MEDICAL REPORT

Patient Information:

Mr. [Last Name], a 54-year-old male, was evaluated for chest pain.

Vital Signs and Physical Examination:

- Age: 54 years
- Sex: Male
- Resting Blood Pressure (BP): 140 mm Hg
- Heart Rate (HR): 150 beats per minute

Diagnostic Results:

- Electrocardiogram (ECG): showed ST depression of 1.2mm with a slope of 2, indicative of myocardial ischemia.
- Fluoroscopy examination revealed normal coronary arteries.

Lab Results:

- Fasting Blood Sugar: >120 mg/dl
- Cholesterol: 233 mg/dl

Medical History:

The patient has Thalassemia major, classified at 3 (thalassemia severity scale).

Chief Complaint and History of Present Illness:

Patient presented with chest pain type 3, which was later confirmed as exercise-induced angina.

Differential Diagnosis:

Based on the patient's history, physical examination, and diagnostic results, the primary diagnosis is Heart Disease, specifically Coronary Artery Disease (CAD).

Plan:

The patient will undergo further evaluation and management to address his CAD. This may include lifestyle modifications, medication, and potential cardiac catheterization.

Referral Information:

This report serves as a referral for further care by [Name of Primary Care Physician or Cardiologist].

Admission Information:

The patient is currently not admitted to the hospital, but will be monitored closely at home with follow-up appointments scheduled with his primary care physician.

Sign-off:

I, [Your Name], Medical Assistant, certify that this medical report accurately reflects my findings and opinions based on my review of the patient's chart.