

Medical History Report for William Smith

Potential diagnoses, assessments, and suggestions are generated by artificial intelligence based on the patient's reported historical information. A licensed healthcare provider must review the patient's history, along with additional data (e.g., medical records, physical examinations, and diagnostic studies), to independently verify diagnoses, assessments, and treatment plans.

Chief Complaint

- Chest pain

History of Present Illness

The patient, a 42-year-old male, presents with a chief complaint of intermittent chest pain that started approximately 6 months ago. The pain is described as a burning sensation, located in the middle of the chest, and does not radiate. The patient rates the pain as a 3 out of 10 in severity and reports that episodes typically last about 10 minutes.

The chest pain appears to be triggered by spicy foods and red wine consumption. The patient initially thought it might be related to exertion but now believes this is not the case. He has found some relief by taking antacids, though the relief is not complete. The patient expresses concern about these symptoms due to his family history of heart disease, specifically mentioning his father who had angina in his forties and a heart attack at age 50.

The patient saw his family physician, Dr. Mary Smart, about 6 months ago regarding these symptoms. An electrocardiogram (EKG) was performed at that time and was reported as normal. Dr. Smart suggested that the symptoms might be related to reflux, heartburn, or possibly a hiatal hernia.

Clinical Summary

Healthcare providers:

- Dr. Mary Smart, family physician (seen approximately 6 months ago)

Diagnostic studies:

- Electrocardiogram (EKG) (performed approximately 6 months ago)

Treatments:

- Over-the-counter antacids for chest pain relief

Future Care Plans:

- Scheduled follow-up appointment with Dr. Mary Smart in 6 months (from the time of the last visit)
- Patient expressed interest in being seen at Volunteers in Medicine clinic due to financial constraints

Upcoming Appointments:

- Follow-up appointment with Dr. Mary Smart (exact date not specified, but scheduled for 6 months after the last visit)

Current Status

The patient reports intermittent chest pain as his primary concern. He describes it as a burning, aching sensation in the middle of his chest, not radiating to other areas. The pain is rated as a 3 out of 10 in severity and typically lasts about 10 minutes. It seems to be triggered by spicy foods and red wine consumption, as well as by stress. The patient has found some relief with over-the-counter antacids.

Apart from the chest pain, the patient reports feeling generally good. He mentions occasional low back ache, describing it as a dull, minor pain that occurs after a day of heavy lifting but resolves on its own. This back pain does not significantly impact his daily activities.

The patient has also noticed a new spot on his face that has been present for about 6 months. It is located on his left cheek, just below his left eye. He describes it as a raised, discolored lesion, approximately half an inch in diameter, which he believes may be getting larger.

Functional Status

The patient reports no significant limitations in his daily activities due to his current health issues.

1. Self-care, personal hygiene: No reported issues

2. Communication: No reported issues

3. Physical activity: No reported limitations

4. Sensory function: Reports gradual hearing loss, especially in the right ear, and persistent

bilateral tinnitus for the past 5 years

5. Nonspecialized hand activities: No reported issues

6. Travel: No reported issues

7. Sexual function: No reported issues

8. Sleep: Reports occasional difficulty sleeping if lying down immediately after a large meal

Past Medical History

- **Hospitalizations:** No hospitalizations reported
 - **Surgeries:** Right knee surgery for torn cartilage, approximately 5 years ago
 - **Major Illnesses:**
 - Hypertension (diagnosed 10 years ago)
 - Hyperlipidemia (diagnosed 5 years ago)
 - **Major Trauma:** None reported
 - **Psychiatric Disorders:** None reported
 - **Allergies:** Penicillin
 - **Drug and Sensitivities:** None reported besides penicillin allergy
 - **Medications:**
 - Hydrochlorothiazide (for hypertension)
 - Lipitor 10mg daily (for hyperlipidemia)
 - Daily multivitamin
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Review of Systems

- **General:** Reports a 5-pound weight gain attributed to increased eating
- **Skin:** New spot on left cheek, raised and discolored, present for 6 months
- **Head:** No reported issues

- **Eyes:** Uses reading glasses
 - **Ears:** Gradual hearing loss, especially in the right ear, and persistent bilateral tinnitus for 5 years
 - **Nose:** Seasonal allergies in spring, causing nasal congestion for about a month, relieved with antihistamines
 - **Mouth/Throat:** Reports dental decay and sensitivity to hot and cold, hasn't seen a dentist in 10 years
 - **Neck:** No reported issues
 - **Respiratory:** No reported issues
 - **Cardiovascular:** Intermittent chest pain as described in HPI
 - **Gastrointestinal:** No reported issues besides the chest discomfort potentially related to reflux
 - **Genitourinary:** No reported issues
 - **Musculoskeletal:** Occasional low back ache after heavy lifting
 - **Neurological:** No reported issues
 - **Psychiatric:** No reported issues
 - **Endocrine:** No reported issues
 - **Hematologic/Lymphatic:** No reported issues
 - **Allergic/Immunologic:** Seasonal allergies in spring
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Family History

The patient reports a significant family history of premature heart disease. His father developed angina in his forties and had a heart attack at age 50. No other significant family medical history was reported.

Personal and Social History

- **Birthplace:** Los Angeles, California
- **Childhood:** Reports a normal childhood with no significant trauma or abuse
- **Education:** Completed 12 years of formal education (high school graduate)
- **Military Service:** No military service reported
- **Legal Issues:** No legal issues or periods of incarceration reported
- **Marital Status:** Married for 10 years, reports a good relationship
- **Children:** One daughter, age 5
- **Living Situation:** Lives in a farmhouse in a rural area with his wife, daughter, one dog, and one cat
- **Social Support:** Reports having lots of friends and a strong support system
- **Religion:** Identifies as Catholic but doesn't attend mass regularly
- **Diet:** Normal diet including red meat, occasional vegetables and fruits. No specific dietary restrictions
- **Exercise:** Daily walking related to work, no structured exercise routine or gym involvement
- **Hobbies:** Enjoys fishing and playing cards
- **Tobacco Use:** Currently smokes half a pack of cigarettes per day, has been smoking for 20 years. Has attempted quitting in the past, including trying nicotine gum, but was unsuccessful
- **Alcohol Use:** Does not currently drink alcohol
- **Illicit Drug Use:** No history of illicit drug use reported

Occupational History

The patient is currently employed full-time as a carpenter, a profession he reports enjoying. He has a positive attitude towards his work and likes his coworkers. His job involves physical demands such as frequent ladder climbing and exposure to loud noises from power

tools like saws and nail guns. Despite these potential occupational hazards, the patient reports no work-related injuries or need for workplace accommodations due to health issues.

A typical workday for the patient begins at 6:00 AM. He has breakfast before leaving for work. His workday includes breaks during the day and for lunch. He returns home at 4:00 PM. After work, he spends time with his wife, walks the dog, has dinner, and watches TV before going to bed at 10:00 PM.

The patient reports that his employment situation feels stable, and his finances are "okay." He has not experienced any work restrictions or modifications due to his health conditions.

Weight & Height

Weight: 160 pounds

Height: 5 feet 6 inches

BMI calculation: 25.8 kg/m² (Overweight category)

Potential Diagnoses (Pending Provider Review)

- *Related To Chief Complaint:*

- Gastroesophageal reflux disease (GERD) (ICD-10: K21.9)
- Angina pectoris (ICD-10: I20.9)

- *Other Diagnoses:*

- Essential (primary) hypertension (ICD-10: I10)
 - Hyperlipidemia, unspecified (ICD-10: E78.5)
 - Tobacco use (ICD-10: Z72.0)
 - Sensorineural hearing loss, bilateral (ICD-10: H90.3)
 - Tinnitus, bilateral (ICD-10: H93.13)
 - Dental caries, unspecified (ICD-10: K02.9)
 - Suspicious skin lesion (ICD-10: R22.9)
 - Seasonal allergic rhinitis (ICD-10: J30.2)
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Comorbidities

- **Hypertension:** Diagnosed 10 years ago, currently treated with hydrochlorothiazide. The patient reports it is well-controlled.
- **Hyperlipidemia:** Diagnosed 5 years ago, currently treated with Lipitor 10mg daily. The patient reports his cholesterol level is around 120 mg/dL and believes his lipids are

controlled.

- **Tobacco Use Disorder:** The patient has been smoking half a pack of cigarettes daily for 20 years, indicating a significant nicotine dependence.
- **Hearing Loss and Tinnitus:** The patient reports gradual hearing loss, especially in the right ear, and persistent bilateral tinnitus for the past 5 years. This condition has not been formally evaluated or treated.
- **Dental Issues:** The patient reports problems with tooth decay and has not seen a dentist in 10 years, indicating potentially significant dental health issues.
- **Seasonal Allergies:** The patient experiences nasal congestion for about a month during spring, managed with over-the-counter antihistamines.

Medications

- Hydrochlorothiazide (dosage not specified) - for hypertension
- Lipitor 10mg daily - for hyperlipidemia
- Daily multivitamin
- Over-the-counter antacids (as needed for chest pain)
- Over-the-counter antihistamines (seasonal use for allergies)

Case Summary

William Smith is a 42-year-old male carpenter presenting with a 6-month history of intermittent chest pain. The pain is described as a burning sensation in the middle of the chest, triggered by spicy foods and red wine, and partially relieved by antacids. An EKG performed 6 months ago was reportedly normal. The patient has a significant family history of premature heart disease, with his father developing angina in his 40s and having a heart attack at 50.

The patient's medical history is notable for hypertension and hyperlipidemia, both diagnosed within the last 10 years and currently managed with medication. He is a long-term smoker, consuming half a pack of cigarettes daily for 20 years. Additional health concerns include gradual hearing loss with tinnitus, dental decay, and a new suspicious skin lesion on his face.

The patient maintains an active lifestyle through his work as a carpenter but does not engage in structured exercise. He reports a stable home life and work situation, with good

social support. His main health goals are to feel as good as possible and live at least until age 80.

Clinical Discussion

- ***Chest Pain Evaluation:***

The patient's chest pain presentation requires careful evaluation. While the symptoms are suggestive of gastroesophageal reflux disease (GERD), given the patient's significant family history of premature heart disease, cardiac causes cannot be ruled out without further investigation. The normal EKG from 6 months ago is reassuring but not definitive.

- ***Diagnostic Considerations:***

- A thorough cardiac workup is advisable, including stress testing and potentially coronary artery calcium scoring.
- Upper GI endoscopy may be considered to evaluate for GERD, hiatal hernia, or other gastrointestinal causes of chest pain.
- Regular blood pressure and lipid profile monitoring should continue.

- ***Treatment Approaches:***

- If GERD is confirmed, lifestyle modifications and proton pump inhibitors may be recommended.
- Continued management of hypertension and hyperlipidemia with current medications and regular monitoring.
- Smoking cessation should be strongly encouraged, with consideration of pharmacological aids and behavioral support.

- ***Comorbidities Management:***

- Audiological evaluation for hearing loss and tinnitus, with potential referral to an ENT specialist.
- Urgent dental evaluation and treatment plan for reported dental decay.
- Dermatological assessment of the new facial lesion to rule out skin cancer.

- ***Preventive Care:***

- Age-appropriate cancer screenings should be discussed and implemented.
- Lifestyle modifications including structured exercise program and dietary improvements should be encouraged.

The patient's multiple risk factors (smoking, family history, hypertension, hyperlipidemia) place him at increased risk for cardiovascular disease. A comprehensive approach addressing both his presenting symptoms and overall cardiovascular risk is crucial.

Wellness

- **Physical Activity:** While the patient's job as a carpenter provides some physical activity, implementing a structured exercise program could significantly benefit his cardiovascular health and weight management. Recommend at least 150 minutes of moderate-intensity aerobic activity per week, along with strength training exercises.
 - **Nutrition:** Encourage a balanced diet rich in fruits, vegetables, whole grains, and lean proteins. Suggest reducing intake of spicy foods and red wine, which seem to trigger chest pain. Consider referral to a nutritionist for personalized dietary advice.
 - **Smoking Cessation:** Prioritize smoking cessation efforts. Discuss various options including nicotine replacement therapy, medications like varenicline or bupropion, and behavioral support programs.
 - **Sleep Hygiene:** Address the reported difficulty sleeping after large meals by recommending avoiding large meals close to bedtime and elevating the head of the bed to reduce reflux symptoms.
 - **Stress Management:** Although not explicitly mentioned as a concern, introduce stress management techniques such as mindfulness or deep breathing exercises, which may also help with smoking cessation efforts.
 - **Social Connections:** Encourage maintaining and strengthening the reported good social support system, as this can positively impact overall health and well-being.
 - **Preventive Care:** Emphasize the importance of regular check-ups and screenings, including dental care and skin cancer screenings.
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Health Goals

The patient expressed two main health goals:

1. To feel as good as he can be
 2. To live at least until age 80
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Historian

The patient appeared to be a reliable historian, providing clear and detailed information about his symptoms and medical history. He demonstrated good recall of dates and events, such as the onset of his chest pain and past diagnoses. The patient seemed engaged in the interview process and forthcoming with information, including potentially sensitive topics

like his smoking habits. His health literacy appeared adequate, as evidenced by his understanding of his current medications and conditions. No significant inconsistencies were noted in his responses. The patient's emotional state seemed stable throughout the interview, with appropriate concern expressed about his chest pain and family history of heart disease.

Feedback

The patient reported that the interview experience was "excellent" and "very thorough."

Synopsis

This 42-year-old male carpenter presents with a complex medical picture, primarily focused on recurrent chest pain. While his symptoms are suggestive of GERD, his significant family history of premature heart disease and multiple cardiovascular risk factors necessitate a thorough cardiac evaluation. The patient's long-standing smoking habit, hypertension, and hyperlipidemia contribute to his overall cardiovascular risk profile. Additionally, the patient has several other health concerns that require attention, including hearing loss, tinnitus, dental decay, and a suspicious skin lesion.

The patient appears motivated to improve his health, with clear goals for longevity and well-being. However, there are several barriers to optimal health that need to be addressed, particularly his smoking habit and the need for more structured physical activity outside of work. The patient's stable social situation and reported good support system are positive factors that can be leveraged in his health improvement journey.

A comprehensive, multidisciplinary approach will be essential in managing this patient's health concerns, focusing on both diagnostic clarification of his chest pain and implementation of preventive strategies to reduce his long-term cardiovascular risk. Patient education and support for lifestyle modifications, particularly smoking cessation, will be crucial components of his care plan.