Focused Exam: Chest Pain Results | Completed

Advanced Health Assessment - January 2020, nur634

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Documentation

Documentation / Electronic Health Record

Document: Vitals | Document: Provider Notes

Document: Provider Notes

Student Documentation	Model Documentation
Subjective Mr. Foster is a pleasant 58 years old caucasian man who presented to the clinic with chief complaints of intermittent chest pain that has been going on for the past month. There is no evidence of acute distress at this time and he currently denies chest pain. He states that his chest pain occured at least three times this month. He states "I feel it mostly in the middle of my chest. over my heart." He states that pain severity at its worst is 5/10, non-radiating, and usually goes after a couple of minutes. He describes the pain as "mostly feels tight and uncomfortable right in the middle of the chest." He further states "the pain seems to start when I'm doing something physical and subsides a little bit with rest." He denies taking any medication to relieve his chest pain. He reports history of hypertension and hyperlipidemia and takes Atorvastatin 20mg daily and fish oil for cholesterol and metoprolol 100mg daily for his hypertension. He reports that he has not been checking his blood pressure at home and only gets it checked during clinic visits. He states that his last physical was about three months ago. Reports ocassional alcohol consumption. Denies smoking and substance abuse. He denies shortness of breath, fever or chills and any abdominal dsicomfort. He denies history of blood clot and bleeding. He states that his mom died of heart attack.	Pt. reports: "I have been having some troubling chest pain in my chest now and then for the past month." Experiencing periodic chest pain with exertion such as yard work, as well as with overeating. Points to midsternum as location. Describes pain as "tight and uncomfortable" upon movement or exertion. Mentioned an episode upon going up the stairs to bed. Most recent episode was three days ago after eating a large restaurant dinner. Denies radiation. Pain lasts for "a few" minutes and goes away when he rests. States "It has never gotten 'really bad'" so he didn't think it was an emergency, but is concerned after three episodes in one month and wants his heart checked out. Last physical was 1 year ago but says he hadn't been checked out for several years prior. His regular diet includes grilled meat, some sandwiches, and vegetables. Reports grilling between 4-5 times a week, usually red meat. Has fast food for lunch on busy days. 1-2 cups of coffee a day. Denies coughing, shortness of breath, indigestion, heartburn, jaw pain, fatigue, dizziness, weakness, nausea, vomiting, and diarrhea. Denies chest pain at time of interview. No history of anxiety or depression. • General Survey: Alert and oriented, with clear speech. Sitting comfortably in no acute distress. • Cardiac: S1, S2, without murmurs or rubs. S3 noted at mitral area.

Objective

General Survey: 58 years old male patient is alert and oriented, with clear speech and no acute distress. V/s BP 146/90, HR 104, respiration 19, SpO2 98% on room air and temperatire 36.7C. Facial expression symmetrical.
Cardiac: S1 S2 wit S3 noted at mitral area, without murmurs. No jugular vein distention.
Peripheral Vascular: Capillary refill less than 3 seconds in all extremities. Right carotid pulse with thrill, 3+ and left carotid pulse without thrill, 2+. PMI displaced laterally, brisk and tapping, less than 3 cm. R/L brachial pulses no thrill, 2+. R/L radial pulses no thrill, 2+. R/L femoral pulses no thrill, 2+. R/L popliteal pulses no thrill 1+. R/L tibial pulses no thrill 1+. R/L dorsalis pedis pulses no thrill 1+. All extremities are dry and warm to touch. No edema, varicosities and stasis noted.
Respiratory: Breathing is quiet and unlabored. Chest expansion symmetrical. Breath sounds are clear to ausculation in upper lobes. Fine crackles on pesterior bases of both lungs.
Gastrointestinal: Round, soft, nontender with normoactive bowel sounds in all four quadrants, no abnormal bruits. No tenderness to palpation. Tympanic throughout. Liver is 7cm in the midclavicular line.
Neuro: Alert and oriented, follows commands
EKG: NSR with no ST changes

No swelling or fluid retention present.

• Peripheral Vascular: No JVD present. JVP 3 cm above sternal angle. Left carotid no bruit. Right side carotid bruit. Right carotid pulse with thrill, 3+. Brachial, radial, femoral pulses without thrill, 2+. Popliteal, tibial, and dorsalis pedis pulses without thrill, 1+. Cap refill less than 3 seconds in all 4 extremities.

• Respiratory: Breathing is quiet and unlabored. Breath sounds are clear to auscultation in upper lobes and RML. Fine crackles in posterior bases of L/R lungs.

• Gastrointestinal: Round, soft, non-tender with normoactive bowel sounds in all quadrants; no abdominal bruits. No tenderness to light or deep palpation. Tympanic throughout. Liver is 7 cm at the MCL and 1 cm below the right costal margin. Spleen and bilateral kidneys are not palpable.

• Neuro: Alert and oriented x 3, follows commands, moves all extremities. Gross cranial nerves 2-12 bilaterally and grossly intact.

• Skin: Warm, dry, pink, and intact. No tenting and no sweating.

• Musculoskeletal: Moves all extremities.

• Psych: Normal affect, cooperative, good eye contact.

• EKG (interpretation): Regular sinus rhythm. No ST changes.

• Gastrointestinal: Round, soft, non-tender with normoactive bowel sounds in 4 quadrants; no abdominal bruits. No tenderness to light or deep palpation. Tympanic throughout. Liver is 7 cm at the MCL and 1 cm below the right costal margin. Spleen and bilateral kidneys are not palpable.

• Neuro: Alert and oriented x 3, follows commands, moves all extremities.

• Skin: Warm, dry, pink, and intact. No tenting.

• EKG (interpretation): Regular sinus rhythm. No ST changes.

Assessment

Coronary artery disease with stable angina. Possible congestive heart failure, carotid disease or GERD.

Based on the abnormal findings during cardiovascular and respiratory auscultation, my differentials include coronary artery disease with stable angina; congestive heart failure; carotid disease; aortic aneurysm; pericarditis; or GERD.

Plan

1. Since Mr. Foster's BP is not yet controlled, I will titrate his Lopressor and transition to ACE inhibitor. Will also refer to Cardiologist for start of diuretic therapy, PRN nitroglycerin for chest pain, echocardiogram and stress test. May need an additional consult with a vascular surgeon for carotid evaluation.
2. Cxray, lab workup including cardiac enzyme, electrolyte, CBC, BMP, CMP, Hgb, A1C, lipid profile, and liver function test.
3. Educate patient regarding exercise, diet and lifestyle modification. Educate Mr. Foster to seek immediate medical attention if chest pain returns and gets worse.
7. Return to clinic in 5-7 days for follow-up.

Mr. Foster should receive a 12-lead ECG, chest x-ray, and lab workup (cardiac enzymes, electrolytes, CBC, BNP, CMP, Hgb A1C, lipid profile, and liver function tests) to confirm a diagnosis. He should be referred for an echocardiogram, exercise stress test, and carotid dopplers as well as a consult with a vascular surgeon for carotid evaluation. Mr. Foster should be prescribed diltiazem and a diuretic in addition to his daily Lopressor and Lipitor. If needed, add an ACE inhibitor to manage his hypertension and PRN nitroglycerin for chest pain that does not subside with rest.

Comments

If your instructor provides individual feedback on this assignment, it will appear here.