Subject: 016704 (41521)

ADMISSION NOTE

ADMISSION DATE: 23/03/17 HOSPITAL'S ADMISSION DATE: 23/03/17

NAME:

AGE: 17 SEX: MALE TELEPHONE:

ADDRESS:

CLINICAL HISTORY: IDDM (+) INSULIN NPH 20-20UI
HTN (+) ENALAPRIL, ATENOLOL
CABG 3 YEARS AGO
CARDIAC CATHETERIZATION 2011??

MEDICATION: INSULIN NPH 20-20
ENALAPRIL 20mg/12h
ATENOLOL

ALLERGIES: NONE

DESCRIPTION:

Patient indicates that he has been suffering from chest oppression and chest pains for the last 2 years when making moderate efforts. he now states that this occurs when he makes light efforts, this being why he is seeking emergency services. he notes that the pain has been the oppressive type, with an irradiation towards the back. he took ISB, but saw no apparent improvement; thus, he arrived to Emergency.

BP: 113 / 46 FC: 61 FR: 18 TEM:

PHYSICAL EXAMINATION

TESTS:, PATIENTS'S REGULAR GENERAL APPEARANCE, GOOD HYDRATION AND GOOD NUTRITION CONDITIONS, <2SEC CAPILLARY REFILL, STC IN MODERATE AMOUNT
THORAX- LUNGS: NORMAL BREATH SOUNDS IN BOTH LUNG FIELDS, NO RSA, NO GALLOP, JVP (-)HJR (-)
CV: RCRR NO MURMURS JVP (-) HJR (-)
ABDOMEN: B/D NO PAIN IN THE DEEP OR SUPERFICIAL PALPATION
NEUROLOGICAL: WELL ORIENTED IN TIME AND SPACE, NO SIGNS OF MENINGEAL OR FOCAL NEUROLOGIC SIGNS

EKG: **RS:** FC60X AXIS: 60°, NO SIGNS OF ACUTE ISCHEMIA

CPK-MB: 1.68 TROPONIN: 0.003 TOTAL CPK: 0 HB:11.5
GLUCOSE: 366 CREATININE: 1.23 HEMOGRAM: NORMAL

OTHER EXAMINATIONS:

DIAGNOSTIC IMPRESSION

1. UNSTABLE ANGINA