Identifying Data:

Full Name: Mr. P

Address: Queens, NY

Date of Birth: 11/08/1977

Date & Time: July 13, 2020

Location: Queens Line Medical Center, Ozone Park, NY

Source of Information: Self

Source of Referral: Self

Mode of Transport: wife drove me to the clinic

Chief Complaint: I am experiencing chest pain and palpitation for the past 3 days

HPI:

A 42 years old male with PHMx of GERD presents to the office today complaining of chest pain and palpitation for the past 3 days. Pt went to the Northwell Forest Hill ER on 07/11/20, complaining of chest pain in the middle of the chest. ER performed EKG, chest x ray, lab works and the results was WNL, so pt was discharged on 07/11/20 with a diagnosis of GERD. Pt is still experiencing chest pain, and it has worsened. Pt describes the pain as a sharp intermittent pressure in his chest that causes shortness of breath. Pt was exercising three days ago when he started to feel this chest pain, and he states that he felt "his heart jumping out of his chest. Pt never experienced this type of pain before, and he feels like he is going to die. The pain is aggravated with inspiration and nothing alleviates the pain. Pt rates the pain as 10/10 at it worse and 5/10 at it best. Pt took Bayer and Gas X with no relief. Pt is non-compliant to his medication, has not taken the pantoprazole for the last one month. Pt admits SOB with chest pain, headache, palpitation and feeling hot, fatigue, and sweating profusely. Denies N/V/D, dizziness, syncope, PND, orthopnea, ankle swelling, known heart murmur, fever, chilis, tremor.

Past Medical History:

GERD, Lumbar disk herniation, Vitamin D deficiency, subclinical hyperthyroidism

Past Surgical History: denies any surgical history

Medications:

Pantoprazole Sodium 40mg Delayed-Release Tablet 1- last taken 1 month ago

Naprosyn 500mg Tablet 1 as needed

Allergies:NKDA

Family History:

Grandparents died of GI cancer. Denies family history of cardiovascular diseases and strokes.

Social History:

Mr. P is a healthy male living with his wife and 2 children

Habits –Denies smoking, drinking alcohol, or illicit drug use

Travel- Has not recently traveled anywhere.

Sexual Hx-pt is currently sexually active with his spouse. No past history of STD’s, HIV or any other sexually transmitted diseases.

Review of Systems:

**General** – pt admits of severe weakness and fatigue for the past few days and loss of appetite Denies fever, chills, night sweats, or recent weight loss.

**Skin, hair, nails** –Denies changes in texture, excessive dryness, discolorations, pigmentations. Admits to rashes and pruritus or changes in hair distribution.

**Head** – admits of a headache that comes with the chest pain. Denies vertigo or head trauma.

**Neck** – Denies localized swelling/lumps or stiffness/decreased range of motion

**Pulmonary system** – admits of SOB on rest and dyspnea on exertion denies cough, hemoptysis, cyanosis,

orthopnea, or paroxysmal nocturnal dyspnea (PND).

**Cardiovascular system** – Admits of chest pain and palpitation. Denies HTN, irregular heartbeat,

edema/swelling of ankles or feet. syncope or known heart murmur

**Gastrointestinal system** – denies nausea, vomiting, dysphagia, pyrosis,flatulence, eructation, abdominal pain, diarrhea, jaundice, hemorrhoids, rectal bleeding, blood in stool or constipation.

**Genitourinary system** – denies urinary frequency, urgency, nocturia, polyuria, oliguria, dysuria,

incontinence, or flank pain.

**Sexual Hx** - He is currently sexually active with his wife. Denies history of sexually transmitted diseases.

**Hematological system** – denies blood transfusions, history of DVT/PE, easy bruising or bleeding, lymph node enlargement.

**Psychiatric** –Admits of recent anxiety due to his business problem, denies depression/sadness, OCD or ever seeing a mental health professional.

Physical

General: 42 years old well-developed male, A/O x 3, facial features symmetric. Pt appears clean, well-groomed, speech clear, cooperative, and appears to be in mild physical distress.

**Vital Signs:**

BP: L sitting 122/ 76

R: 24/min unlabored

P: 88, regular

T: 97.7 degrees F (oral)

O2 Sat: 96% Room air

Height 68 inches Weight 209 lbs. BMI: 31.8

Skin/Hair/Nails

**Nails:** no sign of clubbing, cyanosis, koilonychia, paronychia. capillary refill <2 seconds

throughout.

**Skin:** warm, moist and smooth to touch, good turgor. Nonicteric, no evidence of hypo or

hyper pigmentation, erythema, mass, lesions, scars or tattoos.

**Head:** normocephalic, atraumatic, no specific facies.

**Eyes:** Symmetrical OU; no evidence of strabismus, exophthalmos, ectropion, entropion, ptosis,

edema, inflammation, crusting, discharge; Lacrimal gland does not seem enlarged.

**Neck** - Trachea midline. No masses; lesions; scars

LUNGS:

Chest - Symmetrical chest wall movement, no evidence of deformities, kyphosis, scoliosis,

masses, lesions, cyanosis. no evidence of trauma. Lat to AP diameter 2:1 no evidence of barrel

chest.

**Heart:** regular rate and rhythm (RRR); S1 and S2 are normal. There are no murmurs, S3, S4,

splitting of heart sounds, friction rubs or other extra sounds.

**Lungs** – clear to auscultation and no evidence of adventitious sounds. Normal tactile fremitus, normal resonance, no rales, wheezes, or rhonchi

**Abdomen**: Flat / symmetrical / no evidence of scars, striae, caput medusae or abnormal

pulsations. Bowel sounds in all four quadrants; Soft, non-tender; no masses, no organomegaly.

Extremities: no evidence of edema, no pain, swelling or erythema in the calf, non-tender to palpation

**Mental Status:** Alert and oriented to person, place and time. Memory and attention intact.

Receptive and expressive abilities intact. Thought coherent.

Assessment:

a 42 years old male with PHMx of GERD presents to the office today complaining of chest pain and palpitations for the past 3 days. The physical examination is within normal limits and EKG shows sinus rhythm.

Problem list

* GERD
* Facial Tingling
* Anxiety
* Hyperthyroidism
* Vitamin D deficiency
* Chest pain

**Differential Diagnosis**

1. Anxiety attack- based on anxiety screening pt scores a 18 points, which is an indication for severe anxiety.
2. GERD- patient has history of GERD, and he has not been taking the pantoprazole for the last 1 month because pt had no refill
3. Thyroid disfunction: pt has history of subclinical hyperthyroidism, palpitation, muscle weakness restlessness, sweating, but pt has no shaking or tremor
4. Myocardial Ischemia- pt describes the pain as pressure in the chest with SOB in rest and in exertion, sweating, but pt has a normal EKG
5. Pulmonary Embolism- pressure like chest pain, shortness of breath, palpitation but denies calf pain or swelling, prolonged bed rest, long travel  **- can use PERC score to exclude PE**

**Plan:**

1. Labs ordered: CBC, CMP, Lipid Panel, Thyroid Panel, Hemoglobin A1c
2. EKG performed-sinus rhythm

Referred to Psychiatry (New Horizon) for consulting for anxiety and prescribed Lexapro 10 mg tablet once daily by mouth **(personally, would have held lexapro until patient followed with psych)**

Referral to gastroenterology for upper endoscopy as patient has history of GERD for the past 10 years also patient was complaining **discontinue patient using NSAIDs which would exacerbate GERD sx, change to different pain medication**

1. Referred to cardiology- to rule out any serious cardiac issue by farther testing such as stress test, echocardiogram and carotid artery doppler
2. Pt is following up with a ophthalmology last visit June 2020
3. Pt is following up with urology last visit in June 2020
4. Pt was advised to follow up within 1-2 days via telemedicine and if the chest pain worse then go to the Emergency.

**Address Obesity in plan**