HISTORY AND PHYSICAL

James David Heiser:
DOB: 12/15/1965
Age: 58
Sex: M
Visit number: 10107097
Room number: ER-WR
Admission Date: 12/06/2024

Reason for Admission: Symptomatic tachycardia with dizziness

Attending Physician: Jonathan Seale, MD

PCP: Jonathan Seale, MD

History of Present Illness:

This is a 58-year-old male with a past medical history of hypertension presenting with a chief complaint of dizziness. The patient reports that while showering, he felt flushed and dizzy and noted a heart rate greater than 140 bpm on his smartwatch (resting HR is usually in the 58-59 bpm range). He denies associated chest pain, shortness of breath, nausea, vomiting, or generalized weakness. He has no history of coronary artery disease, lung disease, renal disease, or neurological disease. The patient denies any prior similar episodes or recent medical evaluation.

Vital signs in the emergency department showed tachycardia with a heart rate of 128 bpm, blood pressure of 143/82 mmHg, respiratory rate of 17 breaths per minute, oxygen saturation of 97%, and temperature within normal limits. Lab results revealed a mildly elevated NT-proBNP at 152 and elevated BUN at 24, but

were otherwise unremarkable. Imaging with a single-view chest X-ray showed no acute cardiopulmonary pathology, with clear lungs and normal cardiac size. Treatment in the ED included an IV fluid bolus and administration of IV metoprolol 5 mg, which briefly lowered the heart rate to below 100 bpm.

The suspected diagnosis is symptomatic tachycardia of unclear etiology, and the patient is being admitted for observation and further evaluation, including echocardiography and stress testing.

Allergies: No Known Drug Allergy (NKDA)

Home Medications:

- amLODIPine Besylate 2.5MG Oral Tablet - 2.5 milligrams at bedtime
- Benazepril 40MG Oral Tablet - 20 milligrams at bedtime
- Benazepril 40MG Oral Tablet - 40 milligrams in the morning

Past Medical History (PMH):
-Hypertension (Home meds: amLODIPine Besylate 2.5 mg at bedtime, Benazepril 40 mg in the morning and 20 mg at bedtime)

Past Surgical History (PSH): None

Family History: Non-contributory

Social History: The patient is a never smoker, with no alcohol use or drug use.

Review of Systems:

- General: Denies fever, chills, generalized weakness, weight loss, or abnormal weight gain
- Head, Eyes, Ears, Nose, Throat (HEENT): Denies visual changes, nasal congestion, sore throat

- Cardiovascular (CV): **Affirms dizziness and near-syncope, palpitations,** denies chest pain, syncope, edema
- Lungs: Denies dyspnea, cough, wheezing
- Gastrointestinal (GI): Denies abdominal pain, nausea, vomiting, diarrhea, constipation
- Genitourinary (GU): Denies dysuria, hematuria, frequency, urgency
- Musculoskeletal: Denies new joint pain/swelling, back pain
- Skin: Denies rashes, pruritus, dry skin
- Neurologic: Denies paresthesias, focal weakness, headache, altered LOC
- Hematologic: Denies excessive bruising or bleeding
- Endocrine: Denies polyphagia, heat/cold intolerance
- Psychiatric: Denies depression, anxiety, agitation

Vital Signs
Blood Pressure 143/82 mmHg
Mean Arterial Pressure 102 mmHg
Heart Rate (Pulse) 128 bpm
Respiratory Rate (RR) 17 breaths per minute
Oxygen Saturation 97%
Temperature 97°F
Pain Level 0/10
Weight 102 kg
Height 72 inches
BMI 30.5

Physical Exam
Gen: AAO. NAD.
HEENT: MMM, no lymphadenopathy
CV: **Tachycardic rate, irregularly irregular rhythm**. No m/c/g/r.
Lungs: Normal work of breathing. CTAB.
Abd: Normoactive bowel sounds. Soft, non-tender.
Ext: No cyanosis, clubbing, or edema. Peripheral pulses 2+.

Neuro: No focal deficits. Oriented x 3.
Psych: Appropriate mood, affect.
Skin: No rashes or lesions.

Labs:

Test	Result	Flag	Units	Reference Range
CBC WITH AUTO DIFF				
WBC	7.8		10^3/uL	(4.0 - 11.0)
RBC	5.23		10^6/uL	(3.80 - 6.50)
Hemoglobin	16.5		g/dL	(13.5 - 18.4)
Hematocrit	50.8		%	(40.5 - 55.8)
MCV	97.1	High	fL	(76.0 - 96.0)
RDW-CV%	13.4		%	(10.0 - 15.0)
Platelets	224		10^3/uL	(150 - 400)
%Monocytes	11.0	High	%	(3.0 - 10.0)
%Eosinophils	0.5	Low	%	(1.0 - 5.0)
#Monocytes	0.9	High	10^3/uL	(0.2 - 0.8)
NT-ProBNP	152.0	High	pg/mL	(0.0 - 125)
Magnesium	2.10		mg/dL	(1.60 - 2.30)
TSH	2.63		uL	(0.36 - 3.74)
PTT	36.0	High	Secs	(25.0 - 33.0)
Glucose	112	High	mg/dL	(74 - 106)
BUN	24	High	mg/dL	(9 - 20)
Total Protein	8.9	High	g/dL	(6.4 - 8.2)

Imaging:

Chest X-Ray (1V) - 12/06/2024:

- Cardiac size not enlarged; central vessels are unremarkable.
- Clear lungs without pneumonia or pulmonary edema.
- No pleural effusion or pneumothorax.
- Aortic calcification visualized, no aneurysm noted.
- Degenerative changes and scoliotic curvature in the spine.

Assessment/Plan:

Symptomatic Tachycardia, Unclear Etiology (R00.0)
-Tachycardia improved with IV metoprolol, underlying cause unclear.
-Aflutter on monitor here on telemetry. CHADSVASC score of 1. Consider anticoagulation.
-Plan: Monitor telemetry, echocardiogram, IV fluids, PRN metoprolol. start on PO metoprolol 25mg BID.

Dizziness, Likely Secondary to Tachycardia (R42)
-No syncope; no concerning neurological symptoms identified.
-Plan: Monitor symptoms, maintain hydration, rule out secondary causes.

Mildly Elevated NT-proBNP, Likely Strain or Volume Status (R79.89)
-May represent volume shifts; no overt heart failure signs.
-Plan: Echo to assess cardiac function, continue IV fluids.

Elevated BUN, Likely Pre-Renal State (R79.89)
-Mild elevation, potentially dehydration-related.
-Plan: Monitor renal panel, continue IV fluids, ensure adequate perfusion.

Essential Hypertension (I10)
-Home meds: Amlodipine 2.5 mg QHS, Benazepril 40 mg QAM, 20 mg QHS.
-Plan: Continue home medications; monitor BP during hospitalization.

DVT Prophylaxis: scd
GI Prophylaxis: Not indicated

Diet: AHA
Code: Full
Dispo: Observation

Jonathan Seale, MD
12/06/2024
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