HPI:
Pt is a 32 y/o F presenting with one day history of nausea and significant abdominal pain. Patient reports that the previous night, patient was out at a party with husband and reported drinking roughly 3 servings of alcohol. History obtained from husband as patient is unable to continue further discussion. Husband reports fatigue of the patient, decreased appetite, and increased thirst. The husband is confident the patient did not take her home regimen of insulin in addition to recently being poorly compliant. Husband denies patient used any illicit drugs while at party. Patient reporting excessive dry mouth. Husband denies any recent illness with patient including complaints of fevers, chills, cough, dysuria, hematuria, nasal congestion, chest pain, or SOB.

Past Medical History:
IDDM

Past Surgical History:
Denies

Social History:
Alcohol - social drinker
Tobacco - denies
Illicit drugs - denies

Family History:
Husband reports family of diabetes

Medications:
-insulin aspart - 10 units SC THREE TIMES A DAY BEFORE MEALS
-insulin detemir - 25 units SC EVERY DAY

Review of Systems:
General: no chills, no fever, **+change in appetite**
Eyes: denies blurry vision, no eye pain, no eye discharge
Ears, Nose, Mouth, Throat: denies any of the following: nasal congestion, rhinitis, epistaxis, tinnitus, ear ache, hearing loss, dysphagia
Cardiovascular: no chest pain, no palpitations
Respiratory: no cough, no wheezing, no sputum production, no snoring, no dyspnea
Gastrointestinal: **+abdominal pain**, **+nausea**, **+vomiting**, denies diarrhea/constipation/hematochezia/hematemesis
Genitourinary: **+dysuria, +frequency,** no urgency or hematuria
Musculoskeletal: denies myalgia/arthralgia/joint swelling/fractures/rib pain, **+back pain**
Skin: no rash/acne/abnormal bumps/jaundice
Neurological: denies headaches/dizziness/seizures/difficulty with balance
Psychiatric: no change in mood/depression/insomnia/anxiety
Endocrine: **+excessive thirst**

Physical Exam:
General: uncomfortable, lying in bed
HEENT: atraumatic, normocephalic, dry mucous membranes, dry tongue
CV: tachycardic, no murmurs appreciated, no peripheral edema
Respiratory: tachypneic, no wheezing or crackles appreciated, not labored
Abd: mild epigastric tenderness, no rebound tenderness, no guarding, non-distended
MSK: moving all extremities to command
Neuro: alert, oriented, non-focal, only able to nod to questions as oral airway extremely dry
Psych: cooperative

Labs:

pH = 6.93 pCO2 = 24 pO2 = 31 HCO3 = 5 SVO2 = 47
Na = 132K = 4.7 Cl = 98 HCO3 = 5 Ca = 8.7
Mg = 2.3 Phos = 4.6 BUN = 15 SCr = 0.93 Glucose = 472
HgA1c = 12.4
Lactate = 1.1 Albumin = 3 Beta hydroxybutyrate = > 10
APAP < 20 Salicylate < 2 Alcohol < 10 mg/dL HCG-Serum = (-)
WBC = 21.6 Hgb = 14.2 Hct = 43.7 Plt = 407
INR = 1.2
UA: straw color, hazy clarity, SG = 1.012, pH = 5, protein = 30mg/dL, glucose > 500, ketones = 80mg/dL, (-) nitrites, (-) leukocyte esterase, small blood, rare bacteria
UTox: negative
Blood culture pending; Urine culture pending; MRSA culture pending

Diagnostics:
Chest Radiograph: Negative for acute cardiopulmonary process.

Assessment and Plan: