CONFIDENTIAL PATIENT MASTER RECORD

PATIENT ID: 216 | MRN: MRN-216-2025

I. REGISTRATION FACE SHEET

PATIENT IDENTITY	
Name:	Siobhan Roy
DOB:	1984-09-15
Gender:	female
Race:	Caucasian
Height:	5 ft 7 in
Weight:	145 lbs
Telecom:	212-555-2003
Address:	180 E 88th St, New York, NY 10128
Marital Status:	Married
Multiple Birth:	No (Order: 1)

COMMUNICATION	
Language:	English
Preferred:	Yes

EMERGENCY CONTACT	
Relationship:	Spouse
Name:	Thomas Wambsgans
Telecom:	212-555-2004
Address:	180 E 88th St, New York, NY 10128
Gender:	male
Organization:	Waystar RoyCo
Period Start:	2018-06-10
Period End:	ongoing

PRIMARY PROVIDER	
General Practitioner:	Dr. Elizabeth Spiros, MD
Managing Organization:	Mount Sinai Hospital

INSURANCE / PAYER	
Payer ID:	J1113
Payer Name:	Aetna
Plan Name:	Waystar RoyCo Executive Health Plan

Plan Type:	PPO
Group ID:	WRC-NY-8820
Group Name:	Waystar RoyCo
Member ID:	WRC908345112
Policy Number:	AET-PPO-345112
Effective Date:	2015-01-01
Termination Date:	ongoing
Copay:	$20
Deductible:	$500
SUBSCRIBER	
Subscriber ID:	WRC908345112
Subscriber Name:	Siobhan Roy
Relationship:	Self
Subscriber DOB:	1984-09-15
Subscriber Address:	180 E 88th St, New York, NY 10128

II. MEDICAL BIOGRAPHY & HISTORY

Siobhan 'Shiv' Roy is a 39-year-old highly intelligent and ambitious woman living in New York City. She holds a powerful position within her family's global media conglomerate, Waystar RoyCo, a role that entails immense pressure and long hours. Her life is characterized by high-stakes business negotiations and complex family dynamics, contributing to significant chronic stress and anxiety, for which she is medically managed.

Clinically, Ms. Roy has a history of well-controlled essential hypertension and GERD, both common in high-stress individuals. She recently began experiencing intermittent, atypical chest pain, which has become a source of considerable health anxiety. The pain's character is inconsistent with typical cardiac angina, and extensive non-invasive testing, including a negative stress echocardiogram and normal cardiac enzymes during an ER visit for a severe episode (which was ultimately attributed to a panic attack), has failed to identify a cardiac cause. Despite this reassuring data, her cardiologist has proposed a percutaneous coronary intervention (PCI) as a definitive 'rule-out' procedure, a suggestion that seems overly aggressive given the lack of supporting clinical evidence.

III. CLINICAL REPORTS & IMAGING

■ *CARDIOLOGY CONSULT NOTE*

Report Text:
'''

REASON FOR CONSULTATION: Evaluation of intermittent chest pain.

HISTORY OF PRESENT ILLNESS: Ms. Siobhan Roy is a 39-year-old female referred by her PCP, Dr. Elizabeth Spiros, for evaluation of intermittent chest pain which began approximately two months ago. The patient describes the pain as a dull, pressure-like sensation located substernally. Episodes are infrequent, occurring perhaps once or twice a week, and last for 10-20 minutes. She adamantly denies any radiation of the pain to her arms, neck, or jaw. She cannot identify consistent triggers; the pain occurs at rest and has not been associated with physical exertion. She

denies shortness of breath, diaphoresis, nausea, or lightheadedness during these episodes. The patient notes a significant amount of occupational stress recently. She also reports frequent symptoms of acid reflux, especially after large meals or caffeine, which she describes as a burning sensation that is sometimes hard to distinguish from this pressure. An over-the-counter antacid provided some relief on one occasion.

PAST MEDICAL HISTORY:
1. Essential Hypertension - Diagnosed 2022. Well-controlled.
2. Gastroesophageal Reflux Disease - Diagnosed 2023.
3. Anxiety Disorder, Unspecified - Diagnosed 2021.

PAST SURGICAL HISTORY: Appendectomy, age 16.

MEDICATIONS:
1. Lisinopril 10 mg daily
2. Omeprazole 20 mg daily
3. Sertraline 50 mg daily
4. Aspirin 81 mg daily

ALLERGIES: No Known Drug Allergies.

SOCIAL HISTORY: Patient is married. Works in a high-stress executive role. Denies smoking. Reports occasional alcohol use (2-3 glasses of wine per week). She does not follow a specific diet but tries to eat healthy. Reports limited time for regular exercise.

FAMILY HISTORY: Father with a history of coronary artery disease and a myocardial infarction in his late 60s. Mother is alive and well with a history of hypertension.

REVIEW OF SYSTEMS:
- Constitutional: Denies fever, c...

■ *ER VISIT SUMMARY*

Report Text:
'''

CHIEF COMPLAINT: Chest pain.

HISTORY OF PRESENT ILLNESS: Patient is a 39-year-old female with a past medical history of hypertension, GERD, and anxiety who presented to the Emergency Department via private vehicle due to a sudden onset of chest pain that began approximately one hour prior to arrival. She described the pain as a severe, crushing pressure in the center of her chest, accompanied by shortness of breath, diaphoresis, and a sense of impending doom. She states the episode was intensely frightening. The pain did not radiate. She was at home, having a stressful phone conversation, when the symptoms began. She took an extra dose of her Omeprazole without relief. No history of similar severe episodes, though she has had milder, intermittent chest discomfort previously.

REVIEW OF SYSTEMS: As per HPI. Denies fever, cough, recent travel, or sick contacts.

PAST MEDICAL HISTORY: Hypertension, GERD, Anxiety.

MEDICATIONS: Lisinopril, Omeprazole, Sertraline, Aspirin.

PHYSICAL EXAMINATION:
- Vitals on Arrival: BP 145/90 mmHg, HR 110 bpm, RR 22, Temp 98.7 F, SpO2 99% RA.
- General: Anxious, hypervigilant female in moderate distress. Tearful.
- Heart: Tachycardic but regular rhythm. No murmurs.
- Lungs: Clear to auscultation bilaterally.
- Abdomen: Soft, non-tender.
- Extremities: Warm and well-perfused. No edema.

ED COURSE AND WORKUP:
The patient was placed in a monitored bed. An IV was established.
- **EKG (22:20):** Showed sinus tachycardia at 110 bpm. No ST segment elevation, depression, or T-wave inversions to suggest acute ischemia or infarction.
- **Labs (22:45):** CBC, BMP, and a serial cardiac Troponin I were drawn. The initial Troponin I resulted at 23:30 as <0.02 ng/mL (negative). A second Troponin drawn 2 hours later was also negative.
- **Chest X-Ray:** No acute cardiopulmonary process. Heart size normal. No pneumothorax or infiltrate.
- **Treatment:** The patient was given Aspirin 324 m...

■ *LAB REPORT TROPONIN*

Report Text:
'''
Patient: Siobhan Roy (MRN: MRN-216)
DOB: 1984-09-15
Ordering Physician: Dr. Emily Carter, MD
Encounter ID: ENC-216-003
Collection Date/Time: 2024-05-12 22:45
Report Date/Time: 2024-05-12 23:30

CARDIAC MARKERS ---

Test Name: Troponin I, Cardiac
- **Result:** < 0.02 ng/mL
- **Flag:** N/A
- **Reference Range:** < 0.04 ng/mL
- **Status:** Final

Test Name: Troponin I, Cardiac (Repeat)
- **Collection Date/Time:** 2024-05-13 00:45
- **Report Date/Time:** 2024-05-13 01:30
- **Result:** < 0.02 ng/mL
- **Flag:** N/A
- **Reference Range:** < 0.04 ng/mL
- **Status:** Final

Interpretation: Serial cardiac troponin levels are negative and do not show a rising pattern. This result indicates a very low likelihood of acute myocardial injury or infarction during the observed period.

END OF REPORT ---
'''

■ *STRESS ECHO REPORT*

Report Text:
'''

Patient: Siobhan Roy (MRN: MRN-216)
Indication: Atypical chest pain evaluation.
Procedure: Bruce Protocol Treadmill Stress Echocardiogram
Service Date: 2024-05-20

PROCEDURE DETAILS:
The patient exercised on a treadmill according to the Bruce protocol for a total of 9 minutes and 15 seconds, achieving 9.5 METs. This represents 105% of her age-predicted maximum heart rate. Target heart rate of 154 bpm (85% max) was achieved and exceeded.
- Baseline HR: 78 bpm, BP: 135/82 mmHg.
- Peak HR: 190 bpm, BP: 188/90 mmHg.
- The test was terminated due to patient fatigue. The patient did not experience any chest pain, significant dyspnea, or other limiting symptoms during the test.
- There were no significant ST-segment deviations or arrhythmias observed on the stress EKG.

ECHOCARDIOGRAPHIC FINDINGS:

1. RESTING ECHOCARDIOGRAM:
- **Left Ventricle:** Normal left ventricular size, wall thickness, and systolic function. The estimated ejection fraction is 60-65%. No regional wall motion abnormalities are seen.
- **Right Ventricle:** Normal size and function.
- **Atria:** Left and right atria are normal in size.
- **Valves:** All valves appear structurally normal with no evidence of significant stenosis or regurgitation. Trivial mitral and tricuspid regurgitation noted, which is physiologically normal.
- **Pericardium:** No pericardial effusion.

2. POST-STRESS ECHOCARDIOGRAM:
- **Left Ventricle:** Hyperdynamic left ventricular systolic function is observed post-stress. The estimated ejection fraction increases appropriately. Crucially, there are NO new or worsening regional wall motion abnormalities to suggest stress-induced ischemia. All 17 segments of the left ventricle thicken and move normally.

IMPRESSION:
1. **Negative Stress Echocardiogram:** This is a normal, negative study for inducible myocardial ischemia. The patient exercised to an excellent workload without developing symptoms, E...

■ *PCP PROGRESS NOTE*

Report Text:
'''

SUBJECTIVE: Ms. Roy presents for her annual physical examination. She feels generally well but reports a high level of stress at work which she feels is contributing to fatigue and poor sleep. She is compliant with her medications for hypertension (Lisinopril), GERD (Omeprazole), and anxiety (Sertraline). She notes her blood pressure readings at home have been in the 120s/80s. She denies any new major complaints today but mentions some vague, intermittent chest discomfort over the past month. She describes it as a fleeting pressure that does not seem related to activity. She wonders if it is her reflux acting up.

OBJECTIVE:
- Vitals: BP 130/84 mmHg, HR 75 bpm, Wt 145 lbs, Ht 5 ft 7 in.
- General: Alert and oriented, appears well.
- Exam: HEENT, neck, lung, cardiovascular, and abdominal exams are all within normal limits. Specifically, heart sounds are regular with no murmur, and chest is clear.

ASSESSMENT & PLAN:
1. **Health Maintenance:** Patient is up to date on age-appropriate screenings. Labs ordered today include CBC, CMP, and a lipid panel.
2. **Hypertension:** Well-controlled. Continue Lisinopril 10 mg daily.
3. **GERD:** Symptoms present but controlled. Continue Omeprazole 20 mg daily. Advised to avoid trigger foods and late-night meals.
4. **Anxiety:** Clearly exacerbated by occupational stress. Sertraline dose appears adequate for now. Discussed non-pharmacological stress management techniques, including mindfulness and importance of scheduling downtime.
5. **Atypical Chest Pain:** The description is not classic for angina. Given her history of GERD and anxiety, these are the most likely culprits. However, to be thorough and address her concerns, a referral to Cardiology for a formal evaluation is prudent.

PLAN:
- Continue current medications.
- Bloodwork drawn today.
- Placed referral to Dr. Armin Tariq at Manhattan Cardiology Associates for evaluation of atypical chest pain.
- Follow up in 3 months...
