REASON FOR CONSULTATION: , Atrial fibrillation and shortness of breath.,HISTORY OF PRESENTING ILLNESS: , The patient is an 81-year-old gentleman. The patient had shortness of breath over the last few days, progressively worse. Yesterday he had one episode and got concerned and came to the Emergency Room, also orthopnea and paroxysmal dyspnea. Coronary artery disease workup many years ago. He also has shortness of breath, weakness, and tiredness.,CORONARY RISK FACTORS: , History of hypertension, no history of diabetes mellitus, ex-smoker, cholesterol status elevated, no history of established coronary artery disease, and family history positive.,FAMILY HISTORY: , Positive for coronary artery disease.,SURGICAL HISTORY: , Knee surgery, hip surgery, shoulder surgery, cholecystectomy, and appendectomy.,MEDICATIONS: , Thyroid supplementation, atenolol 25 mg daily, Lasix, potassium supplementation, lovastatin 40 mg daily, and Coumadin adjusted dose.,ALLERGIES: , ASPIRIN.,PERSONAL HISTORY:, Married, ex-smoker, and does not consume alcohol. No history of recreational drug use.,PAST MEDICAL HISTORY: , Hypertension, hyperlipidemia, atrial fibrillation chronic, on anticoagulation.,SURGICAL HISTORY: , As above.,PRESENTATION HISTORY: , Shortness of breath, weakness, fatigue, and tiredness. The patient also relates history of questionable TIA in 1994.,REVIEW OF SYSTEMS:,CONSTITUTIONAL: Weakness, fatigue, tiredness.,HEENT: No history of cataracts, blurry vision or

glaucoma.,CARDIOVASCULAR: Arrhythmia, congestive heart failure, no coronary artery disease.,RESPIRATORY: Shortness of breath. No pneumonia or valley fever.,GASTROINTESTINAL: Nausea, no vomiting, hematemesis, or melena.,UROLOGICAL: Some frequency, urgency, no hematuria.,MUSCULOSKELETAL: Arthritis, muscle weakness.,SKIN: Chronic skin changes.,CNS: History of TIA. No CVA, no seizure disorder.,ENDOCRINE: Nonsignificant.,HEMATOLOGICAL: Nonsignificant.,PSYCHOLOGICAL: No anxiety or depression.,PHYSICAL EXAMINATION:,VITAL SIGNS: Pulse of 67, blood pressure 159/49, afebrile, and respiratory rate 18 per minute.,HEENT: Atraumatic and normocephalic.,NECK: Neck veins flat. No significant carotid bruits.,LUNGS: Air entry bilaterally fair, decreased in basal areas. No rales or wheezes.,HEART: PMI displaced. S1 and S2 regular.,ABDOMEN: Soft and nontender. Bowel sounds present.,EXTREMITIES: Chronic skin changes. Pulses are palpable. No clubbing or cyanosis.,CNS: Grossly intact.,LABORATORY DATA: , H&H; stable 30 and 39, INR of 1.86, BUN and creatinine within normal limits, potassium normal limits. First set of cardiac enzymes profile negative. BNP 4810.,Chest x-ray confirms unremarkable findings. EKG reveals atrial fibrillation, nonspecific ST-T changes.,IMPRESSION: