REASON FOR CONSULTATION: , Congestive heart failure.,HISTORY OF PRESENT ILLNESS: , The patient is a 75-year-old gentleman presented through the emergency room. Symptoms are of shortness of breath, fatigue, and tiredness. Main complaints are right-sided and abdominal pain. Initial blood test in the emergency room showed elevated BNP suggestive of congestive heart failure. Given history and his multiple risk factors and workup recently, which has been as mentioned below, the patient was admitted for further evaluation. Incidentally, his x-ray confirms pneumonia.,CORONARY RISK FACTORS: , History of hypertension, no history of diabetes mellitus, active smoker, cholesterol elevated, questionable history of coronary artery disease, and family history is positive.,FAMILY HISTORY: , Positive for coronary artery disease.,PAST SURGICAL HISTORY: , The patient denies any major surgeries.,MEDICATIONS: ,Aspirin, Coumadin adjusted dose, digoxin, isosorbide mononitrate 120 mg daily, Lasix, potassium supplementation, gemfibrozil 600 mg b.i.d., and metoprolol 100 mg b.i.d.,ALLERGIES: , None reported.,PERSONAL HISTORY:, Married, active smoker, does not consume alcohol. No history of recreational drug use.,PAST MEDICAL HISTORY: , Hypertension, hyperlipidemia, smoking history, coronary artery disease, cardiomyopathy, COPD, and presentation as above. The patient is on anticoagulation on Coumadin, the patient does not recall the reason.,REVIEW OF SYSTEMS:,CONSTITUTIONAL: Weakness, fatigue, and

tiredness.,HEENT: History of blurry vision and hearing impaired. No glaucoma.,CARDIOVASCULAR: Shortness of breath, congestive heart failure, and arrhythmia. Prior history of chest pain.,RESPIRATORY: Bronchitis and pneumonia. No valley fever.,GASTROINTESTINAL: No nausea, vomiting, hematemesis, melena, or abdominal pain.,UROLOGICAL: No frequency or urgency.,MUSCULOSKELETAL: No arthritis or muscle weakness.,SKIN: Non-significant.,NEUROLOGICAL: No TIA. No CVA or seizure disorder.,ENDOCRINE: Non-significant.,HEMATOLOGICAL: Non-significant.,PSYCHOLOGICAL: Anxiety. No depression.,PHYSICAL EXAMINATION:,VITAL SIGNS: Pulse of 60, blood pressure of 129/73, afebrile, and respiratory rate 16 per minute.,HEENT: Atraumatic and normocephalic.,NECK: Supple. Neck veins flat.,LUNGS: Air entry bilaterally decreased in the basilar areas with scattered rales, especially right side greater than left lung.,HEART: PMI displaced. S1 and S2, regular. Systolic murmur.,ABDOMEN: Soft and nontender.,EXTREMITIES: Trace edema of the ankle. Pulses are feebly palpable. Clubbing plus. No cyanosis.,CNS: Grossly intact.,MUSCULOSKELETAL: Arthritic changes.,PSYCHOLOGICAL: Normal affect.,LABORATORY AND DIAGNOSTIC DATA: , EKG shows sinus bradycardia, intraventricular conduction defect. Nonspecific ST-T changes.,Laboratories noted with H&H; 10/32 and white count of 7. INR 1.8. BUN and creatinine within normal limits. Cardiac enzyme profile first set 0.04, BNP of 10,000.,Nuclear myocardial perfusion scan with adenosine

in the office done about a couple of weeks ago shows ejection fraction of 39% with inferior reversible defect.,IMPRESSION: , The patient is a 75-year-old gentleman admitted for: