Name: John Doe

Age: 65

Gender: Male

Date of Birth: MM/DD/YYYY

Patient ID: 000123456

Date of Visit: MM/DD/YYYY

Physician: Dr. Jane Smith

Chief Complaint:

Patient presents with palpitations and episodes of lightheadedness over the past few weeks.

History of Present Illness:

65-year-old male with a history of hypertension, reports experiencing irregular heartbeats and intermittent episodes of lightheadedness. Denies chest pain, dyspnea on exertion, or syncope. Symptoms appear to be worsening, prompting visit.

Past Medical History:

Hypertension

Type 2 Diabetes Mellitus

Hyperlipidemia

Physical Examination:

Vital Signs: BP 145/85 mmHg, HR 110 bpm (irregular), Temp 98.6 F, Resp 16/min, O2 Sat 98% on room air

General Appearance: Alert, oriented, in no acute distress

Cardiovascular: Irregular rhythm, no murmurs, rubs, or gallops detected

Respiratory: Clear to auscultation bilaterally

Extremities: No cyanosis, clubbing, or edema

Diagnostic Findings:

Lab Values:

Complete Blood Count (CBC) with Indices:

WBC: 7.2 x10^3/uL

RBC: 4.5 x10^6/uL

Hemoglobin: 14 g/dL

Hematocrit: 42%

MCV: 93 fL

MCH: 31 pg

MCHC: 33 g/dL

Platelets: 250 x10^3/uL

RDW: 12.8%

White Blood Cell Differential:

Neutrophils: 60%

Lymphocytes: 30%

Monocytes: 7%

Eosinophils: 2%

Basophils: 1%

Comprehensive Metabolic Panel (CMP):

Sodium: 140 mmol/L

Potassium: 4.2 mmol/L

Chloride: 100 mmol/L

Bicarbonate: 24 mmol/L

BUN: 18 mg/dL

Creatinine: 1.0 mg/dL

Glucose: 126 mg/dL

Calcium: 9.4 mg/dL

Albumin: 4.0 g/dL

Total Protein: 7.1 g/dL

AST: 20 IU/L

ALT: 25 IU/L

Alkaline Phosphatase: 70 IU/L

Bilirubin, Total: 0.9 mg/dL

Lipid Panel:

Total Cholesterol: 210 mg/dL

HDL: 40 mg/dL

LDL: 130 mg/dL

Triglycerides: 150 mg/dL

Troponin: <0.01 ng/mL

CK-MB: 5 ng/mL

PT (Prothrombin Time): 12.5 seconds

PTT (Partial Thromboplastin Time): 30 seconds

D-Dimer: 250 ng/mL FEU

ECG Findings:

Irregularly irregular rhythm with no P waves, consistent with atrial fibrillation.

Heart rate noted to be approximately 110 bpm.

No significant ST-T changes.

Clinical Notes:

Patient exhibits clinical signs and symptoms consistent with atrial fibrillation. Lab values are within normal limits, excluding the lipid panel which indicates dyslipidemia. ECG confirms atrial fibrillation. The absence of elevated troponin and CK-MB levels suggests no acute myocardial injury. Coagulation studies (PT, PTT) are within normal range, and D-Dimer is slightly elevated, warranting further evaluation for possible thromboembolic events.

Assessment:

Atrial Fibrillation without acute myocardial injury. Further evaluation and management needed.

Plan:

[This section intentionally left blank as per user request not to include therapies, lifestyle changes, medications, or recommendations.]