

Case 1 - Sample

PATIENT: A 45-year-old female

PRESENTATION: A long-time patient, Vivian, presents to your office with difficulty breathing. She mentions of chest pain that she describes as dull and increasing in pain. She denies referral of pain. On vacation 8 days ago, she had been diagnosed with a Salmonella infection that was treated with antibiotics. The diarrhea she was experiencing has resolved, but the next day she began to feel pressure in her chest and had difficulty breathing.

MEDICAL HISTORY: Her medical history is unremarkable except for mild arthritis.

FAMILY HISTORY: diabetes (father), family history of hypertension (father and mother)

PSYCHOSOCIAL: Vivian is active in her community, but lives alone.

HEALTH HABITS: Vivian walks 2 km per day and plays golf twice a month

MEDICATIONS: None

SUPPLEMENTS: Ginseng, magnesium, B-complex and Omega-3 fish oil

ALLERGIES: None

VITAL SIGNS: Blood pressure 130/80 mmHg, pulse 78, respirations 19, and temperature 97.3 °F (36.2°C)

PHYSICAL EXAMINATION: Vivian is a thin female and appears to be in no obvious distress. She locates the pain precordial. She reports pain worsening when asked to lie flat on the exam table. Lungs are clear, friction rub heard at right lower sternal border.

PRELIMINARY LAB RESULTS: Normal, except for sedimentation rate 40 mm/hr (0-29 mm/hr)
Creactive protein of 8.6 mg/L (< 3 mg/L)

DIAGNOSTIC IMAGING: None