TTE Chart 1 – Post-NSTEMI Follow-up

Chief Complaint: NSTEMI follow-up

History of Present Illness:

58-year-old male with HTN, HLD, and OSA was hospitalized 6 weeks ago for NSTEMI after presenting with sudden onset substernal chest pain radiating to left arm with diaphoresis. Cardiac cath revealed 85% LAD lesion → DES placed. Discharged on DAPT, statin, beta-blocker, and ACE inhibitor.

Today he reports adherence to all medications, no recurrent chest pain, orthopnea, or PND. Participating in phase II cardiac rehab twice weekly. Energy gradually improves, but notes occasional mild fatigue and reduced exercise stamina compared to baseline. No palpitations, syncope, or presyncope.

Past Medical History:

NSTEMI (6 weeks ago)

CAD

HTN

HLD

OSA (on CPAP)

Past Surgical History:

PCI with DES to LAD

Medications:

Aspirin 81 mg

Clopidogrel 75 mg

Atorvastatin 80 mg

Metoprolol succinate

Lisinopril

Allergies: NKDA

Family History: Father with MI age 62

Social History:

Former smoker, quit at time of MI

No alcohol or drug use

Lives with spouse, employed full time

Review of Systems:

General: No fever/chills, weight stable

CV: No chest pain, palpitations, syncope

Resp: No SOB, no cough

GI: No N/V

Neuro: No focal deficits

Psych: Mild fatigue, no depression

Physical Examination:

BP 122/76, HR 64, RR 16, SpO₂ 97%

General: Well-appearing, no distress

Cardiac: Regular rhythm, no murmurs or gallops

Lungs: Clear bilaterally

Abdomen: Soft, non-tender

Extremities: No edema

Skin: No cyanosis

Assessment:

58-year-old male 6 weeks post-NSTEMI, clinically stable and adherent to secondary prevention regimen. Functional recovery ongoing, no signs of recurrent ischemia or heart failure. Cardiac rehab participation appropriate. Repeat TTE warranted to reassess EF and wall motion abnormalities after revascularization.

Plan:

CAD: Continue DAPT, high-intensity statin, beta-blocker, ACE inhibitor

Cardiac Rehab: Continue participation and gradual activity progression

Repeat TTE at 3 months post-MI to reassess EF and wall motion

Risk Factor Control: Reinforce smoking cessation, low-sodium diet, regular exercise

Follow-up in 6–8 weeks or sooner if new chest pain, syncope, or worsening dyspnea

TTE Chart 2 – Chest Pain (Stable Angina)

**Chief Complaint:**

Intermittent chest pressure x 3 months

**History of Present Illness:**

68-year-old female with a history of HTN, HLD, CAD (s/p LAD stent 2 yrs ago) presents with intermittent substernal chest pressure. Episodes occur 2–3 times/week, precipitated by exertion, relieved by rest and nitroglycerin within minutes. No recent worsening in frequency or severity. Denies shortness of breath, palpitations, syncope, cough, fevers, or recent illness. No hospitalizations or medication changes.

**Past Medical History:**

- CAD (s/p LAD PCI 2023) - Hypertension  
- Hyperlipidemia

**Past Surgical History:**

- PCI with stent to LAD (2023)

**Medications:**

- Aspirin 81 mg  
- Metoprolol succinate - Atorvastatin  
- Lisinopril  
- PRN nitroglycerin

**Allergies:**

- No known drug allergies

**Family History:**

- Father with MI at age 62

**Social History:**

- Former smoker (quit 10 yrs ago) - No alcohol or drug use

**Physical Examination:**

- Vitals: BP 130/74, HR 72, SpO■ 98% RA  
- Lungs: Clear  
- Cardiac: Regular rhythm, no murmurs, rubs, or gallops - No peripheral edema

**EKG:**

Normal sinus rhythm, no acute ST-T changes

**Assessment:**

68-year-old female with stable exertional angina. History of LAD PCI, no acute coronary syndrome symptoms today. Hemodynamically stable, normal exam, normal EKG. Chronic CAD with preserved functional capacity, no signs of decompensation. Ongoing risk factor management is important.

**Plan:**

- Continue aspirin, beta-blocker, statin  
- Repeat TTE to assess LV function and wall motion - Outpatient follow-up in 1–2 weeks

TTE Chart 3 – Aortic Stenosis Follow-up

**Chief Complaint:**

Follow-up for known AS

**History of Present Illness:**

75-year-old male with moderate AS on prior TTE (18 months ago) presents for follow-up. Currently asymptomatic, denies chest pain, syncope, or worsening dyspnea. Remains active, able to walk daily without limitations.

**Past Medical History:**

- Moderate aortic stenosis - HTN  
- HLD

**Medications:**

- Amlodipine - Atorvastatin

**Allergies:**

- NKDA

**Family History:**

- Non-contributory

**Social History:**

- Never smoker

**Physical Examination:**

- BP 128/76, HR 66  
- 3/6 crescendo-decrescendo systolic murmur at RUSB radiating to carotids - Lungs clear  
- No edema

**EKG:**

Normal sinus rhythm

**Assessment:**

75-year-old male with known moderate aortic stenosis, clinically stable and asymptomatic. Murmur consistent with prior exams. No clinical evidence of progression to severe AS or LV dysfunction. The patient remains active with good exercise tolerance.

**Plan:**

- Repeat TTE to reassess valve gradient and LV function - Monitor for symptom development  
- Return in 6–12 months or sooner if symptoms develop

TTE Chart 4 – Mitral Regurgitation + DOE

**Chief Complaint:**

DOE x 1 month

**History of Present Illness:**

63-year-old female with known moderate MR presents with new exertional dyspnea over the past month. No chest pain, syncope, orthopnea, or PND. Reports occasional palpitations lasting seconds.

**Past Medical History:**

- Moderate MR - HTN

**Medications:**

- Lisinopril - HCTZ

**Allergies:**

- Sulfa allergy

**Family History:**

- Mother with rheumatic heart disease

**Social History:**

- Non-smoker

**Physical Examination:**

- BP 124/78, HR 82  
- Holosystolic murmur at apex radiating to axilla - Mild bibasilar crackles  
- No edema

**EKG:**

Normal sinus rhythm

**Assessment:**

63-year-old female with moderate MR now presenting with progressive exertional dyspnea, bibasilar crackles on exam, suggestive of early LV volume overload or MR progression. No orthopnea/PND, so compensated state.

**Plan:**

- Repeat TTE to assess MR severity and LV function - BMP, CBC  
- Consider cardiology referral

TTE Chart 5 – Asymptomatic Screening (Bicuspid Aortic Valve FH)

**Chief Complaint:**

Annual physical

**History of Present Illness:**

52-year-old male presenting for annual exam. No chest pain, dyspnea, palpitations, or syncope. Exercises regularly, walks 3x/week. No recent illness.

**Past Medical History:**

- None significant

**Family History:**

- Brother with bicuspid aortic valve

**Medications:**

- None

**Physical Examination:**

- Vitals normal, BMI 26  
- Cardiac and lung exams normal

**Assessment:**

52-year-old asymptomatic male with significant family history of BAV. Screening warranted to detect subclinical valvular disease or aortopathy. No abnormal findings today.

**Plan:**

- Order screening TTE to evaluate for structural heart disease - Routine labs (CBC, CMP, Lipid panel)  
- Follow up annually

TTE Chart 6 – Heart Failure Exacerbation

**Chief Complaint:**

Shortness of breath and fatigue

**History of Present Illness:**

74-year-old male with a history of HFrEF (EF 40%), ischemic cardiomyopathy, CAD s/p PCI, type 2 diabetes, and HTN presents with progressive exertional dyspnea over the past 3 weeks. Reports orthopnea requiring 2 pillows, mild paroxysmal nocturnal dyspnea, and 6-lb weight gain. Denies chest pain or syncope. Notes mild ankle swelling and decreased exercise tolerance. No recent medication changes or hospitalizations.

**Past Medical History:**

- HFrEF (EF 40%)  
- CAD s/p LAD stent (2022) - Type 2 diabetes  
- HTN  
- HLD

**Past Surgical History:**

- PCI with LAD stent (2022)

**Medications:**

- Metoprolol succinate 100 mg daily - Lisinopril 20 mg daily  
- Furosemide 40 mg daily  
- Atorvastatin 40 mg nightly

- Metformin 1 g BID - Aspirin 81 mg daily

**Physical Examination:**

- BP 148/82, HR 88 (irregularly irregular) - JVD mildly elevated at 45°  
- Bibasilar rales  
- S3 gallop present

- 1+ pitting edema

**Prior TTE:**

EF 40%, mild MR, mild LAE (1/2025)

**Assessment:**

This patient is presenting with an acute-on-chronic exacerbation of HFrEF, likely precipitated by dietary indiscretion or suboptimal diuretic regimen. The presence of weight gain, orthopnea, bibasilar crackles, elevated JVD, and S3 gallop all support a diagnosis of volume overload and worsening systolic heart failure. There is no chest pain or ischemic ECG changes to suggest ACS. His hemodynamics remain stable, and there is no evidence of cardiogenic shock. Close monitoring and intensification of diuresis are warranted, as well as reassessment of LV function to guide long-term therapy.

**Plan:**

- Increase furosemide to 80 mg daily - Repeat TTE to reassess EF  
- Chem 8, BNP, CBC today  
- Sodium restriction counseling

- RTC in 1 week

TTE Chart 7 – Valvular Disease Follow-up (AS)

**Chief Complaint:**

Aortic stenosis surveillance

**History of Present Illness:**

78-year-old female with moderate AS on TTE 12/2023 presents for follow-up. Reports mild exertional dyspnea but remains active. Denies syncope or angina.

**Past Medical History:**

- Moderate AS - HTN  
- CKD Stage 3 - HLD

**Medications:**

- Amlodipine 10 mg daily  
- Rosuvastatin 20 mg nightly

- Aspirin 81 mg daily

**Physical Examination:**

- BP 132/76, HR 70  
- 3/6 systolic murmur RUSB radiating to carotids - Lungs clear  
- No edema

**Prior TTE:**

Moderate AS, mean gradient 30 mmHg, preserved EF

**Assessment:**

The patient has moderate AS and now reports very mild exertional symptoms, which may represent early functional limitation due to progressive valvular obstruction. The exam murmur is consistent with prior findings, and there are no red flag symptoms such as syncope or angina. The risk of progression to severe AS is approximately 5–10% per year, warranting close surveillance. Given her age and CKD, monitoring of LV hypertrophy and valve gradient over time will be essential to guide potential timing of valve intervention.

**Plan:**

- Repeat TTE to evaluate gradient and valve area  
- Monitor symptoms closely  
- RTC in 6 months or sooner if syncope or angina develops

TTE Chart 8 – Palpitations Evaluation

**Chief Complaint:**

Palpitations

**History of Present Illness:**

60-year-old female with history of HTN presents with intermittent palpitations for 2 months, lasting seconds to minutes, occurring 3-4×/week. Reports mild lightheadedness during episodes but no syncope. Denies chest pain, SOB, orthopnea, or edema.

**Past Medical History:**

- HTN  
- GERD

**Medications:**

- Lisinopril 10 mg daily  
- Omeprazole 20 mg daily

**Physical Examination:**

- BP 128/74, HR 78  
- Regular rhythm on exam, no murmurs

**Prior EKG:**

NSR, no ectopy

**Assessment:**

The presentation of intermittent palpitations with preserved hemodynamics suggests a benign arrhythmia such as PACs or paroxysmal SVT. Her history of hypertension increases risk of atrial remodeling and potential future atrial fibrillation. No red flag symptoms such as syncope, severe chest pain, or sustained tachyarrhythmia are present. Structural heart evaluation via TTE is appropriate to rule out underlying cardiomyopathy or valvular pathology.

**Plan:**

- Ambulatory monitor (2 weeks)  
- Repeat TTE for structural evaluation - Electrolytes, TSH  
- RTC after results

TTE Chart 9 – Asymptomatic Screening (Marfan’s)

**Chief Complaint:**

Annual physical

**History of Present Illness:**

45-year-old male with known Marfan syndrome presents for annual surveillance. No chest pain, dyspnea, or syncope. Active lifestyle, runs 2–3×/week.

**Past Medical History:**

- Marfan syndrome

**Medications:**

- Losartan 50 mg daily

**Physical Examination:**

- BP 118/72, HR 64  
- Normal cardiac exam

**Prior TTE:**

8/2024: Normal EF, aortic root 3.8 cm

**Assessment:**

Patient is stable and asymptomatic with Marfan syndrome, with prior TTE showing mildly dilated but stable aortic root. Given the risk of progressive aortic root enlargement and potential dissection in Marfan patients, annual surveillance is essential. Continued beta-blocker/ARB therapy is appropriate, as it may slow rate of aortic dilation. No indication for surgical intervention at this time.

**Plan:**

- Repeat TTE to monitor aortic root size  
- Continue ARB therapy  
- Return annually or sooner if acute chest/back pain develops

TTE Chart 10 – Heart Failure + Aortic Regurgitation

Chief Complaint:

Cardiology follow-up

History of Present Illness:

79-year-old male with HFrEF (LVEF 40%), moderate aortic regurgitation, CAD s/p CABG 2018, and HTN presents for routine follow-up. Reports gradual decline in exertional capacity over past 4 months, now limited to walking one block before dyspnea. Sleeps on 2 pillows but denies orthopnea or PND. No chest pain or palpitations. Mild ankle swelling noted. No recent hospitalizations.

Past Medical History:

- HFrEF (EF 40%) - Moderate AR

- CAD s/p CABG - HTN, HLD

Medications:

- Carvedilol

- Sacubitril/valsartan - Furosemide

- Spironolactone

- Aspirin

- Atorvastatin

Physical Examination:

- BP 124/68, HR 72

- Displaced PMI, diastolic murmur at LSB - Bibasilar rales

- 1+ pedal edema

Prior TTE:

2/2025: EF 40%, moderate AR, mild LV dilation

Assessment:

Chronic HFrEF with moderate AR, presenting with NYHA II–III symptoms and clinical evidence of mild volume overload. AR may be contributing to progressive LV dilation and worsening functional status. No ischemic symptoms. Candidate for repeat TTE to reassess regurgitant severity, LV dimensions, and to guide potential surgical/structural evaluation.

Plan:

- Repeat TTE

- BMP, BNP

- Optimize diuretics, titrate GDMT as tolerated

- Refer to valve clinic if AR progression confirmed

TTE Chart 11 – Post-NSTEMI Follow-up

Chief Complaint:

Post-MI follow-up

History of Present Illness:

66-year-old female s/p NSTEMI 6 weeks ago with PCI to LAD presents for follow-up. No recurrent chest pain, dyspnea, or syncope. Adherent to DAPT and attending cardiac rehab twice weekly. Reports improved energy and exercise tolerance.

Past Medical History:

- CAD s/p NSTEMI + PCI (LAD) - Type 2 diabetes

- HTN, HLD

Medications:

- Aspirin

- Clopidogrel

- Metoprolol succinate - Lisinopril

- Atorvastatin

- Metformin

Physical Examination:

- BP 118/64, HR 64

- Lungs clear

- Cardiac: Regular rhythm, no murmurs

Prior TTE:

8/2025: EF 50%, mild apical hypokinesis

Assessment:

Clinically stable post-NSTEMI with good adherence to therapy and no recurrent ischemic symptoms. Prior TTE showed preserved LV function with mild RWMA, consistent with infarcted territory. Continued secondary prevention measures and monitoring are key to minimize recurrent events.

Plan:

- Repeat TTE at 3 months post-MI - Continue DAPT x 12 months

- Continue cardiac rehab

- Repeat lipid panel in 6 weeks

TTE Chart 12 – Mitral Stenosis

Chief Complaint:

Dyspnea on exertion

History of Present Illness:

72-year-old female with history of rheumatic fever presents with 3 months of progressive DOE. Denies chest pain, syncope, or orthopnea. Reports occasional palpitations.

Past Medical History:

- Moderate rheumatic MS - HTN

Medications:

- Metoprolol

- Furosemide

Physical Examination:

- BP 126/74, HR 78

- Opening snap and diastolic rumble at apex - Mild crackles

- No edema

Prior TTE:

1/2024: MVA 1.5 cm2, mean gradient 8 mm Hg

Assessment:

Progressive exertional symptoms concerning for worsening MS. Exam findings correlate with rheumatic etiology and prior imaging showing moderate stenosis. Pulmonary venous congestion likely contributing to DOE. Needs repeat TTE to evaluate for progression to severe MS and rising pulmonary pressures, which may warrant percutaneous intervention.

Plan:

- Repeat TTE

- Consider structural heart referral if progression - Continue diuretics for symptom relief

TTE Chart 13 – HFpEF + Atrial Fibrillation

Chief Complaint:

Fatigue and DOE

History of Present Illness:

81-year-old male with HFpEF, persistent AF, and HTN presents with fatigue and mild DOE x 2 months. Denies chest pain, syncope, orthopnea. Reports adherence to apixaban and rate control meds.

Past Medical History:

- HFpEF (EF 60%) - Persistent AF

- HTN, HLD

Medications:

- Apixaban

- Diltiazem CD

- Chlorthalidone - Rosuvastatin

Physical Examination:

- BP 132/78, HR 80 (irregularly irregular) - Lungs clear

- No edema

Prior TTE:

6/2024: EF 60%, mild LAE

Assessment:

Stable HFpEF with chronic AF. Persistent fatigue likely due to diastolic dysfunction and limited cardiac output reserve. Adequate rate control on exam. No overt volume overload or HF exacerbation. Repeat TTE warranted to evaluate for LA enlargement progression and diastolic function parameters to optimize management.

Plan:

- Repeat TTE

- CBC, TSH

- Continue rate control and anticoagulation - RTC in 3 months

TTE Chart 14 – Annual Physical (Marfan Syndrome)

**Chief Complaint:**

Annual physical exam

**History of Present Illness:**

42-year-old male with Marfan syndrome presents for annual exam. Reports no chest pain, dyspnea, back pain, or visual changes. Denies palpitations, syncope, or orthostatic intolerance. No new musculoskeletal issues, no worsening scoliosis, and no joint pain. Follows a low-salt diet and exercises with light aerobic activity 3 days per week. No recent illness or weight change.

**Past Medical History:**

- Marfan syndrome

**Medications:**

- Losartan 50 mg daily

**Physical Examination:**

- BP 116/70, HR 64, SpO■ 98%  
- Tall habitus, no new skeletal deformities - Cardiac: Regular rhythm, no murmurs

**Assessment:**

This 42-year-old male with Marfan syndrome is clinically stable and asymptomatic. There are no new cardiovascular, skeletal, or ocular symptoms. Physical exam is reassuring, with no evidence of murmurs, skeletal progression, or other complications. Annual imaging remains crucial to monitor for progressive aortic root dilation, valvular insufficiency, or left ventricular dysfunction. Continued adherence to ARB therapy is recommended to slow aortic enlargement and reduce dissection risk.

**Plan:**

- Repeat TTE for aortic root and valve surveillance - Routine labs (CBC, CMP, Lipids)  
- Annual follow-up

TTE Chart 15 – Bicuspid Aortic Valve Surveillance

**Chief Complaint:**

Annual exam

**History of Present Illness:**

48-year-old female with known bicuspid aortic valve presents for routine follow-up. Reports no chest pain, dyspnea, or presyncope. No recent hospitalizations. She maintains a Mediterranean diet and exercises regularly.

**Past Medical History:**

- Bicuspid aortic valve (no significant AS/AR)

**Physical Examination:**

- BP 120/74, HR 70  
- Soft systolic ejection murmur at RUSB - Lungs clear

**Assessment:**

This patient remains asymptomatic with a bicuspid aortic valve. Physical exam shows a soft systolic murmur consistent with prior findings and no signs of heart failure or progressive valvular disease. Because bicuspid aortic valves carry an increased lifetime risk of aortic root dilation, progressive stenosis, and regurgitation, serial imaging is warranted. Current guidelines support surveillance every 1–2 years depending on valve function and aortic dimensions.

**Plan:**

- Repeat TTE to evaluate valve gradient and aortic root size - Reinforce healthy lifestyle measures  
- RTC in 1 year or earlier if symptoms arise

TTE Chart 16 – Lupus Surveillance

**Chief Complaint:**

Annual follow-up

**History of Present Illness:**

39-year-old female with systemic lupus erythematosus presents for annual surveillance. No new rash, arthralgias, or dyspnea. Denies chest pain, palpitations, or edema. No recent lupus flares and tolerating hydroxychloroquine well.

**Past Medical History:**

- SLE

**Medications:**

- Hydroxychloroquine 200 mg daily

**Physical Examination:**

- BP 114/68, HR 72  
- No rashes, joint swelling, or edema - Cardiac and lung exam normal

**Assessment:**

This patient’s lupus appears well controlled, with no evidence of flare or organ involvement. Cardiac complications of lupus, including pericarditis, myocarditis, and Libman–Sacks endocarditis, may be subclinical and require periodic imaging. A repeat TTE is appropriate to evaluate for valvular lesions, pericardial effusion, or ventricular dysfunction. Continued hydroxychloroquine therapy and regular labs will help maintain remission and reduce long-term CV risk.

**Plan:**

- Order TTE to assess for valvular or pericardial disease - Routine lupus labs (CBC, CMP, complements)  
- Continue hydroxychloroquine  
- Annual follow-up

TTE Chart 17 – Hypertrophic Cardiomyopathy Family Screening

**Chief Complaint:**

Screening due to family history

**History of Present Illness:**

34-year-old male with first-degree relative diagnosed with HCM presents for screening. No chest pain, syncope, palpitations, or exertional dyspnea. Exercises recreationally without limitation.

**Past Medical History:**

- None

**Physical Examination:**

- BP 118/76, HR 64  
- Cardiac: Regular rhythm, no murmurs

**Assessment:**

This patient is asymptomatic but has a strong family history of hypertrophic cardiomyopathy, placing him at elevated risk for developing structural abnormalities and arrhythmias. Baseline TTE is warranted to assess for asymmetric septal hypertrophy, systolic anterior motion of the mitral valve, and LVOT obstruction. If imaging is normal, periodic repeat echocardiography every 1–3 years is recommended, along with ECG screening and genetic counseling. Early detection allows risk stratification for sudden cardiac death and timely intervention if hypertrophy or obstruction develops.

**Plan:**

- Baseline TTE and ECG  
- Referral to genetic counseling - RTC annually if normal

TTE Chart 18 – Post-NSTEMI Follow-up

**Chief Complaint:**

NSTEMI follow-up

**History of Present Illness:**

61-year-old male with type 2 diabetes, HTN, and prior tobacco use was hospitalized 5 weeks ago for NSTEMI. Found to have 95% mid-RCA stenosis on cath → treated with DES. Discharged on DAPT, high-intensity statin, beta-blocker, and ACE inhibitor. TTE during hospitalization: EF 50%, mild inferior wall hypokinesis.

Today he reports medication adherence and improved exercise tolerance. Denies chest pain, syncope, orthopnea, or new dyspnea. Has enrolled in cardiac rehab. Reports mild fatigue but no depressive symptoms.

**Past Medical History:**

- NSTEMI (5 weeks ago) - CAD  
- Type 2 diabetes  
- Hypertension

**Past Surgical History:**

- PCI with DES to RCA

**Medications:**

- Aspirin  
- Ticagrelor  
- Atorvastatin 80 mg nightly - Metoprolol succinate  
- Lisinopril  
- Metformin

**Allergies:**

No known drug allergies

**Family History:**

Father with MI at age 64

**Social History:**

- Quit smoking after hospitalization - No alcohol or drugs  
- Married, lives with spouse

**Review of Systems:**

- CV: No chest pain or palpitations - Resp: No SOB or cough  
- GI: No N/V  
- Psych: Normal mood

**Physical Examination:**

- BP 124/72, HR 64  
- Cardiac: Regular rhythm, no murmurs - Lungs clear

**Assessment:**

61-year-old male, 5 weeks post-NSTEMI, clinically stable on guideline-directed therapy with no recurrent ischemic symptoms. Cardiac rehab initiation appropriate and risk factor modification underway. No evidence of heart failure.

**Plan:**

1. CAD: Continue DAPT, statin, beta-blocker, ACEi  
2. Cardiac Rehab: Continue participation  
3. Repeat TTE at 3–6 months to reassess wall motion  
4. Risk factor control: encourage diet, exercise, diabetes management 5. RTC in 6 weeks

TTE Chart 19 – Post-PCI Follow-up with New Angina

**Chief Complaint:**

Chest pain follow-up

**History of Present Illness:**

70-year-old female with CAD s/p PCI 2 months ago presents with 2 weeks of exertional chest tightness and mild SOB. Pain resolves with rest, not associated with diaphoresis. Reports

adherence to DAPT and statin. No palpitations or syncope.

**Past Medical History:**

- CAD s/p PCI (2 months ago) - HTN  
- HLD

**Past Surgical History:**

- DES to LAD

**Medications:**

- Aspirin  
- Clopidogrel  
- Rosuvastatin - Metoprolol  
- Amlodipine

**Allergies:**

Penicillin (rash)

**Social History:**

- Non-smoker  
- Lives with husband

**Review of Systems:**

- CV: Exertional chest tightness, no syncope - Resp: Mild exertional SOB  
- GI/Neuro: Negative

**Physical Examination:**

- BP 130/78, HR 68  
- Regular rhythm, no murmurs - No edema

**Assessment:**

70-year-old female with recurrent exertional angina 2 months post-PCI, concerning for restenosis or progression of CAD. Hemodynamically stable, requiring further ischemic evaluation.

**Plan:**

1. CAD: Continue current regimen  
2. Stress test: Schedule exercise stress echo 3. Repeat TTE to reassess LV function  
4. Reinforce med adherence  
5. RTC after stress test results

TTE Chart 20 – NSTEMI Follow-up with Depression

**Chief Complaint:**

Post-MI follow-up

**History of Present Illness:**

58-year-old male admitted 6 weeks ago with NSTEMI, treated with PCI to LCx. Since discharge, reports adherence to DAPT, statin, and beta-blocker. Denies recurrent chest pain, but notes poor sleep, irritability, and loss of motivation to exercise.

**Past Medical History:**

- NSTEMI (6 weeks ago) - CAD  
- HTN, HLD

**Medications:**

- Aspirin  
- Clopidogrel - Atorvastatin - Metoprolol  
- Losartan

**Review of Systems:**

- CV: No angina  
- Psych: Depressed mood, insomnia, anhedonia

**Physical Examination:**

- BP 118/70, HR 60  
- Cardiac: Regular rhythm - Lungs clear  
- Psych: Flat affect

**Assessment:**

58-year-old male s/p NSTEMI clinically stable from a cardiac standpoint but with significant post-MI depressive symptoms. Post-MI depression increases risk of recurrent CV events and poor adherence if untreated.

**Plan:**

1. CAD: Continue secondary prevention regimen  
2. Depression: Initiate SSRI (sertraline), refer to behavioral health 3. Repeat TTE at 3 months  
4. Encourage participation in cardiac rehab  
5. Close follow-up in 4–6 weeks