1 Patient Information

1 PATIENT DETAILS

Name
Harold J. Whitmore

Date of Service
05/06/2026

DOB / Age / Sex
03/14/1958 | 66M

Provider
Dr. Catherine L. Nguyen, MD

MRN
IM-2024-8841

Visit Type
Urgent Follow-up / ED Referral

CC Chief Complaint

2 PRIMARY REASON FOR VISIT

Patient presents with a 4-hour history of pressure-like substernal chest discomfort radiating to the left jaw and left arm, rated 7/10 in severity, associated with diaphoresis and mild shortness of breath. Symptoms began at rest while watching television and prompted his wife to call 911.

HPI History of Present Illness

3a ONSET, CONTEXT & DURATION

Onset & Context
Acute onset at rest, approximately 4 hours prior to presentation, while seated at home with no precipitating exertion or emotional stress identified.

Duration & Course
Continuous since onset with one brief period of partial relief approximately 90 minutes in; overall worsening trajectory over the 4-hour course.

Location & Radiation
Substernal chest tightness radiating to the left jaw and left upper arm; no radiation to the back or right side.

Character / Quality
Pressure-like, described as 'an elephant sitting on my chest'; non-pleuritic, non-positional.

Severity
7/10 at its worst; currently 5/10 after 325 mg aspirin administered by EMS en route. Associated with significant functional limitation — patient unable to walk to bathroom without worsening.

Timing / Pattern
Continuous onset; no prior similar episodes. One prior episode of exertional chest tightness 3 weeks ago that resolved with rest, which patient had attributed to indigestion and had not sought evaluation.

Aggravating Factors
Physical activity, deep inspiration at its onset; aspirin and rest provided partial relief.

Relieving Factors
Aspirin 325 mg PO administered pre-hospital; sublingual nitroglycerin 0.4 mg x1 in ED with moderate relief of discomfort to 4/10.

3b ASSOCIATED SYMPTOMS & PERTINENT NEGATIVES

Associated diaphoresis onset simultaneously with chest pain. Patient reports mild dyspnea at rest, progressive over the past hour. He denies nausea or vomiting. He denies palpitations, syncope, or pre-syncope. No cough, hemoptysis, or pleuritic chest pain. No recent immobilization, long-distance travel, or lower extremity swelling. He denies fever, chills, or URI symptoms. He does report a 3-week history of intermittent exertional dyspnea that he attributed to deconditioning. Pertinent negatives include no history of DVT or PE, no family history of early MI, and no cocaine or stimulant use.

ROS Review of Systems

4 SYSTEM REVIEW

- **Constitutional:** Positive for diaphoresis and fatigue. Denies fever, chills, unintentional weight loss.
- **Cardiovascular:** Positive for chest pressure, dyspnea on exertion, and diaphoresis. Denies palpitations, orthopnea, PND, or lower extremity edema. History of hypertension and hyperlipidemia.
- **Respiratory:** Positive for mild dyspnea at rest. Denies cough, hemoptysis, pleuritic pain, wheezing.
- **GI:** Denies nausea, vomiting, abdominal pain, dysphagia, or heartburn. No recent change in bowel habits.

- **GU:** No hematuria, dysuria, or change in urinary frequency. No symptoms of urinary retention.
- **Neurological:** Denies headache, dizziness, syncope, visual changes, or focal neurological deficits.
- **MSK:** Denies myalgia, arthralgia, or joint swelling. Left arm ache present in the context of chest pain radiation.
- **Psychiatric:** Reports significant anxiety related to this acute illness. Denies depressed mood, suicidal ideation, or recent major stressors.

V Vitals

V VITAL SIGNS

Temperature	Blood Pressure	Heart Rate
98.4°F (oral)	162/94 mmHg (right arm, supine)	96 bpm (regular)
Respiratory Rate	**SpO_2**	**Weight**
18 breaths/min	96% on 2L NC	214 lbs (97.1 kg)

PE Physical Examination

5a FOCUSED EXAM

General Appearance
Alert and oriented x4, mild distress, diaphoretic, sitting upright in stretcher, speaking in full sentences.

Cardiovascular
Regular rate and rhythm. S1 and S2 present; S4 gallop audible at the apex. No murmurs or rubs. JVD estimated at 8 cm at 45°. Peripheral pulses 2+ bilaterally. No lower extremity edema.

Abdomen
Soft, non-distended, non-tender to palpation. Bowel sounds present and normoactive in all four quadrants. No organomegaly. No pulsatile abdominal mass.

Neurological
Alert and oriented x4. Cranial nerves II–XII grossly intact. Motor strength 5/5 in all extremities. Sensation intact to light touch. Gait not assessed given acute presentation.

Psychiatric
Anxious but cooperative. Appropriate affect. Thought process linear and goal-directed.

HEENT
Normocephalic, atraumatic. Pupils equal, round, reactive to light bilaterally. Conjunctivae non-icteric, non-injected. Oropharynx clear without lesions.

Respiratory
Mild tachypnea. Breath sounds clear to auscultation bilaterally; no wheezes, rales, or rhonchi. Symmetric chest expansion. No accessory muscle use.

MSK
Full range of motion of all extremities. No joint effusions or deformities. No calf tenderness.

Skin
Diaphoretic, warm, appropriate perfusion. No rashes, petechiae, or cyanosis. Nail beds without clubbing.

L Lab & Imaging

6a LABORATORY STUDIES

Troponin I (high sensitivity): 0.48 ng/mL (elevated; ULN 0.04) — repeat at 3h pending. BMP: Na 138, K 4.1, Cl 102, CO2 22, BUN 18, Cr 1.1, Glucose 147. CBC: WBC 10.2, Hgb 13.8, Plt 224. BNP: 310 pg/mL (mildly elevated). LDL-C (prior result 3 months ago): 148 mg/dL on statin therapy.

6b IMAGING STUDIES

Portable CXR: Cardiac silhouette mildly enlarged. No pulmonary edema. No pleural effusions. No pneumothorax. Mediastinum within normal limits. Aortic knuckle prominent, consistent with known hypertension.

6c OTHER DIAGNOSTICS

12-lead ECG: Sinus rhythm at 96 bpm. ST-segment depressions of 1.0–1.5 mm in leads V4–V6 and lateral limb leads I and aVL. No ST elevation. No new bundle branch block. Q waves absent. T-wave inversions noted in leads I and aVL.

A Assessment

7 DIAGNOSES, DIFFERENTIAL, REASONING, SEVERITY

Mr. Whitmore is a 66-year-old male with hypertension, hyperlipidemia, and active tobacco use presenting with a classic anginal syndrome with ECG changes and markedly elevated high-sensitivity troponin I, consistent with Non-ST-Elevation Myocardial Infarction (NSTEMI). The presence of lateral ST depressions and troponin elevation in the setting of ongoing chest pain at rest stratifies this patient as high-risk per TIMI and GRACE scoring. Differential diagnosis includes unstable angina (less likely given troponin elevation), aortic dissection (atypical presentation, no widened mediastinum), and demand ischemia; these are lower on the differential given clinical and ECG findings. Comorbid hypertension with uncontrolled BP of 162/94 and known hyperlipidemia with suboptimal LDL control contribute significantly to cardiovascular risk. Urgent cardiology consultation for consideration of coronary angiography within 24 hours is indicated.

P Plan

8 MANAGEMENT STRATEGY

1. Aspirin 325 mg PO x1 (given), continue aspirin 81 mg PO daily. 2. Ticagrelor 180 mg PO loading dose, then 90 mg BID (DAPT). 3. Heparin IV infusion — weight-based protocol initiated. 4. Metoprolol succinate 25 mg PO (if hemodynamically stable). 5. Atorvastatin increased to 80 mg PO nightly. 6. Nitroglycerin SL PRN for breakthrough chest pain, IV nitroglycerin if recurrent pain. 7. Cardiology consultation placed — urgent inpatient angiography anticipated. 8. Continuous cardiac monitoring, repeat troponin at 3 and 6 hours. 9. NPO after midnight in anticipation of possible PCI. 10. Patient counseled on diagnosis, importance of dual antiplatelet therapy, smoking cessation resources provided.

F Follow-Up

9 NEXT STEPS

Timeframe & Return Precautions

Admission to telemetry unit pending cardiology evaluation. If PCI performed, follow-up in cardiology clinic within 1–2 weeks post-discharge. Return precautions: return immediately if chest pain recurs, shortness of breath worsens, or new symptoms develop.

TIME DOCUMENTATION & BILLING

Total Time	**E/M Level**
72 minutes	99285 (Emergency Department E/M, high complexity)
Counseling Time	**Basis**
20 minutes	Medical Decision Making — High Complexity
Primary Dx Code	**Secondary Dx Code(s)**
I21.4 — Non-ST elevation myocardial infarction (NSTEMI)	I10 — Essential hypertension; E78.5 — Hyperlipidemia; F17.210 — Nicotine dependence, cigarettes, uncomplicated

PROVIDER NAME	CREDENTIALS	DATE & TIME
Catherine L. Nguyen, MD — Internal Medicine / Hospital Medicine	MD — Internal Medicine	05/06/2026