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PATIENT INTAKE FORM

CLINICAL INTAKE TEMPLATE

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1 Patient Information

1a DEMOGRAPHICS

Full name:	Marcus J. Hartley	**MRN / Patient ID:**	MHV-2026-04147
Date of birth:	03/18/1979	**Date of intake:**	04/21/2026
Age:	47 years	**Preferred language:**	English
Sex:	Male	**Interpreter needed:**	No

1b CONTACT INFORMATION

Phone (primary):	(614) 555-0284	**Street address:**	2847 Ridgewood Drive
Phone (secondary):	(614) 555-0391 (work)	**City / State / ZIP:**	Columbus, OH 43214
Email address:	m.hartley@gmail.com	**Preferred contact method:**	Phone call — mornings preferred before 10:00 AM

1c EMERGENCY CONTACT

Name:	Sandra K. Hartley	**Phone:**	(614) 555-0319
Relationship:	Spouse	**Alternative phone:**	(614) 555-0391 (work)

1d INSURANCE INFORMATION

Primary insurance:	UnitedHealthcare Choice Plus (employer-sponsored)	**Secondary insurance:**	None
Member ID:	UHC-847201934	**Member ID (secondary):**	Not applicable — no secondary coverage
Group number:	GRP-00447821	**Co-pay / Deductible:**	$35 specialist co-pay; $1,500 annual deductible (partially met as of 04/2026)
Policy holder name:	Marcus J. Hartley (self)	**Referring provider:**	Dr. Angela R. Chen, MD — PCP, Westside Internal Medicine, Columbus OH

2 Chief Complaint

2 PRIMARY REASON FOR SEEKING CARE

Primary complaint (patient's words):	"I've been having tightness in my chest and I'm exhausted all the time. It started about a month ago and it's definitely getting worse, not better."
Duration of current concern:	Approximately 3–4 weeks; gradual onset with progressive worsening
Urgency / acuity:	Non-emergent; referred urgently by PCP following borderline ECG changes on 04/15/2026; patient ambulatory and hemodynamically stable at time of intake

3 History of Present Illness

3a ONSET & DURATION

When did symptoms begin:	Late March 2026; patient estimates onset approximately 3–4 weeks prior to today's intake visit
Onset (sudden / gradual):	Gradual — symptoms developed slowly without a clear precipitating event; patient first noticed chest tightness while climbing stairs to his office approximately 3 weeks ago
Course (improving / worsening / stable):	Worsening — chest tightness episodes now occurring 3–4 times per week (up from 1–2×/week initially); fatigue has become a daily symptom limiting afternoon work productivity
Frequency / pattern:	Chest tightness: 3–4 episodes/week, exclusively with moderate exertion (stair climbing, brisk walking >2 blocks); episodes last 3–8 minutes and resolve completely with rest; fatigue: daily, present by early afternoon regardless of sleep duration

3b SEVERITY & PROGRESSION

Severity (0–10 scale):	Chest tightness: 5–6/10 at peak during exertion; Fatigue: 6/10 sustained daily; Dyspnea: 3–4/10 with same activities that trigger chest tightness
Progression since onset:	Both symptoms have progressively worsened over the past 3–4 weeks; patient reports his exercise tolerance has declined — previously could walk 3 blocks to lunch without symptoms, now symptoms arise within 1.5–2 blocks
Aggravating factors:	Moderate physical exertion (stair climbing, brisk walking, carrying groceries); work-related stress; large meals (reports mild post-prandial chest heaviness on 2–3 occasions); cold weather; lying flat at night (occasional mild dyspnea when supine, relieved by propping with second pillow)
Alleviating factors:	Rest relieves chest tightness within 3–8 minutes consistently; patient has not tried nitroglycerin (none prescribed); sitting upright relieves nocturnal dyspnea; no medications trialed for current symptoms

3c ASSOCIATED SYMPTOMS

Exertional dyspnea — mild, co-occurring with all chest tightness episodes; resolves with rest within same timeframe as chest tightness; no dyspnea at rest.
Diaphoresis — intermittent mild diaphoresis during chest tightness episodes; patient describes "breaking a light sweat" even in air-conditioned environments during episodes; no nocturnal diaphoresis.
Palpitations — occasional brief palpitations (seconds) described as "heart fluttering"; 2–3 episodes this week; not associated with lightheadedness, presyncope, or syncope.
Bilateral ankle edema — patient and spouse both noticed bilateral ankle swelling over the past 2 weeks; worse by end of the day, partially resolves overnight; shoes feel tight by 5 PM; no calf pain or tenderness.
Orthopnea — mild; requires a second pillow for comfort at night (new over past 2 weeks); no frank paroxysmal nocturnal dyspnea.
No chest radiation to jaw, left arm, or back at this time. No nausea or vomiting with episodes. No pre-syncope or syncope. No fever, chills, or weight change (patient unsure of exact weight — stable by clothing fit).

3d PRIOR EVALUATIONS & TREATMENTS

Previously seen by:	Dr. Angela R. Chen, MD (PCP, Westside Internal Medicine) — office visit 04/15/2026; urgent cardiology referral placed same day
Prior diagnoses (if any):	Hypertension (2019), Hyperlipidemia (2021), Prediabetes (2023) — all established prior diagnoses; no prior cardiac diagnosis

PCP visit 04/15/2026: ECG performed — interpreted by Dr. Chen as "borderline changes, possible ST-segment flattening in lateral leads and left ventricular strain pattern"; patient referred urgently to cardiology the same day. Basic labs ordered 04/15/2026 (results not yet available at time of this intake): CBC, CMP, fasting lipid panel, HbA1c, TSH, BNP. No prior cardiac stress testing on record. No prior echocardiogram. No prior cardiac catheterization or coronary imaging. No prior Holter monitor or event recorder. No prior ER visits for chest pain or cardiac symptoms.
Prior relevant labs (from Westside Internal Medicine records): LDL 118 mg/dL (01/2026, above target on atorvastatin 40 mg); HbA1c 6.1% (01/2026, prediabetic range); BP 148/92 mmHg at PCP visit (04/15/2026, suboptimally controlled on lisinopril 10 mg). No cardiac biomarkers (troponin) have been checked to date.
No prior treatment specifically targeting current presenting symptoms — no nitroglycerin, no beta-blockers, no antiarrhythmics. Aspirin 81 mg self-initiated by patient after PCP visit based on personal research.

4 Past Medical History

4a CHRONIC CONDITIONS

1. Essential Hypertension (I10) — diagnosed 2019; currently managed with lisinopril 10 mg daily; suboptimally controlled (last BP 148/92 mmHg at PCP visit 04/15/2026); no end-organ damage workup documented.
2. Hyperlipidemia (E78.5) — diagnosed 2021; currently managed with atorvastatin 40 mg daily; last LDL 118 mg/dL (01/2026), above cardiovascular risk target of <70 mg/dL given risk factor burden.
3. Prediabetes (R73.09) — diagnosed 2023; HbA1c 6.1% (01/2026); managed with lifestyle modification only; no pharmacotherapy; no formal diabetes education program enrolled.
4. Obesity Class I (E66.09) — BMI 31.8 kg/m² at PCP visit; ongoing; no bariatric program enrollment; minimal structured exercise.
5. No prior documented coronary artery disease, heart failure, arrhythmia, valvular disease, stroke, TIA, peripheral artery disease, thyroid disease, or pulmonary disease.

4b PRIOR HOSPITALIZATIONS

No prior hospitalizations. Patient has never been admitted to an inpatient facility. No prior ICU stays. No prior cardiac monitoring admissions. No observation status visits for cardiac or chest pain complaints.

4c SURGICAL HISTORY

Right knee arthroscopic meniscectomy — 2017, Columbus Orthopedic Surgery Center, Dr. James Fowler MD; uncomplicated recovery under general anesthesia; no perioperative cardiac concerns noted at that time; mild residual intermittent knee discomfort. No cardiac, thoracic, abdominal, or neurovascular surgical history. No implanted devices (pacemaker, ICD, stents, artificial valves).

5 Medications

5 CURRENT MEDICATIONS

MEDICATION NAME	DOSE	FREQUENCY	PRESCRIBING PROVIDER
Lisinopril 10 mg	10 mg PO	Once daily (morning)	Dr. Angela R. Chen, MD
Atorvastatin 40 mg	40 mg PO	Once daily (evening)	Dr. Angela R. Chen, MD
Aspirin 81 mg (OTC)	81 mg PO	Once daily (self-initiated	Self — after PCP visit
Multivitamin (OTC)	Standard adult dose	Once daily	Self
Ibuprofen 400 mg (OTC)	400 mg PO PRN	2–3×/month for knee pair	Self — OTC
Fish oil 1000 mg (OTC)	1000 mg PO	Once daily	Self — OTC supplement

OTC / SUPPLEMENTS / VITAMINS

Fish oil (omega-3) 1000 mg daily — self-initiated for cardiovascular health approximately 6 months ago. Vitamin D3 2000 IU daily — self-initiated. Magnesium glycinate 400 mg nightly — started 3 months ago for sleep. Occasional antacids (Tums, PRN) — for infrequent heartburn; no regular use. Note: ibuprofen use (listed above) flagged as potential concern given HTN and current cardiovascular presentation — to be addressed at today's visit. No herbal or homeopathic preparations. No testosterone supplements or performance-enhancing substances.

6 Allergies

6 KNOWN ALLERGIES & REACTIONS

ALLERGEN (DRUG / FOOD / ENVIRONMENTAL)	TYPE	REACTION / SEVERITY
Penicillin	Drug	Diffuse urticarial rash — childhood react
Shellfish (shrimp, lobster, crab)	Food	Nausea, vomiting, oral tingling within 30
Cardiology — Electrophysiology	Evaluation of intermittent palpitations; 4	Routine — within 2 weeks
Sleep Medicine	Evaluation for obstructive sleep apnea –	Routine — within 4 weeks

Contrast / latex allergy: No known contrast or latex allergy; no prior contrast exposure — iodinated contrast tolerance unknown; no latex sensitivity reported

NKDA (No Known Drug Allergies): No — penicillin allergy documented above; all other drug classes tolerated without known reactions

7 Family History

7 HEREDITARY & FAMILIAL CONDITIONS

RELATION	CONDITION(S)	AGE OF ONSET / NOTES
Father (deceased, age 61)	Coronary artery disease; hypertension;	First MI at age 54 (CABG performed); se
Mother (living, age 72)	Hypertension; hyperlipidemia; osteoarth	Well-controlled on medications; no card
Paternal grandfather (deceased)	CAD; ischemic stroke	MI at age 58; stroke at age 67; died age
Paternal uncle (age 65)	Coronary artery disease	Stent placement at age 59; living with st
Brother (age 44)	Hypertension	Recently diagnosed; on amlodipine; no c

Family history of cancer: No known family history of malignancy on either maternal or paternal side

Family history of cardiac disease: Strongly positive — premature CAD on paternal side (father MI at 54, paternal grandfather MI at 58, paternal uncle stent at 59); represents a major independent cardiovascular risk factor

Family history of mental illness: No known family history of psychiatric conditions; no family history of substance use disorder

8 Social History

8a OCCUPATION & LIVING SITUATION

Occupation: Senior Logistics Manager, Amazon Fulfillment Center, Columbus OH

Employment status: Full-time; approximately 45–50 hours/week; salaried position with high-pressure deadline-driven responsibilities

Work environment: Primarily office and desk-based with periodic warehouse floor inspections; largely sedentary; high occupational stress with quarterly performance reviews and team management responsibilities

Living situation: Owner-occupied single-family home in Columbus, OH; suburban neighborhood

Lives with: Spouse (Sandra Hartley, age 45, high school teacher) and two children (daughter age 14, son age 11)

Support system: Strong — supportive and engaged spouse; close extended family in Columbus area; no social isolation; patient is primary financial provider for household

8b SUBSTANCE USE

Tobacco use: Former cigarette smoker — quit 2020 (6 years ago)

Pack-year history: 12 pack-years — smoked approximately 1 PPD from age 19 to age 41 (22 years); cessation achieved without pharmacotherapy; no current tobacco or vaping use

Alcohol use: Social drinker — primarily beer and occasional wine on weekends and social occasions

Drinks per week: Estimated 8–10 standard drinks/week; no binge drinking pattern; no alcohol-related legal, occupational, or relationship consequences; no prior treatment for alcohol use

Recreational drug use: Denies current or recent recreational drug use of any kind

Substance(s) used: Marijuana — occasional use in college (early 20s); last use >20 years ago; no other illicit or recreational substances ever used

Caffeine intake: 2–3 cups of coffee daily (mornings); 1 energy drink (Red Bull) 2–3×/week in afternoons for fatigue; total estimated caffeine intake 350–500 mg/day

Exercise habits: Minimal structured exercise — no gym membership or regular exercise program; walks to/from parking and within office approximately 5–10 minutes daily; previously more active (casual jogging 2–3×/week) until 2 years ago when job demands increased significantly

8c ADDITIONAL SOCIAL CONTEXT

Marital / relationship status: Married — 14 years; stable and supportive relationship per patient report

Number of children / dependants: Two dependent children (daughter age 14, son age 11); no other financial dependants

Highest education level:	Bachelor of Science, Business Administration — The Ohio State University, Columbus OH (2002)
Diet / nutritional patterns:	High-sodium, high-saturated-fat diet predominates — eats out or orders delivery 4–5 times/week (fast food, pizza, takeout); skips breakfast 4–5 days/week; large portion sizes at dinner; minimal fruit and vegetable intake; limited whole grains; spouse has recently begun encouraging dietary changes following PCP visit
Stress level (0–10):	7/10 — work demands are primary stressor (high-stakes deadlines, team management, performance targets); secondary financial stressors related to mortgage and children's college planning; new health anxiety following PCP ECG findings
Sleep (hours/night, quality):	5–6 hours weeknights; 7–8 hours weekends; poor quality — difficulty falling asleep (mind racing from work), occasional nocturnal awakenings; spouse reports loud snoring most nights with occasional witnessed apneic pauses; no prior sleep study; possible obstructive sleep apnea undiagnosed

9 Review of Systems

9 BRIEF SYSTEM-BASED SYMPTOM SCREENING

Document positive and pertinent negative findings. Use the field to record specific symptoms, or note "Negative" if no symptoms in that system.

Constitutional:	Significant daily fatigue (6/10 severity); no fever, chills, or night sweats; mild unintentional weight loss uncertain — clothing fit stable; no anorexia	**HEENT:**	No headaches; no visual disturbances; no tinnitus or hearing changes; no epistaxis; no oral lesions; mild dry mouth at times — likely dehydration
Cardiovascular:	Exertional chest tightness (PRIMARY — see HPI); exertional dyspnea; intermittent brief palpitations; bilateral ankle edema ×2 weeks; mild orthopnea (2-pillow); no syncope or presyncope; no jaw/arm/back radiation with episodes	**Respiratory:**	Mild exertional dyspnea concurrent with chest tightness; no resting dyspnea; no chronic cough; no wheezing; no hemoptysis; former smoker — no known COPD diagnosis; no sleep apnea diagnosis (see social history)
Gastrointestinal:	No nausea or vomiting; mild constipation (BMs every 2–3 days); no abdominal pain; no GERD symptoms currently (occasional antacid use PRN); no rectal bleeding or change in stool; appetite normal	**Genitourinary:**	No dysuria, no hematuria, no urinary frequency changes; no nocturia; no erectile dysfunction reported
Musculoskeletal:	Prior right knee meniscectomy — mild intermittent residual discomfort managed with occasional ibuprofen PRN; no new joint pain, swelling, or myalgia; no claudication or exertional leg pain	**Neurological:**	No headaches; no dizziness or vertigo; no focal weakness or numbness; no tingling; no syncope; no cognitive impairment; no prior stroke or TIA
Dermatologic:	No rash or skin lesions; no jaundice; diaphoresis present during chest tightness episodes (see HPI); no xanthomas noted by patient	**Psychiatric:**	Mild health anxiety (new — onset since PCP visit and ECG finding); work-related stress (chronic); no prior psychiatric diagnoses; no depression; no panic attacks; denies suicidal or self-harm ideation
Endocrine:	No polydipsia or polyuria; no heat or cold intolerance; no hair or skin changes suggesting thyroid disease; prediabetes (HbA1c 6.1%) — no osmotic symptoms currently	**Hematologic / Lymphatic:**	No easy bruising or bleeding; no lymphadenopathy noted by patient; no history of blood clots or clotting disorders; no anemia symptoms
Immunologic / Allergic:	Penicillin and shellfish allergy (documented); no seasonal environmental allergies; no recurrent infections; no immunosuppression; influenza and COVID-19 vaccinations up to date per PCP records	**Reproductive:**	Male — no reproductive concerns; no gynecomastia; no testicular symptoms

A Initial Assessment

10 PRELIMINARY CLINICAL IMPRESSION

47-year-old male presenting with a 3–4 week history of progressive exertional chest tightness, fatigue, exertional dyspnea, intermittent palpitations, bilateral ankle edema, and mild orthopnea against a high-risk cardiovascular background (hypertension, hyperlipidemia, prediabetes, Class I obesity, former smoker, sedentary lifestyle, strong family history of premature CAD — father's first MI at age 54). Borderline ECG changes noted by PCP on 04/15/2026 (possible lateral ST-segment flattening and LV strain pattern) increase pre-test probability of significant coronary artery disease.

Working diagnoses in clinical priority order:
1. Stable angina pectoris secondary to obstructive CAD — highest priority given symptom pattern (exertional onset, rest relief, progressive worsening), risk factor burden, family history, and ECG changes; must be evaluated urgently with stress testing and/or coronary imaging.
2. Heart failure with reduced or preserved ejection fraction — bilateral ankle edema, orthopnea, exertional dyspnea, and fatigue raise concern for early HF; echocardiogram required to assess LV function and wall motion.
3. Hypertensive heart disease with LVH — longstanding suboptimally controlled hypertension may have resulted in LV hypertrophy contributing to symptoms; echo will clarify.

4. Cardiac arrhythmia (intermittent) — brief palpitations warrant Holter monitoring or event recorder; low probability of primary arrhythmic etiology given symptom pattern but should not be excluded.
5. Obstructive sleep apnea — spouse-reported snoring and witnessed apneas; untreated OSA contributes to cardiovascular morbidity; sleep study referral warranted.
6. Non-cardiac chest discomfort (GERD, musculoskeletal, anxiety) — less likely given classic exertional pattern and multi-symptom cardiovascular presentation; will be considered if cardiac workup is unrevealing.

This patient's cardiovascular risk profile is high. Aggressive workup and risk factor management are indicated regardless of stress test outcome.

11 RISK FACTORS & RED FLAGS

Check all that apply and document relevant detail in the field below.

- [ ] Suicidal / self-harm ideation
- [x] Acute cardiac symptoms
- [ ] Neurological deficit
- [ ] Unintentional weight loss
- [ ] New-onset severe headache
- [ ] Fever of unknown origin
- [ ] Respiratory distress
- [ ] Immunocompromised state
- [ ] History of malignancy
- [ ] Recent trauma / injury
- [x] Substance use disorder
- [ ] Domestic violence / safety concern

ACTIVE RED FLAGS IDENTIFIED AT INTAKE:
1. Acute cardiac symptoms — exertional chest tightness with concurrent dyspnea and diaphoresis in a 47-year-old male with a Framingham high-risk profile represents a potential acute coronary syndrome pattern until proven otherwise; urgent cardiac biomarker assessment and stress testing are prioritized.
2. Bilateral ankle edema + orthopnea — new onset in the setting of exertional dyspnea and fatigue raises early heart failure as a co-existing diagnosis requiring echocardiographic evaluation.
3. Borderline ECG changes (PCP, 04/15/2026) — possible lateral ST-segment flattening and LV strain pattern documented; original ECG to be obtained for cardiology review today.

4. Suboptimal BP control (148/92 mmHg at last PCP visit) — ongoing hypertensive end-organ stress; NSAID use (OTC ibuprofen) likely contributing to BP elevation; needs immediate medication review.
5. Undiagnosed probable obstructive sleep apnea — spouse-reported snoring with witnessed apneic pauses; OSA is an independent cardiovascular risk factor; sleep study referral to be placed.
6. Alcohol use — 8–10 drinks/week (above recommended cardiovascular limit); mild cardiac depressant effect; counseling warranted.
7. Sedentary lifestyle + obesity + prediabetes + high-fat high-sodium diet — cumulative modifiable risk factor burden requiring structured lifestyle intervention alongside pharmacological management.

P Plan

12 DIAGNOSTIC WORKUP

LABS (ordered today, 04/21/2026):
- Troponin I (high-sensitivity) × 2, 3 hours apart — rule out acute myocardial injury
- BNP (B-type natriuretic peptide) — assess for heart failure; evaluate ankle edema and dyspnea
- CBC with differential — assess for anemia as contributing cause of fatigue and exertional symptoms
- CMP (Comprehensive Metabolic Panel) — electrolytes, renal function (BUN/creatinine), LFTs; baseline before medication adjustments
- Fasting lipid panel — reassess LDL; current LDL 118 mg/dL (01/2026), requires intensification
- HbA1c — reassess glycemic status; last 6.1% (01/2026)
- TSH — thyroid dysfunction can contribute to fatigue, palpitations, and dyslipidemia
- Uric acid — relevant in the context of cardiovascular risk and potential diuretic therapy
- Fasting glucose — reassess given prediabetic status and new symptom onset

IMAGING & PROCEDURES:
- 12-lead ECG (today) — obtain new tracing; compare to PCP ECG 04/15/2026; assess for interval changes, ischemia, arrhythmia, LVH
- Chest X-ray (PA and lateral) — assess for cardiomegaly, pulmonary edema, pleural effusion
- Transthoracic echocardiogram (schedule within 1 week) — assess LV function (EF), wall motion abnormalities, LVH, valvular disease, diastolic function; primary imaging for this presentation
- Exercise stress test with ECG (schedule within 1–2 weeks, pending troponin results) — functional assessment of ischemia; if ECG non-interpretable or patient unable to exercise, consider nuclear stress test or stress echo
- Coronary CT angiography (CTA) — consider if stress test equivocal or intermediate probability; non-invasive coronary assessment
- Holter monitor × 48 hours — evaluate intermittent palpitations; assess for arrhythmia burden

13 REFERRALS

SPECIALTY / PROVIDER	REASON FOR REFERRAL	URGENCY
Registered Dietitian / Nutrition	Therapeutic lifestyle change — DASH di	Non-urgent — within 6 weeks
Cardiac Rehabilitation Program	Supervised exercise training and cardio\	Non-urgent — initiate after stress test re
Primary Care — Dr. Angela R. Chen, MD	Co-management of hypertension, hyper	Routine — within 2 weeks; send cardiolc

14 INITIAL MANAGEMENT STEPS

MEDICATIONS — CHANGES AND INITIATIONS:
1. Lisinopril: INCREASE to 20 mg PO daily (from 10 mg) — BP 148/92 mmHg at last visit, suboptimally controlled; renal function and potassium to be rechecked in 1–2 weeks.
2. Atorvastatin: INCREASE to 80 mg PO daily (from 40 mg) — LDL 118 mg/dL is above target of <70 mg/dL given high cardiovascular risk; high-intensity statin therapy indicated.
3. Aspirin 81 mg PO daily — continue (already self-initiated); appropriate given high cardiovascular risk profile and presenting symptoms.
4. Metoprolol succinate 25 mg PO daily (NEW) — initiated pending workup; indicated for exertional chest tightness management, heart rate control, and cardioprotection; titrate as tolerated.
5. Ibuprofen: DISCONTINUE — NSAIDs contraindicated given hypertension, potential cardiac pathology, and borderline renal function; replace with acetaminophen 500 mg PRN for knee pain.

SAFETY & PATIENT EDUCATION:
- Patient counseled to present to ER immediately for: chest pain at rest lasting >15 minutes, chest pain with radiation to jaw/left arm, associated syncope, or sudden severe dyspnea — 911 activation instructed.
- Activity modification: avoid moderate-to-vigorous exertion until stress test completed and results reviewed; light walking only; no stair climbing or heavy lifting.
- Dietary counseling initiated: reduce sodium to <2,000 mg/day (cardiac diet); reduce saturated fats; eliminate fast food as much as possible; alcohol reduction discussed (target ≤7 drinks/week).
- Sleep: sleep study referral placed for probable OSA evaluation.

15 FOLLOW-UP

Return appointment: 2 weeks — to review echocardiogram results, stress test scheduling, troponin/BNP results, and medication response (BP recheck)

Return earlier if: Chest pain at rest, radiation to jaw or left arm, syncope, pre-syncope, palpitations lasting >30 minutes, significant worsening of dyspnea, rapid weight gain (>3 lbs in 24 hours suggesting fluid retention), or any new neurological symptoms — these require immediate ER evaluation, not an office visit

Patient instructions: (1) Avoid moderate-to-vigorous exertion until stress test completed. (2) Begin DASH-style low-sodium diet immediately. (3) Discontinue ibuprofen — use acetaminophen only. (4) Take new metoprolol as directed; do not stop abruptly. (5) Continue aspirin 81 mg daily. (6) Monitor blood pressure at home daily — log readings to bring to follow-up. (7) Call 911 or go to ER if any rest chest pain, jaw/arm radiation, syncope, or severe breathlessness. (8) Schedule echocardiogram and fasting labs as directed by front desk before leaving today.

CLINICIAN SIGNATURE

Clinician name: Dr. David R. Patel, MD, FACC

Credentials / NPI: MD, FACC (Fellow, American College of Cardiology) / NPI: 1598204731

Signature:

Date & Time: 04/21/2026, 9:45 AM

Facility / Clinic: Midwestern Heart & Vascular Institute — Cardiology Outpatient, Suite 410, Columbus, OH

Visit type: New patient intake — cardiology outpatient; referral from primary care