1 Patient Identification

Name:	Harold B. Washington
DOB / Age:	09/05/1957 / 67 years
MRN:	MRN-7743921
Date of Visit:	April 27, 2025
Provider:	Dr. Angela M. Torres, MD, FACP
Specialty / Dept:	Internal Medicine

S Subjective

2 CHIEF COMPLAINT

Primary concern:	Chest tightness with exertion and worsening blood sugar control
Duration:	Chest tightness onset 3 weeks ago; diabetes management concerns for 6 months

3 HISTORY OF PRESENT ILLNESS

Onset:	Gradual onset of exertional chest tightness over 3 weeks. Initially with vigorous exertion, now with moderate activity such as walking one block.
Duration HPI:	Episodes lasting 2–5 minutes, resolving with rest. No episodes at rest. Occurring daily.
Location:	Substernal pressure with radiation to the left shoulder. No jaw or arm pain.
Quality:	Pressure-like, described as 'a heavy weight on my chest.' Not sharp or stabbing.
Severity:	Moderate severity, 5–6/10. Has caused patient to stop activities and sit down.
Timing:	With exertion — walking uphill, climbing stairs. Occurs predictably with similar exertion levels.
Context:	Patient recently started a walking program for weight loss and diabetes management. Symptoms began within days of increasing activity level.
Modifying factors:	Relieves with rest within 2–5 minutes. Nitroglycerin not prescribed. No change with position or breathing.
Associated symptoms:	Mild dyspnea with symptoms. Diaphoresis on two occasions. No syncope, palpitations, nausea, or emesis.
Pertinent positives / negatives:	Positive: exertional chest pressure, radiation to left shoulder, diaphoresis, dyspnea. Negative: no rest pain, no pleuritic component, no cough, no fever, no leg swelling.

4 REVIEW OF SYSTEMS

Constitutional:	Reports 15 lb weight gain over past 6 months. Fatigue present daily. No fever or chills.
HEENT:	Denies vision changes, headache, nasal congestion, or sore throat.
Cardiovascular:	Exertional chest pressure with radiation (as above). No palpitations. Mild bilateral ankle edema.
Respiratory:	Exertional dyspnea tied to chest symptoms. Denies cough, wheezing, or orthopnea.
Gastrointestinal:	Increased appetite. Denies nausea, vomiting, abdominal pain, diarrhea, or constipation.
Genitourinary:	Nocturia x2. Denies dysuria or hematuria. Erectile dysfunction present — not previously addressed.
Musculoskeletal:	Bilateral knee pain with prolonged activity. Denies joint swelling or morning stiffness.
Neurologic:	Bilateral foot numbness and tingling — chronic, diabetic neuropathy. No new focal deficits.
Psychiatric:	Mild anxiety regarding cardiac symptoms. PHQ-9: 5 (minimal). No depression.
Endocrine:	Polyuria and polydipsia. Diabetes management suboptimal — A1c 9.8% at last check 6 weeks ago.
Hematologic / Lymphatic:	Denies easy bruising, bleeding, or lymphadenopathy.
Allergic / Immunologic:	Seasonal allergies. Drug allergy: contrast dye (hives) — on file.

5 PAST HISTORY

Medical:	Type 2 Diabetes Mellitus (diagnosed 2008), Hypertension (diagnosed 2010), Hyperlipidemia (diagnosed 2012), Obesity (BMI 34.2), Diabetic peripheral neuropathy, Osteoarthritis bilateral knees
Surgical:	Right knee arthroscopy 2017, Cholecystectomy 2003 — both uncomplicated
Medications:	Metformin 1000mg BID, Glipizide 10mg BID, Lisinopril 20mg daily, Amlodipine 10mg daily, Atorvastatin 40mg nightly, Aspirin 81mg daily, Gabapentin 300mg TID (neuropathy)
Allergies:	Iodinated contrast dye — urticaria and angioedema. Penicillin — rash (childhood, unverified).

6 FAMILY HISTORY

Father: MI at age 61, died age 68 from second MI
Mother: Type 2 diabetes, hypertension, stroke at age 75, currently alive age 88
Brother (age 70): Coronary artery disease, 2-vessel CABG 2019
Sister (age 64): Type 2 diabetes, hypertension
Family history strongly positive for premature CAD and T2DM

7 SOCIAL HISTORY

Occupation:	Retired postal worker. Previously moderately active. Now sedentary lifestyle for past 5 years since retirement.
Living situation:	Lives with wife in single-story home in Columbus, OH. Two adult children live locally. Good social support.

Substance use:	Former smoker — 30 pack-year history, quit 2012. Alcohol — 1–2 beers on weekends. No illicit drug use.

O Objective

8 VITALS

Blood pressure:	158/94 mmHg (right arm, seated x2 readings averaged)	**Respiratory rate:**	16 breaths/minute	**Oxygen saturation:**	96% on room air
Heart rate:	78 bpm, regular	**Temperature:**	98.4°F (36.9°C) — oral	**BMI:**	34.2 kg/m² (Weight 224 lbs, Height 5'9")

9 PHYSICAL EXAMINATION

General:	Well-developed, obese male appearing stated age. Alert and oriented x3. In no acute distress. Mildly anxious.
HEENT exam:	Normocephalic, atraumatic. PERRL. Fundi: bilateral AV nicking noted, no papilledema, no hemorrhages. Oral mucosa moist.
Neck:	Supple. No JVD. Carotid bruits absent bilaterally. No thyromegaly. Lymph nodes not palpable.
Cardiovascular exam:	Regular rate and rhythm. S1 and S2 present. S4 gallop appreciated at apex. No murmurs. No rubs. PMI displaced laterally.
Respiratory exam:	Clear to auscultation bilaterally. No wheezes, crackles, or rhonchi. Symmetric chest expansion.
Abdomen:	Obese, soft, non-tender. No guarding or rigidity. No organomegaly. Bowel sounds active x4 quadrants.
Musculoskeletal exam:	Bilateral knee crepitus. No effusion. Range of motion mildly limited bilaterally. Trace bilateral ankle edema.
Neurologic exam:	Cranial nerves II–XII intact. Decreased vibratory sensation in bilateral feet to mid-shin. Diminished ankle reflexes bilaterally. Upper extremity strength 5/5.
Skin:	Acanthosis nigricans at nape and bilateral axillae. No diabetic ulcers. No pallor or cyanosis.
Psychiatric exam:	Alert, oriented, appropriate affect. Mildly anxious about cardiac symptoms. Good insight and judgment.

10 DIAGNOSTIC DATA

Labs reviewed:	HbA1c 9.8% (6 weeks ago); LDL 118 mg/dL; eGFR 62 mL/min/1.73m²; microalbumin/creatinine ratio 142 mg/g; K+ 4.1; Na+ 138; BMP within normal limits except creatinine 1.3
Imaging:	EKG today: NSR, rate 78, LVH by voltage criteria, non-specific ST-T changes in lateral leads (V5–V6), no acute ischemic changes. CXR (2023): cardiomegaly, no infiltrates.
Other studies:	

	Stress test: NOT yet performed — URGENT referral placed today. ABI not performed.

A Assessment

Primary diagnosis with status:	Suspected Stable Angina Pectoris — New, active, urgent evaluation required. Type 2 DM with poor glycemic control — chronic, worsening.
ICD-10 Code:	I20.9 (Angina pectoris, unspecified); E11.65 (T2DM with hyperglycemia); I10 (Hypertension)
Differential diagnoses:	1. Stable angina — most likely given exertional pattern, radiation, risk factors, family history; 2. ACS — less likely (no rest pain, no EKG changes), cannot exclude; 3. GERD — less likely given exertional pattern; 4. Musculoskeletal — less likely given radiation and diaphoresis
Problem list:	1. New exertional chest pressure — urgent cardiac evaluation; 2. T2DM, A1c 9.8% — medication intensification needed; 3. Hypertension, BP 158/94 — uncontrolled; 4. CKD Stage 3a (eGFR 62); 5. Diabetic neuropathy; 6. Hyperlipidemia; 7. Obesity
Pertinent positives:	Exertional substernal pressure, left shoulder radiation, diaphoresis, strong family history of CAD (father MI 61, brother CABG), S4 gallop, LVH on EKG, elevated A1c, poorly controlled HTN
Pertinent negatives:	No rest pain, no EKG ST elevation, no acute hemodynamic instability, no pulmonary edema, no fever, no pleuritic component

P Plan

12 MANAGEMENT

Medications plan:	1. START sublingual nitroglycerin 0.4mg PRN chest pain — instruct on use and when to call 911; 2. INCREASE atorvastatin to 80mg nightly (LDL goal <70 for high-risk); 3. ADD isosorbide mononitrate 30mg daily if stress test confirms angina; 4. Intensify diabetes regimen — add semaglutide 0.5mg SQ weekly (cardioprotective, also aids weight loss); 5. INCREASE lisinopril to 40mg daily for BP and renal protection
Diagnostics:	URGENT nuclear stress test within 72 hours (pre-authorized). Repeat BMP, CBC, HbA1c, lipid panel in 6 weeks. Urine microalbumin recheck in 3 months. Resting echocardiogram ordered.
Procedures:	No procedures performed today. EKG performed and interpreted.
Referrals:	URGENT Cardiology referral — Dr. Michael Chang, MD at Ohio Heart Institute (fax sent today). Endocrinology referral for diabetes intensification. Nephrology referral for CKD Stage 3a and microalbuminuria.
Patient education:	Patient instructed: (1) call 911 immediately if chest pain at rest, lasts >20 min, or associated with severe dyspnea; (2) nitroglycerin use instructions; (3) strict activity restriction pending stress test results; (4) importance of diabetes and BP control on cardiac risk; (5) dietary sodium reduction, Mediterranean diet counseling provided.
Follow-up:	

	Return in 1 week or sooner if symptoms worsen or occur at rest. Cardiology appointment within 1 week. Phone call from nurse at 48 hours to confirm stress test scheduling.
Safety considerations:	Patient advised to avoid strenuous exertion until stress test completed. Given nitroglycerin and clear instructions. Emergency precautions reviewed. If chest pain at rest → call 911 immediately.

13 TIME / BILLING

Total time (minutes):	55 minutes
Counseling time:	25 minutes (counseling on cardiac risk, nitroglycerin use, diabetes management, lifestyle modifications)
Complexity:	High complexity MDM — new problem requiring additional workup, multiple chronic conditions with exacerbation, prescription drug management

Provider name & credentials:	Dr. Angela M. Torres, MD, FACP
Signature:	A.M. Torres, MD
NPI:	1467839205
Date / Time:	April 27, 2025 — 9:15 AM
Facility:	Columbus Internal Medicine Associates, 3400 Olentangy River Rd., Columbus, OH 43202
Visit type:	Office Visit — Established Patient (99215, High Complexity MDM)