Patient Case

HISTORY AND PHYSICAL

Chief Complaint (CC): Chest pain

History of Present Illness (HPI): Bettie is a 48-year-old female presenting with a chief complaint of chest pain. She describes the pain as a tightness under the middle of her chest that has been occurring for the past 3 months. The pain is worse with solid food and exercise after eating, and it is relieved by regurgitation. The episodes have been increasing in duration over the past 3 months. She denies any shortness of breath, palpitations, fever, chills, cough, runny nose, or sick contacts. No recent changes in activity or injuries reported, although she has reduced her running activity due to stress from work and a recent verbally abusive relationship. The chest pain does not radiate and is not associated with diaphoresis or nausea/vomiting.

Past Medical History (PMH): Heartburn and acid reflux for over 10 years, hypertension.

Past Surgical History (PSH): N/A

Family History (FH): Father had hypertension and passed away from a heart attack in his 50s.

Social History (SH): Recently out of a verbally abusive relationship, which has been a source of stress. No history of smoking, alcohol, or recreational drug use.

Home Medications: Amlodipine 5mg once daily.

Allergies: No known drug allergies.

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Review of Systems (ROS):

- Constitutional: Denies fever, chills, or weight changes.
- HEENT: Denies headaches, vision changes, or sore throat.
- Respiratory: Denies shortness of breath, cough, or wheezing.
- Cardiovascular: Denies palpitations, syncope, or lower extremity edema.
- Gastrointestinal: Positive for heartburn, regurgitation, and chest pain as described in HPI. Denies nausea, vomiting, or abdominal pain.
- Genitourinary: No complaints.
- Musculoskeletal: No complaints.
- Neurological: Denies dizziness, weakness, or numbness.
- Psychiatric: Denies anxiety or depression but reports stress from work and recent relationship.
- Endocrine: No complaints.
- Hematologic/Lymphatic: No complaints.
- Integumentary: No complaints.

Physical Exam (PE):

- Vital Signs: Blood pressure 130/80 mmHg, pulse 75 bpm, respiratory rate 16 breaths/min, temperature 37.0°C, SpO2 97%.
- General Appearance: Well-nourished, no acute distress.
- Head and Neck: Normocephalic, atraumatic.
- Cardiovascular: Regular rate and rhythm with no murmurs, gallops, or rubs detected.
- Respiratory: Clear breath sounds bilaterally with no wheezes, rales, or rhonchi observed.
- Abdomen: Soft, non-tender, non-distended.
- Extremities: No edema, good distal pulses.
- Skin: Warm, dry, and intact.
- Neurological: Oriented to person, place, time, and situation.

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Laboratory and Imaging Results:

- EKG: Normal sinus rhythm, no ST segment changes, no significant arrhythmias, no signs of myocardial infarction.

Assessment and Plan:

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