Patient Name: John Doe

Date of Birth: January 1, 1980

Date of Examination: April 11, 2024

Referring Physician: Dr. Jane Smith

Medical Facility: Copilot General Hospital

Chief Complaint:

The patient presents with a two-week history of intermittent chest pain, exacerbated by physical exertion, and associated shortness of breath.

History of Present Illness:

Mr. Doe has been experiencing chest discomfort, characterized as a pressure-like sensation in the central chest, radiating to his left arm. The episodes last approximately 5-10 minutes and are relieved by rest. He denies any recent infections, cough, or fever.

Past Medical History:

- Hypertension, controlled with medication.

- Hyperlipidemia, managed with diet and statin therapy.

- No previous surgeries or hospitalizations.

Family History:

- Father had a myocardial infarction at age 50.

- Mother has type 2 diabetes mellitus.

- No known genetic disorders.

Social History:

- Non-smoker.

- Occasional alcohol consumption.

- Sedentary lifestyle with minimal physical activity.

Medications:

- Lisinopril 10 mg daily for hypertension.

- Atorvastatin 20 mg daily for hyperlipidemia.

Allergies:

- No known drug allergies.

- No known food allergies.

Review of Systems:

- Cardiovascular: No palpitations or syncope.

- Respiratory: No cough or wheezing.

- Gastrointestinal: No abdominal pain or changes in bowel habits.

- Genitourinary: No dysuria or hematuria.

- Musculoskeletal: No joint pain or muscle weakness.

- Neurological: No headaches or dizziness.

- Dermatological: No rashes or lesions.

- Psychiatric: No anxiety or depression.

Physical Examination:

- General: Well-nourished male in no acute distress.

- Vital Signs: Blood pressure 130/80 mmHg, heart rate 72 bpm, respiratory rate 16 breaths/min, temperature 98.6°F (37°C).

- Cardiovascular: Regular rate and rhythm, no murmurs, rubs, or gallops.

- Respiratory: Clear to auscultation bilaterally, no wheezes or crackles.

- Abdomen: Soft, non-tender, no hepatosplenomegaly.

- Extremities: No edema, pulses intact.

- Neurological: Alert and oriented, cranial nerves II-XII intact, normal strength and sensation.

Diagnostic Studies:

- Electrocardiogram (ECG): Normal sinus rhythm, no acute ST or T wave changes.

- Chest X-Ray: No cardiomegaly or pulmonary congestion.

- Echocardiogram: Normal chamber sizes, no valvular abnormalities, ejection fraction estimated at 60%.

- Exercise Stress Test: Negative for inducible ischemia at a high workload.

- Blood Tests: Comprehensive metabolic panel within normal limits, complete blood count normal, thyroid-stimulating hormone (TSH) normal, fasting lipid panel shows improved LDL cholesterol levels.

Assessment:

The patient's clinical presentation is consistent with stable angina pectoris. The risk factors include hypertension, hyperlipidemia, and a positive family history of coronary artery disease. The diagnostic studies do not show evidence of acute coronary syndrome or structural heart disease.

Plan:

1.

Continue current medications and monitor blood pressure and lipid levels.

2.

Initiate anti-anginal therapy with a beta-blocker, considering metoprolol 50 mg daily.

3.

Recommend low-dose aspirin for its antiplatelet effect, unless contraindicated.

4.

Encourage lifestyle modifications, including a heart-healthy diet, regular aerobic exercise, and smoking cessation counseling.

5.

Schedule an outpatient coronary angiography to evaluate for coronary artery disease.

6.

Arrange a follow-up visit in two weeks to assess response to therapy and review angiography results.

Prognosis:

With adherence to medical therapy and lifestyle changes, the patient's prognosis is good. The goal is to prevent the progression of coronary artery disease and reduce the risk of acute coronary events.

Physician's Signature:

Dr. Jane Smith

April 11, 2024