Medical Report

Patient Information
- Name: John Doe
- Age: 45 years
- Gender: Male
- Patient ID: 2025-1001
- Date of Admission: 02-Oct-2025
- Date of Report: 03-Oct-2025

Presenting Complaint
- Severe chest pain radiating to the left arm for the past 2 hours.
- Associated with shortness of breath and sweating.

History of Present Illness
- Onset: Sudden
- Duration: 2 hours
- Progression: Increasing in severity
- Relieving factors: None reported
- Aggravating factors: Physical exertion

Past Medical History
- Hypertension (diagnosed 5 years ago)
- Type 2 Diabetes Mellitus (diagnosed 8 years ago)
- No prior history of myocardial infarction

Family History
- Father: Heart disease (died at 62 due to MI)
- Mother: Type 2 Diabetes

Medications
- Metformin 500 mg twice daily
- Amlodipine 5 mg once daily

Allergies
- No known drug allergies

Examination Findings
- General: Patient anxious, diaphoretic
- Vitals:
- Blood Pressure: 150/95 mmHg
- Heart Rate: 110 bpm
- Respiratory Rate: 24/min
- Oxygen Saturation: 92% on room air
- Cardiovascular: S4 present, no murmurs
- Respiratory: Clear breath sounds
- Abdomen: Soft, non-tender

Investigations
- ECG: ST elevation in leads II, III, aVF
- Troponin I: Positive (5.2 ng/mL)
- Blood Sugar (RBS): 230 mg/dL
- HbA1c: 7.9%

Diagnosis
- Acute Inferior Wall Myocardial Infarction

Management Plan
1. Admit to Coronary Care Unit (CCU)
2. Oxygen supplementation
3. Antiplatelet therapy: Aspirin 325 mg + Clopidogrel 300 mg (loading dose)
4. Anticoagulation: IV Heparin 5000 IU bolus
5. Analgesia: IV Morphine 5 mg
6. Prepare for urgent coronary angiography and possible PCI

Prognosis
- Guarded; requires close monitoring in CCU

Physician
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