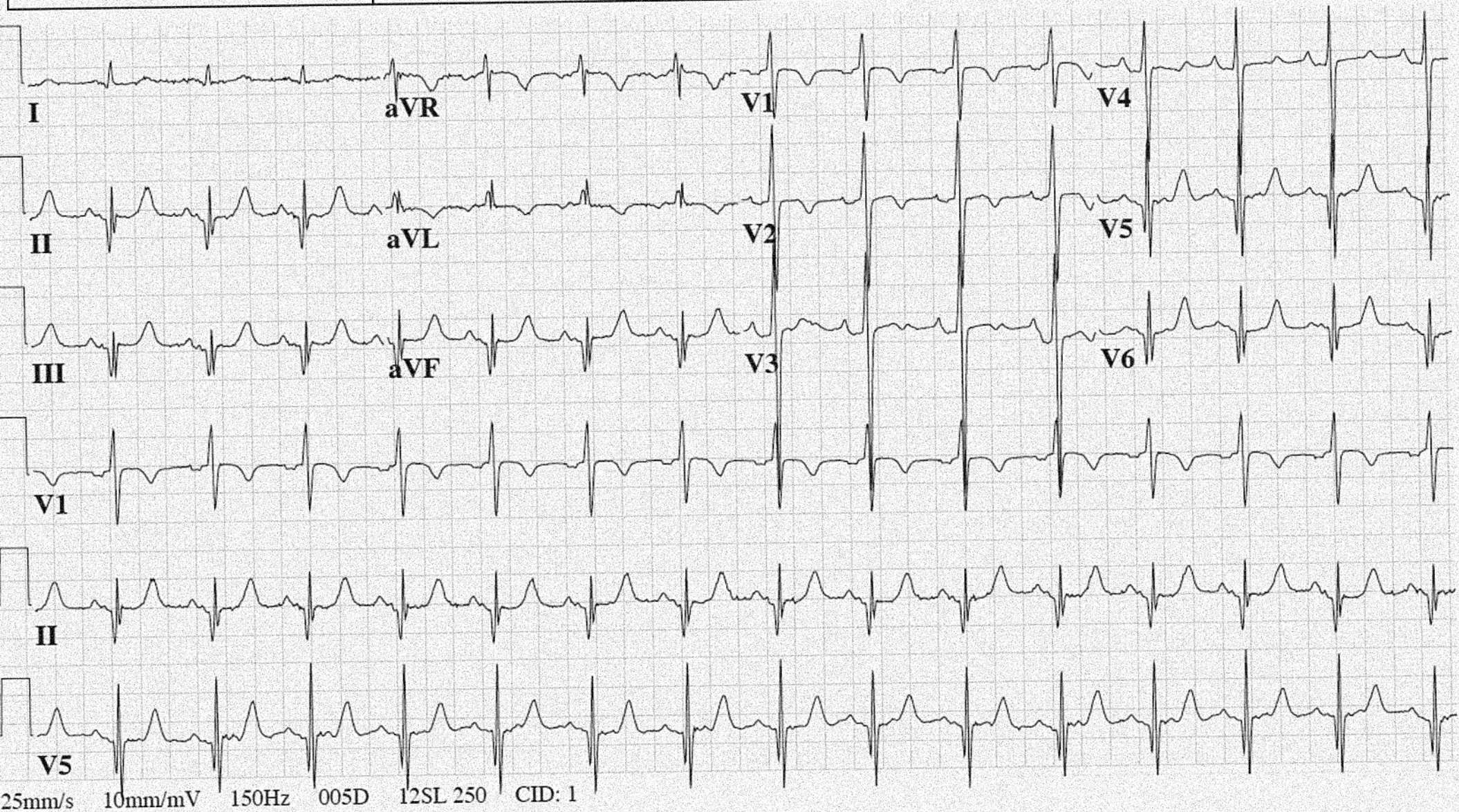


City Hospital ECG Report

Report ID : 1000001 QRS : 78 ms QT / QTcBaz : 373 / 434 ms PR : 158 ms P : 98 ms RR / PP : 734 / 731 ms P / QRS / T : 79 / -2 / 66 degrees	Impression: Sinus bradycardia. Otherwise no change from prior ECG.	Patient Name: Shui Chan Patient ID: 11110001 DOB: 1966-08-01 04:10:48 Date/Time: 2022-03-04 12:25:31 Technician: ML Ordering MD: Valeria Perrin Attending MD: Obi Okonkwo
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General Heart Hospital

Cardiac Imaging Laboratory
100 Main Street
Anywhere, ST 99999
(800) 555-5555

DOB: 1966-08-01 04:10:48 Patient Location: Outpatient Accession: 1000012	Check-in #: 1111222 Procedure date: 2022-01-29 05:52:57	Unit #: n/a MRN: 11110001
Shui Chan 333 Anytown Street Anystate,USA 55511		Dictating Physician: Obi Okonkwo Ordering Physician: Cathaoir Mac Griogair
INDICATION: Cardiomegaly. Father had severe aortic stenosis. TECHNIQUE: Echocardiogram was performed including 2-D and M-mode imaging, Doppler analysis continuous wave and pulse echo outflow velocity mapping was all seen in M-mode. FINDINGS: Comparison was made to the previous echocardiogram from July 2011. Cardiac chamber dimensions: Left atrial enlargement 4.4 cm. Left ventricle, right ventricle, and right atrium are grossly normal. LV wall thickness and wall motion appeared normal. LV ejection fraction is estimated at 65%. Aortic root and cardiac valves appeared normal. No evidence of pericardial effusion. No evidence of intracardiac mass or thrombus. There is mild tricuspid regurgitation. Calculated pulmonary systolic pressure 42 mmHg. IMPRESSION: 1. LV Ejection fraction estimated at 65%. 2. Mild left atrial enlargement. 3. Mild tricuspid regurgitation. 4. Mildly elevated pulmonary systolic pressure. Recommend follow-up echocardiogram in 12 months out of concern for pulmonary arterial hypertension.		

FINAL

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X-RAY REPORT

SOUTHWESTERN IMAGING CENTER

SUITE 201, 34 DUNSTER ROAD, FLAGSTAFF, AZ 86001 TELEPHONE: 928-555-1212

Requesting Physician: Dr. Ulick Martin
Patient Name: Shui Chan
Patient ID: 11110001
Patient DOB: 1966-08-01 04:10:48
Patient gender: male

Accession #: 1000023

Study Date: 2022-02-19 08:31:13

XR RIGHT WRIST AND RIGHT SCAPULA

HISTORY: Right wrist injury with shoulder trauma.

TECHNIQUE: Two views of the scapula and three views of the right wrist.

COMPARISION: Right wrist x-ray from 2008/10/11.

FINDINGS:

SCAPULA:

There is a fracture of the scapula involving the cranial border of the scapular body, not well seen on these views however. The glenohumeral joint is in normal alignment. No separation of the AC joint or widening of the coracoclavicular interval is detected. A right PICC is noted.

RIGHT WRIST:

There is a severely comminuted, intra-articular fracture of the distal radius. There is however volar angulation of the distal radial articular surface. There is 3mm of impaction at the dorsal aspect of the fracture, with mild ulnar positive variance. A non-displaced fracture of the ulnar styloid is also present.

IMPRESSION:

1. Right scapular body fracture.
2. Right wrist fractures.

The scapular body fracture was communicated to Dr. Hayward in the ER at 9:15 a.m.

Attending Physician: Rajni Ahmad

City Hospital
City Health

Patient: Shui Chan
MRN: 11110001
DOB: 1966-08-01
Ordering MD: Nithin Amantea
Accession: 1000034

RADIOLOGICAL REPORT

Exam Date: 2022-01-01 03:09:17

EXAM TYPE:
CT KUB

REASON FOR EXAM:
History of stones, rule out stones.

TECHNIQUE:
Noncontrast CT abdomen and pelvis KUB protocol.

COMPARISON: Correlation is made with a prior examination dated 01/20/09.

FINDINGS:
Again identified are small intrarenal stones bilaterally. These are unchanged. There is no hydronephrosis or significant ureteral dilatation. There is no stone along the expected course of the ureters or within the bladder. There is a calcification in the low left pelvis not in line with ureter, this finding is stable and is compatible with a phlebolith. There is no asymmetric renal enlargement or perinephric stranding.

The appendix is normal. There is no evidence of a pericolic inflammatory process or small bowel obstruction.

Scans through the pelvis disclose no free fluid or adenopathy.

Lung bases aside from very mild dependent atelectasis appear clear.

Given the lack of contrast, liver, spleen, adrenal glands, and the pancreas are grossly unremarkable. The gallbladder is present. There is no abdominal free fluid or pathologic adenopathy.

IMPRESSION:
1. Bilateral intrarenal stones, no obstruction.
2. Normal appendix.

Signed by: Rajni Ahmad, MD



City Hospital
100 Francis Street
El Dorado, AR 71730

Surgical Pathology Report

Patient: Shui Chan
Patient ID: 11110001
DOB: 1966-08-01 04:10:48
Gender: male
Requesting Physician: Margaux Bonaventura

Accession Number: 1000045
Procedure: COLON BIOPSY
Attending: Esther Johnsen
Date: 2022-01-31 15:16:17

TISSUE:

1) TI bx 2) Right colon 3) Rectum

CLINICAL HISTORY:

History of spirochetosis +HIV. 1) R/O Crohn's/infection 2) R/O microscopic colitis 3) R/O Proctitis

GROSS DESCRIPTION:

1) SCO 2 fragments of tan tissue measuring 0.2 cm each EIT. 2) SCO 2 fragments of tan tissue measuring 0.2-0.3 cm EIT. 3) SCO 4 fragments of tan tissue measuring 0.2,0.4 cm EIT.

DIAGNOSIS:

1) Terminal ileum biopsy: - Mild active ileitis. - No granulomas or viral inclusions identified. 2) Colon biopsy (right): - Colonic mucosa with persistent intestinal spirochetosis. - No evidence of microscopic colitis. - No granulomas or viral inclusions identified. - Negative for dysplasia. 3) Colon biopsy (rectum): - Mild active colitis and persistent intestinal spirochetosis. - No evidence of microscopic colitis. - No granulomas or viral inclusions identified. - Negative for dysplasia.

Patient Name: Shui Chan
MRN: 11110001
Age: 55
DOB: 1966-08-01 04:10:48

Document ID: 1000056
Dictating Physician: Rin He
Document Date: 2022-03-13 12:00:00

City Hospital Discharge Summary

CHIEF COMPLAINT: Admitted from rehabilitation for hypotension (systolic blood pressure to the 70s) and decreased urine output.

HISTORY OF PRESENT ILLNESS: The patient is a 61-year-old male who had been hospitalized after undergoing a left fem-pop bypass graft and was discharged home.

On presentation to our Emergency Department, the patient appeared well but was complaining of feeling dizzy when standing up. He was found to have systolic blood pressure of 85. He was given 6 liters of intravenous fluids and transiently started on dopamine for his hypotension.

PAST MEDICAL HISTORY:

1. Coronary artery disease with diffuse 3-vessel disease; right-dominant, status post proximal LAD stent in 2016 with occlusion of the distal LAD and status post right coronary artery stent on 01/08/2017.
2. Congestive heart failure (with an ejection fraction of 30%).
3. Type 2 diabetes mellitus.
4. Essential hypertension.
5. Diverticulosis with prior episodes of diverticulitis.
6. Alzheimer's disease.
7. History of gastrointestinal bleed (while the patient was taking eptifibatide).
8. Hypercholesterolemia.
9. Severe peripheral vascular disease; status post left fem-pop bypass graft on 10/01/2017.
10. Depression.
11. Nonhealing foot ulcers.
12. Right pedal cellulitis.

ALLERGIES: The patient has no known drug allergies.

MEDICATIONS ON ADMISSION:

1. Vancomycin 1 g intravenously q.24h. for a level of less than 15.
2. Levofloxacin 500 mg p.o. q.d. (started on 10/11/2017).
3. Metronidazole 1000 mg p.o. q.8h. (started on 10/11/2017).
4. Heparin 10000 units subcutaneous b.i.d.
5. Simvastatin 60 mg p.o. q.d.
6. Regular insulin sliding-scale.
7. Percocet 5/325 mg one tablet p.o. q.4-6h. as needed for pain.
8. Aspirin 81 mg p.o. q.d.
9. Metoprolol 75 mg p.o. b.i.d.

SOCIAL HISTORY: The patient is retired and lives at home with his wife. He is an occasional drinker and has a 40-pack-year smoking history, although he quit smoking 20 years ago.

PHYSICAL EXAMINATION: Initial physical examination revealed temperature was 96.1 degrees Fahrenheit, heart rate was 83, blood pressure was 124/42 (following administration of 3 liters of normal saline), respiratory rate was 24, and his oxygen saturation was 100% on 2 liters nasal cannula. His heart had a regular rate and rhythm. There were normal first and second heart sounds. There was a 2/6 systolic ejection murmur, and there were no rubs or gallops. His lungs were clear to auscultation bilaterally. His abdomen was soft, nontender, and nondistended, and there were hypoactive bowel sounds. He had a palpable bypass graft pulse, palpable dorsalis pedis and posterior tibialis pulses bilaterally; and his surgical incision was clean, dry, and intact. Please note that the above examination was done by the Vascular Surgery team, which was the team that was initially planning to admit the patient to the hospital.

LABORATORY DATA: On initial laboratory evaluation the patient had a white blood cell count of 14.3, hct was 45.2, and platelets were 301,000. His INR was 1.2. Blood glucose was 91. Serum electrolytes were all within normal limits. Blood cultures were ultimately negative. A urine culture taken on admission grew *Candida albicans*. Sputum culture taken on admission also grew yeast.

RADIOLOGY/IMAGING: His admission chest x-ray demonstrated stable prominence of the right main pulmonary artery; there were no acute findings. Specifically, there was no evidence of congestive heart failure or pneumonia.

An initial abdominal CT demonstrated severe atherosclerotic disease of the aortoiliac vessels. There was no evidence of an abdominal aortic aneurysm or free fluid, but there was coronary artery calcification, a pancreatic cyst, colonic diverticulosis, and prostatomegaly.

ECG: His admission ECG demonstrated normal sinus rhythm, low QRS voltages in the limb leads, and T wave changes in V4 and V5 when compared with an ECG dated 8/16/2017.

HOSPITAL COURSE:

CARDIAC:

The patient was initially admitted to the Intensive Care Unit with hypotension, decreased urine output, and acute renal failure; most likely secondary to a presumed gram-negative urosepsis (although cultures failed to prove this). While in the ICU on the night of admission, the patient had a cardiorespiratory arrest. He was resuscitated with epinephrine, lidocaine, and direct current cardioversion x4. He was also intubated for airway protection.

The patient returned to normal sinus rhythm with a systolic blood pressure of approximately 100; the total time elapsed from the beginning of the arrest to SROC was approximately 16 minutes. He subsequently required continued pressors to maintain his blood pressure.

An echocardiogram performed at the bedside demonstrated a LVEF of 20% to 25% in the setting of tachycardia and a hyperdynamic right ventricle; suggesting elevated right-sided filling pressures. Although the definitive etiology of this arrest remained unknown, the most likely trigger was a myocardial infarction, as his troponin levels were elevated to greater than 55 following the arrest.

On 10/12/2017, the patient was loaded with amiodarone and was subsequently started on oral amiodarone. The following day, he was started on heparin IV given his elevated troponins to greater than 55 which was continued for 96 hours.

After discussions between the Medical Intensive Care Unit team and the patient's family, however, the decision was made to not pursue further invasive procedures given that the patient had been made do not resuscitate/do not intubate following the resuscitation mentioned above, and his family no longer wished for aggressive resuscitating measures.

By 10/13/2017, he was off levophed and he was restarted on a beta blocker and ACE inhibitor at low doses. By hospital day four, the patient began to develop evidence of CHF given his fluid resuscitation, and diuresis with furosemide was begun.

By the time of his transfer to the Internal Medicine Service on 10/16/2017, the patient was still significantly volume overloaded, so he was continued on diuresis given that he was having signs and symptoms of right-sided failure. He continued to improve, and his oxygen saturation was greater than 95% on 2 liters nasal cannula.

INFECTIOUS DISEASE:

The patient was started on gentamicin and pip/tazo in addition to the levofloxacin, metronidazole, and vancomycin he was already taking for right lower extremity cellulitis prior to admission for empiric coverage of a presumed gram-negative urosepsis.

On 10/13/2017, his levofloxacin and metronidazole was discontinued, and he was started on fluconazole given the growth of yeast on urine culture. He was taken off of gentamicin on hospital day three, and his fluconazole was discontinued on hospital day five (as per the Infectious Disease Service). He was taken off of vancomycin on 10/15/2017, and his pip/tazo was discontinued on 10/16/2017.

Despite the presumption of a gram-negative urosepsis, the patient did not have any positive blood or urine cultures aside from the growth of yeast in two urine cultures noted above. He remained afebrile both before and after discontinuation of his antibiotics, and he was found to be negative for C. difficile on 10/15/2017.

RENAL:

At admission, the patient had prerenal azotemia that resolved following fluid resuscitation. By the time of discharge, his serum creatinine was back to his preadmission baseline.

VASCULAR:

The patient's operative incisions and foot ulcers continued to heal throughout this admission. He was started on an multivitamin, vitamin C, and zinc for improved wound healing.

CONDITION AT DISCHARGE: Stable.

DISCHARGE STATUS: Home.

DISCHARGE DIAGNOSES:

1. Cardiorespiratory arrest.
2. Myocardial infarction.
3. Acute renal failure.

-
4. Coronary artery disease with diffuse 3-vessel disease; right-dominant system, status post proximal LAD stent in 2016 with occlusion of the distal LAD and status post RCA stent on 01/08/2017.
 5. Congestive heart failure (with an ejection fraction of 30%).
 6. Type 2 diabetes mellitus.
 7. Essential hypertension.
 8. Diverticulosis with prior episodes of diverticulitis.
 9. Alzheimer's disease.
 10. History of gastrointestinal bleed (while the patient was taking eptifibatide).
 11. Hypercholesterolemia.
 12. Severe peripheral vascular disease; status post left fem-pop bypass graft on 10/01/2017.
 13. Depression.
 14. Nonhealing foot ulcers.
 15. Right pedal cellulitis.

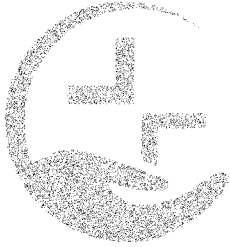
DISCHARGE MEDICATIONS:

1. Metoprolol 50 mg p.o. b.i.d.
2. Captopril 6.25 mg p.o. t.i.d.
3. Aspirin 325 mg p.o. q.d.
4. Protonix 40 mg p.o. q.d.
5. Heparin 5000 units subcutaneously b.i.d.
6. Multivitamin one tablet p.o. q.d.
7. Zinc sulfate 220 mg p.o. q.d.
8. Vitamin C 500 mg p.o. q.d.
9. Ipratropium nebulizers q.4-6h. as needed (for wheezing).
10. Acetaminophen 325 mg to 650 mg p.o. q.4-6h. as needed (for pain).
11. Regular insulin sliding-scale.

CODE STATUS: Do not resuscitate/do not intubate.

Transcribed/Edited by: ML

Copies: Dr. Arnold Chang, Dr. Jim Owens



City Hospital

1717 St. James Avenue
La Jolla, CA 92037

Operative Report

Patient Name: Shui Chan
Account #: 1018291
MRN: 11110001
DOB: 1966-08-01 04:10:48

Procedure Date: 2022-02-06 10:51:13
Adding MD: Stanislova Cadwallader
Document ID: 1000067

PROCEDURE:

Elective male sterilization via bilateral vasectomy.

PREOPERATIVE DIAGNOSIS:

Fertile male who does not wish to have any more children.

POSTOPERATIVE DIAGNOSIS:

Fertile male with completed family.

MEDICATIONS:

Anesthesia is local with conscious sedation.

COMPLICATIONS:

None.

ESTIMATED BLOOD LOSS:

Minimal.

INDICATIONS:

This 55-year-old gentleman has come to the office requesting sterilization via bilateral vasectomy. I discussed the indications and the need for procedure with the patient in detail, and he has given consent to proceed. He has been given prophylactic antibiotics.

PROCEDURE NOTE:

Once satisfactory sedation have been obtained, the patient was placed in the supine position on the operating table. Genitalia was shaved and then prepped with Betadine scrub and paint solution and were draped sterilely. The procedure itself was started by grasping the right vas deferens in the scrotum, and bringing it up to the level of the skin. The skin was infiltrated with 2% Xylocaine and punctured with a sharp hemostat to identify the vas beneath. The vas was brought out of the incision carefully. A 2-inch segment was isolated, and 1-inch segment was removed. The free ends were cauterized and were tied with 2-0 silk sutures in such a fashion that the ends double back on themselves. After securing hemostasis with a cautery, the ends were allowed to drop back into the incision, which was also cauterized.

Attention was now turned to the left side. The vas was grasped and brought up to the level of the skin. The skin was infiltrated with 2% Xylocaine and punctured with a sharp hemostat to identify the vas beneath. The vas was brought out of the incision carefully. A 2-inch segment was isolated, and 1-inch segment was removed. The free ends were cauterized and tied with 2-0 silk sutures in such a fashion that

the ends double back on themselves. After securing hemostasis with the cautery, the ends were allowed to drop back into the incision, which was also cauterized.

Bacitracin ointment was applied as well as dry sterile dressing. The patient was awakened and was returned to Recovery in satisfactory condition.

Pacific Endoscopy Associates Ltd

301-32 West 96th Street, Portland, OR 97220

Patient: Shui Chan

Date of Birth: 1966-08-01 04:10:48

Medical Record Number: 11110001

Gender: male

Age: 55

Procedure Date: 2022-03-04 12:25:31

Attending MD: Cerys Lengyel

Document ID: 1000078

Sigmoidoscopy

PROCEDURE:

Sigmoidoscopy.

INDICATIONS:

Performed for evaluation of anemia, gastrointestinal Bleeding.

MEDICATIONS:

Fentanyl (Sublazine) 0.1 mg IV Versed (midazolam) 1 mg IV

PROCEDURE:

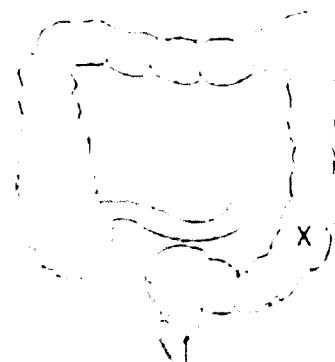
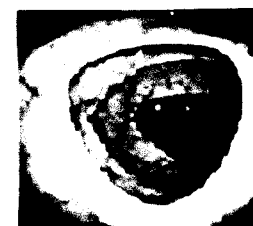
A history and physical examination were performed. The procedure, indications, potential complications (bleeding, perforation, infection, adverse medication reaction), and alternative available were explained to the patient who appeared to understand and indicated this. Opportunity for questions was provided and informed consent obtained. After placing the patient in the left lateral decubitus position, the sigmoidoscope was inserted into the rectum and under direct visualization advanced to 25 cm. Careful inspection was made as the sigmoidoscope was withdrawn. The quality of the prep was good. The procedure was stopped due to patient discomfort. The patient otherwise tolerated the procedure well. There were no complications.

FINDINGS:

I was unable to pass the scope beyond 25 cm because of stricture vs very short bends secondary to multiple previous surgeries. Retroflexed examination of the rectum revealed small hemorrhoids. External hemorrhoids were found. Other than the findings noted above, the visualized colonic segments were normal.

IMPRESSION:

Internal hemorrhoids. External hemorrhoids. Unable to pass scope beyond 25 cm due either to stricture or very sharp bend secondary to multiple surgeries. Unsuccessful Sigmoidoscopy. Otherwise Normal Sigmoidoscopy to 25 cm.



CITY HOSPITAL CLINIC

2600 Laurier Avenue
Waltham, MA 02451
Telephone: 617-555-1212

Patient ID: 11110001**Name:** Shui Chan**DOB:** 1966-08-01**Gender:** male**Attending Physician:** Dr. Rajendra Nagarkar**Document ID:** 1000089**Document Date:** 2022-02-02

SOAP Note

SUBJECTIVE:

This 55-year-old male presents with a complaint of chronic seasonal allergies. He used to have allergies when he lived in Cleveland but he thinks they are worse here. He has a history of using Allegra and Zyrtec. Both worked for a short time but then seemed to stop working. He has used over-the-counter nasal spray like Otrivin but no prescription nasal sprays. He does have asthma but does not require daily medication for this and does not think it is an asthma exacerbation.

MEDICATIONS:

His only medication is hydrochlorothiazide for mild hypertension.

ALLERGIES:

He has no known allergies.

OBJECTIVE:

Vitals: Weight is 178 pounds and blood pressure was 138/82.

HEENT: His throat was mildly erythematous without exudate. Nasal mucosa was obviously erythematous and swollen. No mucous was seen. Tympanic membranes were clear.

Neck: Neck exam was normal without adenopathy.

Lungs: Clear to auscultation bilaterally.

ASSESSMENT:

It is clear that this gentleman has chronic allergic rhinitis.

PLAN:

1. He will try Allegra again. We can also try loratadine if the Allegra doesn't seem to work.
2. I will write him a prescription for Nasonex two sprays in each nostril b.i.d. for three weeks.
3. Return to office for follow-up in 4 weeks.

City Hospital**ULTRASOUND DEPARTMENT**

1598 Norwood Street
Bethlehem, PA 18015

Tel: 866-555-1212
Fax: 866-555-1213

Accession #: 1000100	MRN: 11110001 Gender: male Procedure date: 2022-06-05 DOB: 1966-08-01	Unit #: n/a Admission ID: 110001111
Shui Chan 333 Anytown Street Anystate, USA 55511		Dictating Physician: Rajni Ahmad Ordering Physician: Jean-Claude Barzetti
REASON FOR EXAM: Scrotal pain. Rule out testicular torsion. TECHNIQUE: Ultrasound examination of the scrotum. COMPARISON: None. FINDINGS: Duplex and color flow imaging as well as real time gray-scale imaging of the scrotum and testes was performed. The left testis measures 5.1 x 2.8 x 3.0 cm. There was no evidence of a testicular mass. There was normal blood flow. The left epididymis was normal. There is a trace left hydrocele. The right testis measures 5.3 x 2.4 x 3.2 cm. The epididymis was normal. There was a trace right hydrocele. No testicular mass or evidence of torsion is identified. There was no significant scrotal skin thickening. IMPRESSION: Non-specific trace bilateral hydroceles. Otherwise normal study.		

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misdirected, please destroy.



City Hospital

3200 Hospital Drive, Lodi, CA 95240

MRN: 11110001

Patient Name: Shui Chan

Date of Birth: 1966-08-01 04:10:48

Gender: male

Referred by: Dr. Cathaoir MacGriogair

Study Date: 2022-05-02 10:43:00

Accession #: 1000111

MRI RIGHT WRIST

INDICATION: This is a 55-year-old male with pain and swelling, status post injury.

FINDINGS:

There are posttraumatic cysts along the volar midline and volar lateral aspects of the lunate which are likely posttraumatic. There is no acute marrow edema (series 12 images 7). Marrow signal is otherwise normal in the distal radius and ulna, throughout the carpals and throughout the proximal metacarpals.

There is a partial tear of the volar component of the scapholunate ligament in the region of the posttraumatic lunate cyst with retraction and thickening towards the scaphoid (series 6 image 5, series 8 images 22). There is tearing of the membranous portion of the ligament. The dorsal component is intact.

The lunatotriquetral ligament is thickened and lax, but intact (series 8 image 32).

There is no tearing of the radial or ulnar attachment of the triangular fibrocartilage (series #6 image #7). There is a mildly positive ulnar variance. Normal ulnar collateral ligament.

The patient was positioned in dorsiflexion. Carpal alignment is normal and there are no tears of the dorsal or ventral intercarpal ligaments (series 14 image 9).

There is a longitudinal split tear of the ECU tendon which is enlarged both at the level of and distal to the ulnar styloid with severe synovitis (series 4 images 16, series 3 images 16).

There is thickening of the extensor tendon sheaths within the fourth dorsal compartment with intrinsically normal tendons (series 4 image 12).

There is extensor carpi radialis longus and brevis synovitis in the second dorsal compartment (series 4 image 13).

Normal flexor tendons within the carpal tunnel. There is mild thickening of the tendon sheaths and the median nerve demonstrates increased signal without compression or enlargement (series 3 image 7, and series 4 image 7).

There are no pathological cysts or soft tissue masses.

IMPRESSION:

1. Partial tear of the volar and membranous components of the scapholunate ligament with an associated posttraumatic cyst in the lunate. There is thickening and laxity of the lunatotriquetral ligament.
2. Longitudinal split tear of the ECU tendon with tendinosis and severe synovitis.
3. Synovitis of the second dorsal compartment and tendon sheath thickening in the fourth dorsal compartment.
4. Tendon sheath thickening within the carpal tunnel with increased signal within the median nerve.

Dr. Obi Okonkwo
Consultant Radiologist

Note: This is a digitally verified report and does not require manual signature

CITY HOSPITAL CLINIC

2600 Laurier Avenue
Waltham, MA 02451
Telephone: 617-555-1212

Patient ID: 11110001**Name:** Shui Chan**DOB:** 1966-08-01**Gender:** male**Attending Physician:** Dr. Rin He**Document ID:** 1000127**Document Date:** 2022-07-05

SOAP Note

SUBJECTIVE:

The patient has NG tube in place for decompression. He says he is feeling a bit better.

OBJECTIVE:

VITAL SIGNS: He is afebrile. Pulse is 58 and blood pressure is 110/56.

SKIN: There is good skin turgor.

GENERAL: He is not in acute distress.

CHEST: Clear to auscultation. There is good air movement bilaterally.

CARDIOVASCULAR: First and second sounds are heard. No murmurs appreciated.

ABDOMEN: Less distended. Bowel sounds are absent.

EXTREMITIES: He has 3+ pedal swelling.

NEUROLOGICAL: The patient is alert and oriented x3. Examination is nonfocal.

LABORATORY DATA:

White count is down from 20,000 to 12.5, hemoglobin is 12, hematocrit 37, and platelets 199,000. Glucose is 157, BUN 14, creatinine 0.6, sodium is 131, potassium is 4.0, and CO2 is 31.

ASSESSMENT AND PLAN:

1. Small bowel obstruction/paralytic ileus, rule out obstipation. Continue with less aggressive decompression. Follow surgeon's recommendation.
2. Pulmonary fibrosis, status post biopsy. Manage as per pulmonologist.
3. Leukocytosis, improving. Continue current antibiotics.
4. Bilateral pedal swelling. Ultrasound of the lower extremity negative for DVT.
5. Hyponatremia, improving.
6. DVT prophylaxis.
7. GI prophylaxis.