Patient ID: 123456

Name: [REDACTED]

Age: 54

Gender: Male

Date of Admission: 2023-03-15

Date of Discharge: 2023-03-20

Attending Physician: Dr. John Smith

Chief Complaint

Chest pain and shortness of breath for 2 hours prior to admission.

History of Present Illness

The patient is a 54-year-old male with a history of hypertension and type 2 diabetes who presented to the ER with complaints of substernal chest pain radiating to the left arm, associated with sweating and nausea. Pain began while walking upstairs.

Past Medical History

- Hypertension (10 years)
- Type 2 Diabetes Mellitus (5 years)
- Hyperlipidemia
- No prior surgeries

Medications on Admission

- Metformin 500mg BID
- Lisinopril 10mg daily
- Atorvastatin 20mg at bedtime

Physical Examination

- BP: 142/86 mmHg
- HR: 98 bpm
- RR: 20
- Temp: 98.7°F
- O2 Sat: 96% on room air
- Lungs: Clear
- Cardiovascular: S1/S2 normal, no murmurs
- Extremities: No edema

Laboratory Results

- Troponin I: 0.45 ng/mL elevated
- ECG: ST-segment elevation in leads II, III, aVF
- CBC, CMP within normal limits

Diagnosis

- ST-Elevation Myocardial Infarction (STEMI)
- Hypertension
- Type 2 Diabetes Mellitus

Hospital Course

The patient was admitted to the cardiac unit. He underwent emergent percutaneous coronary intervention (PCI) with stent placement in the right coronary artery. He was monitored for 48 hours post-PCI without complications. Blood glucose and blood pressure were managed with medications. Patient was started on dual antiplatelet therapy and statin.

Discharge Medications

- Aspirin 81 mg daily
- Clopidogrel 75 mg daily
- Metoprolol 50 mg BID
- Atorvastatin 40 mg at bedtime
- Metformin 500 mg BID
- Lisinopril 10 mg daily

Follow-Up

- Cardiology OPD in 1 week
- Lifestyle modification counseling scheduled