International Cardiac Care Centre

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Patient Health Report

Name	Mr. Pratheep
Age	58 years
Gender	Male
Patient ID	SCCC-2025-0456
Date of Admission	15-Aug-2025
Date of Report	20-Aug-2025

Patient Mr. Pratheep, a 58-year-old male with patient ID SCCC-2025-0456, was admitted on 15-Aug-2025 and this report is issued on 20-Aug-2025. He has a past medical history of hypertension for 10 years and type 2 diabetes mellitus for 5 years, along with a family history of coronary artery disease. The patient presented with shortness of breath on exertion, occasional chest pain (angina), and fatigue.

On physical examination, his blood pressure was recorded at 150/95 mmHg, heart rate at 88 bpm, respiratory rate at 20 breaths per minute, temperature at 98.6°F, and BMI of 27 kg/m^2. Laboratory investigations revealed an ECG showing ST-segment depression in leads II, III, and aVF, and echocardiography indicated a left ventricular ejection fraction (LVEF) of 45% with mild left ventricular hypertrophy. Lipid profile showed total cholesterol of 240 mg/dL, LDL 160 mg/dL, HDL 38 mg/dL, and triglycerides 180 mg/dL. Fasting blood sugar was 130 mg/dL and troponin I was slightly elevated at 0.06 ng/mL.

Based on the clinical presentation and investigation results, the patient is diagnosed with chronic ischemic heart disease, hypertensive heart disease, and dyslipidemia. The current treatment plan includes aspirin 75 mg once daily, atorvastatin 20 mg at night, metoprolol 50 mg twice daily, and ramipril 5 mg once daily. Lifestyle modifications such as a low-salt diet, regular exercise, and smoking cessation have also been advised. The patient is recommended to have regular follow-ups every three months, monitor blood pressure and blood sugar daily, and undergo a cardiac stress test if angina symptoms worsen.

Attending Physician: Dr. Anjali Mehra, Senior Cardiologist