HISTORY: Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.

48 yo female c/o chest pain. Began 1.5 hours ago, pain is burning in character, no radiation, slight SOB, slight nausea and diaphoresis. Pain resolved after 20 mins. No treatment. No pain now. Has had several similar episodes over past 2-3 months. Usually after a heavy meal or exertion with some relief with antacids. Has Hx of elevated cholesterol but no follow-up treatment. Play tennis weekly, ex-smoker x 3 yrs. (30 packs/yrs). Denies unusual stress. Mother with NIDDM and brother with unknown heart problem. No Hx of HTN, DM but has not seen MD x 2 yrs.

PHYSICAL EXAMINATION: Indicate only pertinent positive and negative findings related to patient's chief complaint.

No obvious distress, minimizing symptoms, anxious to leave.
BP 160/80 noted
Chest- no tenderness, clear BS bilaterally without wheezes, rhonchi or rales
Heart- apical impulse not displaced, regular rhythm, no murmur or rubs
Abdomen- non-distended, BS+, no masses or organomegaly, tenderness in epigastrum, no rebound

DIFFERENTIAL DIAGNOSES: In order of likelihood (with 1 being the most likely), list up to 5 potential or possible diagnoses for this patient's presentation (in many cases, fewer than 5 diagnoses are likely).

1. Esophageal reflux disease
2. Peptic ulcer
3. Coronary artery disease
4. Cholecystitis
5. Musculoskeletal chest pain

DIAGNOSTIC WORK UP: List immediate plans (up to 5) for further diagnostic workup.

1. Stool for OB
2. EKG
3. CXR
4. Upper GI endoscopy
5.