Patient Information:

- **Name:** Rajesh Kumar
- **ID Number:** 1000
- **Date of Birth:** 1985-06-15
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-01-05
- **Join Date:** 2024-01-05
- **Discharge Date:** 2024-01-15
- **Attending Physician:** Dr. Ananya Rao

Vital Signs:

- **Temperature:** 37.2°C
- **Pulse Rate:** 85 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Shortness of breath and chest discomfort.

Medical History:

- **Past Medical History:** Hypertension, Asthma
- **Allergies:** Penicillin
- **Medications:** Atenolol (for hypertension), Salbutamol (for asthma)

Physical Examination:

- **General Appearance:** Slightly anxious, in mild distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Wheezing on exhalation.
- **Heart:** Regular rhythm, no murmurs.
- **Abdomen:** Soft, non-tender.
- **Extremities:** No edema or cyanosis.
- **Neurological:** Alert and oriented.

Assessment:

- Acute asthma exacerbation with associated anxiety.

Plan:

- **Tests Ordered:** Chest X-ray, Pulmonary Function Tests (PFTs)
- **Treatment Plan:** Nebulized bronchodilators (Albuterol), Steroid therapy, Blood pressure monitoring
- **Follow-Up:** Follow-up in 1 week or sooner if symptoms worsen.

Patient Information:

- **Name:** Priya Sharma
- **ID Number:** 1001
- **Date of Birth:** 1990-09-22
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-02-10
- **Join Date:** 2024-02-10
- **Discharge Date:** 2024-02-20
- **Attending Physician:** Dr. Rajeev Nair

Vital Signs:

- **Temperature:** 37.6°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 16 breaths/min
- **Blood Pressure:** 115/75 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Fever, headache, and body aches.

Medical History:

- **Past Medical History:** No significant past medical history.
- **Allergies:** None
- **Medications:** Paracetamol for fever

Physical Examination:

- **General Appearance:** Appears fatigued, moderate fever.
- **Head and Neck:** Tender cervical lymph nodes.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rate and rhythm.
- **Abdomen:** Mild tenderness in the lower abdomen.
- **Extremities:** No swelling or redness.
- **Neurological:** No focal neurological deficits.

Assessment:

- Viral infection, likely influenza.

Plan:

- **Tests Ordered:** Rapid antigen test for influenza, CBC, Chest X-ray
- **Treatment Plan:** Antipyretics (Paracetamol), Rest, Fluid intake
- **Follow-Up:** If symptoms persist beyond 5 days, follow-up with GP.

Patient Information:

- **Name:** Ahmed Khan
- **ID Number:** 1002
- **Date of Birth:** 1978-03-05
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-03-12
- **Join Date:** 2024-03-12
- **Discharge Date:** 2024-03-22
- **Attending Physician:** Dr. Neha Joshi

Vital Signs:

- **Temperature:** 38.5°C
- **Pulse Rate:** 90 BPM
- **Respiratory Rate:** 20 breaths/min
- **Blood Pressure:** 130/85 mmHg
- **Oxygen Saturation:** 96%

Chief Complaint:

- Severe abdominal pain and vomiting.

Medical History:

- **Past Medical History:** Diabetes Mellitus Type 2, Peptic Ulcer Disease
- **Allergies:** No known drug allergies
- **Medications:** Metformin, Omeprazole

Physical Examination:

- **General Appearance:** Pale, anxious.
- **Head and Neck:** No lymphadenopathy.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal S1/S2, no murmurs.
- **Abdomen:** Tender in the epigastric region, no rebound tenderness.
- **Extremities:** No edema.
- **Neurological:** Alert, no signs of distress.

Assessment:

- Likely peptic ulcer exacerbation with complications.

Plan:

- **Tests Ordered:** Upper abdominal ultrasound, Endoscopy, CBC, Serum electrolytes
- **Treatment Plan:** Proton pump inhibitors, IV fluids, Dietary modifications
- **Follow-Up:** Follow-up in 2 weeks for review of symptoms.

Patient Information:

- **Name:** Anjali Verma
- **ID Number:** 1003
- **Date of Birth:** 2001-11-17
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-04-01
- **Join Date:** 2024-04-01
- **Discharge Date:** 2024-04-10
- **Attending Physician:** Dr. Suresh Kumar

Vital Signs:

- **Temperature:** 36.8°C
- **Pulse Rate:** 70 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 110/70 mmHg
- **Oxygen Saturation:** 99%

Chief Complaint:

- Severe leg pain following an injury.

Medical History:

- **Past Medical History:** No known chronic conditions.
- **Allergies:** None
- **Medications:** Ibuprofen for pain

Physical Examination:

- **General Appearance:** No signs of distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear.
- **Heart:** Normal rhythm and rate.
- **Abdomen:** Soft, non-tender.
- **Extremities:** Right lower leg swelling, tenderness, and bruising.
- **Neurological:** No motor or sensory deficits.

Assessment:

- Fracture of the right tibia.

Plan:

- **Tests Ordered:** X-ray of the right leg
- **Treatment Plan:** Immobilization with a cast, pain management with acetaminophen
- **Follow-Up:** Recheck in 1 week for cast removal and reassessment.

Patient Information:

- **Name:** Arvind Patil
- **ID Number:** 1004
- **Date of Birth:** 1975-02-11
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-04-15
- **Join Date:** 2024-04-15
- **Discharge Date:** 2024-04-20
- **Attending Physician:** Dr. Kavita Reddy

Vital Signs:

- **Temperature:** 37.0°C
- **Pulse Rate:** 76 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 125/80 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Severe lower back pain after lifting heavy objects.

Medical History:

- **Past Medical History:** Chronic low back pain, No other significant medical history.
- **Allergies:** None
- **Medications:** Paracetamol (as needed for pain)

Physical Examination:

- **General Appearance:** Normal, appears in moderate discomfort.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rate and rhythm, no murmurs.
- **Abdomen:** Soft, non-tender.
- **Extremities:** No swelling or tenderness in joints.
- **Neurological:** No neurological deficits.

Assessment:

- Acute lumbar strain with possible disc involvement.

Plan:

- **Tests Ordered:** MRI of the lumbar spine.
- **Treatment Plan:** Rest, heat therapy, NSAIDs for pain, Physical therapy.
- **Follow-Up:** Recheck in 1 week for pain management and MRI results.

Patient Information:

- **Name:** Rani Yadav
- **ID Number:** 1005
- **Date of Birth:** 1993-06-20
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-05-01
- **Join Date:** 2024-05-01
- **Discharge Date:** 2024-05-10
- **Attending Physician:** Dr. Anjali Desai

Vital Signs:

- **Temperature:** 38.1°C
- **Pulse Rate:** 95 BPM
- **Respiratory Rate:** 22 breaths/min
- **Blood Pressure:** 118/76 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- High fever, chills, and a sore throat.

Medical History:

- **Past Medical History:** Asthma (mild).
- **Allergies:** Dust mite allergy
- **Medications:** Salbutamol inhaler

Physical Examination:

- **General Appearance:** Feverish, mildly distressed.
- **Head and Neck:** Swollen lymph nodes, red throat with exudate.
- **Chest and Lungs:** Mild wheezing on auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Soft, non-tender.
- **Extremities:** No swelling or edema.
- **Neurological:** No focal neurological signs.

Assessment:

- Suspected viral pharyngitis with secondary bacterial infection.

Plan:

- **Tests Ordered:** Rapid strep test, CBC, Throat culture.
- **Treatment Plan:** Antibiotics (if streptococcus confirmed), antipyretics (Paracetamol), and nebulized bronchodilators for wheezing.
- **Follow-Up:** In 5 days for review of symptoms.

Patient Information:

- **Name:** Vijay Kumar
- **ID Number:** 1006
- **Date of Birth:** 1982-04-17
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-05-12
- **Join Date:** 2024-05-12
- **Discharge Date:** 2024-05-22
- **Attending Physician:** Dr. Raghavendra Bhat

Vital Signs:

- **Temperature:** 37.5°C
- **Pulse Rate:** 80 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 125/85 mmHg
- **Oxygen Saturation:** 99%

Chief Complaint:

- Persistent cough and mild fever for 1 week.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** None
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly fatigued, not in acute distress.
- **Head and Neck:** No lymphadenopathy.
- **Chest and Lungs:** Mild wheezing, productive cough.
- **Heart:** Normal S1/S2, no murmurs.
- **Abdomen:** Soft and non-tender.
- **Extremities:** No edema.
- **Neurological:** No neurological deficits.

Assessment:

- Acute bronchitis, likely viral.

Plan:

- **Tests Ordered:** Chest X-ray, CBC, Sputum culture.
- **Treatment Plan:** Symptomatic treatment with antipyretics and cough suppressants, Fluid intake, Humidifier at night.
- **Follow-Up:** Follow-up in 1 week if symptoms persist.

Patient Information:

- **Name:** Neha Singh
- **ID Number:** 1007
- **Date of Birth:** 2000-11-30
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-06-01
- **Join Date:** 2024-06-01
- **Discharge Date:** 2024-06-07
- **Attending Physician:** Dr. Sanjeev Pandey

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 72 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/78 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Menstrual irregularity and pelvic pain.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** None
- **Medications:** Birth control pills (occasional)

Physical Examination:

- **General Appearance:** Healthy, non-distressed.
- **Head and Neck:** Normal.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal S1/S2, no murmurs.
- **Abdomen:** Mild tenderness in the lower abdomen.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Possible ovarian cyst or hormonal imbalance.

Plan:

- **Tests Ordered:** Pelvic ultrasound, Hormonal profile.
- **Treatment Plan:** NSAIDs for pain relief, Follow-up in 1 week.
- **Follow-Up:** Follow-up after ultrasound results to discuss treatment options.

Patient Information:

- **Name:** Sunil Rao
- **ID Number:** 1008
- **Date of Birth:** 1969-07-12
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-06-10
- **Join Date:** 2024-06-10
- **Discharge Date:** 2024-06-17
- **Attending Physician:** Dr. Chandra Prakash

Vital Signs:

- **Temperature:** 36.7°C
- **Pulse Rate:** 82 BPM
- **Respiratory Rate:** 20 breaths/min
- **Blood Pressure:** 135/85 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Difficulty in swallowing and sore throat.

Medical History:

- **Past Medical History:** History of GERD (Gastroesophageal reflux disease).
- **Allergies:** No known drug allergies.
- **Medications:** Omeprazole (for GERD), Pantoprazole (occasionally).

Physical Examination:

- **General Appearance:** Appears slightly uncomfortable, not acutely ill.
- **Head and Neck:** Redness in the back of the throat, slight swelling.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Non-tender, no distension.
- **Extremities:** No edema.
- **Neurological:** No signs of neurological impairment.

Assessment:

- Possible pharyngitis with a history of GERD contributing to symptoms.

Plan:

- **Tests Ordered:** Throat culture, Laryngoscopy if symptoms persist.
- **Treatment Plan:** Antacids, Antibiotics if bacterial infection is confirmed.
- **Follow-Up:** Follow-up in 1 week for reassessment.

Patient Information:

- **Name:** Sanjay Gupta
- **ID Number:** 1009
- **Date of Birth:** 1989-01-30
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-06-15
- **Join Date:** 2024-06-15
- **Discharge Date:** 2024-06-22
- **Attending Physician:** Dr. Sumanth Rao

Vital Signs:

- **Temperature:** 36.8°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 16 breaths/min
- **Blood Pressure:** 120/76 mmHg
- **Oxygen Saturation:** 99%

Chief Complaint:

- Persistent cough and occasional hemoptysis (blood in sputum).

Medical History:

- **Past Medical History:** Asthma, Smoker (10 years).
- **Allergies:** None
- **Medications:** Salbutamol inhaler

Physical Examination:

- **General Appearance:** Appears anxious, no acute distress.
- **Head and Neck:** No lymphadenopathy.
- **Chest and Lungs:** Rhonchi and wheezing on auscultation.
- **Heart:** Regular rate and rhythm, no murmurs.
- **Abdomen:** Non-tender, soft.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Chronic obstructive pulmonary disease (COPD) exacerbation with a history of smoking.

Plan:

- **Tests Ordered:** Chest X-ray, Sputum culture, Spirometry.
- **Treatment Plan:** Nebulized bronchodilators, corticosteroids, smoking cessation support.
- **Follow-Up:** In 1 week for reassessment.

Patient Information:

- **Name:** Sneha Patel
- **ID Number:** 1010
- **Date of Birth:** 2002-07-25
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-06-18
- **Join Date:** 2024-06-18
- **Discharge Date:** 2024-06-25
- **Attending Physician:** Dr. Arvind Sharma

Vital Signs:

- **Temperature:** 37.1°C
- **Pulse Rate:** 80 BPM
- **Respiratory Rate:** 17 breaths/min
- **Blood Pressure:** 110/70 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Abdominal bloating and diarrhea for 3 days.

Medical History:

- **Past Medical History:** No known chronic illnesses.
- **Allergies:** None
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly uncomfortable, no fever.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Tenderness in the lower abdomen, no rebound tenderness.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Gastroenteritis, possibly viral.

Plan:

- **Tests Ordered:** Stool culture, Blood tests for infection.
- **Treatment Plan:** Rehydration therapy, Antiemetics, Probiotics.
- **Follow-Up:** Recheck in 3-5 days for symptom resolution.

Patient Information:

- **Name:** Kiran Nair
- **ID Number:** 1011
- **Date of Birth:** 1983-10-08
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-01
- **Join Date:** 2024-07-01
- **Discharge Date:** 2024-07-10
- **Attending Physician:** Dr. Jayanth Menon

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 88 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 130/85 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Severe pain in the right knee after an accident.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** No known allergies.
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly distressed due to pain.
- **Head and Neck:** Normal.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm, no murmurs.
- **Abdomen:** Soft, non-tender.
- **Extremities:** Swelling and bruising on the right knee, limited range of motion.
- **Neurological:** Normal.

Assessment:

- Right knee fracture, possible ligament injury.

Plan:

- **Tests Ordered:** X-ray of the knee, MRI to assess ligament damage.
- **Treatment Plan:** Ice, pain management (NSAIDs), Knee immobilizer.
- **Follow-Up:** Follow-up in 2 weeks for review of X-ray and MRI results.

Patient Information:

- **Name:** Priyanka Deshmukh
- **ID Number:** 1012
- **Date of Birth:** 1995-02-14
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-05
- **Join Date:** 2024-07-05
- **Discharge Date:** 2024-07-15
- **Attending Physician:** Dr. Shweta Iyer

Vital Signs:

- **Temperature:** 37.2°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Fatigue, dizziness, and lightheadedness on standing.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** None
- **Medications:** Iron supplements

Physical Examination:

- **General Appearance:** Mildly pale, appears fatigued.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm, no murmurs.
- **Abdomen:** Soft, non-tender.
- **Extremities:** No swelling.
- **Neurological:** Normal.

Assessment:

- Iron deficiency anemia.

Plan:

- **Tests Ordered:** CBC, Serum ferritin, Serum iron studies.
- **Treatment Plan:** Oral iron supplementation, dietary adjustments.
- **Follow-Up:** Recheck in 2 weeks to assess response to treatment.

Patient Information:

- **Name:** Arun Mishra
- **ID Number:** 1013
- **Date of Birth:** 1987-12-03
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-10
- **Join Date:** 2024-07-10
- **Discharge Date:** 2024-07-20
- **Attending Physician:** Dr. Nisha Verma

Vital Signs:

- **Temperature:** 37.8°C
- **Pulse Rate:** 90 BPM
- **Respiratory Rate:** 19 breaths/min
- **Blood Pressure:** 128/82 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Acute lower abdominal pain and nausea.

Medical History:

- **Past Medical History:** No known chronic illnesses.
- **Allergies:** None
- **Medications:** None

Physical Examination:

- **General Appearance:** Anxious, in moderate pain.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Tenderness in the lower quadrants, no guarding.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Suspected appendicitis or diverticulitis.

Plan:

- **Tests Ordered:** Abdominal ultrasound, CT scan of the abdomen.
- **Treatment Plan:** IV fluids, Pain management, NPO (Nil Per Os) status until diagnosis confirmed.
- **Follow-Up:** Surgery consult if appendicitis confirmed.

Patient Information:

- **Name:** Rajesh Kumar
- **ID Number:** 1014
- **Date of Birth:** 1991-05-22
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-15
- **Join Date:** 2024-07-15
- **Discharge Date:** 2024-07-22
- **Attending Physician:** Dr. Radhika Goyal

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 85 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/75 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Pain in the right shoulder after lifting heavy objects.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** None
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly uncomfortable, no distress.
- **Head and Neck:** Normal.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Soft, non-tender.
- **Extremities:** Right shoulder has reduced range of motion, tenderness on palpation.
- **Neurological:** Normal.

Assessment:

- Rotator cuff strain.

Plan:

- **Tests Ordered:** X-ray of the shoulder, MRI if symptoms persist.
- **Treatment Plan:** Ice, NSAIDs for pain, physical therapy.
- **Follow-Up:** In 1 week for progress assessment.

Patient Information:

- **Name:** Deepika Saini
- **ID Number:** 1015
- **Date of Birth:** 1988-11-10
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-18
- **Join Date:** 2024-07-18
- **Discharge Date:** 2024-07-25
- **Attending Physician:** Dr. Madhuri Patil

Vital Signs:

- **Temperature:** 37.0°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Persistent headache and blurred vision.

Medical History:

- **Past Medical History:** Migraines (occasional), No chronic illnesses.
- **Allergies:** No known allergies.
- **Medications:** Triptans (for migraine).

Physical Examination:

- **General Appearance:** Well-nourished, mildly fatigued.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** No edema.
- **Neurological:** Blurred vision on testing, no focal deficits.

Assessment:

- Migrainous headache with possible visual disturbances due to elevated blood pressure.

Plan:

- **Tests Ordered:** Fundoscopy, Blood pressure monitoring, MRI of the brain.
- **Treatment Plan:** NSAIDs for pain, blood pressure management if elevated.
- **Follow-Up:** In 1 week for review and to monitor BP.

Patient Information:

- **Name:** Anil Joshi
- **ID Number:** 1016
- **Date of Birth:** 1974-04-30
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-20
- **Join Date:** 2024-07-20
- **Discharge Date:** 2024-07-27
- **Attending Physician:** Dr. Vikram Desai

Vital Signs:

- **Temperature:** 37.2°C
- **Pulse Rate:** 80 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 130/85 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Sharp pain in the lower left abdomen.

Medical History:

- **Past Medical History:** Hypertension, Hyperlipidemia.
- **Allergies:** None
- **Medications:** Amlodipine, Atorvastatin

Physical Examination:

- **General Appearance:** Appears in mild distress due to pain.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Left lower quadrant tenderness, no rebound tenderness.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Suspected diverticulitis.

Plan:

- **Tests Ordered:** Abdominal ultrasound, CBC, CT scan of the abdomen if needed.
- **Treatment Plan:** Antibiotics (Ciprofloxacin + Metronidazole), Rest.
- **Follow-Up:** Recheck in 5 days or sooner if symptoms worsen.

Patient Information:

- **Name:** Priya Menon
- **ID Number:** 1017
- **Date of Birth:** 1993-03-10
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-22
- **Join Date:** 2024-07-22
- **Discharge Date:** 2024-07-29
- **Attending Physician:** Dr. Subhashree Reddy

Vital Signs:

- **Temperature:** 36.8°C
- **Pulse Rate:** 75 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 110/70 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Unexplained weight loss, fatigue, and poor appetite.

Medical History:

- **Past Medical History:** Thyroid problems (Hypothyroidism), No allergies.
- **Medications:** Levothyroxine (for hypothyroidism).

Physical Examination:

- **General Appearance:** Thin, appears fatigued.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Soft, non-tender.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Possible malignancy or chronic infection.

Plan:

- **Tests Ordered:** Comprehensive blood work (CBC, liver function tests, thyroid function tests), Chest X-ray, Abdominal ultrasound.
- **Treatment Plan:** Symptomatic management until diagnosis confirmed.
- **Follow-Up:** Recheck in 1 week with test results.

Patient Information:

- **Name:** Ravi Prasad
- **ID Number:** 1018
- **Date of Birth:** 1980-09-25
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-25
- **Join Date:** 2024-07-25
- **Discharge Date:** 2024-08-01
- **Attending Physician:** Dr. Asha Nayak

Vital Signs:

- **Temperature:** 37.3°C
- **Pulse Rate:** 85 BPM
- **Respiratory Rate:** 20 breaths/min
- **Blood Pressure:** 125/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Persistent chest pain and discomfort on exertion.

Medical History:

- **Past Medical History:** Family history of heart disease, No prior cardiac issues.
- **Allergies:** No known allergies.
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly anxious, no distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation, mild tenderness over the sternum.
- **Heart:** Regular rhythm, no murmurs.
- **Abdomen:** Non-tender.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Likely angina, possibly related to exertion or stress.

Plan:

- **Tests Ordered:** ECG, Cardiac enzymes, Stress test.
- **Treatment Plan:** Nitroglycerin (PRN for chest pain), Lifestyle changes, Cardiology referral.
- **Follow-Up:** Recheck in 1 week with test results.

Patient Information:

- **Name:** Sumathi Kannan
- **ID Number:** 1019
- **Date of Birth:** 1976-11-18
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-07-30
- **Join Date:** 2024-07-30
- **Discharge Date:** 2024-08-06
- **Attending Physician:** Dr. Nandini Kulkarni

Vital Signs:

- **Temperature:** 37.1°C
- **Pulse Rate:** 88 BPM
- **Respiratory Rate:** 17 breaths/min
- **Blood Pressure:** 120/78 mmHg
- **Oxygen Saturation:** 99%

Chief Complaint:

- Recurrent lower back pain with stiffness.

Medical History:

- **Past Medical History:** Osteoarthritis (knee), no allergies.
- **Medications:** Paracetamol for pain relief.

Physical Examination:

- **General Appearance:** Mildly obese, no acute distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** Mild knee deformity (from arthritis).
- **Neurological:** Normal.

Assessment:

- Chronic lower back pain, likely due to degenerative disc disease.

Plan:

- **Tests Ordered:** X-ray of the spine, MRI of the lumbar region.
- **Treatment Plan:** NSAIDs for pain, Physical therapy, Lifestyle modifications (weight loss).
- **Follow-Up:** Recheck in 2 weeks.

Patient Information:

- **Name:** Mohan Reddy
- **ID Number:** 1020
- **Date of Birth:** 1969-08-10
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-02
- **Join Date:** 2024-08-02
- **Discharge Date:** 2024-08-09
- **Attending Physician:** Dr. Manish Bhaskar

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 128/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Difficulty in swallowing and mild chest pain.

Medical History:

- **Past Medical History:** GERD (Gastroesophageal reflux disease), Hypertension.
- **Allergies:** No known allergies.
- **Medications:** Lansoprazole for GERD, Amlodipine.

Physical Examination:

- **General Appearance:** No distress.
- **Head and Neck:** No cervical lymphadenopathy.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** No tenderness.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- GERD with possible esophageal stricture.

Plan:

- **Tests Ordered:** Endoscopy (EGD), Esophageal manometry.
- **Treatment Plan:** Continue acid suppression therapy, possible dilation if stricture confirmed.
- **Follow-Up:** In 1 week for endoscopy results.

Patient Information:

- **Name:** Nisha Gupta
- **ID Number:** 1021
- **Date of Birth:** 1995-06-05
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-05
- **Join Date:** 2024-08-05
- **Discharge Date:** 2024-08-12
- **Attending Physician:** Dr. Raghavendra Prabhu

Vital Signs:

- **Temperature:** 37.2°C
- **Pulse Rate:** 82 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/75 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Persistent lower abdominal pain and bloating.

Medical History:

- **Past Medical History:** None
- **Allergies:** No known allergies
- **Medications:** None

Physical Examination:

- **General Appearance:** Normal, no distress.
- **Head and Neck:** Normal.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Tenderness in the lower abdomen, bloating.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Suspected irritable bowel syndrome (IBS).

Plan:

- **Tests Ordered:** Stool test, Abdominal ultrasound.
- **Treatment Plan:** Antispasmodic medication, increase fiber intake, avoid triggers.
- **Follow-Up:** In 1 week for symptom review.

Patient Information:

- **Name:** Gaurav Sharma
- **ID Number:** 1022
- **Date of Birth:** 1982-11-25
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-07
- **Join Date:** 2024-08-07
- **Discharge Date:** 2024-08-14
- **Attending Physician:** Dr. Kiran Kapoor

Vital Signs:

- **Temperature:** 37.0°C
- **Pulse Rate:** 72 BPM
- **Respiratory Rate:** 16 breaths/min
- **Blood Pressure:** 128/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Painful swelling in the right ankle following an injury during sports.

Medical History:

- **Past Medical History:** No chronic illnesses.
- **Allergies:** No known allergies.
- **Medications:** None

Physical Examination:

- **General Appearance:** Mild swelling and bruising over the right ankle.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm, no murmurs.
- **Abdomen:** Non-tender.
- **Extremities:** Swelling and tenderness on the right ankle with limited movement.
- **Neurological:** Normal.

Assessment:

- Right ankle sprain/ligament injury.

Plan:

- **Tests Ordered:** X-ray of the right ankle to rule out fractures.
- **Treatment Plan:** RICE (Rest, Ice, Compression, Elevation), pain management with NSAIDs, ankle brace.
- **Follow-Up:** In 1 week for further assessment of recovery.

Patient Information:

- **Name:** Meena Iyer
- **ID Number:** 1023
- **Date of Birth:** 1977-02-17
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-08
- **Join Date:** 2024-08-08
- **Discharge Date:** 2024-08-15
- **Attending Physician:** Dr. Anjali Kaur

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 76 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 125/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Severe headache with nausea and light sensitivity.

Medical History:

- **Past Medical History:** Migraines, occasional anxiety.
- **Allergies:** No known allergies.
- **Medications:** Ibuprofen (for migraine).

Physical Examination:

- **General Appearance:** Pale, light-headed.
- **Head and Neck:** No abnormalities, mild photophobia.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** No edema.
- **Neurological:** Mild sensitivity to light, no focal deficits.

Assessment:

- Acute migraine with aura.

Plan:

- **Tests Ordered:** None (based on clinical presentation).
- **Treatment Plan:** Triptans for migraine relief, antiemetics for nausea, rest in a dark room.
- **Follow-Up:** In 1 week to check for recurrence and symptom management.

Patient Information:

- **Name:** Pradeep Raj
- **ID Number:** 1024
- **Date of Birth:** 1990-08-14
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-10
- **Join Date:** 2024-08-10
- **Discharge Date:** 2024-08-17
- **Attending Physician:** Dr. Sanjana Rao

Vital Signs:

- **Temperature:** 37.0°C
- **Pulse Rate:** 78 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/75 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Severe pain and swelling in the left elbow after lifting a heavy object.

Medical History:

- **Past Medical History:** No significant medical history.
- **Allergies:** None
- **Medications:** None

Physical Examination:

- **General Appearance:** Mild discomfort, no acute distress.
- **Head and Neck:** Normal.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Normal rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** Left elbow swollen, bruised, with limited range of motion.
- **Neurological:** Normal.

Assessment:

- Left elbow sprain/strain.

Plan:

- **Tests Ordered:** X-ray of the left elbow to rule out fractures.
- **Treatment Plan:** Rest, Ice, NSAIDs for pain relief, elbow brace.
- **Follow-Up:** In 1 week for reassessment and further imaging if needed.

Patient Information:

- **Name:** Rakesh Kumar
- **ID Number:** 1025
- **Date of Birth:** 1979-03-29
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-12
- **Join Date:** 2024-08-12
- **Discharge Date:** 2024-08-19
- **Attending Physician:** Dr. Karthik Rao

Vital Signs:

- **Temperature:** 36.8°C
- **Pulse Rate:** 80 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 130/85 mmHg
- **Oxygen Saturation:** 97%

Chief Complaint:

- Shortness of breath and wheezing for 3 days.

Medical History:

- **Past Medical History:** Asthma, seasonal allergies.
- **Allergies:** Dust and pollen.
- **Medications:** Salbutamol inhaler, Montelukast.

Physical Examination:

- **General Appearance:** Mildly anxious, no acute distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Wheezing on expiration, use of accessory muscles.
- **Heart:** Normal rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Asthma exacerbation.

Plan:

- **Tests Ordered:** Peak flow meter test, Chest X-ray.
- **Treatment Plan:** Increased dose of inhaled corticosteroids, short-acting beta agonists.
- **Follow-Up:** In 1 week for reassessment.

Patient Information:

- **Name:** Snehal Shah
- **ID Number:** 1026
- **Date of Birth:** 1998-02-22
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-14
- **Join Date:** 2024-08-14
- **Discharge Date:** 2024-08-21
- **Attending Physician:** Dr. Neelam Kapoor

Vital Signs:

- **Temperature:** 36.9°C
- **Pulse Rate:** 84 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 110/70 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Nausea, vomiting, and dizziness after a meal.

Medical History:

- **Past Medical History:** No significant history.
- **Allergies:** No known allergies.
- **Medications:** None

Physical Examination:

- **General Appearance:** Mildly pale, no acute distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Mild tenderness in the epigastric area.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Likely gastroenteritis or food poisoning.

Plan:

- **Tests Ordered:** Stool test, Abdominal ultrasound.
- **Treatment Plan:** Oral rehydration, antiemetic medications, light diet.
- **Follow-Up:** In 2 days for reassessment.

Patient Information:

- **Name:** Prashant Yadav
- **ID Number:** 1027
- **Date of Birth:** 1984-09-01
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-16
- **Join Date:** 2024-08-16
- **Discharge Date:** 2024-08-23
- **Attending Physician:** Dr. Nitin Thakur

Vital Signs:

- **Temperature:** 37.1°C
- **Pulse Rate:** 88 BPM
- **Respiratory Rate:** 20 breaths/min
- **Blood Pressure:** 120/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Severe abdominal pain and constipation for 4 days.

Medical History:

- **Past Medical History:** IBS (Irritable Bowel Syndrome), mild depression.
- **Allergies:** No known allergies.
- **Medications:** Sertraline (for depression).

Physical Examination:

- **General Appearance:** Mildly distressed.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Distended, tender on palpation.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Acute exacerbation of IBS with constipation.

Plan:

- **Tests Ordered:** Abdominal X-ray, Stool test.
- **Treatment Plan:** Stool softeners, increase fiber intake, stress management techniques.
- **Follow-Up:** In 1 week for symptom review.

Patient Information:

- **Name:** Ranjitha Reddy
- **ID Number:** 1028
- **Date of Birth:** 1994-04-12
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-18
- **Join Date:** 2024-08-18
- **Discharge Date:** 2024-08-25
- **Attending Physician:** Dr. Rajesh Kumar

Vital Signs:

- **Temperature:** 36.8°C
- **Pulse Rate:** 82 BPM
- **Respiratory Rate:** 18 breaths/min
- **Blood Pressure:** 120/75 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Pain and discomfort in the lower back radiating to the left leg.

Medical History:

- **Past Medical History:** No chronic conditions.
- **Allergies:** No known allergies.
- **Medications:** None

Physical Examination:

- **General Appearance:** Slightly overweight, no acute distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** Mild tenderness in the lower back with sciatic nerve involvement (positive straight leg raise test).
- **Neurological:** Mild tingling sensation on the left leg, no focal neurological deficits.

Assessment:

- Lumbar radiculopathy (sciatica).

Plan:

- **Tests Ordered:** MRI of the lumbar spine, X-ray of the lower back.
- **Treatment Plan:** NSAIDs for pain relief, physical therapy, and possible referral to a spine specialist if no improvement.
- **Follow-Up:** In 2 weeks to monitor progress.

Patient Information:

- **Name:** Vinod Kumar
- **ID Number:** 1029
- **Date of Birth:** 1986-12-20
- **Gender:** Male
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-19
- **Join Date:** 2024-08-19
- **Discharge Date:** 2024-08-26
- **Attending Physician:** Dr. Priya Shankar

Vital Signs:

- **Temperature:** 37.0°C
- **Pulse Rate:** 76 BPM
- **Respiratory Rate:** 16 breaths/min
- **Blood Pressure:** 125/80 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Persistent cough and fever for 5 days.

Medical History:

- **Past Medical History:** History of asthma.
- **Allergies:** No known allergies.
- **Medications:** Albuterol inhaler.

Physical Examination:

- **General Appearance:** Mild fever, looks fatigued.
- **Head and Neck:** No lymphadenopathy, throat mildly erythematous.
- **Chest and Lungs:** Wheezing on expiration, crackles heard on auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Non-tender.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Acute bronchitis with an asthma exacerbation.

Plan:

- **Tests Ordered:** Chest X-ray, sputum culture.
- **Treatment Plan:** Inhaled corticosteroids, bronchodilators (Salbutamol), antibiotics if bacterial infection suspected.
- **Follow-Up:** In 1 week for re-evaluation and further management if needed.

Patient Information:

- **Name:** Shalini Mehta
- **ID Number:** 1030
- **Date of Birth:** 1992-07-30
- **Gender:** Female
- **Country:** India
- **State:** Karnataka
- **Date of Admission:** 2024-08-20
- **Join Date:** 2024-08-20
- **Discharge Date:** 2024-08-27
- **Attending Physician:** Dr. Arun Kumar

Vital Signs:

- **Temperature:** 36.7°C
- **Pulse Rate:** 80 BPM
- **Respiratory Rate:** 17 breaths/min
- **Blood Pressure:** 110/70 mmHg
- **Oxygen Saturation:** 98%

Chief Complaint:

- Severe abdominal pain with nausea and bloating.

Medical History:

- **Past Medical History:** Polycystic ovary syndrome (PCOS), no other chronic conditions.
- **Allergies:** No known allergies.
- **Medications:** Metformin (for PCOS).

Physical Examination:

- **General Appearance:** Mild discomfort, no acute distress.
- **Head and Neck:** No abnormalities.
- **Chest and Lungs:** Clear to auscultation.
- **Heart:** Regular rhythm.
- **Abdomen:** Tender in the epigastric region with some bloating.
- **Extremities:** No edema.
- **Neurological:** Normal.

Assessment:

- Possible gastrointestinal upset, likely related to PCOS and hormonal fluctuations.

Plan:

- **Tests Ordered:** Abdominal ultrasound, basic metabolic panel, and liver function tests.
- **Treatment Plan:** Antacids, dietary modifications (avoid high-fat meals), continued Metformin for PCOS management.
- **Follow-Up:** In 1 week to review test results and symptoms.