abd - benign

Ext - 2+ pitting edema LLE; tender calf; swollen; skin tense.

(+) TTP c palp of posterior calf + popliteal fossa; (+) homan's.

PLAN

(L) calf - 47cm @ largest

(R) calf - 43cm @ largest

A) unilateral calf tenderness and swelling; ddx: VTE / DVT; baker's cyst; less likely - obstruction of pelvic lymph nodes

D/w Cardiol → repeat interval U/S to r/o DVT. Pt to radiology → will return to FPC c completion of study.

[signature]
MAJ, USAF, MC

Name: SMITH,ROBBIE L
Spon: SMITH,ROBBIE L
Rank: MAJOR
Unit: SPONSOR RETIRED
MTF : 89TH MEDICAL GROUP
Ins Co:
MC Status: ENROLLED
PCM : TANG,PEI-YUEN

FMP/SSN: 20/256887864 Sex: M PCat: A31
Clinic: FAM PRACTICE MG
Outpt Rec Rm: MG FAMILY PRACTICE FILE R
H#: 3018058310 DOB: 20 Oct 52
W#: 2027270922 Ins: NO
Policy #:
Reg Comm:
POC: FAM PRACTICE MG

CHRONOLOGICAL RECORD OF MEDICAL CARE/STANDARD FORM 600E (Rev. 5-84)

smith, robbie ID: 256887864 24-May-2005 14:05:57

52years Male Black

Vent. rate 68 bpm
PR interval 192 ms
QRS duration 102 ms
QT/QTc 446/474 ms
P-R-T axes 59 -46 35

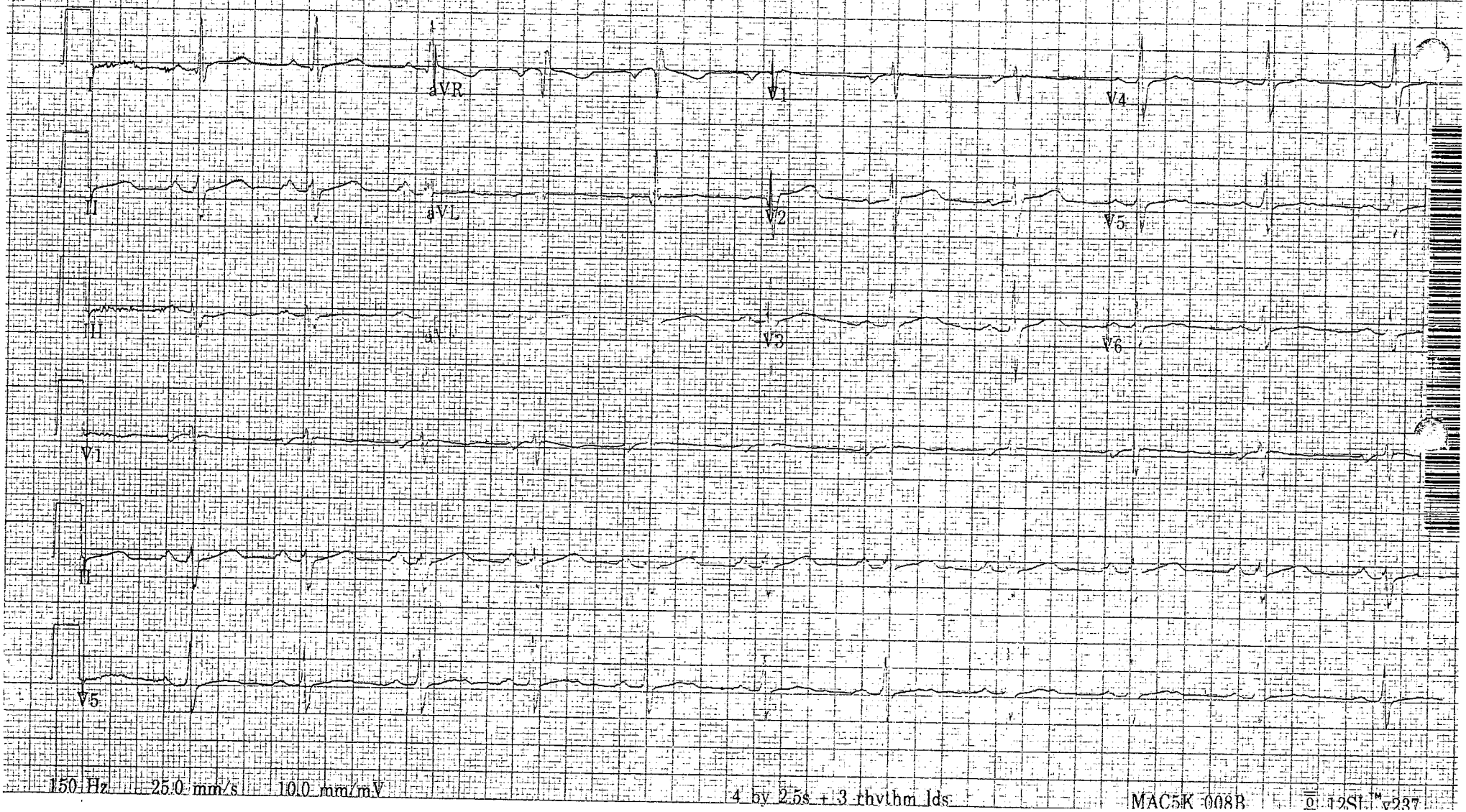
Normal sinus rhythm
~~Possible Left atrial enlargement~~
Left anterior fascicular block
Abnormal ECG

THACY BOZUNG, Capt, USAF, MC
44F1, Family Practice Resident
99 MDG, Andrews AFB, MD 20762

Technician: byron
Test ind:

Referred by: bozung, famp

Unconfirmed



150 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 3 rhythm lds MAC5K 008B 12SL™ v237

smith, robbie ID: 256887864 24-May-2005 14:05:57

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Male Black

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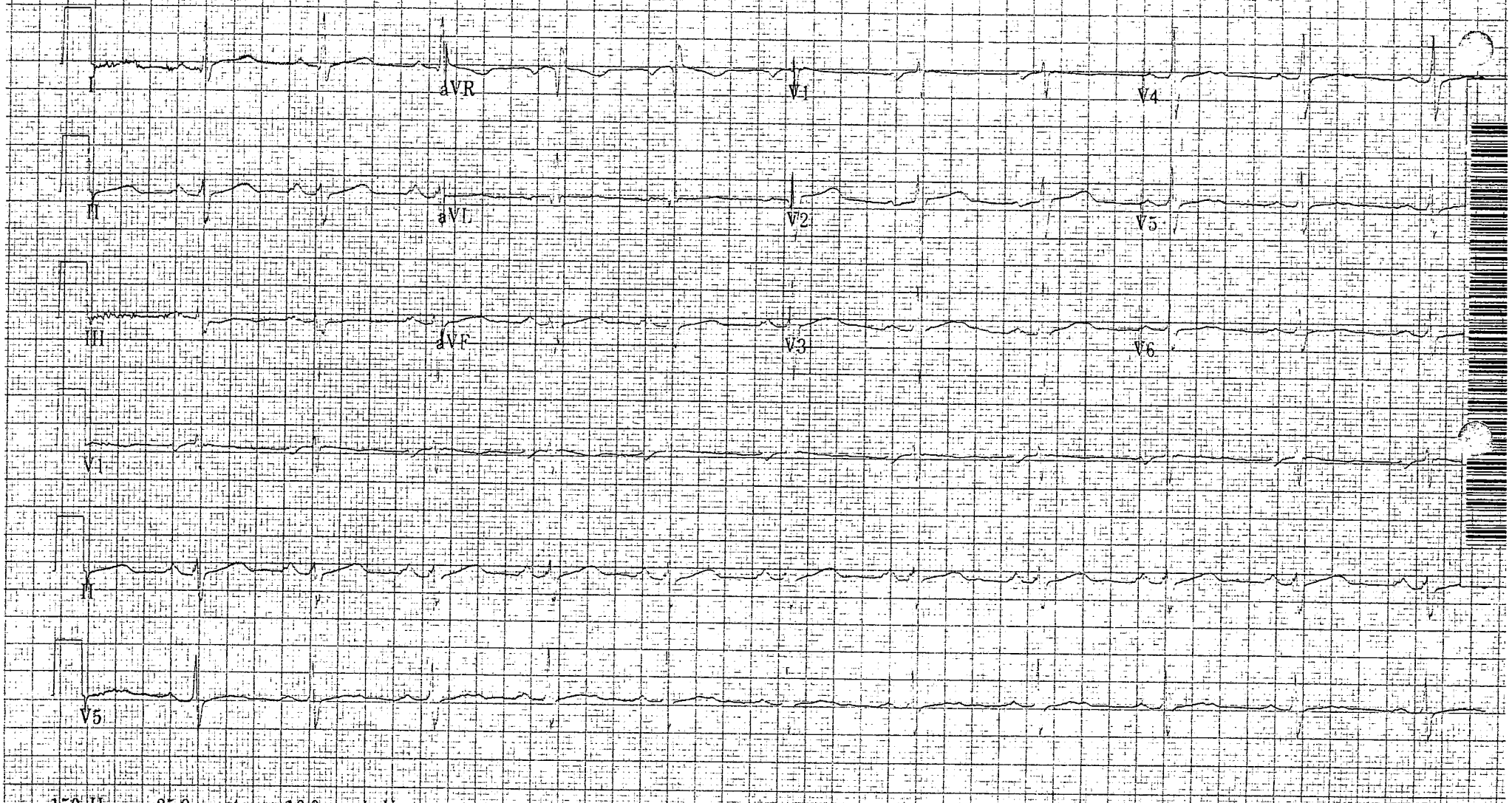
Normal sinus rhythm
Possible Left atrial enlargement
Left anterior fascicular block
Abnormal ECG

Technician: byron
Test ind:

Referred by: bozung, famp

Unconfirmed



150 Hz 25.0 mm/s 10.0 mm/mV 4 by 2.5s + 3 rhythm lds MAC5K 008B 12SL™ v237

RADIOLOGIC EXAMINATION REPORT

Patient: SMITH,ROBBIE L FMP/SSN: 20/256-88-7864

MALCOLM GROW
Procedure: US, EXTREMITY
Requested by: KOKKONEN,JANA S
Ward/Clinic: EMERGENCY RM MG

MG ULTRASOUND
Exam Date: 03 Jan 2005É2219
Status: COMPLETE
Exam #: 05002570
Pregnant:

Reason for Order:
R/O DVT LLE

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

LEFT LOWER EXTREMITY ULTRASOUND DATED 3 FEB 05:

Comments: Duplex doppler examination of the left lower extremity was performed, with no prior studies available for comparison. No thrombus is seen in the left common femoral, femoral or popliteal veins. There is limited visualization of the distal left femoral vein, due to patient body habitus. Adequate compressibility, good doppler flow, and augmentation are present in these vessels.

IMPRESSION:
NO EVIDENCE FOR DEEP VEIN THROMBOSIS IN THE LEFT LOWER EXTREMITY.
MILDLY LIMITED VISUALIZATION IN THE DISTAL LEFT FEMORAL VEIN. IF CLINICALLY CONCERNED, REPEAT EVALUATION IN THIS AREA IS RECOMMENDED.

These results were discussed with Dr. Kokkonen in the ER at the time of the examination.

cwp

Transcription Date/Time: 15 Feb 2005É1119

Interpreted by: MICHELLE L POHLAND, CPT, USAF, MC
Supervised by:

Approved by: MICHELLE L POHLAND, CPT, USAF, MC 15 Feb 2005É1124

RADIOLOGIC EXAMINATION REPORT

Patient: SMITH,ROBBIE L FMP/SSN: 20/256-88-7864

Supervised by:

20/256-88-7864 SMITH,ROBBIE L USA RET LOS OFFICER
20 Oct 1952 / MALE H:3018058310 W:2024427030
Loc:
Spon: SMITH,ROBBIE L Rank: MAJOR D:2024427030
SF519-B Unit: RR: OUTPATIENT RECORDS KI
O/Site Rec Loc: DD2569 081612AB, 080312M HAND CARRY RECORDS-MALCOLM GROW

20/256-88-7864
SMITH, ROBBIE L
18 Jan 2006@2001

26

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
89 MDG Form 500, file as SF 558

EMERGENCY PHYSICIAN RECORD
Headache (5)

LOG #: 64 Triage: non-urgent urgent emergent
DATE: 18 JAN TIME: 2330 ROOM: J EMS Arrival
HISTORIAN: patient spouse paramedics
AGE 53 (M) F RACE
__HX / __EXAM LIMITED BY:

HPI

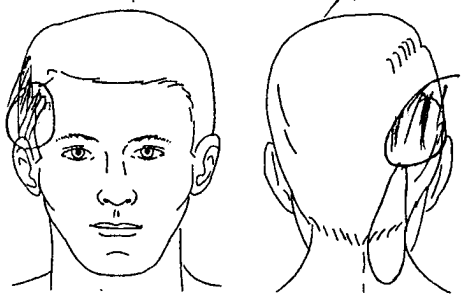
chief complaint: headache facial pain fever *migraine hx*
SINUS Headache

started: X 4 DAYS.

time course:
abrupt / gradual onset
still present better
gone now
lasted
intermittent episodes lasting
worse / persistent since

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

location: 8/10



associated symptoms:
preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
light bothers eyes
blurred vision
nausea
vomiting
power loss R/L arm / leg
tingling / numb sensation

severity:
maximum
mild moderate severe relieved by OTC meds
when seen in ED
gone mild moderate severe

Similar symptoms previously YES

Recently seen / treated by doctor 4-months ago
X SAME PROB

ROS

CONST
fever
subjective / to ____ °F
muscle aches

EENT
visual disturbances
sore throat
sinus pressure / drainage

For new, gradual-onset HA-
CO exposure
tick bite(s)
head injury

CVS / PULMONARY
chest pain
cough
sputum
trouble breathing

GI / GU
abdominal pain
diarrhea
pain on urination

SKIN / LYMPH / MS
skin rash swelling (LT) leg
back pain
X 6 YEARS
INTERMITTENTLY

☐ all systems neg. except as marked

PAST HX negative

chronic headaches X 6 Y.
occasional frequent "migraine"
mild moderate severe
high blood pressure
sinus problems
SAH risk factors:
1° relative
connective tissue disorder
Marfan's / Ehlers disease

cancer history
immunosuppressed
glaucoma
diabetes *insulin / oral / diet*
asthma
+HIV / AIDS

other problems

Medications none see nurses note
ASA NSAID acetaminophen

Allergies NKDA
see nurses note

SOCIAL HX

smoker drugs
alcohol *(recent / heavy / occasional)*

FAMILY HX

cerebral aneurysm
stroke
migraine headaches
HTN

PATIENT INFORMATION (Label): 20/256-88-7864
SMITH,ROBBIE L
18 Jan 2006@2001

FMP/LAST 4 SSN#:

NAME:

OUTPATIENT RECORD: PCM:

EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS

Your DIAGNOSIS is: Headache, Borderland HTN, Chronic LT leg edema

You should follow up with: ✓ your primary care manager ___ (other) PCM

Within ___ 24 hours ___ 72 hours ___ routine ___ (other) _____

Specific appointment Date: _____ Time: _____ Location: _____

You should be seen before, or return to the emergency department if: Severe headache, weakness in extremities, nausea vomiting

Other instructions: recommend Head CT x headache (6 years) and chronic LT leg edema.

You will receive the following new medications:

1. Name: Percocet, _____ mg, take 1-2 tablet/tsp, 4 time(s) per day, for ___ day(s)
2. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
3. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
4. Name: _____, _____ mg, take ___ tablet/tsp, ___ time(s) per day, for ___ day(s)
5. Others: _____

Your emergency department evaluation was focused and based on your presenting chief complaint. Your evaluation was limited to delineating urgent and emergent causes of these symptoms. It is therefore important for you to follow up with your doctor in a timely manner for further evaluation if your symptoms persist, and for recommended screening and preventative healthcare. Should you have new symptoms or concerns, you may return to the emergency department if you feel it necessary.

I understand the above discharge instructions: Robbie L Smith Date: 19 Jan 06

Patient (or guardian) SIGNATURE

(ED personnel)

1. Have patient (or guardian) sign after reading above

Discharge with:

2. Photocopy of this discharge instruction sheet
3. ___ Aftercare sheet: _____
4. ___ Follow up sheet: _____
5. ___ Quarters ___ 24 hrs ___ 48 hrs ___ 72 hrs
6. Medications ___ will be given to patient
   ___ are at ___ main ___ satellite ___ other pharmacy: _____

[signature] Date/Time: 19 Jan06@0110

ED Personnel Completing Discharge

Personal Data - Privacy Act of 1974 (PL 93-579) Automated Version SF558

EMERGENCY CARE & TREATMENT - MALCOLM GROW ! LOG NUMBER: 060118-00064

Arrival Date/Time: 18 Jan 2006@2000 ! Medications ! Allergies: NKDA

Trans to Hospital: PRIVATELY OWNED VE !
History Obtained From: PATIENT ! ! Tetanus:

Addr: 12005 AUGUSTA DR GLENN DALE,MD 20769-9306 ! H.Phone: 3018058310
Chief Complaint: sinus headache ! Sex: MALE Age: 53

VITAL SIGNS

Time: ____ ____ ____
BP SY: ____ ____ ____
BP DI: ____ ____ ____
Pulse: ____ ____ ____
Resp: ____ ____ ____
Temp: ____ ____ ____
WT (Child) ____ ____ ____

PRP (YES) (NO)
FLY (YES) (NO)
INJURY (YES) (NO)
LOD (YES) (NO)
X-RAY (YES) (NO)

! 3rd Party Payer: NO
! Time Seen: 0@
! Category:

Orders Inits Time

[illegible]

ASSESSMENT/DIAGNOSIS

Chronic Headaches - Recurrent
Chronic [illegible] Edema
[illegible] Hypertension

VICTOR INGA PA-C

====== DISPOSITION =====

_ Home __Full Duty
__Quarters
__24hrs __48hrs __72hrs
Modified Duty Until
Day:____ Mon:____ Yr:____

Referred To: PC
__Emergency __Today
__72 hours _Routine

Admitted To:
Others:
Condition Upon Release:
__Improved __Unchanged
* Deteriorated
Release Tm: 0@! Signature of Provider/Stamp:

Rotimi Iluyomade, MD
Civilian
Department of Emergency Medicine
89th MDOS Andrews AFB, MD 20762

20/256-88-7864 SMITH,ROBBIE L
20 Oct 1952
CS:
Spon: SMITH,ROBBIE L
Unit: SPONSOR RETIRED
Record Location: MG FAMILY PRACTICE FILE ROOM
PATIENT'S PCM: OCHIA,SAMIA A

USA RET LOS OFFICER
Work Phone: 2027270922
CIC:
Sponsor Rank: MAJOR

Patient: **SMITH, ROBBIE L**
Facility: **NNMC Bethesda, MD**

Date: **21 Feb 2007 1030 EST**
Clinic: **Internal Med PCC WR**

Appt Type: **ROUT**
Provider: **SREEKUMAR, SUSHAMA NILAKA**

Patient Status: **Outpatient**

Reason for Appointment: sinus and leg problems
Appointment Comments:
ob/

AutoCites Refreshed by SREEKUMAR, SUSHAMA NILAKA @ 21 Feb 2007 1114 EST

Problems

No Problems Found.

Allergies

No Allergies Found.

Active Medications
No Active Medications Found.

Vitals
Vitals Written by MANDEFRO, SIRGUTE @ 21 Feb 2007 1057 EST
BP: 162/101 Adult Cuff, Left Arm, HR: 80 Radial Artery, RR: 18, T: 97.7 ?F Oral, HT: 74 in With Shoes, Actual, WT: 255.4 lbs Upright Scale, With Shoes, Actual, BMI: 32.79, BSA: 2.411 square meters, Tobacco Use: No, Alcohol Use: No,
Comments: All physical is current including colonoscopy.Denied depressiohn.

SO Note Written by SREEKUMAR, SUSHAMA NILAKA @ 21 Feb 2007 1552 EST
History of present illness
The Patient is a 54 year old male.
° Encounter Background Information: 54 yrold Ret/A/Major with c/o "sinus "headache and "leg Problem ".Followed at Malcolm Grow Andrews AFB ,Not on any medications ,denies any chest pains or SOB.Denies family H/o HTN.,consumes lot of salt in diet ,snacks ,
• Head symptoms headache since 2 days

° No eye symptoms ° No cardiovascular symptoms ° No pulmonary symptoms ° No gastrointestinal symptoms ° No genitourinary symptoms ° No musculoskeletal symptoms ° No neurological symptoms
Physical findings
Vital signs:
• Vital signs: BP162/101 recheck 160/110
Standard Measurements:
° Normal
General appearance:
° Normal
Head:
° Normal
Eyes:
General/bilateral:
° Eyes: normal
Ears, Nose, Throat:
° ENT: normal
Neck:
° Normal
Chest:
° Normal
Lungs:
° Normal
Cardiovascular system:
° Normal
Abdomen:
° Normal
Skin:
° Normal
Musculoskeletal system:
General/bilateral: • Musculoskeletal system: no pedal edema ,no

A/P Written by SREEKUMAR, SUSHAMA NILAKA @ 21 Feb 2007 1552 EST
1. ESSENTIAL HYPERTENSION

Disposition Written by SREEKUMAR, SUSHAMA NILAKA @ 21 Feb 2007 1557 EST
Released w/o Limitations
Follow up: as needed with PCM. - Comments: patient declines treatment for hypertension ,Not convinced that has high BP .Wants to attend the Hyper tension class on monday and start on diet and exercise ./Counselled patient to get A PCM here or Bethesda as will not be seen in Andrews again .To avoid salty food and make an appointment with PCM in1 month
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
30 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By **SREEKUMAR, SUSHAMA NILAKA** (Physician Internal Medicine, wramc) @ 21 Feb 2007 1558

20/256-88-7864
SMITH, ROBBIE L
02 Mar 2007@1451

26

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
89 MDG Form 500, file as SF 558

EMERGENCY PHYSICIAN RECORD
Headache (5)

LOG #:_____ Triage Level: I II III (IV) V
DATE: 2 Mar TIME: 17:30 ☐ on arrival
ROOM: 3 __ EMS Arrival _____
HISTORIAN: patient spouse paramedics_____
AGE 54 (M) / F RACE_____
__HX / __EXAM LIMITED BY:_____

HPI

chief complaint: (headache) facial pain fever *migraine hx*

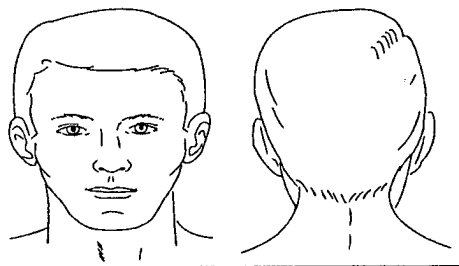
started: today. Also c left leg swelling. Both intermittent for 6-7 years. No CT, PE, DVT

time course:
abrupt / thunderclap / gradual
onset _____ *hrs / days*
(cannot pinpoint exact onset)
still present better
gone now *lasted*_____
intermittent episodes lasting
worse / persistent since

severity:
mild (moderate) severe worst of life *maximum*
when seen in ED
unchanged gone mild (moderate) severe

quality:
(similar to previous headaches)
"pain"
~~tightness~~
(throbbing)
sharp

location:



associated symptoms:
preceding symptoms ϕ
visual disturbance scotoma
typical of prior aura ϕ
speech problems ϕ
light bothers eyes / blurred vision
confusion_____
nausea / vomiting_____
power loss (R / L) *arm leg*
trouble walking_____
tingling / numb sensation_____
neck pain / stiff neck_____
syncope_____
dizziness_____

exacerbated by: light noise movement position_____

Similar symptoms previously yes, for 6-7 years.

Recently seen / treated by doctor last week

ROS

CONST
fever ϕ
subjective / to _____ °F
muscle aches_____

EENT
visual disturbances ϕ
sore throat_____
sinus pressure / drainage_____
difficulty swallowing_____

NEURO
dizziness ϕ
vertigo lightheadedness
For new, gradual-onset HA-
CO exposure_____
tick bite(s) / insect bite(s)_____
head injury_____

CVS / PULMONARY
chest pain_____
cough_____
*sputum*_____
trouble breathing_____

GI / GU
abdominal pain_____
diarrhea_____
pain on urination_____
incontinence_____

SKIN / LYMPH / MS
rash / swelling_____
back pain_____
skin lesions_____

☑ all systems neg except as marked

PAST HX ☑ negative

chronic headaches
occasional frequent "migraine"
mild moderate severe
high blood pressure_____
sinus problems_____
SAH risk factors:
1° relative
connective tissue disorder
Marfan's / Ehlers disease

cancer history_____
immunosuppressed_____
glaucoma_____
diabetes *Type 1 Type 2*_____
*diet / oral / insulin*_____
asthma_____
HIV / AIDS_____
prior CNS infection_____

Medications __none see nurses note
ASA NSAID acetaminophen
coumadin_____
Tylenol

Allergies ☑ __NKDA
see nurses note

SOCIAL HX

smoker ϕ drug use / abuse *cocaine* ϕ
recent ETOH occasional

FAMILY HX

cerebral aneurysm_____
stroke_____
pseudotumor_____
migraine headaches_____
HTN_____
denies hx aneurysm

20/256-88-7864
SMITH, ROBBIE L
02 Mar 2007@1451

3

15

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
File as 89 MDG, Form 433

EMERGENCY NURSING RECORD
Headache

__FLY __PRP __INJURY

TRIAGE TIME 1540 emergent urgent non-urgent

NAME:
D.O.B: AGE: 54 (M) / F
HISTORIAN: (patient) paramedics family
ARRIVAL MODE: (car) EMS police
PCP: none
^IMMUNIZATIONS: (current) referral
flu pneumovax

TREATMENT PTA see EMS report IV O_2
last blood glucose

VITALS
BP 143/80 P 70 RR 16 temp 98.4 TM (O) R Ax
SaO_2 99% (RA) O_2 GCS

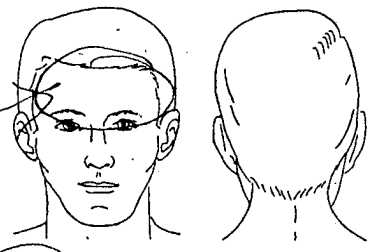
PAIN LEVEL current: 8 /10 max 10 /10 acceptable /10
scale used quality throbbing headache

CHIEF COMPLAINT Headache, cough
started ___ hrs / days ago sudden onset gradual onset
(L) knee down to toes swollen

fever / chills
visual disturbance
blurred double vision
photophobia
dizziness / syncope
nausea / vomiting x
neck discomfort
mental status change
chemical / CO exposure

quality:
similar to previous headaches
"pain"
tightness
(throbbing)
sharp
"worst ever"

location of pain:



ALLERGIES NKDA
drug - PCN / ASA / sulfa / latex / codeine / iodine
food -

MEDS none (see med list)
TYLENOL

PAST MEDICAL HX negative
migraines / HTN / diabetes: *insulin*
past surgeries none

SOCIAL HX
smoker ppd drugs / alcohol OCCASIONAL
^TB exposure / symptoms
^has been physically hurt or threatened by someone close

LNMP NA G P Ab pregnant / postmenop / hyst

RN Signature Myrlene Di Valdez, OSNC

TIME TO ROOM: ROOM:

INITIAL ASSESSMENT TIME: 1540

GENERAL APPEARANCE
no acute distress
alert
mild / moderate / severe distress
anxious / decreased LOC
tearful / crying

^FUNCTIONAL / NUTRITIONAL ASSESSMENT
independent ADL
appears well
nourished / hydrated
assisted / total care
obese / malnourished
recent weight loss / gain

RESPIRATORY
no resp distress
nml breath sounds
mild / moderate / severe distress
wheezing / crackles / stridor
decreased breath sounds
tachypnea

CVS
regular rate
pulses strong
tachycardia / bradycardia
pulse deficit

NEURO
oriented x 3
PERRL
moves all extremities
nml gait
disoriented to *person / place / time*
confused / memory loss
pupils unequal R L
pinpoint / dilated
facial droop / tongue deviated
weakness / sensory loss

PSYCH
cooperative
nml speech
responds appropriately
uncooperative / combative
inappropriate speech / behavior
speech slurred

SKIN
warm, dry
intact
pale / cyanotic
cool / diaphoretic
skin rash

ADDITIONAL FINDINGS

INITIAL ACTIONS

TIME			INIT
1455	ID band applied	ID band verified	
	disrobed / gowned	blanket provided	
	bed low position	side rails up x1 x2	
	call light in reach	head of bed elevated	
	room darkened		

Nurse Signature Myrlene Di Valdez, OSNC

^ protocol available

20/256-88-7864
SMITH,ROBBIE L
08 Mar 2007@1609

26

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
89 MDG Form 500, file as SF 558

EMERGENCY PHYSICIAN RECORD
Headache (5)

LOG #: ____ Triage Level: I II III IV V
DATE: 8 Mar 07 TIME: 1710 ☐ on arrival
ROOM: 4 __ EMS Arrival ____
HISTORIAN: patient spouse paramedics ____
AGE 54 M / F RACE ____
__HX / __EXAM LIMITED BY: ____

HPI

chief complaint: headache facial pain fever *migraine hx*

started: ~~4 days ago error~~
2 weeks

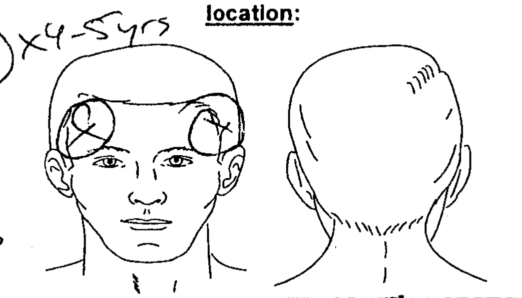
time course:
abrupt / thunderclap / gradual
onset 14 hrs / days
cannot pinpoint exact onset
still present better
gone now *lasted* ____
intermittent episodes lasting ____
worse / persistent since ____

severity:
maximum
mild moderate severe worst of life
when seen in ED
unchanged gone mild moderate severe

quality:
similar to previous headaches
"pain"
tightness
throbbing
sharp

x4-5yrs

location:



associated symptoms:
preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
speech problems
light bothers eyes / blurred vision
confusion
nausea / vomiting
power loss (R / L) *arm leg*
trouble walking
tingling / numb sensation
neck pain / stiff neck
syncope
dizziness

exacerbated by: light noise movement position ____

Similar symptoms previously 6 days ago seen in ED c sinusitis/HA CT read [illegible] sinus thickening d/c c Levaquin

Recently seen / treated by doctor Sx started to improve now worsened

ROS

CONST
fever
subjective / to ___ °F
muscle aches

EENT
visual disturbances
sore throat
sinus pressure / drainage
difficulty swallowing

NEURO
dizziness
vertigo lightheadedness
For new, gradual-onset HA-
CO exposure
tick bite(s) / insect bite(s)
head injury

CVS / PULMONARY
chest pain
cough
sputum
trouble breathing

GI / GU
abdominal pain
diarrhea
pain on urination
incontinence

SKIN / LYMPH / MS
rash / swelling
back pain
skin lesions

☐ all systems neg except as marked

~~intermittent epistaxis~~
lower ext pain intermittently x 4-5yrs

PAST HX __negative
chronic headaches
occasional frequent migraine
mild moderate severe
high blood pressure
sinus problems
SAH risk factors:
1° relative
connective tissue disorder
Marfan's / Ehlers disease
cancer history
immunosuppressed
glaucoma
diabetes *Type 1 Type 2*
diet / oral / insulin
asthma
HIV / AIDS
prior CNS infection

Medications __none see nurses note
ASA NSAID acetaminophen
coumadin
SJS reviewed

Allergies NKDA
see nurses note

SOCIAL HX smoker ____ drug use / abuse *cocaine* ____
recent ETOH ____

FAMILY HX
cerebral aneurysm ____
stroke ____
pseudotumor ____
migraine headaches ____
HTN ____

Personal Data - Privacy Act of 1974 (PL 93-579) Automated Version SF558

EMERGENCY CARE & TREATMENT - MALCOLM GROW | LOG NUMBER: 090429-00074

Arrival Date/Time: 29 Apr 2009@2007
Trans to Hospital: PRIVATELY OWNED VEHICLE
History Obtained From: PATIENT

3rd Party Payer: NO
Time Seen:
Category:

Addr: 12005 AUGUSTA DR GLENN DALE, MD 20769
Chief Complaint: Pain/swelling in left leg below the

Phone: 3018058310
Sex: MALE Age: 56

VITAL SIGNS

Time			
BP-SY			
BP-DI			
Pulse			
Resp			
Temp			
WT-Ped			

Orders	Inits	Time

ASSESSMENT/DIAGNOSIS

====== DISPOSITION =====
__Home __Full Duty
__Quarters
__24hrs __48hrs __72hrs

Modified Duty Until:
Day:____ Mon:____ Yr:___

Referred to:

__Emergency __Today
__72 hours __Routine

Admitted to:

Others:

Condition Upon Release:
__Improved __Unchanged
__Deteriorated
Release Time:

Medications

Tetanus:
Allergies:
NKDA

Signature of Provider/Stamp:

Sandra McCatty, MD
Civilian
Dept of Emergency Medicine
[illegible] AFB, MD 20762

Instructions to Patient:

I HAVE RECEIVED AND UNDERSTAND MY DISCHARGE INSTRUCTIONS

20/256-88-7864 SMITH,ROBBIE L
20 Oct 1952 MALE
Loc: EMERGENCY RM MG
Spon: SMITH,ROBBIE L
SF558 Unit:

A31
W:202-442-7030 H:3018058310
Rank: MAJ D:202-442-7030
RR: OUTPATIENT RECORDS KI

20/256-88-7864
SMITH, ROBBIE L
24 Aug 2007@1829

26

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
79 MDG Form 500, file as SF 558

EMERGENCY PHYSICIAN RECORD
Headache (5)

LOG #: ______ Triage Level: I II III IV V
DATE: 24 Aug 07 TIME: 1904 ☐ on arrival
ROOM: 4 __ EMS Arrival ______
HISTORIAN: (patient) spouse paramedics ______
AGE 54 y/o (M) / F RACE ______
__HX / __EXAM LIMITED BY: ______

HPI

chief complaint: headache facial pain fever *migraine hx*

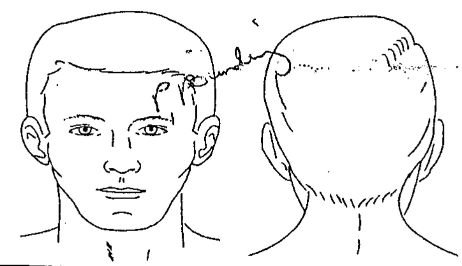
started: 4-5 days - said stiff neck. Legs swollen but was the same as past headaches

time course: abrupt / thunderclap (gradual) (onset) 4-5 hrs / days
cannot pinpoint exact onset
still present better
gone now lasted ______
intermittent episodes lasting ______
worse / persistent since ______

severity:
maximum
mild moderate severe worst of life
when seen in ED
unchanged gone mild moderate severe

quality: (similar to previous headaches) "pain" tightness throbbing sharp

location:



associated symptoms:
preceding symptoms
visual disturbance scotoma
typical of prior aura(s)
speech problems ______
(light bothers eyes) / blurred vision
confusion ______
nausea / vomiting ______
power loss (R / L) *arm leg*
trouble walking ______
tingling / numb sensation ______
neck pain / stiff neck ______
syncope ______
dizziness ______

exacerbated by: light noise movement position ______

Similar symptoms previously yes, 2-3 mths
tried aleve

Recently seen / treated by doctor ______
This HA is like his past headaches.
Legs always swell c̄ headaches

ROS

CONST
fever ______
(subjective) / to ______ °F
muscle aches ______

CVS / PULMONARY
chest pain ______
cough ______
sputum ______
trouble breathing ______

EENT
visual disturbances ______
sore throat ______
sinus pressure / drainage ______
difficulty swallowing ______

GI / GU
(abdominal pain)
diarrhea ______
pain on urination ______
incontinence ______

NEURO
dizziness ______
vertigo lightheadedness
For new, gradual-onset HA-
CO exposure ______
tick bite(s) / insect bite(s) ______
head injury ______

SKIN / LYMPH / MS
rash / swelling ______
back pain ______
skin lesions ______

☒ all systems neg except as marked

Ø trouble swallowing, speaking
Ø weakness or trouble walking

PAST HX
__negative
chronic headaches
occasional frequent "migraine"
mild moderate severe
(high blood pressure)
sinus problems ______
SAH risk factors:
1° relative
connective tissue disorder
Marfan's / Ehlers disease

cancer history ______
immunosuppressed ______
glaucoma ______
diabetes *Type I Type 2* ______
diet / oral / insulin
asthma ______
HIV / AIDS ______
prior CNS infection ______

Migraines
allergies
Sinus infection

Medications ☐ 508 reviewed and updated
(__none)

Allergies (NKDA)
see nurses note

SOCIAL HX
smoker ______ drug use / abuse *cocaine* ______
recent ETOH ______

FAMILY HX
cerebral aneurysm ______
stroke ______
pseudotumor ______
migraine headaches ______
HTN ______

Patient: **SMITH, ROBBIE L**
Treatment Facility: **KIMBROUGH AMBULATORY CARE CENTER**
Patient Status: **Outpatient**

Date: **21 Nov 2007 1300 EST**
Clinic: **FAM PRACTICE KI**

Appt Type: **OPAC**
Provider: **FARAZ,SABINA F**

Reason for Appointment: SINUS INFECTION AND HEADACHE
Appointment Comments:
TST/WR

AutoCites Refreshed by FARAZ, SABINA F. @ 21 Nov 2007 1319 EST

Problems
• ESSENTIAL HYPERTENSION

Active Family History
No Active Family History Found.

Allergies
• No Known Allergies

Active Medications
No Active Medications Found.

Screening Written by HEATH, DIANA S @ 21 Nov 2007 1319 EST

Allergen information verified by HEATH, DIANA S @ 21 Nov 2007 1319 EST
-

Vitals
Vitals Written by HEATH, DIANA S @ 21 Nov 2007 1323 EST
BP: 170/101,
Comments: Manual BP
Vitals Written by HEATH, DIANA S @ 21 Nov 2007 1319 EST
BP: 166/111 Right Arm, Adult Cuff, HR: 82, RR: 18, T: 97.8 °F Otic, HT: 73 in Stated, Without Shoes, WT: 258.2 lbs Upright Scale, Actual, With Shoes, BMI: 34.07, BSA: 2.399 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 7/10 Severe, Pain Scale Comments: facial pain

Questionnaire AutoCites Refreshed by FARAZ, SABINA F. @ 21 Nov 2007 1319 EST
Questionnaires
No Questionnaires Found.

SO Note Written by HEATH,DIANA S @ 21 Nov 2007 1323 EST
History of present illness
The Patient is a 55 year old male.

LEARNING ASSESSEMENT DONE [X] YES [ ] NO
DATE:21 November 2007
PT DESIRES TO HAVE PROVIDER ADDRESS HIS/HER PAIN DURING THIS VISIT.
[ ] YES [ ] NO [X] N/A.
Past medical/surgical history
Reported History:
Reported medications: Not taking medication
, no over-the-counter medications
, no dietary supplements
, and no vitamin supplements
.

Previous therapy
No history of herbal medicines

SO Note Written by FARAZ,SABINA F @ 21 Nov 2007 1335 EST
Reason for Visit
SINUS SX AND HEADACHES.

History of present illness
The Patient is a 55 year old male.
H/O HTN.
Having symptoms HEADACHES. No generalized pain, not feeling tired or poorly, and no recent weight change.
No rash.
C/O HEADCAHE RT SIDE SINCE 1 WEEK, POUNDING IN NATURE, NO RADIATION, NOT ASSOCITED WITH VOMITTING OR VISUAL DISTURBANCE. DENIES CHEST PAIN OR DIFFICULTY BREATHING. HAD RUNNY NOSE CONGESTION EARLY IN THE WEEK. TOOK PERCOCET AND DECONGESTANT IT DIDNT HELP.
Allergies
No allergies SEE ALLERGIES. SEE ALLERGIES.
Current medication
CURRENT MEDICATIONS REVIEWED/RECONCILED WITH PT. CURRENT MEDICATIONS REVIEWED/RECONCILED WITH PT.
Past medical/surgical history
Reported History:
Reported medications: Taking medication.
Diagnosis History:
Hypertension [ ] CONTROLLED
[ ] UNCONTROLLED. [ ] CONTROLLED
[ ] UNCONTROLLED.
No asthma.
No urinary tract infection.
No hypothyroidism
No type II diabetes mellitus
Family history
No cancer NO H/O CAD OR STOKE IN THE FAMILY
No diabetes mellitus.
Review of systems
Encounter background information: Past medical history reviewed TO INCLUDE RECONCILIATION OF THE FOLLOWING WITH THE PATIENT/PARENT
[X] MASTER PROBLEM LIST
[X] ALLERGIES
[X] MEDICATIONS and with patient.
Systemic symptoms: Feeling fine. No fever and no chills.
Head symptoms: Headache.
Otolaryngeal symptoms: No sore throat.
Cardiovascular symptoms: No chest pain or discomfort.
Pulmonary symptoms: No dyspnea.
Gastrointestinal symptoms: No nausea, no vomiting, and no diarrhea.
Endocrine symptoms: No muscle weakness and no feelings of weakness.
Neurological symptoms: No dizziness and no limb weakness.
Physical findings
PT WITH H/O HEADCAHES 1 WEEK, TAKING EXCEDRIN, NOT HELPING, NOTE BP HIGH, NEEDS ANTIHYPERTENSIVES, LAB WORK AND F/U.
Vital signs:
° Current vital signs reviewed BP HIGH.
General appearance:
° Well-appearing. ° Awake. ° Alert. ° Oriented to time, place, and person. ° Well developed. ° Well hydrated. ° In no acute distress.
Head:
• Head:
Neck:
Palpation: ° No tenderness of the neck.
Suppleness: ° Neck demonstrated no decrease in suppleness.
Thyroid: ° Showed no abnormalities.
Eyes:
General/bilateral:
Extraocular Movements: ° Normal.
Pupils: ° PERRLA.
Sclera: ° Normal.
Lymph Nodes:
° No adenopathy.
Lungs:

° Respiration rhythm and depth was normal. ° Clear to auscultation. ° Normal breath sounds/voice sounds. ° No wheezing was heard. ° No rhonchi were heard.

Cardiovascular system:

Heart Rate And Rhythm: ° Normal. ° Heart rate was normal.
Murmurs: ° No murmurs were heard.
Apical Impulse: ° Normal.
Arterial Pulses: ° No bruit in the carotid artery.
Edema: • Pitting edema. • Unilateral pitting edema. • Pitting edema seen on the left. • Localized pitting edema at left ankle. • Localized pitting edema at left knee LEFT LEG SWOLLEN NO CALF TENDERNESS, HOMAN'S SIGN NEG.

Abdomen:

Auscultation: ° Bowel sounds were normal.
Palpation: ° Abdominal palpation revealed no abnormalities.

Neurological:

Mental Status Findings: ° Cognitive functioning was normal.
Cranial Nerves: ° Normal.
Motor: ° A motor exam demonstrated no dysfunction.
Coordination / Cerebellum: ° No coordination/cerebellum abnormalities were noted.
Balance: ° Normal.
Gait And Stance: ° Normal.
Reflexes: ° Normal.

Lab Result Cited by FARAZ, SABINA F. @ 21 Nov 2007 1328 EST

Test / Result Name	Site/Specimen	Collection Date / Result Values	Origin
MTF/Facility	Units	Ref Rng	Result Comments
Interpretations			
Hemoglobin A1c	**Site/Specimen**	**22 Feb 2007 1054**	Units / Ref Rng
Hemoglobin A1c	BLOOD	5.7 <i>	% (4.8-5.9)

Lab Result Cited by FARAZ, SABINA F. @ 21 Nov 2007 1328 EST

Test / Result Name	Site/Specimen	Collection Date / Result Values	Origin
MTF/Facility	Units	Ref Rng	Result Comments
Interpretations			
Metabolic Panel Comprehensive	**Site/Specimen**	**22 Feb 2007 1054**	Units / Ref Rng
Albumin	SERUM	4.5	g/dL (3.9-5.0)
Alkaline Phosphatase	SERUM	86	U/L (38-126)
Alanine Aminotransferase	SERUM	46 <i>	U/L (21-72)
Aspartate Aminotransferase	SERUM	34	U/L (15-59)
Bilirubin	SERUM	0.8	mg/dL (0.2-1.3)
Urea Nitrogen	SERUM	10	mg/dL (9-20)
Calcium	SERUM	9.5	mg/dL (8.4-10.2)
CO2	SERUM	**34 (H)**	mmol/L (22-31)
Chloride	SERUM	102	mmol/L (98-107)
Creatinine	SERUM	1.03	mg/dL (0.8-1.5)
Glucose	SERUM	94	mg/dL (75-110)
Potassium	SERUM	4.2	mmol/L (3.6-5.0)
Total Protein	SERUM	7.6	g/dL (6.3-8.2)
Sodium	SERUM	141	mmol/L (137-145)
Anion Gap	SERUM	**5 (L)**	mmol/L (7-16)
GFR	SERUM	87 <i>	mL/min (>/=60)

Lab Result Cited by FARAZ, SABINA F. @ 21 Nov 2007 1328 EST

Test / Result Name	Site/Specimen	Collection Date / Result Values	Origin
MTF/Facility	Units	Ref Rng	Result Comments
Interpretations			
Lipid Panel	**Site/Specimen**	**22 Feb 2007 1054**	Units / Ref Rng
Cholesterol	SERUM	189 <i>	mg/dL (50-200)
Triglyceride	SERUM	117 <i>	mg/dL (35-250)
HDL Cholesterol	SERUM	48	mg/dL (35-82)

VLDL Cholesterol	SERUM	9 <i>		
Cholesterol/HDL Cholesterol	SERUM	3.94		
LDL Cholesterol Direct	SERUM	**132 (H) <i>**	mg/dL	(0-129)

Lab Result Cited by FARAZ, SABINA F. @ 21 Nov 2007 1328 EST

Test / Result Name	**Site/Specimen**	**Collection Date / Result Values**	**Origin**
MTF/Facility Interpretations	**Units**	**Ref Rng**	**Result Comments**
Thyroid Stimulating Hormone	**Site/Specimen**	**22 Feb 2007 1054**	Units / Ref Rng
Thyrotropin	SERUM	1.74 <i>	mcIU/mL (0.27-4.20)

A/P Written by FARAZ, SABINA F. @ 21 Nov 2007 1411 EST

1. ESSENTIAL HYPERTENSION: UNCONT

Medication(s): -TELMISARTAN/HCTZ--PO 40MG-12.5MG TAB - T1 TAB PO QD #60 RF0 Qt: 60 Rf: 0
-ASPIRIN (ENTERIC COATED)--PO 81MG TBEC - T1 TAB PO QD #90 RF3 Qt: 90 Rf: 3
-IBUPROFEN--PO 800MG TAB - T1 TAB PO TID PRN #60 RF0 Qt: 60 Rf: 0

Laboratory(ies): -COMPREHENSIVE METABOLIC PNL (Routine); THYROID FUNCTION PANEL (ARMY) (Routine); LIPID PANEL (Routine)

Radiology(ies): -US, DOPPLER VEIN EXTREMITY (Routine) Impression: 55 YR OLD MALE WITH HTN, H/O UNILATERAL LOWER LEFT LEG EDEMA

2. headache

3. (Lower) Leg Localized Swelling

Disposition Written by FARAZ, SABINA F. @ 21 Nov 2007 1448 EST

Released w/o Limitations

Follow up: as needed in the FAM PRACTICE KI clinic. - Comments: F/U NEXT WEEK

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Note Written by FARAZ, SABINA F. @ 21 Nov 2007 1411 EST

PT GIVEN CLONIDINE 0.2 MG BP CAME DOWN, TO 138/ 98, FEELS BETTER HEADACHE HAS SUBSIDED, ADVISED TO TAKE BP MEDICINE AT NIGHT, TAKE BP AT HOME, GET LAB WORK , MAKE F/U APPOINTMENT ON MONDAY, ANY CHANGE SEVERE HEADACHE, VOMITTING WEAKNESS GO TO ED, HIGH BP CAN CAUSE HEART ATTACKE STROKE AND INTRACRANIAL BLLED. NO FOCAL NEUROLOGICAL DEFECIT ON EXAM

Note Written by FARAZ, SABINA F. @ 21 Nov 2007 1340 EST

PT NEEDS MEDICATION, WORK UP FOR LEG SWELLING, NO C/O REDNESS INCREASE TEMP, NO PAIN, WILL GET US TO R/O CLOT, IF NORMAL, CONSIDER US ABDOMEN/ PELVIS TO R/O OBSTRUCTION

Signed By FARAZ, SABINA F. (MD, FP, KACC) @ 21 Nov 2007 1448

Patient: **SMITH, ROBBIE L**
Treatment Facility: **WALTER REED ARMY MEDICAL CENTER**
Patient Status: **Outpatient**

Date: **06 Feb 2008 1600 EST**
Clinic: **Peripheral Vascular Surgery Clinic WR**

Appt Type: **EST**
Provider: **ADAMS, ERIC D**

Reason for Appointment:

AutoCites Refreshed by HWANG, PAUL FRANCIS @ 06 Feb 2008 1632 EST

Problems

- HYPERLIPIDEMIA
- visit for: therapeutic drug monitoring
- INSUFFICIENT SLEEP SYNDROME
- SLEEP APNEA OBSTRUCTIVE
- visit for: administrative purpose
-
- snoring
- (Lower) Leg Localized Swelling
- headache
- ESSENTIAL HYPERTENSION

Allergies

No Allergies Found.

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
TELMISARTAN/HYDROCHLOROTHIAZID, 40-12.5MG, TABLET	Active	T1 TAB PO QD #14 RF0	NR	04 Feb 2008
SIMVASTATIN, 40MG, TABLET	Active	T1 TAB PO HS #90 RF0	NR	30 Nov 2007
FINASTERIDE, 5MG, TABLET	Active	T1 TAB PO QD #90 RF1	1 of 1	26 Nov 2007
ASPIRIN, 81MG, TABLET EC	Active	T1 TAB PO QD #90 RF3	3 of 3	21 Nov 2007

Vitals
No Vitals Found.

SO Note Written by HWANG, PAUL FRANCIS @ 06 Feb 2008 1632 EST
History of present illness
The Patient is a 55 year old male.
° Encounter Background Information: 55yo male, hx sig for HTN, comes in with complaints of LLE swelling intermittently since 1978 when he started the army, most notable at the end of day or long periods of PT/running. Primary care directed patient to vascular with some concerns for the possibility of a blood clot. Denies CP/SOB
Review of systems
Systemic symptoms: No systemic symptoms
Cardiovascular symptoms: No cardiovascular symptoms
Pulmonary symptoms: No pulmonary symptoms
Gastrointestinal symptoms: No gastrointestinal symptoms
Genitourinary symptoms: No genitourinary symptoms
Physical findings
Vital signs:
° Normal
Objective
Palpable DP/PT bilaterally, no calf tenderness, noticeable larger calve on L > R

SO Note Written by ADAMS, ERIC D @ 13 Feb 2008 0810 EST
History of present illness
The Patient is a 55 year old male.
He reported; Encounter Background Information: 55yo male, hx sig for HTN, comes in with complaints of LLE swelling intermittently since 1978 when he started the army, most notable at the end of day or long periods of PT/running. Primary care directed patient to vascular with some concerns for the possibility of a blood clot. Denies CP/SOB.
Review of systems
Systemic symptoms: No systemic symptoms.
Cardiovascular symptoms: No cardiovascular symptoms.
Pulmonary symptoms: No pulmonary symptoms.
Gastrointestinal symptoms: No gastrointestinal symptoms.

Genitourinary symptoms: No genitourinary symptoms.

Physical findings

Vital signs:

° Normal.

Objective

Palpable DP/PT bilaterally, no calf tenderness, noticeable larger calve on L > R.

A/P Last updated by ADAMS, ERIC D @ 13 Feb 2008 0812 EST

1. **VENOUS INSUFFICIENCY**: Given prescription for compression stockings. If he finds that this does not give him adequate symptom relief he should return and we will obtain a venous (duplex) reflux study,

Disposition Written by ADAMS, ERIC D @ 14 Feb 2008 1321 EST

Released w/o Limitations

Follow up: as needed in the PVS CLINIC WR clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

Signed By ADAMS, ERIC D (Physician/Workstation, NNMC Bethesda, MD) @ 14 Feb 2008 1322

CHANGE HISTORY

The following A/P Note Was Overwritten by ADAMS, ERIC D @ 13 Feb 2008 0810 EST:

The A/P section was last updated by ADAMS, ERIC D @ 13 Feb 2008 0810 EST - see above.Previous Version of A/P section was entered/updated by HWANG, PAUL FRANCIS @ 06 Feb 2008 1646 EST.

1. **VENOUS INSUFFICIENCY**: Pt to try conservative therapy with prescription compressive stockings. Followup if symptoms worsen.

The following Disposition Note Was Overwritten by ADAMS, ERIC D @ 13 Feb 2008 0813 EST:

The Disposition section was last updated by ADAMS, ERIC D @ 13 Feb 2008 0813 EST - see above.Previous Version of Disposition section was entered/updated by HWANG, PAUL FRANCIS @ 06 Feb 2008 1646 EST.

Released w/o Limitations

Follow up: as needed in the PVS CLINIC WR clinic.

Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

15 minutes face-to-face/floor time. >50% of appointment time spent counseling and/or coordinating care.

29 Apr 2009@02007
Smith, Robbie
20/256-88-7864
DOB 20 Oct 1952

PATIENT INFORMATION (Label):
FMP/LAST 4 SSN#:
NAME:

EMERGENCY DEPARTMENT DISCHARGE INSTRUCTIONS

Your DIAGNOSIS is: L leg Pain Chronic Venous Insufficiency

FOLLOW_UP:
☐ Primary Care Manager: ☐ 24 hours ☐ 48 hours ☐ 72 hours ☑ other _____
☐ Orthopedic Cast Clinic (fractures only): Call (240) 857-8599 for an appointment.
☐ Wound care clinic: Walk-in between 0715 – 0800. You will not be seen after 0800.
☐ Public Health: Call 240-857-5498 for follow-up
☐ Consult placed with: _____. Call 1-888-999-1212 to schedule appointment.
☐ Specific appointment Date: _____ Time: _____ Location: _____

You should be seen before, or return to the emergency department if: _____
Shortness of breath.

OTHER: Motrin for pain Keep leg Elevated when sitting
Follow up with your Primary MD

MEDICATION: See the medication reconciliation form 508. Bring the MDG 508 to your primary care provider to have your medications updated in the system.
Your evaluation was limited to identifying urgent causes of your symptoms. You must follow up with your doctor for further evaluation if your symptoms persist and for routine and preventative healthcare. Return to the Emergency Department for new symptoms or any concern.

I understand the above discharge instructions: Robbie L Smith Date: 29Apr09
Patient (or guardian) SIGNATURE

Discharge with:
1. Photocopy of this discharge instruction sheet
2. Medication reconciliation form MDG 508
3. ☐ Hypertension sheet (if box is checked)
4. ☐ Radiology follow up sheet (if box is checked)
5. ☐ Other discharge instruction sheet: _____
6. ☐ Quarters ☐ 24 hrs ☐ 48 hrs ☐ 72 hrs
7. Medications: ☐ no medications prescribed
   ☐ will be given to patient
   ☐ are at main pharmacy
   ☑ written prescription: You may take the prescription to a retail pharmacy or have it filled at any Military Treatment pharmacy during duty hours. The satellite pharmacy at Andrews will fill written prescriptions M-F 0730-1700. The main pharmacy at Andrews does not fill written prescriptions.

Brittany L. Brown, SSgt, USAF
Emergency Dept. Tech
ED Personnel Completing Discharge

Date/Time: 29 Apr 09 2325

EMERGENCY DEPARTMENT SIGN IN

DATE: 29 April 2009	TIME: 8:00 PM
PATIENTS NAME: Robbie L. Smith	AGE OF PATIENT 56
ADDRESS: 12005 Augusta Drive Glenn Dale, MD 20769	PHONE NUMBER (202) 441-6816
SPONSOR SSN: 256-88-7864	

WHAT BRINGS YOU TO THE EMERGENCY ROOM TODAY:

Pain & swelling in left Leg below the knee and in hip

VISIT INFORMATION — **PLEASE ANSWER ALL QUESTIONS**

1. Are you on **FLYING STATUS**? (AF IMT 1042) — (NO) YES
2. Are you **PRP/PSP**? (If you don't know what PRP/PSP is then circle NO) — (NO) YES
3. Do you have any **ALLERGIES?** (NO) YES (Please List) _____
4. **ACTIVE DUTY ONLY**: Have you suffered an **INJURY?** (fill out AMC 441 Injury Report) — NO YES
5. Do you have **OTHER HEALTH INSURANCE?** — (NO) YES
6. Did you attempt to make an appointment for this issue? — (NO) YES

RESULT: _____

EMERGENCY STATEMENT

Triage is a process whereby an Emergency Medicine nurse will determine the urgency of the care you need. Patients who have an immediate threat to life, limb, or eyesight will be seen first. If you do not have these problems then you may have to wait a significant period of time or may be referred to your Primary Care Clinic. We are concerned about the health and well-being of all our patients and ask for your understanding if we are unable to see you quickly.

PATIENT/GUARDIAN SIGNATURE: Robbie L Smith

29 Apr 2009@02007
Smith, Robbie
20/256-88-7864
DOB 20 Oct 1952

42 Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
File as 779 MDG, Form 433

EMERGENCY PHYSICIAN RECORD
Lower Extremity Problem

LOG #:_____ Triage Level: I II III IV V
DATE: 4/29/09 TIME: 2138 ☐on arrival ROOM:_____ _EMS Arrival
HISTORIAN: patient spouse paramedics_____
AGE_____ (M) F RACE AA
__HX / __EXAM LIMITED BY: _____

HPI

chief complaint: (pain) swelling altered sensation
R / L foot ankle leg knee thigh hip back

onset / duration: _____ min / hrs / days ago _____
2 days

timing:
still present
better
gone now
constant sudden-onset
intermittent episodes lasting_____
worse / persistent since_____

recent injury? no yes possibly

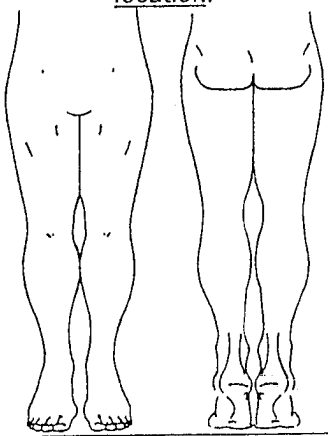
context: prolonged pressure on extremity_____
Pt has h/o chronic leg swelling for 2 days has had increased pain

When? as above_____
Where? home work_____

severity: mild moderate severe (1/10)_____

quality:
pain
swelling
tenderness
erythema
numbness
tingling

location:



exacerbated by: nothing
walking movement Standing

relieved by: nothing
rest ice Stretching

associated symptoms:
chest pain shortness of breath rapid heart rate fainting_____

Similar symptoms previously_____

Recently seen / treated by doctor / hospitalized
Month ago saw MD regarding HTN

ROS

CONST
recent illness_____
fever / chills_____
sweating_____
weakness_____
MS / SKIN / LYMPH
neck / back pain_____
joint pain_____
rash_____
swollen glands_____
CVS / RESP
chest pain_____
shortness of breath_____
cough_____
LNMP_____ preg post- menop

GI / GU
abdominal pain_____
nausea / vomiting_____
diarrhea_____
black stools_____
problems urinating_____
EYES / ENT
problems with vision_____
sore throat_____
nasal drainage_____
NEURO / PSYCH
headache_____
difficulty walking_____
dizziness_____
anxiety / depression_____
☐all systems neg except as marked

*CVS / RESP / NEURO components also addressed in HPI

PAST HX

intervertebral disc disease_____
lumbar thoracic cervical
back injury_____
chronic back pain_____
diabetes Type I Type 2_____
diet / oral / insulin_____
DVT / PE risk factors: cast cancer
recent surgery leg swelling bedridden
paralysis prior DVT/PE_____

aortic aneurysm_____
cardiac disease_____
CAD AMI angina A-Fib CHF
gout_____
hyperlipidemia_____
hypertension_____
peptic ulcer disease_____
peripheral vascular disease_____

__old records ordered / summary:_____

Surgeries / Procedures __none
back surgery_____
knee surgery_____
appendectomy_____
cholecystectomy_____
c-section / hysterectomy_____
cardiac bypass / stent_____
TURP_____

Immunizations: UTD / referred to PCP_____

Medications
☑ 508 reviewed and updated

Allergies __NKDA
see nurses note

SOCIAL HX smoker 0
alcohol (recent / heavy / occasional)_____ drugs_____
occupation_____

FAMILY HX DVT/PE_____

29 Apr 2009@02007
Smith, Robbie
20/256-88-7864
DOB 20 Oct 1952

05

Malcolm Grow USAF Medical Center
Andrews AFB, MD 20762
File as 779 MDG, Form 433

EMERGENCY NURSING RECORD
Extremity Trauma / Pain

__FLY __PRP __INJURY

TRIAGE TIME 2003 1 2 3 (4) 5

TIME TO ROOM: 2040 ROOM: I

NAME:
D.O.B: AGE: 56 (M) / F
HISTORIAN: (patient) paramedics family Spouse
ARRIVAL MODE: (ear) EMS police
PCP: none
^IMMUNIZATIONS: current / referral
tetanus flu pneumovax

TREATMENT PTA see EMS report IV O_2 c-collar backboard
last blood glucose

VITALS
BP 131/86 P 69 99 RR 20 temp 97.1 TA (TM) O R Ax
SaO_2 99 (RA) / O_2

PAIN LEVEL current: 7 /10 max /10 acceptable /10
scale used quality throbbing

CHIEF COMPLAINT Pain in L leg
occurred *just PTA* 2 *hrs / days ago* hip & below knee & swell
* has had pain x 6-7

INJURIES / PAIN

R			L		
shldr	hip		shldr	(hip)	
arm	thigh		arm	thigh	
elbow	knee		elbow	(knee)	
f-arm	leg		f-arm	(leg)	
wrist	ankle		wrist	ankle	
hand	foot		hand	foot	
fingers	toes		fingers	toes	

MECHANISM
fall animal bite
twisting GSW / stab wound
direct blow / crush burn
puncture wound cut with

ALLERGIES (NKDA)
drug - PCN / ASA / sulfa / latex / codeine / iodine
food -
☐ allergy band applied

MEDS none see med list

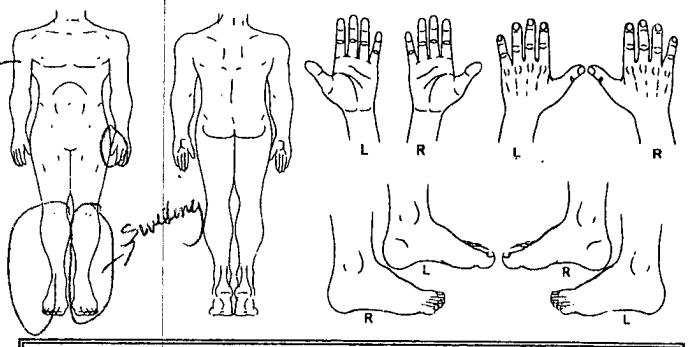
PAST MEDICAL HX negative
R / L handed (HTN) diabetes: *insulin*
past surgeries (none)

SOCIAL HX
smoker 0 ppd drugs (alcohol) occ
^TB exposure / symptoms
^has been physically hurt or threatened by someone close N
^fall risk screen completed Score=
Fall Risk Assessment Score of = 4 = Fall Protocol intiated

LNMP N/A G P Ab pregnant / postmenop / hyst

Print Name / Signature SJohnson04

Page 1 of 2



KEY: T=Tenderness S=Swelling E=Erythema B=Burn
A= Abrasion V=Vesicles Lac=Laceration

UPPER EXTREMITIES see diagram
no evidence of trauma active bleeding
skin intact deformity
non-tender ROM limited
no deformity pulse deficit
full ROM
pulses nml

LOWER EXTREMITIES see diagram
no evidence of trauma active bleeding
skin intact deformity
non-tender ROM limited
no deformity unable to bear weight
full ROM pulse deficit
pulses nml

ADDITIONAL FINDINGS
- pedal edema 1+-2+ L>R.
- Sister hx of Kidney disease

INITIAL ASSESSMENT TIME: 2003

GENERAL APPEARANCE
no acute distress mild / moderate / severe distress
alert / oriented x3 anxious / decreased LOC
disoriented to *person / place / time*

^FUNCTIONAL / NUTRITIONAL ASSESSMENT
independent ADL assisted / total care
appears well obese / malnourished
nourished / hydrated recent weight loss / gain

CVS
skin warm & dry cool / diaphoretic
cap refill less than 2 sec pale / cyanotic
cap refill greater than 2 sec

INITIAL ACTIONS

TIME			INIT
2003	ID band applied	ID band verified	SJ
	Fall Risk band applied		SJ
	c-collar	backboard	
	disrobed / gowned	blanket provided	
	ice pack	elevation / immobilization	
	bandage applied	wet to dry dressing	
	bed low position	side rails up x1 x2	
	call light in reach	head of bed elevated	

Print Name / Signature SJohnson04

^ protocol available

Patient: **SMITH, ROBBIE L**
Treatment Facility: **WALTER REED ARMY MEDICAL CENTER**
Patient Status: **Outpatient**

Date: **10 Apr 2009 1400 EDT**
Clinic: **INT MED PCC WR**

Appt Type: **EST**
Provider: **DENNISTON,SKY A**

Co-signer: **RITTER, JOAN B**

Reason for Appointment:

AutoCites Refreshed by DENNISTON, SKY A @ 10 Apr 2009 1427 EDT
Vitals
No Vitals Found.

Vitals
Vitals Written by OWENS, ANGELA M @ 10 Apr 2009 1409 EDT
BP: 135/86, HR: 88, T: 97.0 °F, HT: 74 in, WT: 261 lbs, BMI: 33.51, BSA: 2.433 square meters, Tobacco Use: No, Alcohol Use: Yes, Have you ever felt you should Cut down on your drinking? No, Have people Annoyed you by criticizing or complaining about your drinking? No, Have you ever felt bad or Guilty about your drinking? No, Have you ever had a drink or drug in the morning (Eye opener) to steady your nerves or to get rid of a hangover? No, Alcohol Comments: ocassionally, Pain Scale: 2/10 Mild, Pain Scale Comments: left leg

Questionnaire AutoCites Refreshed by DENNISTON, SKY A @ 10 Apr 2009 1427 EDT
Questionnaires
PHQ-2 Questionnaire Version: 2 Completed On: 10 Apr 2009
1. Over the past two weeks, how often have you felt little interest or pleasure in doing things?: 0 = Not at all
2. Over the past two weeks, how often have you felt down, depressed, or hopeless?: 0 = Not at all
3. TOTAL SCORE = : 0

SO Note Written by DENNISTON,SKY A @ 10 Apr 2009 1558 EDT
History of present illness
The Patient is a 56 year old male.
He reported: Encounter Background Information: see below.

A/P Written by DENNISTON, SKY A @ 10 Apr 2009 1509 EDT
1. ESSENTIAL HYPERTENSION
2. MALE ERECTILE DISORDER
3. (Lower) Leg Localized Swelling
4. joint pain, localized in the hip
5. visit for: screening exam

Disposition Written by DENNISTON, SKY A @ 10 Apr 2009 1558 EDT
Released w/o Limitations
Follow up: with PCM.

Note Written by DENNISTON, SKY A @ 10 Apr 2009 1559 EDT
clinic note
HPI: 56 y.o. man who presents for BP refill. Leg wants to "pop" out socket. Esp with leg swelling. Hose causes no change. Home 125-136/ 80-86. ED not fully helped with levitra. Running and sitting ok. Standing, walking gets left hip pain. No pain with lying on left side. Sudden onset about every other day until sitting or stretch. Stretching helps esp after 10 minutes. Elevation helps. Associated with swelling. Bending helps.esp with turning in. Toes are swollen. Patient interested in prostate and colon cancer screening.

PMH:
-ED