Patient: John Smith

Age: 45

Date of Visit: April 22, 2024

Chief Complaint: Chest pain and shortness of breath.

History of Present Illness: Mr. Smith presents with a sudden onset of chest pain radiating to his left arm, accompanied by shortness of breath. Symptoms began approximately 1 hour ago while he was at rest. He denies any previous episodes. No alleviating or exacerbating factors reported.

Past Medical History: Hypertension, hyperlipidemia, and family history of coronary artery disease.

Medications: Lisinopril and simvastatin.

Allergies: None reported.

Social History: Non-smoker, occasional alcohol use, sedentary lifestyle.

Physical Examination:

- Vital Signs: BP 160/100 mmHg, HR 90 bpm, RR 20 breaths/min, Temp 98.6°F

- General: Appears uncomfortable, diaphoretic

- Cardiovascular: Regular rate and rhythm, no murmurs or gallops, diminished breath sounds in left lower lung field

- Respiratory: Tachypneic, using accessory muscles

Assessment:

1. Acute coronary syndrome

2. Rule out myocardial infarction

Plan:

1. Administer oxygen at 2L/min via nasal cannula

2. Aspirin 325 mg chewed

3. Nitroglycerin sublingual 0.4 mg every 5 minutes x3 doses

4. EKG and cardiac enzymes

5. Morphine sulfate 2 mg IV for pain relief

6. Immediate transfer to cardiac care unit for further management and observation.