Patient Name: Johnathan Ray Parker
Date of Birth: 12/07/1984
Age: 40
Gender: Male
Date of Examination: 09/23/2024
Patient ID: JR-840707

Presenting Complaint:

Mr. Johnathan Parker presented to the clinic with complaints of fatigue, shortness of breath, and mild chest discomfort for the past two weeks. He reports no recent changes in diet or exercise and denies any fever, night sweats, or significant weight loss.

Medical History:

- **Hypertension** – diagnosed in 2016, currently managed with Lisinopril 20mg daily.
- **Hyperlipidemia** – diagnosed in 2020, currently on Atorvastatin 40mg daily.
- **Allergies:** No known drug allergies.
- **Surgical History:** Appendectomy in 2005.
- **Family History:**
    - Father: Hypertension, deceased at 67 due to myocardial infarction.
    - Mother: Type 2 Diabetes, alive, age 72.

Social History:

- **Smoking:** 10 pack-year history, quit in 2019.
- **Alcohol:** Occasional (2-3 drinks/week).
- **Occupation:** Office Manager at a local financial firm.
- **Exercise:** Limited to light walking; reports sedentary lifestyle due to desk work.

Physical Examination:

General:
Well-nourished, alert, oriented, no acute distress.

Vitals:

- Blood Pressure: 148/92 mmHg

- Heart Rate: 86 bpm
- Respiratory Rate: 18 breaths/min
- Oxygen Saturation: 96% on room air
- Temperature: 98.6°F (37°C)

Cardiovascular:
S1, S2 heard clearly, no murmurs, gallops, or rubs. Peripheral pulses 2+ bilaterally. Mild edema noted in lower extremities.

Respiratory:
Lungs clear to auscultation bilaterally. No wheezing, rales, or rhonchi.

Abdomen:
Soft, non-tender, non-distended. Bowel sounds present. No masses or organomegaly.

Neurological:
Cranial nerves II-XII intact. No focal neurological deficits. Strength 5/5 in all extremities.

Musculoskeletal:
No joint swelling or tenderness. Full range of motion in all extremities.

Investigations:

Laboratory Results (09/22/2024):

- Hemoglobin: 13.8 g/dL (Normal: 13.5-17.5 g/dL)
- White Blood Cell Count: 7,800/mcL (Normal: 4,000-11,000/mcL)
- Platelets: 240,000/mcL (Normal: 150,000-450,000/mcL)
- Blood Urea Nitrogen (BUN): 18 mg/dL (Normal: 7-20 mg/dL)
- Serum Creatinine: 0.9 mg/dL (Normal: 0.7-1.3 mg/dL)
- Fasting Blood Glucose: 104 mg/dL (Normal: 70-100 mg/dL)
- Lipid Panel:
    - Total Cholesterol: 210 mg/dL (High)
    - LDL: 140 mg/dL (High)
    - HDL: 45 mg/dL (Borderline)
    - Triglycerides: 190 mg/dL (High)

Electrocardiogram (ECG):
Normal sinus rhythm, no signs of ischemia or previous infarct.

Chest X-Ray:
No acute pulmonary findings. Heart size within normal limits.

Assessment:

1. **Hypertension, poorly controlled**
2. **Hyperlipidemia, suboptimal response to current therapy**
3. **Exertional dyspnea with a history of smoking** – likely secondary to cardiovascular risk factors. Differential diagnosis includes mild heart failure or early coronary artery disease, but more testing required.

Plan:

1. **Adjust antihypertensive therapy:** Increase Lisinopril to 40mg daily. Monitor blood pressure bi-weekly.
2. **Continue Atorvastatin 40mg** but reassess lipid levels in 6-8 weeks. Consider adding Ezetimibe if LDL levels remain high.
3. **Order stress test and echocardiogram** to further evaluate for underlying coronary artery disease or heart failure.
4. **Lifestyle modifications:**
    - Encourage a heart-healthy diet (Mediterranean diet recommended).
    - Increase daily physical activity with gradual introduction of light aerobic exercise.
    - Counseling for weight loss with a target of 10% reduction over the next 6 months.
5. **Follow-up:** In 4 weeks for stress test results and reevaluation of hypertension.

Physician: Dr. Emily White, MD
Signature: _____
Date: 09/23/2024