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

48yo female - Chest pain x 90 mins

HPI- Burning
No radiation
Slight burning
Slight nausea & diaphoresis
Resolved spontaneously
Similar episodes 2-3 mos, after heavy meal or exertion
Some relief with antacids

PMH- Increased cholesterol, no follow-up or treatment
Tennis weekly
Smoked 30 pk yrs, stopped 3 yrs ago
No unusual stress
Mother w/ NIDDM, brother with unknown heart
No hx of HTN, has not seen MD x 2 yrs.

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

BP 160/80 No obvious distress, anxious to leave.

Chest- non tender, clear BS bilat, no wheezes, crackles or rales

Heart- PMI not displaced, reg rhythm, no murmur or rubs

Abdomen- +BS, non-distended, no masses or organomegaly, tenderness in epigastrum w/o 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.