Plain Text Medical Report (Sample)

Patient Name: Rahul Sharma
Age: 42 years
Hospital: Fortis Health, Delhi
Date of Admission: 10 October 2025
Date of Discharge: 14 October 2025

Chief Complaint:
The patient presented with persistent chest discomfort for two days, shortness of breath, and fatigue on minimal activity.

Diagnosis:

1. Acute Unstable Angina.
2. Hypertension (Stage 2).
3. Hyperlipidemia with elevated LDL cholesterol.

Investigations:
ECG done on 10 October 2025 showed ST-segment depression in leads V4 to V6, with no ST elevation.
Cardiac enzyme tests showed Troponin-I at 0.08 ng/mL (normal < 0.04) and CK-MB at 20 U/L (normal < 7).
Lipid profile indicated high LDL cholesterol at 168 mg/dL, low HDL at 36 mg/dL, and triglycerides at 210 mg/dL.
The patient’s blood pressure on admission was 150/96 mmHg.

Imaging:
Echocardiogram showed a left ventricular ejection fraction of 55 percent, with no wall-motion abnormalities.

Treatment Given:
The patient was treated with Aspirin 150 mg once daily, Clopidogrel 75 mg once daily, Atorvastatin 40 mg at bedtime, Metoprolol 50 mg twice daily, and intravenous Nitroglycerin infusion for 24 hours.

Discharge Plan:
The patient was advised to continue Aspirin, Clopidogrel, Atorvastatin, and Metoprolol.
He was instructed to avoid heavy physical activity for two weeks.
A low-fat diet was recommended.
A follow-up visit with the cardiology department was scheduled in seven days.