Diagnosis Card

Patient Name: John Doe

Age: 45

Date of Consultation: 2024-11-27

Ref. No.: DC000001

Chief Complaint (CC):

- Persistent chest pain lasting for 3 weeks, occasional shortness of breath.

History of Present Illness (HPI):

- The patient reports dull, non-radiating chest pain that worsens after physical exertion. No associated nausea or vomiting.
- History of hypertension for 10 years, non-compliant with medications.
- Family history of cardiovascular diseases.

Vital Signs:

- Blood Pressure (BP): 150/100 mmHg
- Heart Rate (HR): 88 bpm
- Respiratory Rate (RR): 16 breaths/min
- Temperature: 36.8°C

Physical Examination (PE):

- General: Alert, well-oriented. No signs of acute distress.
- Cardiovascular: S1 and S2 normal, no murmurs detected.
- Respiratory: Clear breath sounds bilaterally.
- Extremities: No edema, pulses are intact bilaterally.

Investigations:

1. Electrocardiogram (ECG): Mild ST-segment depression.
2. Chest X-ray: No abnormalities detected.
3. Blood Tests:
    - Total Cholesterol: 240 mg/dL (high)
    - LDL: 160 mg/dL (high)
    - HDL: 35 mg/dL (low)

Diagnosis:

- Stable Angina Pectoris
- Hypertension, poorly controlled

- Hyperlipidemia

Treatment Plan:

1. Lifestyle Modifications:
    - Low-sodium, low-fat diet.
    - Regular aerobic exercise (30 mins/day, 5 days/week).
2. Medications:
    - **Aspirin 81 mg**: Once daily.
    - **Atorvastatin 40 mg**: Once daily, at night.
    - **Metoprolol 50 mg**: Twice daily.
    - **Nitroglycerin 0.4 mg**: Sublingually as needed for chest pain.
3. Follow-up:
    - In 2 weeks for blood pressure and lipid profile review.
    - Stress test to evaluate ischemic burden.

Doctor's Notes:

- Patient advised to strictly adhere to the prescribed medication and lifestyle changes.
- Referred to a cardiologist for further evaluation.

Doctor's Signature:
Dr. Sarah Bennett, MD
Cardiologist, Union Medical Hospital