REASON FOR CONSULTATION:, Cardiac evaluation.,HISTORY: , This is a 42-year old Caucasian male with no previous history of hypertension, diabetes mellitus, rheumatic fever, rheumatic heart disease, or gout. Patient used to take medicine for hyperlipidemia and then that was stopped. He used to live in Canada and he moved to Houston four months ago. He started complaining of right-sided upper chest pain, starts at the right neck and goes down to the right side. It lasts around 10-15 minutes at times. It is 5/10 in quality. It is not associated with shortness of breath, nausea, vomiting, or sweating. It is not also associated with food. He denies exertional chest pain, dyspnea on exertion, orthopnea, paroxysmal nocturnal dyspnea, or pedal edema. No palpitations, syncope or presyncope. He said he has been having little cough at night and he went to see an allergy doctor who prescribed several medications for him and told him that he has asthma. No fever, chills, cough, hemoptysis, hematemesis or hematochezia. His EKG shows normal sinus rhythm, normal EKG.,PAST MEDICAL HISTORY:, Unremarkable, except for hyperlipidemia.,SOCIAL HISTORY: , He said he quit smoking 20 years ago and does not drink alcohol.,FAMILY HISTORY: , Positive for high blood pressure and heart disease. His father died in his 50s with an acute myocardial infarction.,MEDICATION:, Ranitidine 300 mg daily, Flonase 50 mcg nasal spray as needed, Allegra 100 mg daily, Advair 500/50 bid.,ALLERGIES:, No known allergies.,REVIEW OF SYSTEMS:, As mentioned above,EXAMINATION:, This is a 42-year old male awake,

alert, and oriented x3 in no acute distress.,Wt: 238