Simulated Cardiology Clinic

Eden Fekadu MD | Documentation Sample
Physician Support Specialist

Before & After: Physician Dictation to Completed Note

This sample demonstrates how a rough physician dictation is transformed into complete, structured clinical documentation.

A physician sent over a quick voice memo after seeing a patient and asked for it to be turned into formatted documentation. The following pages show:

1. The original dictation, as it might be received (raw, conversational, unstructured)
2. The completed documentation, based on the same encounter, formatted as:
    - SOAP Note
    - DAP Note
    - Referral Letter
    - Summary Note

This reflects the kind of turnaround a physician can expect when delegating documentation from a quick recorded summary to a full set of finished notes, formatted however the chart or workflow requires.

Every physician has their own preferred note style, templates, and shorthand. This sample shows a general format, but I'm equally comfortable learning and matching your specific style, templates, or preferred phrasing as well as entering completed notes directly into your EHR system.

Patient and physician details are fictional, created to demonstrate documentation formatting.

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Physician Dictation (Raw Input)

"Okay, this is John Doe, 62-year-old male... follow-up for hypertension.

He's been having headaches for like 2 days now — bilateral, dull, getting worse. Says it's worse when his pressure's up, better when he rests. Also, some dizziness, and he's noticed his heart racing a bit.

No chest pain, no shortness of breath, denies the whole stroke/MI list, no vision changes. Been on blood pressure meds for about 7 years but... honestly, he's not taking them regularly.

Vitals — BP is high, like 185 over 110, heart rate's up around 104, breathing's fine, sats normal, temp normal. He looks okay though — alert, not in distress. Heart's a little fast but regular, no murmurs. Lungs clear. Belly's fine. No swelling in the legs. Neuro exam is normal, no weakness, moving everything fine.

My thinking is this is a hypertensive headache, probably urgency given how high the pressure is. Want to get an ECG, some basic labs — renal function, electrolytes. Start him on a blood pressure med, give him something for the headache…Tylenol's fine.

Really need him to stay on his meds this time, told him about cutting salt too. Bring him back to recheck the pressure, get him plugged into cardiology, and told him if anything gets worse ….chest pain, worse headache, weakness …. go to the ER right away."

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SOAP Note

Date: 2/25/2026

Patient Name: John Doe

Age/Gender: 62-year-old male

Provider: Dr.Thomas Ben

S – Subjective

The patient presents with headache of 2 days duration. He describes the headache as bilateral, dull, and progressively worsening. The pain is intermittent and associated with dizziness and occasional palpitations. He reports that the headache becomes worse when his blood pressure is elevated and improves slightly with rest.

The patient reports a history of hypertension diagnosed approximately 7 years ago with inconsistent medication adherence. He denies previous history of stroke, myocardial infarction, or heart failure. He denies trauma or recent illness.

The patient denies chest pain, shortness of breath, nausea, vomiting, abdominal pain, visual changes, syncope, seizures, focal weakness, urinary symptoms, or lower extremity swelling.

Medical History

Past Medical History: Hypertension × 7 years

Past Surgical History: None reported

Medications: Antihypertensive medications taken inconsistently

Allergies: None reported

Family History: Not discussed

Social History: Not discussed (no history of tobacco, Alcohol, or drug use)

Review of Systems (ROS)

The patient denies fever or fatigue. He reports headache with no associated vision loss or hearing changes. Cardiovascular review is notable for occasional palpitations, with no chest pain or peripheral edema. He denies cough or shortness of breath. Gastrointestinal review is negative for nausea, vomiting, abdominal pain, or diarrhea. He also denies any urinary symptoms. Musculoskeletal review is unremarkable for joint pain or body swelling. Neurologically, he reports dizziness but denies weakness, syncope, or seizures. Psychiatric review is negative for anxiety or depressive symptoms.

O – Objective

General: Patient appears stable, alert, and oriented ×3.

Vital Signs:

- BP: 185/110 mmHg
- HR: 104 bpm
- RR: 20/min
- SpO_2: 97% on room air
- Temperature: 36.7°C

HEENT: Pupils equal and reactive; no signs of trauma.

Cardiovascular: Mild tachycardia with regular rhythm; no murmurs or gallops.

Respiratory: Clear breath sounds bilaterally; no wheezes or crepitations.

Gastrointestinal: Abdomen soft and non-tender with normoactive bowel sounds.

Genitourinary: No CVA tenderness.

Musculoskeletal: No lower extremity edema.

Neurological: Cranial nerves grossly intact. Motor strength 5/5 in all extremities. No pronator drift or focal neurologic deficits.

Other Findings: None reported.

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A – Assessment

1. I10 – Essential (Primary) Hypertension
2. R51.9 – Headache, unspecified
3. Hypertensive urgency
4. Headache likely secondary to uncontrolled hypertension

P – Plan

1. Diagnostic Tests:

- Obtain ECG to evaluate for cardiac involvement
- Order CBC, renal function tests, and serum electrolytes
- Consider CT head if headache worsens or neurologic symptoms develop

2. Medications / Treatment:

- Initiate antihypertensive therapy for gradual blood pressure reduction
- Administer Tylenol for headache relief
- Monitor blood pressure and neurologic status closely
- Counsel patient regarding medication adherence and salt restriction

3. Follow-Up:

- Reassess blood pressure response and symptom improvement after treatment
- Schedule cardiology follow-up for long-term hypertension management
- Advise patient to seek immediate care for chest pain, worsening headache, weakness, or visual changes

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DAP Note

Patient: John Doe

Date: 05/07/2026

Clinician: Dr Thomas Ben

Session Type: Initial Consultation

D – Data

Patient is a 62 year old male presenting with a 2-day history of progressive headache. The headache is bilateral, dull, and intermittently worsening, associated with dizziness and occasional palpitations. Patient reports that symptoms tend to worsen during episodes of elevated blood pressure and improve slightly with rest.

He denies chest pain, shortness of breath, vision changes, nausea, vomiting, abdominal pain, urinary symptoms, focal weakness, syncope, or seizures.

On examination, patient was alert, oriented, and cooperative with intact cognition. No acute distress noted. Vital signs revealed elevated blood pressure of 185/110 mmHg and heart rate of 104 bpm. Cardiovascular examination showed mild tachycardia with regular rhythm and no murmurs. Respiratory and abdominal examinations were unremarkable. Neurologic examination was grossly intact with no focal deficits or signs of increased intracranial pressure.

A – Assessment

Patient presents with symptoms most consistent with hypertensive headache secondary to poorly controlled chronic hypertension. Blood pressure is significantly elevated, raising concern for hypertensive urgency. No clinical evidence of hypertensive emergency, acute coronary syndrome, or neurologic deficit at this time.

Provisional Diagnoses:

- I10 – Essential (Primary) Hypertension
- R51.9 – Headache, unspecified
- Hypertensive urgency
- Medication nonadherence contributing to uncontrolled blood pressure

P – Plan

1. Diagnostics:

- Order ECG to assess for cardiac strain related to hypertension
- Order CBC, renal function tests, and serum electrolytes
- Consider CT head if headache worsens or neurologic symptoms develop

2. Medical Management:

- Initiate gradual blood pressure control with antihypertensive therapy
- Administer Tylenol for symptomatic headache relief
- Monitor blood pressure and neurologic status closely
- Counsel patient on strict medication adherence and lifestyle modification (low-salt diet, stress reduction)

3. Follow-up:

- Reassess blood pressure response and symptom progression after treatment
- Schedule cardiology follow-up for long-term hypertension management and medication optimization
- Advise patient to return immediately if chest pain, worsening headache, visual changes, weakness, or confusion occur

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Referral letter

From:
Dr. Thomas Ben,

Clinic:
Simulated Cardiology clinic

Address
2345 Alpha Rd, Dallas, Texas

Phone:
234-567-8910

To:
Dr. John Butler

Specialty:
Cardiac Electrophysiologist

Facility:
Simulated cardiac EP centre

Date:
5/7/2026

Patient Information

Full Name	Date of Birth	Gender	Contact Number
John Doe	04/10/1968	Male	(456) 234-5678

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Medical History / Reason for Referral

I am referring John Doe for further evaluation and management regarding the following concerns: persistent headache in the setting of significantly elevated blood pressure, with suspected hypertensive urgency and need to rule out secondary complications.

The patient presents with a 2-day history of progressive bilateral, dull headache associated with dizziness and occasional palpitations. Symptoms are reported to worsen during episodes of elevated blood pressure and partially improve with rest. On evaluation, blood pressure was markedly elevated at 185/110 mmHg with associated mild tachycardia. Although no focal neurologic deficits or signs of acute end-organ damage were identified on initial assessment, the severity of hypertension in combination with persistent headache raises concern for hypertensive urgency and possible underlying cardiovascular or neurologic risk.

Relevant Medical History:

- Chronic hypertension (7 years), poorly controlled due to medication nonadherence
- Recurrent headaches
- No known history of stroke, myocardial infarction, or heart failure
- No known allergies

Current Medication:

- Irregular use of antihypertensive medications

Given the uncontrolled blood pressure and associated symptoms, the patient requires further cardiology evaluation, optimization of antihypertensive therapy, and exclusion of end-organ involvement.

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Physical Examination Findings

System	Findings
Vital Signs	BP: 185/110 mmHg, HR: 104 bpm, RR: 20/min, SpO_2: 97% on room air, Temperature: 36.7°C
Cardiovascular	Mild tachycardia with regular rhythm; no murmurs or gallops.

Requested Assessment / Treatment

Further cardiology evaluation and management is requested for uncontrolled hypertension presenting with persistent headache and associated symptoms. Kindly assess for:

- Optimization of antihypertensive therapy and long-term blood pressure control
- Evaluation for hypertensive urgency and possible end-organ involvement
- Cardiac assessment including ECG interpretation and further cardiovascular workup if indicated
- Assessment of headache in relation to uncontrolled hypertension and need for additional neurologic evaluation
- Lifestyle modification counselling and medication adherence planning

Coordination of care is requested for continued blood pressure monitoring, cardiovascular risk reduction, and ongoing symptom management.

If you require any additional details, please do not hesitate to contact my office. I appreciate your time and expertise in evaluating and managing this patient's condition.

Sincerely,

Drafted by Eden Fekadu, Remote Medical Assistant, On behalf of Dr. Thomas Ben (for physician review and signature)

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Summary Note

Patient is a 62-year-old male with a known history of poorly controlled hypertension presenting with a 2-day history of progressively worsening bilateral headache associated with dizziness and occasional palpitations. Symptoms reportedly worsen during episodes of elevated blood pressure and partially improve with rest. The patient admits inconsistent adherence to antihypertensive medications.

On examination, the patient was alert, oriented, and cooperative with no focal neurologic deficits. Vital signs were significant for severe hypertension (BP 185/110 mmHg) and mild tachycardia (HR 104 bpm). Cardiovascular examination revealed regular tachycardia without murmurs, while respiratory and abdominal examinations were unremarkable.

Clinical findings are concerning for hypertensive headache secondary to uncontrolled hypertension with possible hypertensive urgency. No evidence of acute end-organ damage or hypertensive emergency was identified during the current evaluation.

The patient was managed with blood pressure monitoring, symptomatic headache treatment, and counselling regarding medication adherence and lifestyle modification. Further cardiac evaluation, laboratory investigations, and close follow-up were recommended for long-term hypertension management and cardiovascular risk reduction.