

MIL-*, DORIS F**

SSN: 000-01-1406

DOB: 4/26/1933

MRN: E002035313

Date Registered: 8/13/2013

Treating Physician: THOMPSON, J SPENCER

Requesting Physician: MANNEL, ROBERT

Primary ICD9: 182.0 - Malignant Neoplasm - Carcinoma
Endometrium - Myometrium

Secondary ICD9:

Initial Nurse Assessment - 8/13/2013**Vital Signs/Comfort**

TEMPERATURE FAHRENHEIT : 97.1

PULSE SITTING : 65

RESPIRATIONS : 20

OXYGEN SATURATION : The patient's O2 sat today is 95 %.

SYSTOLIC BP SITTING : 108

DIASTOLIC BP SITTING : 53

HEIGHT, INCHES : 60

HEIGHT, FEET & INCHES : 5 Ft 0 Inches.

WEIGHT, POUNDS : 126.5

BODY MASS INDEX : The body mass index today measures at 24.7 .

PAIN WITHOUT MEDICATION : The patient reports no pain without the use of pain medication.

PAIN INTERVENTION : No pain intervention at this time.

Problem

The patient has not received chemotherapy.

Rx/Allergies

MEDICATION RECONCILIATION : Medication reconciliation was performed.

ALLERGIES : No Known Drug Allergies.

MEDICATIONS :

OUTSIDE MEDICATIONS : tramadol (tramadol) tablet 50 mg : 1 tablet by mouth as directed as needed for pain

Synthroid (levothyroxine) tablet 100 mcg : 1 tablet by mouth once a day

multivitamin (multivitamin) tablet : 1 tablet by mouth once a day

Senokot-S (sennosides-docusate sodium) tablet 8.6-50 mg : 1 tablet by mouth twice a day

Norco (hydrocodone-acetaminophen) tablet 5-325 mg : 1-2 tablet by mouth every six hours as needed for pain

Lyrica (pregabalin) capsule 50 mg : 2 capsule by mouth three times a day

Zocor (simvastatin) tablet 20 mg : 1 tablet by mouth at bedtime

Aggrenox (dipyridamole-aspirin) capsule, ER multiphase 12 hr 200-25 mg : 1 capsule by mouth twice a day

Calcium Citrate + D (calcium citrate-vitamin d3) tablet 315-200 mg-unit : 3 tablet by mouth once a day

acetaminophen-codeine (acetaminophen-codeine) tablet 300-15 mg : 1 tablet by mouth every six hours as needed for pain

Tenex (guanfacine) tablet 2 mg : 1 tablet by mouth at bedtime

Past Medical History

PAST CANCER HISTORY : The patient has had no previous malignancies.

SURGERIES : The patient has had the following surgeries in the past: D&C, Hysterectomy and Knee Replacement, Right.

ILLNESS LISTING : These are: Arthritis, Hemorrhoids, Hypertension, Stroke and Thyroid Disease.

PAST CHEMOTHERAPY : The patient has had no previous chemotherapy in the past for any condition.

CHEMOTHERAPY :

PAST RADIATION THERAPY : The patient has had no previous radiation therapy in any form for any condition.

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HORMONAL THERAPY : No prior hormone therapy is reported.

PAST HORMONE HISTORY : The patient gives a history of having received the following hormones in the past: None Taken.

PRIOR BLOOD TRANSFUSION : No prior blood transfusion is reported.

Social History

TOBACCO USE HISTORY : cigarettes, 1 pack daily

AGE OF FIRST USE OF TOBACCO PRODUCTS : The patient started utilizing tobacco products at the age of 18.

QUIT USE OF TOBACCO : Patient has recently quit utilizing tobacco in any form.

SMOKING STATUS : smoked at least 100 cigarettes during his/her lifetime but does not currently smoke

USE OF ALCOHOL PRODUCTS : The patient does not utilize alcohol in any significant amount.

USE OF CONTROLLED SUBSTANCES : The patient denies ever using controlled substances.

EDUCATION : The patient did not graduate from high school.

JOB STATUS : The patient is retired.

PRIMARY WORK HISTORY : The patient's primary occupation is listed as: Waitress.

MILITARY SERVICE : The patient has never served in the military.

EXERCISE HISTORY : The patient admits to limited exercise at this time.

OCCUPATIONAL HAZARDOUS EXPOSURE : No reports of exposure to hazardous materials at work.

MARITAL STATUS : The patient is widowed.

LIVING ARRANGEMENTS : The patient lives alone.

CURRENT RESIDENCE : The patient lives at home.

CONTROLLED SUBSTANCES USED : None Reported.

LEARNING BARRIERS : There are no learning barriers.

LEARNING PREFERENCE : The patient prefers learning by a combination of written and verbal instruction.

Review of Systems

RACE : The patient's race is white.

GENDER : Female

AGE : 80 years

KARNOFSKY PERFORMANCE SCALE : 90% - Can perform normal activities, minor signs of disease.

HISTORY OF FALLING : The patient has not fallen during the present evaluation period and has no recent history of physiological falls.

MEDICAL DIAGNOSIS : The patient has multiple medical diagnoses listed for this encounter.

AMBULATORY AIDES : Walks without a walking aide, but requires assistance by caregiver.

INTRAVENOUS THERAPY : The patient does not have an active intravenous access.

GAIT : The patient walks without losing balance but steps may be short and shuffling.

MENTAL STATUS : Using a combination of the patient's self-assessment with interpretation by the nursing staff, the patient's mental status is rated at normal.

TOTAL MORSE FALL RISK ASSESSMENT : The total Morse Fall Risk Assessment for this patient is 35. The Morse fall scale is a method of assessing a patient's likelihood of falling utilizing these six variables. The Morse fall scale has been shown to have predictive validity and interrater reliability. A score of 24 or less indicates minimal to no risk of fall. A score of 25 to 50 indicates a low risk of fall and requires implementation of fall prevention interventions. A score of greater than 50 indicates a high risk of fall and requires close supervision and fall prevention interventions.

Advance Directives

HEALTHCARE PROXY : It is unknown if the patient has appointed a healthcare proxy.

LIVING WILL : It is unknown if the patient has a Living Will.

ADVISED OF LIVING WILL INFORMATION : Advising the patient about the availability of information regarding Living Wills was not applicable in this situation.

ADVISED OF HEALTHCARE PROXY INFORMATION : Advising the patient about Healthcare Proxy information was not applicable in this situation.

ADVISED RIGHT TO RESUSCITATION DECISION : Advising the patient about information regarding the right to have a resuscitation decision was not applicable in this situation.

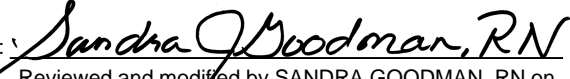
Comments

NURSING COMMENTS : 08-13-13: Consult visit for radiation therapy to pelvis following hysterectomy with BSO.

Education materials and instruction provided to patient and family. Questions answered as they arose. Dr. Sabater and Dr. Thompson met with patient. sjg.

Signature : 
Electronically signed by SANDRA GOODMAN, RN on 8/15/2013 at 11:19 AM

Save History

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Reviewed and modified by SANDRA GOODMAN, RN on
8/15/2013 at 11:19 AM