Markenzie Jean-baptiste
H & P
Pediatric Rotation
09/29/2020

Identifying Data:
Full Name: SD
Address: Queens, NY
Age: 16 year old
Date & Time: Sep 25, 2020 @ 4:45pm
Location: Queens Hospital Center
Religion: None
Reliability: reliable- accompanied by mother
Source of Information: self
Source of Referral: none
Mode of Transport: Ambulatory

Chief Complaint: "I been feeling feverish x 1 day"

History of Present Illness:
16 y/o F, with no significant past medical history, accompanied by her mother, presents to the pediatric emergency room with subjective fever, myalgias, dry cough, vomiting, diarrhea and decreased appetite x 2 days. PT states symptoms began while she was home in which she began to feel warm, felt aches in her mid-back and developed a dry cough. PT states cough is associated with mild SOB described as feeling winded and worsened with deep inspiration. PT states that she had an episode of vomiting yesterday and one episode this morning upon awakening after eating. Reports having diarrhea which consisted of 2-3 watery stools in the past day. PT states that her boyfriend tested positive for covid-19 last week and pt had contact with him 2 weeks ago. PT's states that her boyfriend's grandmother also recently tested positive for covid. PT's states that her mother has also had uri symptoms. PT and her mother got tested for covid -19 at an urgent care yesterday and the results are pending as per mother. PT has been taking thera-flu which she reports minimal improvement of symptoms. Denies recent travel, chest pain, SOB, sore throat, ear pain, abdominal pain, rash, headache, dizziness, syncope.

Differential based off Chief Complaint:

1. Covid-19
2. Influenza
3. Pneumonia
4. Gastroenteritis
5. Upper respiratory infection

Mouth and throat: DENIES bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes, dentures

Neck: DENIES localized swelling/lumps, stiffness/decreased range of motion

Pulmonary: **(+) cough, SOB(mild)**
DENIES chest tightness, hemoptysis, cyanosis, orthopnea,

Cardiovascular: DENIES Chest pain, HTN, palpitations, irregular heartbeat, edema/swelling of ankles or feet, syncope, known heart murmur

Gastrointestinal: **(+) vomiting, decreased appetite, nausea and vomiting, diarrhea,**
DENIES dysphagia, abdominal pain, jaundice, hemorrhoids, constipation.

Nervous System: DENIES seizures, dizziness, loss consciousness, sensory disturbances (numbness, paresthesia, dysesthesias, hyperesthesia), ataxia, loss of strength, change in cognition/mental status/memory, weakness (asymmetric)

Physical

Vital Signs:
Blood Pressure: 99/67
Heart Rate: 86
Respiration Rate: 18
Temperature: 98.7 F
O_2 Sat: 98%
Height: 54 inches
Weight: 113 lbs(51.3 kg)
BMI: 19.4

General: 9 y/o male, A/O x 3, appears well-developed and well-nourished. No distress.

Skin: Skin is warm and moist. Capillary refill takes less than 2 seconds. No petechiae and no rash noted. He is not diaphoretic. No jaundice.

Head: normocephalic, atraumatic, nontender to palpation throughout, no signs of alopecia, seborrhea, or lice.

Eyes: symmetrical OU, no evidence of strabismus or ptosis noted. Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.

Ears: Symmetrical and normal size. No evidence of lesions/ masses/ trauma on external ears. No discharge, foreign bodies in external auditory canals AU. TM's are pearly white/ intact with light reflex at AS/AD (AU).

Nose: **(+)Clear nasal discharge noted on anterior rhinoscopy.** Symmetrical no obvious masses/ lesions/deformities/ trauma. Nares patent bilaterally. Septum midline without lesions/ deformities. No evidence of foreign bodies.

Sinuses: nontender to palpation and percussion over bilateral frontal, ethanoic and maxillary sinuses.

Mouth and Pharynx: Mucous membranes are moist. No tonsillar exudate. Oropharynx is clear. Pharynx is normal.

Neck: Trachea midline. No masses, lesions, scars, pulsation noted. Supple, nontender to palpation. FROM no stridor noted. Thyroid non-tender, no palpable masses, no thyromegaly. No thyroid bruits noted. No rigidity.

Pulmonary/Chest: **(+) wheezes**. Symmetrical, no deformities, no signs of trauma. Respiration unlabored/ no parodoxic respiration or use of accessory muscles noted. Lat AP diameter 2:1. Non-tender to palpation.

Cardiovascular: Regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4, splitting of heart sounds, friction rubs or other extra sounds.

Abdomen: Soft. Bowel sounds are normal. He exhibits no distension. There is no tenderness.

Musculoskeletal: Normal range of motion.

Neurological: He is alert.

Tests/procedures:

Chest X-ray: negative for acute cardiopulmonary disease.
EKG: NSR @ 72 bpm

Adjusted Differential Diagnosis

1. Covid-19
2. Influenza

3. Pneumonia
4. Gastroenteritis
5. Upper respiratory infection

Assessment

16 y/o F, with no significant past medical history c/o subjective fever, myalgias, dry cough, vomiting, diarrhea and decreased appetite x 2 days. PT states that her boyfriend and his grandmother tested positive for covid-19 last week and pt had contact with him 2 weeks ago. Chest x-ray was negative for acute cardiopulmonary disease. EKG showed NSR @ 72 bpm. History, physical and findings suggest viral syndrome likely covid-19.

Plan:

Administer single dose and prescrfibe Zofran 4 mg for nausea

Run Covid Test.

Recommend supportive care. Take acetaminophen to reduce fever/pain. Rest and drink plenty fluids.

PT advised to stay at home and quarantine for at least 14 days. Advised to use masks and not share items such as dishes, towels, and bedding. Practice disinfection of frequently touched surfaces.

Please go to ER if develop worsening symptoms including but not limited to fever, cough, chest pain, SOB.