Medical Decision Making

Patient history and symptoms
Patient name: John Doe
Date of birth:02/14/1985
Gender: Male
Date:12/04/2024
Chief complaint
Describe the patient's main concern or presenting problem:
The patient presents with persistent shortness of breath and chest discomfort over the past week.
Clinical history and presenting problem
History of present illness:
Summarize onset, duration, severity, and context of the problem.
The symptoms began one week ago with mild shortness of breath during physical activity, progressively worsening to occur even at rest. The patient reports associated chest tightness but denies radiating pain or dizziness. No fever or cough noted.
Past medical history:
Describe previous diagnoses, surgeries, or chronic conditions.
Hypertension diagnosed five years ago, managed with amlodipine. No previous surgeries or major illnesses.
Family history:
Include relevant familial diseases or genetic conditions.
Father had a myocardial infarction at age 55. Mother has type 2 diabetes. No known hereditary diseases.
Social history (e.g., lifestyle, occupation):
Describe factors like smoking, alcohol use, or occupational risks.
The patient is a non-smoker, consumes alcohol occasionally, and works as an office administrator with minimal physical activity.

Medications and allergies

Current medications:

List prescribed and over-the-counter medications, including dosage and frequency

Amlodipine 5 mg, once daily for hypertension
Multivitamin, once daily

Allergies:

List known allergies and reactions, including medications, foods, or environmental triggers

Penicillin: Rash and mild swelling
No food or environmental allergies

Physical examination

General vital signs:

Temperature: 36.8° (•) °C ( ) °F

Heart rate: 96 bpm

Blood pressure: 142/88 / mmHg

Respiratory rate: 20 /min

Oxygen saturation: 94 %

General appearance:

Describe the patient's overall presentation, e.g., "Alert and oriented, pale appearance"

Alert and oriented, mild pallor noted, no acute distress.

Additional notes

Describe any other relevant findings from the physical examination/texts specific to the presenting problem:

Bibasilar crackles auscultated during lung examination. Mild pitting edema in lower extremities.

Test results	
Recent tests:	
Summarize completed diagnostic tests and results	
ECG: Sinus tachycardia, no acute ST changes Chest X-ray: Mild pulmonary congestion	
Pending tests:	
List tests ordered but not yet completed	
Echocardiogram Complete blood count	
Medical decision-making level	
Level of medical decision-making	○ N/A ○ Low ◉ Moderate ○ High
Amount and/or complexity of data reviewed and analyzed	○ Limited ◉ Moderate ○ Extensive
Risk of complications and/or morbidity or mortality	○ N/A ○ Minimal ○ Low ○ Moderate ○ High

Interpretation and next steps

Summarize key findings and their significance, detail next steps.

Symptoms and physical exam findings suggest possible congestive heart failure. ECG and chest X-ray findings are concerning but non-diagnostic.

Next steps:

- Schedule an echocardiogram for further cardiac evaluation.
- Initiate low-dose furosemide to address pulmonary congestion.
- Advise lifestyle modifications, including a low-sodium diet and light physical activity.

Patient/family communication notes

Record discussions with the patient or family, including questions or concerns addressed

Discussed potential diagnoses and the need for further tests. Addressed the patient's concern about long-term implications and clarified treatment goals.

Team communication notes

Summarize communication with other healthcare team members

Consulted with cardiology for urgent review and test interpretation.

Healthcare professional: Dr. Jane Smith

Signature:J.S	**Date**:12/04/2024