CHIEF COMPLAINT:, Palpitations.,CHEST PAIN / UNSPECIFIED ANGINA PECTORIS HISTORY:, The patient relates the recent worsening of chronic chest discomfort. The quality of the pain is sharp and the problem started 2 years ago. Pain radiates to the back and condition is best described as severe. Patient denies syncope. Beyond baseline at present time. Past work up has included 24 hour Holter monitoring and echocardiography. Holter showed PVCs.,PALPITATIONS HISTORY:, Palpitations - frequent, 2 x per week. No caffeine, no ETOH. + stress. No change with Inderal.,VALVULAR DISEASE HISTORY:, Patient has documented mitral valve prolapse on echocardiography in 1992.,PAST MEDICAL HISTORY:, No significant past medical problems. Mitral Valve Prolapse.,FAMILY MEDICAL HISTORY:, CAD.,OB-GYN HISTORY:, The patients last child birth was 1997. Para 3. Gravida 3.,SOCIAL HISTORY:, Denies using caffeinated beverages, alcohol or the use of any tobacco products.,ALLERGIES:, No known drug allergies/Intolerances.,CURRENT MEDICATIONS:, Inderal 20 prn.,REVIEW OF SYSTEMS:, Generally healthy. The patient is a good historian.,ROS Head and Eyes: Denies vision changes, light sensitivity, blurred vision, or double vision.,ROS Ear, Nose and Throat: The patient denies any ear, nose or throat symptoms.,ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.,ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea,

vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochezia.,ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence.,ROS Gynecological: Denies any gynecological complaints, such as vaginal bleeding, discharge, pain, etc.,ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.,ROS Extremities: The patient denies any extremities complaints.,ROS Cardiovascular: As per HPI.,EXAMINATION:,Exam Abdomen/Flank: The abdomen is soft without tenderness or palpable masses. No guarding, rigidity or rebound tenderness. The liver and spleen are not palpable. Bowel sounds are active and normal.,Exam Extremities: Lower extremities are normal in color, touch and temperature. No ischemic changes are noted.,Range of motion is normal. There is no cyanosis, clubbing or edema.,General: Healthy appearing, well developed,. The patient is in no acute distress.,Exam Skin Negative to inspection or palpation. There are no obvious lesions or new rashes noted. Non-diaphoretic.,Exam Ears Canals are clear. Throat is not injected. Tonsils are not swollen or injected.,Exam Neck: There is no thyromegaly, carotid bruits, lymphadenopathy, or JVD. Neck is supple.,Exam Respiratory: Normal breath sounds are heard bilaterally. There is no wheezing. There is no use of accessory muscles.,Exam Cardiovascular: Regular heart rate and rhythm, Normal S1 and S2 without murmur, gallops or rubs.,IMPRESSION /

DIAGNOSIS:, Mitral Valve Prolapse. Palpitations.,TESTS ORDERED:, Cardiac tests: Echocardiogram.,MEDICATION PRESCRIBED:, ,Cardizem 30-60 qid prn.