**Physician Summary Report**
**Date of Visit:** August 6, 2025  09:15
**Patient Name:** Mary Johnson  **MRN:** MN-452311  **Visit No.:** PV-08-06-2025
**Attending Physician:** John Smith, MD (Cardiology)

**Chief Complaint**

Progressive shortness of breath, lower extremity swelling, and palpitations.

**Location:**

- Bilateral lower legs
- Precordial chest area

**Quality:**

- “Tightness” in chest
- Pitting edema in ankles

**Severity:**

- Dyspnea 7/10 with exertion
- Palpitations intermittent, moderate

**Duration:**

- Dyspnea over 1 week
- Edema noted over 5 days
- Palpitations for 2 days

**Timing:**

- Worse on exertion and when lying flat
- Improves with sitting up

**Context:**

- History of hypertension and diabetes
- Recent upper respiratory infection

**Modifying Factors:**

- Rest and sitting upright provide partial relief

**Associated S/S:**

- Orthopnea (2 pillows)
- Paroxysmal nocturnal dyspnea

- Mild fatigue

**History of Present Illness**

Ms. Johnson is a 68-year-old female with longstanding hypertension, type 2 diabetes, hyperlipidemia, and coronary artery disease (status post drug-eluting stent in 2018) who presents with one week of progressive dyspnea on exertion, orthopnea requiring two pillows, and bilateral ankle swelling. Over the past two days she has experienced intermittent palpitations described as “racing” and “irregular.” She denies chest pain, syncope, fever, or cough. No history of recent travel or deep vein thrombosis.

**Past Medical History**

- Hypertension (diagnosed 2005)
- Type 2 Diabetes Mellitus (diagnosed 2010)
- Hyperlipidemia
- Coronary artery disease, stent placement (2018)
- Chronic kidney disease, stage 3

**Allergies**

- Penicillin (rash)

**Social History**

- Former smoker (15 pack-years; quit 1995)
- Occasional alcohol use (2–3 drinks/week)
- Lives with spouse; retired schoolteacher
- No illicit drug use

**Review of Systems**

- **Constitutional:** Reports fatigue; no weight loss, fever, or chills
- **Cardiovascular:** Palpitations; no chest pain or syncope
- **Respiratory:** Dyspnea on exertion; orthopnea; denies cough
- **Gastrointestinal:** No nausea, vomiting, or abdominal pain
- **Genitourinary:** No dysuria or hematuria

- **Musculoskeletal:** Bilateral ankle swelling; no joint pain
- **Neurological:** No dizziness or focal weakness
- **Psychiatric:** Mild anxiety due to breathing difficulty
- All other systems negative.

**Physical Examination**

**Vital Signs (09:20):**

- Temperature: 37.0 °C
- Heart Rate: 112 bpm (irregularly irregular)
- Respiratory Rate: 22 breaths/min
- Blood Pressure: 150/88 mm Hg
- $SpO_2$: 94 % on room air

**General:** Alert, in mild respiratory distress when supine.

**Cardiovascular:**

- Rhythm: Irregularly irregular
- S1/S2: Normal; S3 audible
- No murmurs or gallops

**Lungs:**

- Bibasilar crackles to mid-lung fields
- No wheezes

**Abdomen:**

- Soft, non-tender, no hepatosplenomegaly

**Extremities:**

- 2+ pitting edema bilateral ankles
- No calf tenderness

**Neurological:**

- Grossly intact; no focal deficits

**Imaging & Diagnostic Studies**

- **Chest X-Ray (08/06/2025):**

    - Cardiomegaly
    - Mild interstitial pulmonary edema
- **Electrocardiogram (08/06/2025):**
    - Atrial fibrillation with rapid ventricular response (~110 bpm)
- **Echocardiogram (06/15/2025):**
    - Left ventricular ejection fraction 40 %
    - Mild left atrial enlargement

**Diagnoses**

- New-onset atrial fibrillation with rapid ventricular response
- Acute decompensated systolic heart failure
- Hypertension, stable
- Type 2 diabetes mellitus, well controlled

**Ordered Services & Procedures**

- Continuous telemetry monitoring
- Laboratory studies: CBC, BMP, BNP, TSH
- Rate control medications: IV and oral as needed
- Anticoagulation evaluation ($CHA_2DS_2$-VASc score calculation)

**Current Medications**

- **Lisinopril** 10 mg daily
- **Metformin** 500 mg BID
- **Atorvastatin** 20 mg nightly
- **Low-dose aspirin** 81 mg daily

**Physician Plan**

1. **Hospital Admission:**
    - Admit to telemetry for rate control and diuresis
2. **Rate Control:**

    - Initiate IV diltiazem infusion, transition to oral beta-blocker once stable
3. **Diuresis:**
    - IV furosemide 40 mg bolus, adjust per response
4. **Anticoagulation:**
    - Assess stroke risk; likely start direct oral anticoagulant after renal dosing review
5. **Diagnostics & Monitoring:**
    - Monitor electrolytes and renal function during diuresis
    - Repeat echocardiogram if no improvement in volume status
6. **Consults:**
    - Cardiology for rhythm management
    - Endocrinology for diabetes optimization if indicated

**Goals of Care**

- Achieve ventricular rate < 90 bpm at rest
- Resolution of pulmonary congestion and peripheral edema
- Prevent thromboembolic events
- Optimize volume status and renal function

**Disposition**

- Admit to step-down telemetry unit
- Condition: guarded but stable pending response to therapy

**Vital Signs Summary**

| Time | Temp (°C) | HR (bpm) | BP (mm Hg) | RR (breaths/min) | $SpO_2$ (%) |
|---|---|---|---|---|---|
| 09:20 | 37.0 | 112 | 150/88 | 22 | 94 |

**Electronically signed**
John Smith, MD (NPI 0987654321)
Department of Cardiology