Medical Report

Patient Information:

Name: Riley Jones

Age: 27 years

Gender: Male

Date of Birth: January 1, 1979

Date of Examination: March 24, 2024

Chief Complaint:

The patient presents with chest pain, which has been ongoing for the past week.

History of Present Illness:

The patient reports experiencing intermittent chest pain over the past week. The pain is described as a dull ache, localized to the left side of the chest, and occasionally radiating to the left arm. The pain worsens with physical activity and is partially relieved with rest. The patient denies any associated symptoms such as shortness of breath, palpitations, or diaphoresis. He has not taken any medications for the pain.

Past Medical History:

Hypertension, diagnosed 5 years ago, controlled with lisinopril.

Hyperlipidemia, diagnosed 3 years ago, treated with atorvastatin.

No history of diabetes mellitus or coronary artery disease.

No surgical history.

Allergic to penicillin (develops rash).

Family History:

Father had a myocardial infarction at age 50.

Mother has hypertension and diabetes mellitus.

No history of cancer or other hereditary conditions.

Social History:

The patient is employed as an accountant. He is married with two children and lives a sedentary lifestyle. He denies tobacco or illicit drug use. He consumes alcohol occasionally, with an average intake of one drink per week.

Review of Systems:

General: No weight changes or fever.

Respiratory: No cough, dyspnea, or wheezing.

Cardiovascular: Reports chest pain as described above.

Gastrointestinal: Denies abdominal pain, nausea, or vomiting.

Neurological: No headaches, dizziness, weakness, or changes in sensation.

Physical Examination:

Vital Signs: Blood pressure 140/90 mmHg, heart rate 78 bpm, respiratory rate 16 breaths/min, temperature 98.6°F.

General: Patient appears comfortable, in no acute distress.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light. No conjunctival pallor or icterus.

Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops. Radial and pedal pulses intact bilaterally.

Respiratory: Clear breath sounds bilaterally, no wheezes or crackles.

Abdominal: Soft, non-tender, non-distended. No palpable masses or organomegaly.

Neurological: Alert and oriented x3, cranial nerves intact. Strength and sensation normal in all extremities.

Assessment and Plan:

Differential Diagnosis:

Stable angina

Gastroesophageal reflux disease (GERD)

Costochondritis

Further diagnostic tests:

Electrocardiogram (EKG)

Lipid panel

Chest X-ray

Treatment plan:

Nitroglycerin sublingual as needed for chest pain.

Initiate proton pump inhibitor (PPI) for suspected GERD.

Lifestyle modifications including smoking cessation and regular exercise.

Follow-up appointment scheduled in one week for review of diagnostic results and symptom reassessment.

Impression:

The patient presents with chest pain suggestive of cardiac etiology, warranting further evaluation to rule out acute coronary syndrome. Additionally, consideration is given to gastrointestinal and musculoskeletal causes based on the clinical presentation.

Signature:

Dr. Jane Smith, MD

March 24, 2024