# Patient Report

## Patient Information

- Name: Pamela Rogers

- Date: June 2, 2004

- Referral Source: Emergency Department

- Data Source: Patient

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Chief Complaint

- Complaint: Chest pains

- Details: Ms. Rogers is a 56-year-old white female experiencing chest pains for the last week.

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History of Present Illness

- First Admission: Yes

- Patient Age: 56

- General Health: Usual state of good health until one week prior to admission.

- Initial Onset: Abrupt onset of chest pain in the left para-sternal area, radiating to her neck.

Initial Episode

- Activity: Working in the garden

- Duration of Activity: 45 minutes

- Symptoms:

- Pain: Dull and aching

- Shortness of Breath: Yes

- Sweating: No

- Nausea: No

- Vomiting: No

- Pain Duration: 5 to 10 minutes

- Relief: Resolved with rest in a cool area.

### Subsequent Episodes

1. Occurrence: Three days ago

- Activity: Walking her dog

- Duration: 15 minutes

- Relief: Resolved with rest.

2. Occurrence: This evening

- Trigger: Awakened from sleep

- Duration: 30 minutes

- Action: Prompted visit to Emergency Department.

Associated Symptoms

- Dizziness: No

- Palpitations: No

- Shortness of Breath: Yes

Pain Details

- Exertional Dyspnea: No

- Orthopnea: No

- Paroxysmal Nocturnal Dyspnea: No

- Movement-Related Pain: No

- Food-Related Pain: No

- GERD Symptoms: No

- Palpable Pain: No

### Relevant History

- Heart Problems: Never diagnosed with heart problems.

- Previous Chest Pains: None

- Claudication: None

- Hypertension: Diagnosed 3 years ago; medication unknown.

- Smoking: No

- Diabetes: No

- Hormone Replacement Therapy: No

- Family History:

- Premature Coronary Artery Disease (CAD): Yes

- Cholesterol Level: Unknown

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### Past Medical History

Surgical History

- 1994: Total abdominal hysterectomy and bilateral oophorectomy for uterine fibroids.

- 1998: Bunionectomy

Medical History

- 1998: Hypertension, treated with unknown medication, discontinued after 6 months due to drowsiness.

- 1990: Peptic ulcer disease, resolved after 3 months on cimetidine.

Allergies

- Substance: Penicillin

- Reaction: Rash and hives in 1985.

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### Social History

- Alcohol Use: 1 or 2 beers each weekend; 1 glass of wine once a week with dinner.

- Tobacco Use: None

- Medications:

- Prescription Drugs: None

- Illegal Drugs: None

- Over-the-Counter Drugs: Ibuprofen (Advil), occasional use for headache (every other day).

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Family History

- Mother: 79 years old, alive and well.

- Father: Died at age 54 from a heart attack.

- Siblings: No brothers or sisters.

- Family Medical History:

- Hypertension: Yes

- Diabetes: No

- Cancer: No

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## Review of Systems

HEENT

- Headache: No complaints

- Vision Changes: No complaints

- Nose or Ear Problems: No complaints

- Sore Throat: No complaints

Cardiovascular

- Note: See History of Present Illness

Gastrointestinal

- Dysphagia: No complaints

- Nausea: No complaints

- Vomiting: No complaints

- Stool Changes: No complaints

- Epigastric Pain: Burning in quality, approximately twice a month, primarily at night.

Genitourinary

- Dysuria: No complaints

- Nocturia: No complaints

- Polyuria: No complaints

- Hematuria: No complaints

- Vaginal Bleeding: No complaints

Musculoskeletal

- Lower Back Pain: Aching in quality, approximately once every week after working in her garden. Relieved with Tylenol.

- Arthralgias: No complaints

- Muscle Aches: No complaints

Neurological

- Weakness: No complaints

- Numbness: No complaints

- Incoordination: No complaints

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## General Comments/Notes

- Reason for Visit: Define the reason for the patient's visit as specifically as possible.

- Nature of Problem: Convey the acute or chronic nature of the problem; establish a chronology.

- Symptoms:

- Onset

- Character

- Location

- Radiation

- Circumstances/Exacerbating Factors

- Associated Symptoms

- Duration

- Resolution/Alleviating Factors

- Natural History: Describe the natural history of her problem since its onset; identify any change or new circumstances to the problem.

- Patient Relief Attempts: What has the patient tried for relief?

- Relevant Review of Systems (ROS): Review of systems for the relevant organ system; separate each ROS section for easy identification, and refer to History of Present Illness (HPI) if adequately covered.

- Risk Factors: Relevant risk factors/environmental conditions.

- Medications:

- Generic Names: Always use generic names.

- Reaction Type: Always list the type of reported reaction.

- Quantity

- Over-the-Counter Drugs: Include over-the-counter drugs.

- Disease Presence: Comment specifically on the presence or absence of diseases relevant to the chief complaint.

- Findings: List positive and negative findings in brief, concise phrases or sentences.