Patient Case

PATIENT DOOR CHART and Learner Instructions

- Patient Name: Bettie

- Age: 48

- Legal Sex: Female

- Chief Complaint: Chest pain

- Clinical Setting: Outpatient clinic

Vital Signs:

- Blood Pressure Reading: 130/80 mmHg

- Pulse Rate: 75 bpm

- Respiratory Rate: 16 breaths/min

- Temperature (Celsius): 37.0

- SpO2: 97%Learner Tasks:

Learner Tasks

1. Obtain an appropriately focused and detailed history based upon the chief complaint.

2. Perform a pertinent physical examination based upon the chief complaint.

3. Discuss your diagnostic impressions and next steps with the patient.

4. Place appropriate orders for the patient.

5. Review results with the patient and further next steps.

6. Answer any questions the patient may have to the best of your ability.

Patient Case

Clinical Interview:

Doctor: what brings you in today?

Patient: Chest pain.

Doctor: When did it start?

Patient: Three months ago.

Doctor: Is it constant? Or does it come and go?

Patient: It comes and goes.

Doctor: How long does it last each time it comes?

Patient: 1-2 hours, but recently up to 3-4 hours.

Doctor: Is there anything that makes it worse?

Patient: Eating solid food and exercising within an hour of eating.

Doctor: Is there anything that makes it better?

Patient: Relieved by regurgitation.

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Doctor: Is it worse when you lay down?

Patient: Yes, I've noticed it after lying down.

Doctor: Have you had any shortness of breath?

Patient: No, no shortness of breath.

Doctor: Any other symptoms that have started around the same time?

Patient: My hands hurt, it's tough to swallow, and I feel bloated.

Doctor: Do you have any autoimmune conditions?

Patient: I haven't been diagnosed with any.

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Orders:

cxr

Date and Time of Request: 2024-12-04 19:19:04

examine heart

Date and Time of Request: 2024-12-04 19:18:38

examine lungs

Date and Time of Request: 2024-12-04 19:18:12

Results:

Imaging Results:

Physical Exam Findings:

Upon examining the heart:

- Cardiovascular Examination Findings:

Heart rate is regular.

No murmurs, gallops, or rubs noted.

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No jugular venous distention.

Normal S1 and S2 heart sounds heard.

Peripheral pulses are equal and strong bilaterally.

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Vital Signs Check:

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

No additional details or lab tests were ordered besides the heart examination.

Physical Exam Findings:

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- Lung Examination:

Clear to auscultation bilaterally.

No wheezes, crackles, or rhonchi noted.

Normal breath sounds.

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Please note that these findings are based on the specified order to examine the lungs for the current patient scenario.