CHIEF COMPLAINT (1/1):, This 62 year old female presents today for evaluation of angina.,Associated signs and symptoms: Associated signs and symptoms include chest pain, nausea, pain radiating to the arm and pain radiating to the jaw.,Context: The patient has had no previous treatments for this condition.,Duration: Condition has existed for 5 hours.,Quality: Quality of the pain is described by the patient as crushing.,Severity: Severity of condition is severe and unchanged.,Timing (onset/frequency): Onset was sudden and with exercise. Patient has the following coronary risk factors: smoking 1 packs/day for 40 years and elevated cholesterol for 5 years. Patient's elevated cholesterol is not being treated with medication. Menopause occurred at age 53.,ALLERGIES:, No known medical allergies.,MEDICATION HISTORY:, Patient is currently taking Estraderm 0.05 mg/day transdermal patch.,PMH:, Past medical history unremarkable.,PSH:, No previous surgeries.,SOCIAL HISTORY:, Patient admits tobacco use She relates a smoking history of 40 pack years.,FAMILY HISTORY:, Patient admits a family history of heart attack associated with father (deceased).,ROS:, Unremarkable with exception of chief complaint.,PHYSICAL EXAMINATION:,General: Patient is a 62 year old female who appears pleasant, her given age, well developed,,oriented, well nourished, alert and moderately overweight.,Vital Signs: BP Sitting: 174/92 Resp: 28 HR: 88 Temp: 98.6 Height: 5 ft. 2 in. Weight: 150 lbs.,HEENT: Inspection of head and face shows head that is normocephalic, atraumatic, without any gross or neck

masses. Ocular motility exam reveals muscles are intact. Pupil exam reveals round and equally reactive to light and accommodation. There is no conjunctival inflammation nor icterus. Inspection of nose reveals no abnormalities. Inspection of oral mucosa and tongue reveals no pallor or cyanosis. Inspection of the tongue reveals normal color, good motility and midline position. Examination of oropharynx reveals the uvula rises in the midline. Inspection of lips, teeth, gums, and palate reveals healthy teeth, healthy gums, no gingival,hypertrophy, no pyorrhea and no abnormalities.,Neck: Neck exam reveals neck supple and trachea that is midline, without adenopathy or crepitance palpable.,Thyroid examination reveals smooth and symmetric gland with no enlargement, tenderness or masses noted.,Carotid pulses are palpated bilaterally, are symmetric and no bruits auscultated over the carotid and vertebral arteries. Jugular veins examination reveals no distention or abnormal waves were noted. Neck lymph nodes are not noted.,Back: Examination of the back reveals no vertebral or costovertebral angle tenderness and no kyphosis or scoliosis noted.,Chest: Chest inspection reveals intercostal interspaces are not widened, no splinting, chest contours are normal and normal expansion. Chest palpation reveals no abnormal tactile fremitus.,Lungs: Chest percussion reveals resonance. Assessment of respiratory effort reveals even respirations without use of accessory muscles and diaphragmatic movement normal. Auscultation of lungs reveal diminished breath sounds bibasilar.,Heart: The apical impulse on heart

palpation is located in the left border of cardiac dullness in the midclavicular line, in the left fourth intercostal space in the midclavicular line and no thrill noted. Heart auscultation reveals rhythm is regular, normal S1 and S2, no murmurs, gallop, rubs or clicks and no abnormal splitting of the second heart sound which moves normally with respiration. Right leg and left leg shows evidence of edema +6.,Abdomen: Abdomen soft, nontender, bowel sounds present x 4 without palpable masses. Palpation of liver reveals no abnormalities with respect to size, tenderness or masses. Palpation of spleen reveals no abnormalities with respect to size, tenderness or masses. Examination of abdominal aorta shows normal size without presence of systolic bruit.,Extremities: Right thumb and left thumb reveals clubbing.,Pulses: The femoral, popliteal, dorsalis, pedis and posterior tibial pulses in the lower extremities are equal and normal. The brachial, radial and ulnar pulses in the upper extremities are equal and normal. Examination of peripheral vascular system reveals varicosities absent, extremities warm to touch, edema present - pitting and pulses are full to palpation. Femoral pulses are 2 /4, bilateral. Pedal pulses are 2 /4, bilateral.,Neurological: Testing of cranial nerves reveals nerves intact. Oriented to person, place and time. Mood and affect normal and appropriate to situation.Deep tendon reflexes normal. Touch, pin, vibratory and proprioception sensations are normal. Babinski reflex is absent. Coordination is normal. Speech is not aphasic. Musculoskeletal: Muscle strength is 5/5 for all groups tested. Gait and station

examination reveals midposition without abnormalities.,Skin: No skin rash, subcutaneous nodules, lesions or ulcers observed. Skin is warm and dry with normal turgor and there is no icterus.,Lymphatics: No lymphadenopathy noted.,IMPRESSION:, Angina pectoris, other and unspecified.,PLAN:, ,DIAGNOSTIC & LAB ORDERS:, Ordered serum creatine kinase isoenzymes (CK isoenzymes). Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report. The following cardiac risk factor modifications are recommended: quit smoking and reduce LDL cholesterol to below 120 mg/dl.,PATIENT INSTRUCTIONS: