Perfecting the Oral Presentation

Sample Case #4

CC: The patient is a 4 day old with fever

HPI: This is a 4 day old previously well female was in a state of good health until this morning when mom felt that she was warm. She took an axillary temperature of 102.2. She gave her Tylenol but the fever did not abate. She called her primary pediatrician who recommended that she bring the child in to be admitted. Sick contacts include a 4 year old cousin with a cold. Mom denies the baby has had runny nose, cough, vomiting, or diarrhea. No history of asthma or eczema in the baby.

PMH: No hospitalizations, no surgeries, no injuries.

Medicines: Tylenol

Allergies: NKDA

Birth history: Mom is a 24 yo G1P1, rubella immune, HepB negative, GBS positive, HIV negative NSVD. Mom denies history of herpes. Mom had a fever of 102 and rupture of membranes was about 20 hours prior to delivery. Mom received 2 doses of ampicillin prior to delivery. Mom B+. Mom and baby went home together after 2 days.

Immunizations: HepB #1

Family history: Maternal grandfather had hypertension and an MI at age 60. No diabetes, heart disease, asthma, mental illness, cancer in the family

Social history: Lives with his mother in Greensboro. No siblings. No one smokes at home. City water. Does not yet attend daycare.

Diet history: Exclusively breastfeeding for 20-30 minutes every 2-3 hours and is having 4-6 wet diapers and stools each day (down from 6-8 wet diapers before she became febrile)

Development: Turns to sounds, startles, good suck reflex

Primary Care Provider: Bright Futures Pediatrics, Dr. Jones.

ROS:

Skin: No rashes, no hives

Head: No head injury

Eyes: No conjunctivitis

Nose: No nose bleeds, no snoring

Mouth and Throat: No difficulty swallowing

Chest: No wheezing, no cough, no difficulty breathing

Heart: No palpitations, no sweating
Gastrointestinal: No bloody stools
Genitourinary: No voiding difficulties
Neuromuscular: no convulsion, no weakness, no spasticity

Physical Exam:

Vitals: T 102.4, HR 155, BP 80/64, RR 40, Pox 99% on RA, Wt 7#5oz, length 20.5 cm, HC 13.5 cm
General: Initially sleeping in mom's arms. During exam, cried intermittently, no distress
HEENT: NC/AT, AFOF, posterior fontanelle open, pupils equal & reactive, red reflex present, conjunctiva clear, nares clear. oropharynx clear without lesions, palate intact, MM dry, normal cry
Neck: Supple, no lymphadenopathy. Clavicles intact
Chest: CTA bilaterally
Heart: RRR no murmurs. Cap refill <2 sec. Femoral pulses 2+ bilaterally.
Abdomen: Soft, nontender, nondistended, active bowel sounds, no hepatosplenomegaly. Small umbilical hernia. Umbilical stump without erythema or discharge.
Genitalia: Tanner 1 female, small amount vaginal discharge
Extremities: No cyanosis. Hips no clicks or clunks
Skin: No rashes, no sacral dimple, skin dry
Neurological: active, nl moro, suck, and root reflexes, DTRs are 2+ throughout, moves all extremities

Labs:

CBC: wbc11.8, Hb 15.1, platelets 343, 65% neutrophils, 4% bands, 20% lymphocytes
Chem7: Na 136, K 3.8, Cl 102, Bicarb 20, BUN 34, Cr 0.8, Glucose 108
CSF: 1 wbc, 1 rbc, glucose 44, protein 38, gram stain negative
U/A (obtained by catheterization): nl glucose, nl bilirubin, nl urobilinogen, SG 1.035, pH 6, nl reducing substance, nl leukocyte esterase, nl nitrites
Blood, Urine, CSF cultures pending