Electronic Health Record (EHR) Note - General Internal Medicine

# Patient Information

Name: Margaret L. Johnson  
Age: 62 years  
Sex: Female  
Patient ID: P198274  
Date of Admission: 2023-05-11  
Date of Documentation: 2023-05-14  
Location: St. Mary’s Medical Center, IN

# Chief Complaint

Chest pain and shortness of breath for the past 2 days.

# History of Present Illness

Mrs. Margaret Johnson, a 62-year-old female with a significant history of hypertension, type 2 diabetes mellitus, and chronic obstructive pulmonary disease (COPD), presented to the emergency department with complaints of central chest pain radiating to the left arm and jaw, accompanied by shortness of breath and dizziness.   
The chest pain began two days ago, initially intermittent but worsening in severity on the morning of presentation. The patient describes the pain as pressure-like, rated 8/10, and associated with diaphoresis and mild nausea.   
No history of syncope, palpitations, or recent trauma. She denies cough, hemoptysis, or recent infectious symptoms. She is compliant with her prescribed medications but reports poorly controlled blood sugar in recent weeks.

# Past Medical History

- Hypertension (diagnosed 15 years ago)  
- Type 2 Diabetes Mellitus (diagnosed 12 years ago, HbA1c ~8.2%)  
- Chronic Obstructive Pulmonary Disease (COPD) - mild  
- Hyperlipidemia

# Past Surgical History

- Cholecystectomy (10 years ago)  
- Hysterectomy (20 years ago)

# Family & Social History

Family History:  
- Mother: Deceased at 78, myocardial infarction  
- Father: Alive, 85, hypertension  
- Sibling: Brother with type 2 diabetes  
  
Social History:  
- Retired school teacher  
- Former smoker (quit 5 years ago, 20 pack-year history)  
- Occasional alcohol consumption, denies illicit drug use  
- Lives with husband, independent in ADLs prior to admission

# Review of Systems

General: Reports fatigue, denies fever or chills  
Cardiovascular: Chest pain, dyspnea, dizziness, diaphoresis  
Respiratory: Shortness of breath on exertion, no cough or wheezing  
Gastrointestinal: Mild nausea, no vomiting or abdominal pain  
Neurological: No syncope, seizures, or focal neurological deficits  
Endocrine: Reports polydipsia, poor glycemic control  
Psychiatric: No depression or anxiety reported

# Physical Examination

General: Obese, alert, oriented ×3, moderate distress due to chest discomfort  
Vital Signs: BP 168/92 mmHg, HR 102 bpm, Temp 98.4°F, RR 22/min, SpO2 94% RA  
HEENT: No JVD, oral mucosa moist  
Cardiovascular: Tachycardia, regular rhythm, S1/S2 normal, no murmurs/rubs/gallops  
Respiratory: Bilateral diminished breath sounds with mild wheezing, no crackles  
Abdomen: Soft, non-tender, normoactive bowel sounds  
Extremities: No edema, peripheral pulses intact  
Neurological: No focal deficits, normal reflexes  
Skin: Warm, diaphoretic

# Laboratory & Imaging Results

Laboratory:  
- CBC: WBC 9.6 K/uL, Hb 12.8 g/dL, Platelets 220 K/uL  
- CMP: Na 137 mEq/L, K 4.1 mEq/L, Cr 1.0 mg/dL, Glucose 210 mg/dL (high)  
- Cardiac Enzymes: Troponin I 0.12 ng/mL (elevated), CK-MB mildly elevated  
- Lipid Panel: TC 245 mg/dL, LDL 160 mg/dL, HDL 38 mg/dL, TG 180 mg/dL  
  
Imaging:  
- Chest X-ray: Mild cardiomegaly, no infiltrates  
- ECG: ST depressions in leads V4-V6, sinus tachycardia  
- Echocardiogram: EF 45%, mild LV hypertrophy

# Assessment

1. Unstable angina with suspected underlying coronary artery disease  
2. Hypertension, uncontrolled  
3. Type 2 Diabetes Mellitus, poorly controlled  
4. COPD, mild  
5. Hyperlipidemia

# Plan

1. Admit to CCU for monitoring  
2. Initiate oxygen supplementation via nasal cannula at 2L/min  
3. Start IV nitroglycerin drip for chest pain management  
4. Initiate dual antiplatelet therapy: Aspirin 325mg PO and Clopidogrel 75mg PO daily  
5. Beta-blocker: Metoprolol 50mg PO BID  
6. Statin therapy: Atorvastatin 80mg PO daily  
7. Glycemic control: Start insulin sliding scale protocol  
8. Cardiology consult for possible coronary angiography  
9. Monitor troponin, repeat ECG in 6 hours  
10. Patient education regarding lifestyle modification and adherence

# Progress Notes

Day 1 (05/11/2023): Patient admitted with ongoing chest pain. Initiated oxygen, IV nitroglycerin, and antiplatelet therapy. Troponin mildly elevated. Placed on cardiac monitoring.   
Day 2 (05/12/2023): Reports improvement in chest pain. No new ECG changes. Blood glucose remains elevated; insulin adjusted. Cardiology team evaluating for angiography.   
Day 3 (05/13/2023): Patient underwent coronary angiography revealing 80% stenosis in LAD. PCI with stent placement performed successfully.   
Day 4 (05/14/2023): Patient stable, no chest pain. Vitals stable. Plan for discharge tomorrow with optimized medical therapy and follow-up.

# Discharge Summary

Primary Diagnosis: Unstable angina secondary to CAD, status post PCI with stent to LAD  
Secondary Diagnoses: Hypertension, Type 2 Diabetes Mellitus, COPD, Hyperlipidemia  
  
Discharge Medications:  
- Aspirin 81mg PO daily  
- Clopidogrel 75mg PO daily  
- Metoprolol 50mg PO BID  
- Atorvastatin 80mg PO daily  
- Metformin 1000mg PO BID  
- Insulin as prescribed  
- Tiotropium inhaler daily  
  
Follow-Up Plan:  
- Cardiology clinic in 1 week  
- Primary care follow-up in 2 weeks  
- Continue cardiac rehab and lifestyle modifications  
- Monitor blood pressure and blood glucose at home