Patient Case

Chief Complaint (CC):

Chest pain

History of Present Illness (HPI):

Bettie is a 48-year-old female who presents with a chief complaint of intermittent chest pain that started 3 months ago. The chest pain comes and goes, lasting 1-2 hours, but recently up to 3-4 hours. It is exacerbated by eating solid food and exercising within an hour of eating. The pain is relieved by regurgitation and is worse when lying down. No shortness of breath reported. Associated symptoms include hand pain, difficulty swallowing, and bloating.

Past Medical History (PMH):

No autoimmune conditions reported.

Past Surgical History (PSH):

N/A

Family History (FH):

N/A

Social History (SH):

N/A

Home Medications:

N/A

Allergies:

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N/A

Review of Systems (ROS):

N/A

Physical Exam (PE):

Cardiovascular Examination Findings:

- Heart rate is regular.
- No murmurs, gallops, or rubs noted.
- No jugular venous distention.
- Normal S1 and S2 heart sounds heard.
- Peripheral pulses are equal and strong bilaterally.

Lung Examination:

- Clear to auscultation bilaterally.
- No wheezes, crackles, or rhonchi noted.
- Normal breath sounds.

Vital Signs:

- Blood Pressure: 130/80 mmHg
- Pulse Rate: 75 bpm
- Respiratory Rate: 16 breaths/min
- Temperature: 37.0°C
- SpO2: 97%

Laboratory and Imaging Results:

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Chest X-Ray (CXR): No acute cardiopulmonary abnormalities; mild esophageal dilation consistent with esophageal dysmotility.

Assessment and Plan:

[Left blank for further completion]