THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
The South Carolina Workers' Compensation Commission

Appellate Case No.: 2013-001474

Joann Brockington, ...

v.

NHC Lexington, and
Premier Group Insurance Co., Inc., Carrier, ... Respondents,

v.

The South Carolina Second Injury Fund,..... Appellant.

RECORD ON APPEAL

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SC Court of Appeals

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SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Joann Brockington, Claimant, vs. NHC Lexington, Employer, and Premier Group Insurance Co., Inc., Carrier, vs. The S.C. Second Injury Fund.	WCC File No. 0712583 Carrier File No. WC34502007017075 SCSIF No. 145701 **DECISION AND ORDER**

Hearing:	March 6, 2012 in Columbia, South Carolina.
Appearances:	Clarke W. McCants, III, of Nance, McCants & Massey, Attorneys at Law, Aiken, South Carolina, for Employer / Carrier. Latonya Dilligard Edwards, Esquire of Dilligard Edwards, LLC, Columbia, South Carolina for The S.C. Second Injury Fund.
Purpose of Hearing:	To determine those issues set forth on the Forms 54 and 55 and any other matters which may have timely come before the undersigned Commissioner.
Decision and Order:	By Gene McCaskill, Commissioner
Filed:	August 2, 2012

STIPULATIONS

1. The purpose of the Hearing was to determine the issues set forth in the Hearing Notice and Forms 54 and 55, and any other matters which may have timely come before the undersigned Commissioner.

2. The Notice of the Hearing was timely and properly served upon all parties of interest.

3. Venue for this matter is proper in Lexington County, South Carolina; by agreement the hearing for this matter was held in Columbia, South Carolina.

PARTIES' APA SUBMISSIONS

1. Palmetto Health Richland, 5/19/98 - 10/22/07;
2. Eric Schlueter, M.D., 6/23/99 - 3/5/04;
3 H. Rubin Vision Center, 9/26/03 - 3/18/05;
4. Palmetto Health Richland Family Medicine Center, Ambulatory Services, 3/30/04 - 5/29/07;
5. Palmetto Health Richland Family Medicine Center, 5/25/04 - 7/14/10;
6. Children's Hospital Outpatient Center, 3/29/05 - 8/25/09;
7. The Moore Orthopaedic Clinic, 10/24/06 - 11/2/10;
8. Columbia Eye Clinic, 4/4/07 - 8/11/09;
9. Lexington Medical Center, 8/8/07;
10. Family and Preventive Medicine, 8/14/07 - 4/20/10;
11. The South Carolina Neurological Clinic, P.A., 9/4/07;
12. Midlands Neurology & Pain Associates, P.A., 10/25/08;
13. Marc Harari, Ph.D, 3/12/09 & 4/14/09;
14. Te-Long Hwang, M.D., University of South Carolina School of Medicine, 3/27/09;
15. Palmetto Imaging, 4/13/09;
16. Donald R. Johnson, M.D., Southeastern Spine Institute, 11/25/09;
17. Statement of Frank K. Noojin, III, M.D., 6/13/11;
18. Statement of Iris Crum, 6/28/11;
19. Agreement and Final Release, 7/21/11;
20. Form 19, 7/19/11.

STATEMENT OF THE CASE AND EVIDENCE PRESENTED

This matter is before the undersigned Commissioner to determine the issues set

forth in the Parties' Forms 54 and 55. As part of this matter the Defendants seek reimbursement from the Second Injury Fund for compensation and benefits paid to the Claimant, Joann Brockington, and pursuant to the provisions of the South Carolina Workers' Compensation Law (hereinafter "the Act").

The record for this matter shows that the Claimant injured her lower back on August 8, 2007 while working as a dietary aide for the Employer at its nursing home in West Columbia, South Carolina. The Claimant also alleged that she sustained a physical brain injury as a result of the accident involved here. The Defendants deny that the Claimant sustained such an injury.

The Defendants accepted the Claimant's lower back injury as compensable and paid for certain medical treatment provided to her. The Claimant also received temporary total compensation from the date of accident until January 6, 2009, at which time she returned to work with the Employer on a modified basis. Of note, the Claimant left work with the Employer in September 2011 and contended that she was entitled to payment of additional temporary compensation. The Defendants denied that she was entitled to payment of such additional compensation.

Notice of the Defendants' claim for reimbursement was provided to the Second Injury Fund on May 13, 2009 by certified mail - return receipt requested. At that time 74 weeks of temporary total compensation had been paid to the Claimant.

On June 28, 2011 the necessary documents to support the Defendants' claim for reimbursement were delivered to the Second Injury Fund. These documents included Dr. Noojin's statement, referenced in the APA Submissions above, and setting forth the medical

requirements for reimbursement.

This case was settled on a clincher agreement which was approved by the Commission on November 2, 2011. A Form 19 filed with the clincher reflects payment of the 74 weeks of temporary total compensation to the Claimant.

The Second Injury Fund subsequently denied the Defendants' claim for reimbursement. The Fund denied the claim was reimbursable asserting that Carrier did not provide notice of a potential Second Injury Fund claim prior to the payment of seventy-eight (78) weeks of benefits, that Claimant's preexisting arthritis was not permanent and serious enough to constitute a hindrance or obstacle to her employment, that Claimant's preexisting arthritis did not substantially increase Carrier's liability for medical costs and disability, that Carrier did not submit all required documentation for the Fund consideration by June 30, 2011 as required by S.C. Code Ann. §42-7-320(B)(2) and that the claim is barred pursuant to S.C. Code Ann. §42-7-320(B). The Defendants then filed a Form 54 as part of this matter.

At a pre-hearing conference for this matter Counsel for the Parties agreed that the essential facts of this case are not in dispute. The Parties agreed to submit briefs to the undersigned Commissioner for review and for the purpose of issuing a Decision and Order for this case. After a review of those briefs I hereby make and issue the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

1. The Claimant sustained an injury to her lower back on August 8, 2007 as a result of an accident arising out of and in the course of her employment with the Employer.

2. Payment of temporary total compensation to the Claimant commenced on

August 8, 2007 and ended on January 6, 2009, resulting in payment of 74 weeks of temporary compensation to the Claimant.

3. Notice of the Defendants' claim for reimbursement in this matter was provided to the Second Injury Fund on May 13, 2009 by certified mail - return receipt requested.

4. All required information necessary for the Second Injury Fund's consideration, acceptance, compromise or denial of the Defendants' claim for reimbursement was provided to the Fund by June 28, 2011.

5. The Second Injury Fund denied the Defendants' claim for reimbursement on August 26, 2011.

6. This matter was settled by and between the Claimant and the Defendants on November 2, 2011, and by the terms of an Agreement and Final Release; further, a Form 19 for this matter was filed with the Commission on December 19, 2011.

7. The uncontradicted medical evidence in this matter establishes the Defendants' claim for reimbursement in this matter. Specifically, the Claimant suffered from pain and discomfort in her lower back before the accident in August 2007, and as early as 1999. (Defendants' APA Submissions, Pages 39 and 41; Defendants APA Submissions, Pages 80 and 81).

8. Dr. Noojin states affirmatively that the Claimant suffered from arthritis in her lower back prior to the date of accident involved here. (Defendants' APA Submissions, Page 516). He further notes that this condition was serious and permanent, was aggravated by the work-related accident and serves as a hindrance or obstacle to the Claimant employment opportunities. His statement also supports the "substantial increase" requirements established by

statute.

9. The Statement of Iris Crum satisfies the notice requirements in this matter. Specifically Ms. Crum states that the Claimant complained of lower back pain after experiencing non- work related falls in 2004 and 2006, and a decision was made by the Employer to retain the Claimant in employment despite her lower back problems. (Defendants' APA Submissions, Page 518).

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. § 42-9-400 (1976), and other applicable law and regulation, the Defendants provided timely notice of their claim for reimbursement to the Second Injury Fund.

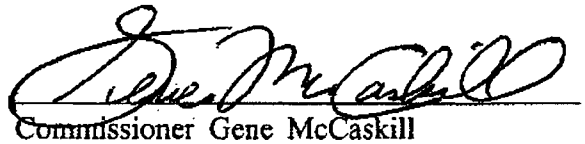
2. Pursuant to S.C. Code Ann. § 42-7-320 (1976), and other applicable law and regulation, all required information necessary for consideration, acceptance, compromise or denial of the Defendants' claim for reimbursement was timely provided to the Second Injury Fund.

3. Pursuant to S.C. Code Ann. § 42-9-400 (1976), and other applicable law and regulation, the Second Injury Fund is required to provide reimbursement to the Defendants for compensation and benefits paid to the Claimant in this matter.

ORDER

IT IS THEREFORE ORDERED that the S.C. Second Injury Fund shall be required to provide reimbursement to the Defendants as part of this matter and pursuant to the provisions of the Act.

SO ORDERED.



Commissioner Gene McCaskill

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

August 2, 2012

By: Kellie Lindler, Administrative Assistant to Commissioner McCaskill

APPELLATE PANEL

DECISION AND ORDER

OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE NO. 0712583
SCSIF NO. 145701

JOANN BROCKINGTON,

-V-

NHC LEXINGTON,

AND

PREMIER GROUP INSURANCE CO., INC., CARRIER,

DEFENDANTS/RESPONDENTS,

-V-

THE SOUTH CAROLINA SECOND INJURY FUND,

APPELLANT.

Appellate Panel Decision and Order filed

6/4, 2013

APPEARANCES:

Defendants/Respondents represented by
Clarke W. McCants, III, Esquire
of Aiken, South Carolina.

Appellant represented by
Latonya Dilligard Edwards, Esquire
of Columbia, South Carolina.

STATEMENT OF THE CASE

The Parties were heard by Commissioner Gene McCaskill on March 6, 2012 in Columbia, South Carolina. On August 2, 2012 he issued the following Order:

> IT IS THEREFORE ORDERED that the S.C. Second Injury Fund shall be required to provide reimbursement to the Defendants as part of this matter and pursuant to the provisions of the Act.

Within the statutory period, Counsel for the Appellant filed an Application for Review in this case setting forth its reasons, a copy of which was furnished to all interested Parties prior to oral argument presented before an Appellate Panel on November 14, 2012, and comprised of Commissioner T. Scott Beck, Commissioner Avery B. Wilkerson, Jr. and Commissioner Susan S. Barden. All proffered testimony had been taken. Such, together with all documentary evidence, was delivered by oral argument to the individual members of the Appellate Panel convened on the aforesaid date.

By appeal, the Appellant respectfully submitted the following issues:

> 1. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 8) that Claimant's preexisting arthritis was serious and permanent enough to constitute a hindrance or obstacle to employment, and substantially increased Carrier's liability, when such a finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
>
> 2. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 1) that pursuant to S.C. Code Ann. § 42-9400 and other applicable law and regulation, that Carrier provided timely notice of its claim for reimbursement to the Second Injury Fund, when such a conclusion is against the greater weight of the reliable, probative and substantial evidence in the record?
>
> 3. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 2) that pursuant to S.C. Code Ann. § 42-7-320 and other applicable law and regulation, all required information necessary for consideration, acceptance, compromise or denial of Carrier's claim for reimbursement was timely provided to the Second Injury Fund, when such a conclusion is against the greater weight of the reliable, probative, and substantial evidence in the record?

4. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 3) that pursuant to S.C. Code Ann. § 42-9400 and other applicable law and regulation, that the Second Injury Fund is required to provide reimbursement to the Carrier for compensation and benefits paid to the Claimant in this matter, when such a conclusion is against the preponderance of the reliable, probative, and substantial evidence in the record and is contrary to prevailing case and statutory law?

In an Appellate Review, the Appellate Panel shall, pursuant to S. C. Code Ann. § 42-17-50 (1976), review the Award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner.

After careful review of the record for this matter, and listening to and considering the statements and arguments of Counsel, a majority of the Appellate Panel hereby makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

1. The Claimant sustained an injury to her lower back on August 8, 2007 as a result of an accident arising out of and in the course of her employment with the Employer.

2. Payment of temporary total compensation to the Claimant commenced on August 8, 2007 and ended on January 6, 2009, resulting in payment of 74 weeks of temporary compensation to the Claimant.

3. Notice of the Defendants' claim for reimbursement in this matter was provided to the Second Injury Fund on May 13, 2009 by certified mail - return receipt requested.

4. All required information necessary for the Second Injury Fund's consideration, acceptance, compromise or denial of the Defendants' claim for reimbursement was provided to the Fund by June 28, 2011.

5. The Second Injury Fund denied the Defendants' claim for reimbursement on August 26, 2011.

6. This matter was settled by and between the Claimant and the Defendants on November 2, 2011, and by the terms of an Agreement and Final Release; further,

a Form 19 for this matter was filed with the Commission on December 19, 2011.

7. The uncontradicted medical evidence in this matter establishes the Defendants' claim for reimbursement in this matter. Specifically, the Claimant suffered from pain and discomfort in her lower back before the accident in August 2007, and as early as 1999. (Defendants' APA Submissions. Pages 39 and 41; Defendants APA Submissions, Pages 80 and 81).

8. Dr. Noojin states affirmatively that the Claimant suffered from arthritis in her lower back prior to the date of accident involved here. (Defendants' APA Submissions, Page 516). He further notes that this condition was serious and permanent, was aggravated by the work-related accident and serves as a hindrance or obstacle to the Claimant employment opportunities. His statement also supports the "substantial increase" requirements established by statute.

9. The Statement of Iris Crum satisfies the notice requirements in this matter. Specifically Ms. Crum states that the Claimant complained of lower back pain after experiencing non- work related falls in 2004 and 2006, and a decision was made by the Employer to retain the Claimant in employment despite her lower back problems. (Defendants' APA Submissions, Page 518).

CONCLUSIONS OF LAW

1. Pursuant to S.C. Code Ann. § 42-9-400 (1976), and other applicable law and regulation, the Defendants provided timely notice of their claim for reimbursement to the Second Injury Fund.

2. Pursuant to S.C. Code Ann. § 42-7-320 (1976), and other applicable law and regulation, all required information necessary for consideration, acceptance, compromise or denial of the Defendants' claim for reimbursement was timely provided to the Second Injury Fund.

3. Pursuant to S.C. Code Ann. § 42-9-400 (1976), and other applicable law and regulation, the Second Injury Fund is required to provide reimbursement to the Defendants for compensation and benefits paid to the Claimant in this matter.

ORDER

IT IS, THEREFORE, ORDERED that the Order of the Single Commissioner filed in this matter on August 2, 2012 is hereby affirmed by a majority of the Appellate Panel, and the same shall constitute the Decision and Order of the Appellate Panel.

IT IS FURTHER ORDERED THAT the South Carolina Second Injury Fund shall be required to provide reimbursement to the Defendants as part of this matter and pursuant to the provisions of the Act.

SO ORDERED.

Andrea C. Roche

T. Scott Beck, Commissioner

Dated : 6-4-13

Columbia, South Carolina

DISSENTING OPINION

I respectfully dissent. Although I would affirm the Single Commissioner's finding that Carrier has established notice pursuant to S.C. Ann.§42-9-400(f), I would reverse the Single Commissioner's decision on the issue of hindrance. Section 42-9-400(d) allows a presumption that certain permanent physical impairments specifically enumerated in that statute are a hindrance or obstacle to employment or reemployment "[w]hen an employer establishes his prior knowledge of the permanent impairment." S.C. Code Ann. §42-9-400 (d). It is noteworthy that effective July 1, 2007, the legislature eliminated arthritis from the list of permanent physical impairments presumed to be permanent and serious enough to constitute a hindrance or obstacle to employment or reemployment. S.C. Code Ann. §42-9- 400 (d) 2007 supplement. Thus, the Carrier in this case no longer enjoys a presumption, but rather is required to prove the issue of hindrance. Here, Carrier presented a questionnaire supporting arthritis as permanent and serious

enough to constitute a hindrance or obstacle to employment. There is other compelling evidence on this issue than the questionnaire submitted by Carrier. The medical evidence indicates that Claimant was diagnosed with a sprained knee in 2004. Carrier APA pp.13 and 15. Claimant's follow up visit regarding the sprained knee revealed normal gait, range of motion, and strength in the right leg with intermittent pain. Carrier APA pp.102-103. When Claimant presented for treatment in March 2005 for a routine follow up examination, she was experiencing head pain and intermittent aching but did not complain of arthritis. Carrier APA pp.341-343. When Claimant presented for treatment in June 2005 for a follow up of her hypertension and diabetes, she denied arthritis; an examination of her eyes, respiratory system, cardiovascular system, gastrointestinal system, and feet were normal. Carrier APA p.347. When Claimant presented for treatment in November 2005, she complained about her arthritis, but she was in no acute distress and her musculoskeletal examination was normal. Carrier APA pp.351-352. When Claimant presented for treatment in May 2007, approximately two (2) months prior to the work injury, she complained of nagging and intermittent headaches, **but no chronic pain or arthritis.** Carrier APA pp.354-355.

Furthermore, the last reference to arthritis in Claimant's back is in 1999--**eight (8) years prior to the date of accident in issue.** While there is indeed a questionnaire supporting reimbursement, we need not give it conclusive effect to the exclusion of other more compelling medical evidence. Ballenger v. Southern Worsted Corporation, 209 S.C. 463, 467, 40 S.E.2d 681, 682-83 (S.C. 1946). Therefore, the questionnaire as to the back is not supported by the medical records, which speak more loudly than the questionnaire. Accordingly, I would reverse the decision of the Hearing Commissioner and deny reimbursement.

Susan S. Barden, Commissioner

Dated: 6-4-13
Columbia, South Carolina

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States mail addressed to any unrepresented party.

By Valerie Deller on June 4, 2013

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE #0712583

PREMIER GROUP INS. PLAINTIFF VS. SC SECOND INJURY FUND DEFENDANT IN RE: JOANN BROCKINGTON VS. NHC OF LEXINGTON	SC WORKERS' COMPENSATION COMMISSION FULL BOARD HEARING OF PREMIER GROUP INSURANCE VS SOUTH CAROLINA SECOND INJURY FUND IN RE: JOANN BROCKINGTON VS. NHC OF LEXINGTON

This is the Transcript of the South Carolina Workers' Compensation Full Board Hearing of Premier Group Insurance versus South Carolina Second Injury Fund, In Re: Joann Brockington versus NHC of Lexington, taken before Gloria Davis, a Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 10:44 A.M., Wednesday, November 14, 2012, at South Carolina Workers' Compensation Commission, 1333 Main Street Columbia, South Carolina.

COPY

REPORTED

BY

GLORIA DAVIS

PALMETTO COURT REPORTING
321 Mac Circle Lexington, SC 29073

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Aiken, SC 29801

COMMISSIONERS PRESENT:

T. Scott Beck, Chair
Susan S. Barden
Andrea Pope Roche

*Reporter's Note: -- Indicates incomplete thought or sentence, trailing off or interruption by speakers.

**This is an Official Transcript governed by 25A S.C. Code ANN. Regs 67-615 D (Supp. 2000). The unauthorized copying of this document is deemed to be conversion of an asset belonging to the Court Reporter.

I N D E X

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STIPULATIONS

Commissioner Beck: All right, please call the case.

Court Reporter: Today is November 14th, 2012. This is South Carolina Workers' Compensation case number 0712583. This is the case of Premier Group Insurance versus the South Carolina Second Injury Fund; In Re: Joann Brockington versus NHC of Lexington. The Appellant is the Defendant, represented by Latonya D. Edwards. The Respondent is represented by Clarke W. McCants. Each side is allowed ten (10) minutes for oral argument and the Appellant three (3) minutes in reply. You are requested to argue the grounds of exception and stay within the record. The Single Hearing Commissioner was Commissioner McCaskill.

Commissioner Beck: All right. We do not have a transcript in this matter.

Ms. Edwards: There was not one.

Commissioner Beck: Is one going to be necessary?

Ms. Edwards: No, it's not.

Commissioner Beck: There was not one made?

Ms. Edwards: No, because when we did the

call of the case the Commissioner asked for memorandum instead; so, we didn't actually go on the record.

Commissioner Beck: Thank you. Okay. All right, Ms. Edwards?

ARGUMENT FOR THE APPELLANT

By Ms. Edwards:

Good morning, I'm Latonya Edwards, I represent the Second Injury Fund and I'm here requesting a reversal for various reasons. The first reason is because The Fund asserted that the carrier did not provide a notice prior to the payment of seventy-eight (78) weeks of benefits and the reason we make that argument is because that was according to the Form 19 that we received in 2011. We have not received an updated Form 19, we understand there may be one in the Commission's file but we have not yet received a Form 19 confirming that; that's the first reason and, of course, June 30 of 2011, the Statute 42-7-320 requires that we get all information in prior to that date. That -- another reason that we believe that this case is appropriate for reversal is because we believe that the pre-existing arthritis was not a hindrance to employment. Now, as you

all know, prior to July 1, 2007, there is a presumption for arthritis; after July 1, 2007, there is not. This case is August 8th, 2007, which means arthritis is not entitled to a presumption and I believe that the medical evidence in the record indicates that it's not a presumption to employment and I will cite those APA's for you: At Carrier APA, page 13 and 15. Claimant -- the evidence indicates that Claimant's pre-existing arthritis was not a hindrance to employment. Claimant had a 2004 knee injury, was diagnosed with a sprained knee; once again, this is at pages 13 and 15. At 102 and 103, Claimant's follow up revealed a normal gait, a normal range of motion and right leg with intermittent pain. In 2005, March 2005, Claimant had a routine follow up examination but she did not complain of any arthritis at that point; I believe she was treated for sinus related issues and head pain and intermittent aching; that's at page 341. At pages 342 and 343, Claimant did not make any complaints of knee or -- knee problems or arthritis and she was noted not to be in any acute distress. At Carrier APA, page 347, the Claimant presented for treatment in June, 2055, to follow up for

hypertension, diabetes, she denied arthritis at that time and her examination of all systems indicated that it was a normal exam; that's at page 347. At pages 351 and 352, she complained about arthritis but was not in any distress and her exam was normal at that time as well. In 2007, at pages 354 and 355, two (2) months prior to this work injury, she complained of headaches but not any chronic pain or arthritis and this is a couple of months before the work injury. And so, just based on those APA's we would assert that the pre-existing arthritis was not a hindrance to employment. We also believe that the claim is appropriate for reversal because the pre-existing arthritis we believe the medical evidence indicates that it did not substantially increase carrier's liability for medical costs or permanent disability and I will cite to the following APA's to support that: Carrier APA, pages 13 through 15, 101 to 103 and 351 to 352. Claimant did receive treatment for arthritis prior to the work injury but when she complained of the knee pain and -- I'm sorry -- prior to the work injury she did complain of knee pain and that's -- I'm sorry, the -- the pages that I'm citing are referencing

this -- she complained of knee pain in 2004, and arthritis in 2005. At page 3 -- pages 360 through 363 -- I'm sorry -- I'm getting tongue-tied, I'm sorry -- 360 through 363, post-injury when she presented she wasn't experiencing any chronic pain; she only complained of blurred vision and headaches, which resulted from the work injury where she was hit on her head on a concrete floor. At page 362, the musculoskeletal -- musculoskeletal examination was normal and she had strength in her lower extremities; that's prior to the injury. Post-injury she also received very limited treatment for arthritis. At Carrier APA, pages 365 to 366, it notes she had normal range of motion in her lower extremities and a normal gait and station at pages 369 through 370, 376, 382 and 422 and she also had negative findings with normal gait and station at pages 388, 393, 399, 405 and 414. And so, even when she presented post-injury her treatment included neck pain and spasms, blurred vision and balance, headaches, post-concussive syndrome, hypertension but no treatment for or problems associated with the pre-existing arthritis and, once again, I -- I'm going to recite the pages again; sorry if I'm

being repetitive, 366, 369, 374, 377, 391, 399 through 400, 405, 412 and 425. And, finally, the twelve percent (12%) impairment rating she got was to the brain and it was based on neurocognitive impairment that resulted from the August, 2007 work related injury. And I'd also reference the March 26, 2010 report of Dr. Wade; I'm sorry, I didn't put the page number in my document. But as you can see from the records she did complain of some limited pain and arthritis before the injury, it was not a hindrance to employment, treatment both before and after the work injury for arthritis was limited or nonexistent in some cases and the problems that she presented with: Neck spasms, blurred vision and balance, post-concussive syndrome; all of those were related to the August 8th, 2007 work related injury and, in fact, the twelve percent (12%) rating that she received was also to the brain from that work related injury. And so -- and also let me also assert that once again this is a case that is post-December, 2011, and, of course, we would assert that 42-7-320 (b) and its subsections bars this case from reimbursement as well. Do you have any questions for me?

Commissioner Beck: Thank you.

Ms. Edwards: Thank you.

Commissioner Beck: Mr. McCants?

ARGUMENT FOR THE RESPONDENT

By Mr. McCants:

Thank you and also good morning. I'll try to address the notice issue first. There is really no issue, I don't believe, that my client had paid seventy-four (74) weeks of compensation to the Claimant at the time that notice of a claim for reimbursement was provided to The Fund on May 13 of 2009. What I think The Fund argues in this case is that absolute proof of that fact by way of the 19 in conjunction with the settlement of this case was not provided until after the deadline established by the new Statute.

Commissioner Roche: Actually, your clincher -- it looks like its seventy-five point three six (75.36) weeks of TTD that were paid. Did you pay any TTD after notifying The Fund?

Mr. McCants: I don't believe we did. I -- if it -- if that's the case I stand by -- did you say seventy-five (75)?

Commissioner Roche: Yes. A little over seventy-five (75).

Mr. McCants: I --

Commissioner Roche: If I take the amount that you all claimed to have paid in the clincher and TTD and divide it by her comp rate. I mean, it's still below --

Mr. McCants: -- all right. Okay.

Commissioner Roche: -- it's still below the threshold but it --

Mr. McCants: Yes, ma'am, and -- and if you computed that by dividing comp rate by amount of temporary compensation there may be an inconsistency there but according to our records seventy-four (74) was paid but I guess my main point is that the notice was given before seventy-eight (78) weeks was paid; if I understand Latonya's argument correctly she's arguing that somehow verification or proof of that was not provided until June -- until after June 30 of 2011. I don't interpret that -- I argue that Statute does not control the decision here for purposes of whether or not notice was given; either notice was given or it wasn't and -- and clearly the facts of this case is that notice was given before seventy-eight (78) weeks was -- was paid. If you look at the Statute it -- it talks

about providing information; I -- I would assert it goes to more the merits of the claim as opposed to notice issues and things like because I believe that they are controlled by other portions of -- of the Statute. So -- so, from our standpoint it -- it's -- actually I will say it's a very clean notice but I certainly understand her argument; I just don't think it rises to the level of defeating a fact in the case and that is that notice was, in fact, given before seventy-eight (78) weeks was paid. Given that, let me shift to the medical evidence in this case and I -- I have to agree that there are certain arguments to be made on the other side. At the nature of the prior back problems that Ms. Brockington had arguably don't rise to a certain level but Commissioner McCaskill had the opportunity to look at the medical in this case; he concluded based upon the medicals that we presented, and just as Ms. Edwards has done, I would cite references to the record including my pages 39 and 41, 80 and 81 of the APA's to document a significant back problem she experienced prior to this incident she was involved in my work -- while work -- while working for my client. More importantly in this

case is -- is Dr. Noojin, who treated her for her spine complaints after the incident set forth in a statement as required, I believe by the Statute and whatnot, that her problems were, in fact, a result of arthritis in her lower back, which pre-existed --

Commissioner Barden: And I'm looking at that from 1999; when is the next back reference? I don't see any in 2005, '06 or '07 but, of course, I'm not through all the records yet. I mean, she did have other problems like with her knee, her shoulder, her thumb; when was the next back reference?

Mr. McCants: I think what you've got to do is -- is go to then the statement of Iris Crumb, who was the -- the --

Commissioner Barden: No, I'm asking in the medical. I'm not asking what your employer said; I'm asking what -- when is the next reference to -- because it has to be a hindrance or obstacle, so --

Mr. McCants: -- I -- I don't disagree with that and -- and --

Commissioner Barden: -- no, I -- I'm not -- I'm not making a statement; I'm asking you, after

the 1999 reference to the back where is the next reference to the back in the medical records?

Mr. McCants: -- I don't think there is clear reference to ongoing back problems up until the time of the -- of the incident, Commissioner Barden.

Commissioner Barden: Okay.

Mr. McCants: Our position would be that these are pre-existing problems that perhaps she didn't address medically during the period of time and Dr. Noojin, when it came time for him to address this issue set forth in his statement, it was his opinion that it -- there was a pre-existing arthritic condition and that was based upon the care of her back after the incident. He sets forth affirmatively that it was a permanent type condition, that it was a hindrance or obstacle, or rose to the level of being a hindrance or obstacle to her employment and that, in fact, that prior condition was such to cause a substantial increase and the exposure wouldn't be medically -- well, from the standpoint of disability; that evidence in our mind is -- is uncontradicted in this case. I -- from the standpoint of notice to the employer and I -- I

kind of treat the notice issue as both from the notice requirements and also as to the severity of the incident. This is, in my mind, an ideal case for reimbursement because this is a situation where an employee came to the employer and said I'm having these problems as is reflected by the statement of Ms. Crumb and they made an affirmative duty to keep her on the job because she was a good employee and they wanted to keep her on and work with her. So, in -- in the context and the philosophical -- the philosophical aspects of the -- of The Second Injury Fund Statute this is one that fits into that grove for purposes of reimbursement. There -- there was a rating to the back in the case by Noojin; it's a four percent (4%) rating. It was in June of 2000, and I don't -- I don't have a reference to that in my APA's; so, I want to note that if I could. So, for the various reasons, I think set forth in our briefs that were submitted to Commissioner McCaskill, as far as that matter we would respectfully submit that he was correct in his decision and should be affirmed.

Commissioner Beck: All right.

Mr. McCants: Thank you.

Commissioner Beck: Thank you, sir. Ms. Edwards?

Ms. Edwards: Just briefly.

RESPONSE FOR THE APPELLANT

By Ms. Edwards:

I -- I certainly -- I don't -- I don't concede a lot of things but I -- I certainly concede that notice is probably not our best argument. But I do think the medical evidence establishes that the pre-existing condition was not a hindrance to employment and, once again, we agree that arthritis pre-existed but we're not in the same posture that we were in 2007; they're not entitled to a presumption and certainly we believe that their medical evidence has to establish that it's a pre-existing condition that was a hindrance to employment and I believe that the medical records that I cited where it cites that she had very limited treatment, either before or after the injury, for arthritis. The fact that -- and I -- I wasn't aware of the four percent (4%) rating; I don't -- I don't -- I don't know what year that was but the twelve percent (12%) rating that she received at the conclusion of this injury was all related to the brain injury, which was sustained

when she was injured on August 8th of 2007. So, I would just reiterate those things and conclude my argument.

Commissioner Beck: Thank you all very much.

Ms. Edwards: Thank you.

Commissioner Beck: That will conclude this proceeding.

Mr. McCants: Thank you.

Commissioner Beck: Good to see you both.

(There being no further arguments, the hearing concluded at 11:00 A.M.)

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
803-737-5675

WCC File #: **0712583**
Carrier File #: **WC34502007017075**
Carrier Code #:
Employer FEIN #:

Claimant's Name: Joann Brockington SSN: Employer's Name: NHC Lexington

Address: 1208 Bush River Road Address: 2993 Sunset Boulevard

City: Columbia State: SC Zip: 29210 City: West Columbia State: SC Zip: 29169

Home Phone: Work Phone: ( ) - Insurance Carrier: Premier Group Insurance Co., Inc.

Preparer's Name: Latonya Dilligard Edwards Law Firm: Dilligard Edwards, LLC Preparer's Phone #: (803) 750-2214

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ claimant ☐ employer x SCSIF(check one) Date of injury: August 8, 2007 (m/d/yyyy)

The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

See Attachment.

Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Clarke W. McCants, III, Esquire, of Nance,

McCants & Massey, Post Office Box 2881, Aiken, South Carolina 29802-2881

Name

Address

on the 16th day of August, 2012 by ☒ first class mail ☐ personal service ☐ certified mail.

Latonya Edwards

Preparer's Signature

Attorney
Title

August 16, 2012
Date

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

WCC Form # 30
Rev. **3/97**

Form 30

REQUEST FOR COMMISSION REVIEW

QUESTIONS PRESENTED

1. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 8) that Claimant's preexisting arthritis was serious and permanent enough to constitute a hindrance or obstacle to employment and substantially increased Carrier's liability, when such a finding is against the greater weight of the reliable, probative, and substantial evidence in the record?

2. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 1) that pursuant to S.C. Code § 42-9-400 and other applicable law and regulation, that Carrier provided timely notice of its claim for reimbursement to the Second Injury Fund, when such a conclusion is against the greater weight of the reliable, probative, and substantial evidence in the record?

3. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 2) that pursuant to S.C. Code Ann § 42-7-320 and other applicable law and regulation, all required information necessary for consideration, acceptance, compromise or denial of Carrier's claim for reimbursement was timely provided to the Second Injury Fund, when such a conclusion is against the greater weight of the reliable, probative, and substantial evidence in the record?

4. Did the Hearing Commissioner err in concluding (Conclusion of Law No. 3) that pursuant to S.C. Code Ann. § 42-9-400 and other applicable law and regulation, that the Second Injury is required to provide reimbursement to the Carrier for compensation and benefits paid to the Claimant in this matter, when such a conclusion is against the preponderance of the reliable, probative, and substantial evidence in the record and is contrary to prevailing case and statutory law?

PALMETTO RICHLAND

EMERGENCY DEPARTMENT RECORD

FIVE RICHLAND MEDICAL PARK
COLUMBIA, S.C. 29203

PATIENT

98-91-22-08-6 05/19/98 17:52 07/04/51 46Y F W D

BROCKINGTON, JOANN
939 SETON ROAD (803)750-1518
COLUMBIA SC 29212

RESPONSIBLE PARTY
BROCKINGTON, JOANN (803)750-1518
939 SETON ROAD
COLUMBIA SC 29212

FINANCIAL DATA: 01 SELF PAY ADM BY: TLA ACCIDENT DATE AND TIME: 05/19/98 17:22

REGULAR PHYSICIAN: NO REFERRAL REQUESTED PHYSICIAN: EMS

MODE OF ARRIVAL: EMS ✓

VALUABLES: ☐ YES ☐ NO WHERE? ____

BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER ____

CHIEF COMPLAINT: MVA

DATE OF LAST VISIT: ____ LAST TETANUS: ____ TIME TO TRIAGE: 1850

PRE-HOSPITAL CARE ☐ SEE AMBULANCE REPORT ☐ SEE NURSE'S NOTES ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

LMP: ____ NURSE'S SIGNATURE: Mark

ADD'L VITAL SIGNS: TEMP 99 ☐ ORAL ☐ RECTAL PULSE 96 RESP. 20 BLOOD PRESS. 171/81 WEIGHT: ____ TIME OUT: 1930

DC VITAL SIGNS: TEMP ____ ☐ ORAL ☐ RECTAL PULSE ____ RESP. ____ BLOOD PRESS. ____ ALLERGIES: PCN LABS AND X-RAY

HISTORY: 46yo AA female c Minor MVA back seat restrained passenger. RTA 12 / GCS 15 c/o Neck, (R) Shoulder pain. ØLOC, ØSOB, ØCP, ØN/V/D. Ø face Ø Visual changes. FCS? Backboard

XRay: Cspine (R) Shoulder

ROS: As above

PAST HX: Ø tbl / ESH

MED HX MEDS: (1) DM

PHYSICAL: (2) HTN

Meds - (1) Pills for DM, HTN ALL - PCN

(1) Obese female - NAD (2) HEENT - Mucous Membrane moist NL, Tms clear
(3) Lungs - CTA (4) RRR (III) (5) Abd - soft, NT, NL BS
(6) Ext - Pulses, 5/5 strength
(7) Cspine - TTP - paraspinal
(R) Shoulder - pain c Abduct / Int rotate
(8) Mid back pain c palpation.

CLINICAL IMPRESSION: Cervical Muscle Strain

TREATMENT: (1) Motrin 800 mg PO

DISPOSITION/SPECIAL PATIENT INSTRUCTIONS: (1) D/C to home (2) RTED if Sx worsen (3) follow up c PCP
(4) Motrin / Tylenol As Directed (5) Flexeril 10 mg PO TID (#20)
(6) Continue other Home Meds.

CONDITION: ☐ IMPROVED ☐ UNCHANGED ☐ WORSE ☐ OTHER ADMIT ROOM

EXPLAIN: ____

PATIENT'S SIGNATURE

TIME SEEN BY MD: 1900

PHYSICIAN'S SIGNATURE: [signature] MD

CHART

Emergency Center at
Richland Memorial Hospital

Date: 5/19
Time: 1745

Name Beckington Tea Age 46

NURSING RECORD To be seen ☐ PMD _____ ☐ EMS

Mode of arrival: ☐ Amb ☐ W/C ☒ EMS ☒ Stretcher ☐ Carried

Chief Complaint: MVC
Head pain ☒ Shoulder Pain Neck pain

99.5 96 174/81 20

Allergies NKA

PMH ☒ HTN ☐ SZ ☐ CAD ☒ DM ☐ RAD ☐ HIV ☐ CVA ☐ CA ☐ NONE (1) DM med (2) HTN med

HOME MEDS ☐ TYLENOL ☐ MOTRIN ☐ NONE

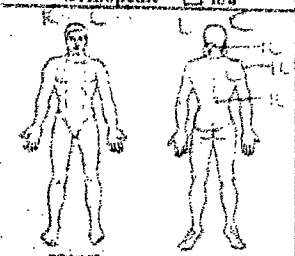
NURSING ASSESSMENT TIME 1750 SIGNATURE Rebecca Williamson

Respiratory

- ☒ Normal Effort ____ RR
- ☐ Nasal Flaring
- ☐ Exp. Grunt
- ☐ Retractions
- ☐ Stridor

R	BREATH SOUNDS	L
☐	Clear	☐
☐	Rales	☐
☐	Rhonchi	☐
☐	Wheezing	☐
☐	Diminished	☐

Orthopedic ☐ n/a



FRONT BACK

1. Abrasion
2. Amputation
3. Bleeding
4. Burn
5. Fracture
6. Gunshot
7. Laceration
8. Contusion
9. Redness
10. Pain
11. Paralysis
12. Penetr Wnd.
13. Sprain
14. Tenderness
15. Swelling
16. Deformity
17. Limited Movement
18. _____

Circulatory

- ☐ Color
  - ☒ Pink
  - ☒ Pale
  - ☐ Mottled
  - ☐ Cyanotic
  - ☐ Jaundiced
- ☐ Capillary Refill
  - ☐ Normal
  - ☐ Delayed

R	PULSES	L
____	radial	____
____	pedal	____
____	femoral	____

Neurological

LOC
☒ awake ☒ alert ☐ drowsy ☐ restless ☐ lethargic ☐ unresponsive

ORIENTATION
☐ time ☐ place ☐ person

MOTOR ABILITY & STRENGTH

	Strong	Weak	Absent
RA	☒	☐	☐
LA	☒	☐	☐
RL	☒	☐	☐
LL	☒	☐	☐

SEE BACK

Abdomen ☒ n/a

- ☐ Appearance
  - ☐ Flat
  - ☐ Rounded
  - ☐ Distended
  - ☐ Soft
  - ☐ Other _____
- ☐ Bowel Sounds
  - ☐ Present
  - ☐ Absent
- ☐ Palpation
  - ☐ Mass _____
  - ☐ Tender _____
  - ☐ Guarding _____

Genitourinary ☐ n/a

- ☐ Flank pain ____ L ____ R
- ☐ Dysuria
- ☐ Hematuria
- ☐ Frequency

GYN ☐ n/a

LMP _____
☐ Preg. _____ wks.
G_____ P_____
FHT _____ / _____
☐ Vag bleed _____ pads/____
☐ Vag d/c _____ color

Vision ☐ n/a

VISUAL ACUITY
L 20/_____ R 20/_____
☐ Correction
☐ Blurred L R
☐ Blind L R
☐ Drainage Present L R

Skin ☒ n/a

- ☐ Turgor ☐ Normal ☐ Decreased
- ☐ Edema ☐ Present ☐ Absent
- ☐ Mucous Membranes ☐ Moist ☐ Sticky ☐ Dry
- ☐ Lesions ☐ Present _____

Psychosocial ☒ n/a

- ☐ Eye contact ☐ Yes ☐ No
- ☐ Affect ☐ Normal ☐ Flat
- ☐ Motor behavior ☐ Cooperative ☐ Restless ☐ Agitated
- ☐ Speech ☐ Normal ☐ Abnormal

SUPPORT SYSTEMS
☐ Lives alone
☐ Family/S.O.
☐ Homeless
☐ Language Barrier

IDEATIONS
☐ N/A ☐ None
☐ Harm to self
☐ Harm to others

ABUSES
☐ N/A
☐ Alcohol
☐ Drug
☐ Tobacco _____/day

INTERVENTIONS ☐ N/A

EXPLAINED TO PATIENT / S.O. and completed

Time and Initials

- ☐ Side Rails Up _____
- ☐ O2 @ _____
- ☐ Cardiac Monitor ☐ Initial Rhythm _____
- ☐ ESP ☐ OA ☐ C-collar ☐ Backboard
  - ☐ Cleared by _____ D/C by _____
- ☐ Pulse Oximeter ☐ Spot check _____ ☐ Cont _____
- ☐ NG/OG _____
- ☐ Restraints ☐ UE ☐ LE Reassessment q 1 hr
  - includes color, movement, skin condition & exercise ext
  - ☐ _____ ☐ _____ ☐ _____ ☐ _____
- ☐ Sutures _____
- ☐ Cast / Splint applied _____
- ☐ Procedures _____
- ☐ Consents _____

LABS _____ ☐ N/A

- ☐ CBC
- ☐ SMA-7
- ☐ PT/PTT
- ☐ ETOH
- ☐ Hold Tubes
  - ☐ Red ☐ Green
  - ☐ Blue ☐ Lavender
- ☐ Retic
- ☐ Amylase
- ☐ Cardiac Enz.
- ☐ Blood C&S 1 2
- ☐ T X C _____ Units
- ☐ Other
- ☐ Redraw _____
- ☐ GC/Chlamydia
- ☐ ABG
- ☐ I/A via ☐ Bag ☐ I&O ☐ CC ☐ Foley
- ☐ Preg

- ☐ EKG 12 Lead _____
- X-RAY _____
  - C-Spine ☐ CT scan
    - ☐ port _____ ☐ Head
    - ☐ comp _____ ☐ Chest
  - ☐ CXR ☐ Abdomen
    - ☐ port ☐ Other _____
    - ☐ PA & Lat _____
  - ☐ Abdomen _____
  - ☐ Upper Ext. _____
  - ☐ Lower Ext _____
  - ☐ U/S _____
- ☐ Special Procedures _____

RICHLAND MEMORIAL HOSPITAL
EMERGENCY CENTER
AFTERCARE INSTRUCTIONS

091998

YOUR DIAGNOSIS TODAY IS: Muscle Strain

If you are worried about your illness and your doctor cannot be contacted, Richland Memorial Emergency Services is available for emergency care. You may call or return to the emergency department. Phone # 434-6350.

Follow-up Care / Referral

Arrange for an appointment in _____ days with:

☑ Private Doctor: Do needed -

Phone Number: _____

☐ Ambulatory Clinic

Call 434-4100 for appointment

☐ Medicine ☐ Orthopedic
☐ Family Practice ☐ Pediatric
☐ Obstetrics/Gynecology ☐ Other _____

☑ Emergency Department for worsening symptoms

Call sooner if not improving or if there is any problem. Until you contact your follow-up doctor, follow instructions as directed.

MEDICATIONS GIVEN TO YOU IN THE ER:

☐ Tylenol ☐ Rocephin ☐ Dilantin
☐ Ibuprofen ☐ Toradol ☐ Lidocaine
☐ Benadryl ☐ Floxin ☐ Mylanta/Donnagel

☑ Other Morphine

TEST RESULTS:

☐ Your x-rays have been read by the ER Doctor. They will also be reviewed by our radiologist. If any other problems are found that have not been called to your attention, you will be notified.

☐ Cultures require 48-72 hours for final reading. You may call 434-3311 for results. If your tests are positive, we will contact you.

Medications Prescribed for you today are:

Drug Name	Used for
Flexeril (#20)	Muscle Pain

Additional Medications / Instructions:

☐ Take all antibiotics as directed and until all medicine is gone.

☐ Do not drink alcohol, drive or operate machinery while taking this medication.

☐ Follow-up visit needed after completion of antibiotics in _____ weeks with private MD.

☐ Take medications with food.

☐ If rash, shortness of breath, or excessive vomiting occurs - stop medications and notify your MD or return to ER.

☐ If there is no improvement after taking antibiotics for 72 hours - contact your private MD.

☐ _____

Over the counter medications you need to take are:

☑ Tylenol _____ every 4-6 hours as needed for fever or pain.

☑ Ibuprofen (e.g.: Motrin Advil) _____ every 6 hours as needed for fever or pain. Take with food.

☐ Benadryl _____ every 6 hours as needed for itching.

☐ _____

FACT SHEETS GIVEN:

Other Instructions: Discharged home. Continue other home meds

☐ INT D/C ☑ Bracelet removed

Nurse: JC Cody

I have received and understand the above instructions for aftercare. I understand that I have had emergency treatment only, which is not a substitute for continuing medical care. I will arrange for follow-up care as instructed.

Patient/ Family: [signature] Ann Brockington

Form 76020461 (Rev. 2/97)

PALMETTO RICHLAND MEMORIAL HOSPITAL

EMERGENCY DEPARTMENT RECORD

FIVE RICHLAND MEDICAL PARK
COLUMBIA, S.C. 29203

UNIT RECORD: 00-91-22-08-6 | DATE: 09/06/99 15:42 | BIRTH DATE: 07/04/51 | AGE: 48Y | MOTHER'S MAIDEN NAME: FORD | SEX: F | MAR: W | RACE: B | PRE REG #: | PATIENT NO.: E/R9924900226

PATIENT

NAME, ADDRESS: BROCKINGTON, JOANN
2100 ELMWOOD AVE APT 4-1
COLUMBIA SC 29204
MIDDLE NAME, PHONE, SOC. SEC.: (803) 256-3560

FINANCIAL DATA: 19 MEDICAID | ADM. BY: DBB | ACCIDENT DATE AND TIME:

REGULAR PHYSICIAN: SCHLUETER, ERIC | REQUESTED PHYSICIAN: EMS

RESPONSIBLE PARTY: BROCKINGTON, JOANN
2100 ELMWOOD AVE APT 4-1
COLUMBIA SC 29204
PHONE: (803) 256-3560

MODE OF ARRIVAL: SELF DRIVEN

VALUABLES: ☐ YES ☐ NO WHERE?

BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER

CHIEF COMPLAINT: HA

DATE OF LAST VISIT: 08/12/99 | LAST TETANUS: | TIME TO TREATMENT: 2229

PRE-HOSPITAL CARE ☐ SEE AMBULANCE REPORT ☐ SEE NURSES NOTES | ☐ EMERGENT ☐ URGENT ☐ NON-URGENT | LMP: | NURSES SIGNATURE/INITIALS: Bailey RN

ADM VITAL SIGNS: TEMP. 99 ☐ ORAL ☐ RECTAL PULSE 89 RESP. 16 BLOOD PRESS. 171/84 | WEIGHT: | TIME OUT: 0030

DC VITAL SIGNS: TEMP. 98 ☐ ORAL ☐ RECTAL PULSE 75 RESP. 18 BLOOD PRESS. 148/82 | ALLERGIES: PCN | LABS AND X-RAY

HISTORY: 48 yo ♀ 1 day hx of HA. HA is described as dull, intermittent pain. Pain is over forehead and descends into sinuses and jaw. Described as pressure behind eyes and in sinuses. ~~Nothing makes it better~~. Motion improves. Light and loud noise make it worse. Sinus drainage x 3 days. ⊕ chills x 5 hrs. ⊕ cough x 1 day. ⊕ dizziness upon rising. ⊕ N/V

ROS: ØF/N/V/D/C ØSOB ØCP Ø Vaginal discharge, dysuria ⊕

FH/SH: Tubal ligation, gallbladder removal. Mother - DM & HTN Grandmother - CHF & Falls

PMH/MEDS: Allergic rhinitis & sinusitis - Sudafed & Claritin HTN - Accupril 10 mg QD

PHYSICAL: Gen - cooperative, alert & oriented x 3.
HEENT - NCAT
Eyes EOMI, Ø erythema, Ø exudate
Ears TM patent & pearly
Nose pain to palpation over lateral aspect of nose. Boggy turbinates
Throat - cobblestoning.
CV RRR & nRG
Lungs - CTAB
Abd - soft, NT, ND BS ⊕ ØCVAT
Neuro - CN II-XII intact
Normal finger nose
5+ strength throughout

CLINICAL IMPRESSION: Headache - resolved, migraine
Addendum: Pages to physician for exam as above, reports she has had HA's for decades - preceded by scotoma & associated w/ nausea + photophobia. Meets criteria for migraine HA

TREATMENT: Compazine 10 mg IV @ 2303
↳ HA resolved

DISPOSITION/SPECIAL PATIENT INSTRUCTIONS:
(1) d/c home (2) Maxidrin
(3) f/u Dr Schlueter as needed
(4) Return prn any concerns

CONDITION OF DISCHARGE ☐ SAME ☐ IMPROVED ☐ OTHER
EXPLAIN

ADMIT ROOM:

PATIENT'S SIGNATURE:

TIME SEEN BY MD: 2245

RESIDENT SIGNATURE: Brain Blankenship

MEETS PRUDENT LAYPERSON: YES ☐ NO ☐

ATTENDING SIGNATURE:

SEP 7 AM 1:45

REPORT NO. (1-9) 018461

DHEC PATIENT CARE FORM

Q.A. NO.

TRIP NO.

PATIENT IDENTIFICATION (Please Print)

LAST NAME (15-29) | FIRST NAME (30-45) | MI (46)

STREET (47-71) | APT. # (72-76)

CITY (77-87) | STATE (88-89) | ZIP CODE (90-94)

SEX (95) 1 Male 2 Female 3 Undetermined

RACE (96) 1 White 2 Black 3 Am. Indian 4 Hispanic 5 Asian 6 Other

AGE (97-100) CHECK ONE 1 YRS. 2 MOS. 3 DAYS

DISPOSITION (101-102)

01 TREAT/NO TRANS. 02 DOA AT SCENE 03 HOSPITAL ER 04 HOSP. DIR. ADMIT. 05 TRAUMA CENTER 06 PATIENT'S HOME 07 NURSING HOME 08 DR.'S OFFICE 09 OUTPATIENT 10 PT. REFUSED TREAT. 11 OTHER

TYPE OF INCIDENT

TRAUMA (103)	MEDICAL (104)
1 MVA	1 ENVIRON
2 MC	2 BEHAV
3 BIKES	3 OB/GYN
4 PED	4 RESP
5 ASSAULT	5 CARDIAC
6 FALL	6 INTERFAC
7 FIRE	7 OTHER
8 INTERFAC	
9 OTHER	

PATIENT STATUS

TO SCENE (105)	ON SCENE (106)	FROM SCENE (107)
1 EMERGENT	1 EMERGENT	1 EMERGENT
2 NONEMERGENT	2 NONEMERGENT	2 NONEMERGENT
CODE	CODE	

INCIDENT LOCATION

ST. OR HWY. NAME OR NO. Front River Watch Squad

CITY

COUNTY (108-109)

SAFETY EQP. (110) 1 Seatbelts 2 Helmets 3 Airbags 4 Child Seat 5 None 6 Unkn.

SITE OF INCIDENT (111) 1 ROADWAY 2 RESIDENCE 3 INDUSTRIAL 4 RECREATIONAL 5 AGRICULTURAL 6 OTHER

PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 3) (112-119)

03 Seizure 04 Diabetic 11 Abrasion/Contusions 13 Laceration 23 Fracture 24 Multitrauma/Shock 30 Head Injury 32 Spinal Injury 64 Stroke 51 G.I. Problems 74 Respiratory Distress 80 Coronary Problems 83 Cardiac Arrest Other Other

PRIMARY IMPRESSION (120-121)

TREATMENT PROCEDURES (122-155)

01 Dressing Applied 02 Limb Splinted 03 Spine Immobilized 04 Neck Immobilized 05 OB Assistance 06 Oral Airway Used 07 Oxygen Given 08 Suction Used 09 Antishock Trousers 10 Airway Maintained 11 Antishock Treatment 12 Artificial Resp. 13 Cardiac Massage 14 Bleeding Controlled 15 Cold Application 16 Patient Restrained 17 Other (Use Comments)

ICD9 CODE (156-160)

SITE OF TRAUMA (161-169)

1 Head 2 Face 3 Neck 4 Chest 5 Abdomen 6 Hip/Pelvis 7 Upper Ext. 8 Lower Ext. 9 Back

ADVANCED PROCEDURES (170-197)

1. EKG Monitored — Rhythm — Time
2. First Defib Attempted — Watt Sec — Time — Post Defib Rhythm
3. Second Defib Attempted — Watt Sec — Time — Post Defib Rhythm
4. Third Defib Attempted — Watt Sec — Time — Post Defib Rhythm
5. INTUBATED (Method) — Size
6. EXTERNAL PACING
7. BLOOD DRAWN — DEXTROSE ROLL
8. I.V. STARTED/GAUGE — SOLUTION — RATE — I.V. TIME — I.V. VOLUME
9. I.V. STARTED/GAUGE — SOLUTION — RATE — I.V. TIME — I.V. VOLUME
10. PLEURAL DECOMPRESSION — Time
11. INTRAOSSEOUS INF. — 14. #IV ATTEMPTED
12. AUTOMATIC DEFIB
13. PATIENT ASSISTED MEDS — Ordering Physician (Name) — (Signature)

DRUGS USED (198-213)

DRUG	DOSE	TIME	DRUG	DOSE	TIME

REVISED TRAUMA SCORE

GCS: (214) EYES 4 (215) VERBAL 5 (216) MOTOR 6 (217-218) GLASGOW 15

(219-221) SBP 130 (222-224) RR 14 RTS (226-227) 7.84

(225) ANATOMICAL INJ. 1 YES 2 NO

VITAL SIGNS

BP	PULSE	RESPIRATIONS	PUPILS	LEVEL OF CONSC.	TIME
130/110	RATE 84 REG. IRREG.	RATE 16 REG. IRREG.	E	A	1726
/	REG. IRREG.	REG. IRREG.	E=EQUAL U=UNEQUAL N=NO RESP. C=CONSTR. D=DILATED	A=ALERT V=VERBAL ST. P=PAINFUL ST. U=UNRESP.	
/	REG. IRREG.	REG. IRREG.			
/	REG. IRREG.	REG. IRREG.			
/	REG. IRREG.	REG. IRREG.			

EXPOSURE TO PT's BODY FLUIDS? (228) 1. YES 2. NO

1ST Responder (229) 1. YES Name 2. NO

COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE OF STIMULI)

46 y/o M/V driver restrained driver front seat

Patient Care Form Left In (230): 1. ED 2. ICU 3. OTHER

See Page 2

TIME RECORD

RUN DATE (231-236) MONTH DAY YEAR

Call Received: (237-242)	
Call Dispatched: (243-248)	
Departed Base: (247-250)	
Arrive Scene: (251-254)	
Departed Scene: (255-258)	
Arrive Destination: (259-262)	

CAUSE OF DELAY

DHEC PERMIT NO. (263-267)

RECEIVING AGENCY (268-271)

SENDING AGENCY (272-275)

PROVIDER TIME (OPTIONAL)

ATTENDANT'S SIGNATURE & CERTIFICATION NO.

PRIMARY PATIENT ATTENDANT (276-280)

2ND ATTENDANT/DRIVER (281-285)

3RD ATTENDANT/DRIVER (286-290)

(RECEIVING NURSE OR PHYSICIAN)

DHEC 1050 (07/1997)

RECEIVER'S COPY

05-JAN-2000

Richland Memorial Hospital

RADIOLOGY SERVICES

FIVE RICHLAND MEDICAL PARK
COLUMBIA, SC 29203

	PATIENT'S NAME				MEDICAL REC. NO
	BROCKINGTON, JOANN				R009122086
DATE/TIME TO BE DONE	DOB / AGE	SEX	RM NO SOURCE	PATIENT TYPE	BILLING NO
05/19/98 1927	07/04/51 46Y	F	DIS	E/R	R9813901143
CHECK-IN DATE/TIME	CHECK IN	ADMITTING			REPORT RELEASED
05/19/98 1936	1803535	SHELTON, STEPHEN L 5 RICHLAND MEDICAL PK DR EMERGENCY MEDICINE D COLUMBIA, SC 29203			05/20/98 1014
ORDERING PRIVETTE, TROY W JR 5 RICHLAND MEDICAL PK DR COLUMBIA, SC 29203					

Exam: 00776 XR CERVICAL SPINE
Ord Diag: MVA

HISTORY: 46 year old female in MVA.

RIGHT SHOULDER FOUR VIEWS INCLUDING AXILLARY VIEW 5-13-98:

This is the initial exam of record in this department.

No fracture or subluxation is seen. DJD is seen in the AC joint.

CERVICAL SPINE FIVE VIEWS:

This is the initial exam of record in this department.

There is extensive bridging osteophytosis from C4 to C7 anteriorly. Slight posterior osteophytosis is also seen. No fracture or subluxation is identified.

IMPRESSION: LARGE OSTEOPHYTES WITH NO EVIDENCE OF FRACTURE OR SUBLUXATION.

AA /Read By/ Robert L Waldron II, M.D.
05/20/98 1014 /Released By/ Robert L Waldron II, M.D.

FINAL

Emergency Center at
Palmetto Richland Memorial Hospital

Date: 9/6/99
Time: 1541

H/P

Name [illegible], Age 48

NURSING RECORD To be seen ☐ PMD _____ ☑ EMS

Mode of arrival: ☑ Amb ☐ W/C ☐ EMS ☐ Stretcher ☐ Carried

Chief Complaint: HA

Nausea, vomiting, photophobia, neck pain

Allergies PCN

SEP 6 3:00 PM

T 99 ☐ R HR 84 RR 16 B/P 157/84 WT TETANUS

PMH ☒ HTN ☐ SZ ☐ CAD ☐ DM ☐ RAD ☐ HIV ☐ CVA ☐ CA ☐ NONE

HOME MEDS ☐ TYLENOL ☐ MOTRIN ☐ NONE BP meds

TRIAGE SIGNATURE [signature]

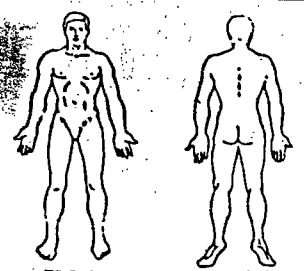
NURSING ASSESSMENT TIME _____ SIGNATURE _____

Respiratory

- ☐ Normal Effort _____ RR
- ☐ Nasal Flaring
- ☐ Exp. Grunt
- ☐ Retractions _____
- ☐ Stridor _____

R	BREATH SOUNDS	L
☐	Clear	☐
☐	Rales	☐
☐	Rhonchi	☐
☐	Wheezing	☐
☐	Diminished	☐

Orthopedic ☐ n/a



FRONT

1. Abrasion
2. Amputation
3. Bleeding
4. Burn
5. Fracture
6. Gunshot
7. Laceration
8. Contusion
9. Redness
10. Pain

BACK

11. Paralysis
12. Penetr. Wnd.
13. Sprain
14. Tenderness
15. Swelling
16. Deformity
17. Limited Movement
18. Skin Breakdown
19. _____

Circulatory

- ☐ Color
  - ☐ Pink
  - ☐ Pale
  - ☐ Mottled
  - ☐ Cyanotic
  - ☐ Jaundiced
- ☐ Capillary Refill
  - ☐ Normal
  - ☐ Delayed _____

R	PULSES	L
___	radial	___
___	pedal	___
___	femoral	___

Neurological

LOC
☐ awake ☐ alert ☐ drowsy
☐ restless ☐ lethargic
☐ unresponsive

ORIENTATION
☐ time ☐ place ☐ person

MOTOR ABILITY & STRENGTH

	Strong	Weak	Absent
RA			
LA			
RL			
LL			

SEE BACK

Abdomen ☐ n/a

- ☐ Appearance
  - ☐ Flat
  - ☐ Rounded
  - ☐ Distended
  - ☐ Soft
  - ☐ Other _____
- ☐ Bowel Sounds
  - ☐ Present
  - ☐ Absent
- ☐ Palpation
  - ☐ Mass _____
  - ☐ Tender _____
  - ☐ Guarding _____

Genitourinary ☐ n/a

- ☐ Flank pain ___L ___R
- ☐ Dysuria
- ☐ Hematuria
- ☐ Frequency

GYN ☐ n/a

LMP _____
☐ Preg. _____ wks.
G _____ P _____
FHT _____ +/-
☐ Vag bleed _____ pads/___
☐ Vag d/c _____ color

Vision ☐ n/a

VISUAL ACUITY
L 20/_____ R 20/_____
☐ Correction
☐ Blurred L R
☐ Blind L R
☐ Drainage Present L R

Skin ☐ n/a

- ☐ Turgor
  - ☐ Normal ☐ Decreased
- ☐ Edema
  - ☐ Present ☐ Absent
- ☐ Mucous Membranes
  - ☐ Moist ☐ Sticky ☐ Dry
- ☐ Lesions
  - ☐ Present _____

Psychosocial ☐ n/a

- ☐ Eye contact
  - ☐ Yes ☐ No
- ☐ Affect
  - ☐ Flat ☐ Normal
- ☐ Motor behavior
  - ☐ Cooperative
  - ☐ Restless
  - ☐ Agitated
- ☐ Speech
  - ☐ Normal
  - ☐ Abnormal

SUPPORT SYSTEMS
☐ Lives alone
☐ Family/S.O.
☐ Homeless
☐ Language Barrier

IDEATIONS
☐ N/A ☐ None
☐ Harm to self
☐ Harm to others

ABUSES
☐ N/A
☐ Alcohol
☐ Drug
☐ Tobacco _____ /day

INTERVENTIONS ☐ N/A

EXPLAINED TO PATIENT / S.O. and completed

Time and Initials

- ☐ Side Rails Up _____
- ☐ O2 @ _____
- ☐ Cardiac Monitor ☐ Initial Rhythm _____
- ☐ FSP ☐ OA ☐ C-collar _____ ☐ Backboard _____
  - ☐ Cleared by _____ D/C by _____
- ☐ Pulse Oximeter ☐ Spot check _____ ☐ Cont. _____
- ☐ NG/OG _____
- ☐ Restraints ☐ UE ☐ LE Reassessment q 1 hr, includes color, movement, skin condition & exercise ext
  - ☐ ___ ☐ ___ ☐ ___ ☐ ___
- ☐ Sutures _____
- ☐ Cast / Splint applied _____
- ☐ Procedures _____
- ☐ Consents _____

LABS _____ N/A

- ☐ CBC
- ☐ SMA-7
- ☐ PT/PTT
- ☐ ETOH
- ☐ Hold Tubes
  - ☐ Red ☐ Green
  - ☐ Blue ☐ Lavender
- ☐ Retic
- ☐ Amylase
- ☐ Cardiac Enz.
- ☐ Blood C&S 1 2
- ☐ T X C ___ Units
- ☐ Other
- ☐ Redraw _____
- ☐ GC/Chlamydia
- ☐ ABG
- ☐ U/A via ☐ Bag ☐ I&O ☐ CC ☐ Foley
- ☐ Preg

- ☐ EKG 12 Lead _____
- ☐ X-RAY _____ ☐ n/a
  - C-Spine ☐ CT scan
  - ☐ port _____ ☐ Head
  - ☐ comp _____ ☐ Chest
  - ☐ CXR ☐ Abdomen
  - ☐ port ☐ Other _____
  - ☐ PA & Lat _____
- ☐ Abdomen _____
- ☐ Upper Ext. _____
- ☐ Lower Ext. _____
- ☐ U/S _____
- ☐ Special Procedures _____

76020615 (Rev. 10/96)

VITAL SIGNS

TIME	T	BP	P	R	%O2 Sat	Rhythm	EO L/R	MTR L/R	Verb	Pupils L	Pupils R	Breath Sounds L/R	Pain Assessment	Other
Discharge														

Breath Sounds
Cl - clear
D - Diminished
Ab - absent
R - rales
Rh - rhonchi
W - Wheezing

Pain Assessment Scale
0 (Pain Free) ... 10 (Severe)

Eye Opening
4 - spontaneously
3 - to speech
2 - to pain
1 - none

Best Motor Response
6 - obeys commands
5 - localizes pain
4 - withdraws to pain
3 - abnormal flexion pain
2 - abnormal extension (pain)
1 - none

Best Verbal Response
5 - oriented
4 - confused
3 - inappropriate
2 - incomprehensible sounds
1 - none-intubated

R - Brisk
S - Sluggish
N - Nonreactive

ORTHOSTATICS

Lying / Standing

TIME		
	BP	
	HR	
TIME		
	BP	
	HR	

IV

TIME	GAUGE	SITE	BY	TIME	DC'd W O COMPLICATIONS	BY
2300	20	(R) AC	BS	0030	Uyo	BS

MEDICATIONS

TIME	DRUG/DOSE/ROUTE/SITE	GIVEN BY
2302	Compazine 10mg IV	BS

PARENTERAL INTAKE

TIME	BAG #	TYPE & AMOUNT	SITE	AMT. INFUSED

TOTAL INTAKE

VALUABLES

☐ w/patient ☐ cashier ☐ w/family

- ☐ wallet
- ☐ purse
- ☐ keys
- ☐ home meds
- ☐ clothing ☐ cut ☐ bagged
- ☐ shoes
- ☐ dentures
- ☐ glasses
- ☐ jewelry ☐ n/a
- ☐ rings
- ☐ watch
- ☐ necklace
- ☐ earrings
- ☐ other

ENTERAL INTAKE

TIME	TYPE	ROUTE	AMT.

TOTAL INTAKE

OUTPUT

TIME	URINE HR CUM	NG EMESIS	OTHER

TOTAL OUTPUT

PROGRESS NOTES

2240 Dr. Bhavya @ BS for exam. By 2330 States feels "a little better, HA has "eased up" By 0020 States feels "much better" but has not received total relief. Ready to go home. BS

☐ See continued RN notes

DISCHARGE EVALUATION TIME: 0030

☒ Home ☐ Other _____ Accompanied with ☒ Self ☐ Family ☐ EMS ☐ In Custody

Via ☐ W/C ☒ Ambulatory ☐ Stretcher ☐ Carried

Assessment of c/c: ☒ Improved ☐ N/C ☐ Other _____

☒ Pt/S.O. verbalized understanding of D/C instructions _____

ADMIT

Time Report Called _____ Transported with:

Room # _____ ☐ Monitor ☐ O2

Report to _____ ☐ Pulse Ox ☐ RN

☐ Time to floor _____

Nurses Signature/Initials B. McGuzman, RN

PALMETTO RICHLAND MEMORIAL HOSPITAL EMERGENCY CENTER AFTERCARE INSTRUCTIONS

ADDRESSOGRAPH

YOUR DIAGNOSIS TODAY IS:
Acute Headache - Resolved Migraines

If you are worried about your illness and your doctor cannot be contacted, Palmetto Richland Memorial Emergency Services is available for emergency care. You may call or return to the emergency department. Phone # 434-6350.

Follow-up Care / Referral

Arrange for an appointment in _____ days with:

- ☐ Private Doctor: _____
  Phone Number: _____
- ☐ Ambulatory Clinic
  Call 434-4100 for appointment
  - ☐ Medicine
  - ☐ Family Practice
  - ☐ Obstetrics/Gynecology
  - ☐ Orthopedic
  - ☐ Pediatric
  - ☐ Other _____
- ☐ Emergency Department for any more problems

Call sooner if not improving or if there is any problem. Until you contact your follow-up doctor, follow instructions as directed.

MEDICATIONS GIVEN TO YOU IN THE ER:

- ☐ Tylenol
- ☐ Ibuprofen
- ☐ Benadryl
- ☐ Tetanus
- ☐ Rocephin
- ☐ Toradol
- ☐ Floxin
- ☐ Dilantin
- ☐ Lidocaine
- ☐ Mylanta/Donnagel
- ☐ Other Compazine

TEST RESULTS:

- ☐ Your x-rays have been read by the ER Doctor. They will also be reviewed by our radiologist. If any other problems are found that have not been called to your attention, you will be notified.
- ☐ Cultures require 48-72 hours for final reading. You may call 434-3311 for results.

Medications Prescribed for you today are:

Drug Name	Used for
~~Reglan~~ Rx Admin	for Migraine

Additional Medications / Instructions:

- ☐ Take all antibiotics as directed and until all medicine is gone.
- ☑ Do not drink alcohol, drive or operate machinery while taking this medication.
- ☐ Follow-up visit needed after completion of antibiotics in _____ weeks with private MD.
- ☑ Take medications with food.
- ☐ If rash, shortness of breath, or excessive vomiting occurs - stop medications and notify your MD or return to ER.
- ☑ If there is no improvement after taking antibiotics for 72 hours - contact your private MD.
- ☐ _____

Over the counter medications you need to take are:

- ☐ Tylenol _____ every 4-6 hours as needed for fever or pain.
- ☐ Ibuprofen (e.g.: Motrin, Advil) _____ every 6 hours as needed for fever or pain. Take with food.
- ☐ Benadryl _____ every 6 hours as needed for itching.
- ☐ _____

FACT SHEETS GIVEN:

Other Instructions: Discharge Home
Follow up with Dr Schlueter as needed
Return to ER if any more Concerns
Work as desired 6/7/99

I have received and understand the above instructions for aftercare. I understand that I have had emergency treatment only, which is not a substitute for continuing medical care. I will arrange for follow-up care as instructed.

Nurse: B. de Guzman, RN ☒ INT D/C Patient/Family: X [illegible]

Form 78020461 (Rev. 7.98)

EMERGENCY DEPARTMENT RECORD

FIVE RICHLAND MEDICAL PARK
COLUMBIA, S.C. 29203

RICHLAND

302

DATE	BIRTH DATE	AGE	MOTHER'S MAIDEN	SEX	MAR	RACE	PREREG #	PATIENT NO.
22-08-6 04/12/01 17:00	07/04/51	49Y	FORD	F	M	B		E/R011630107

MIDDLE NAME PHONE SOC SEC	FINANCIAL DATA	ADM BY	ACCIDENT DATE AND TIME
FELTON, JOANN	19 MEDICAID	SKH	
208 BUSH RIVER RD APT J1 (803) 798-4194	REGULAR PHYSICIAN	REQUESTED PHYSICIAN	
IA SC 29210	FELTON, DANIEL H	EMS	

PHONE
FELTON, JOANN (803) 798-4194
208 BUSH RIVER RD APT J1
IA SC 29210

MODE OF ARRIVAL SELF DRIVE Presents reviewed with patient

VALUABLES: ☐ YES ☐ NO WHERE?

BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER

MULTIPLE COMPLAINTS

DATE OF LAST VISIT: 02/02/02 LAST TETANUS:

TIME TO TREATMENT: 1950

☐ SEE AMBULANCE REPORT ☐ SEE NURSE'S NOTES ☐ EMERGENT ☐ URGENT ☐ NON-URGENT

TEMP 99F	☑ ORAL ☐ RECTAL	PULSE 101	RESP. 18	BLOOD PRESS 133/89	WEIGHT	NURSE'S SIGNATURE MB	TIME OUT 1930
TEMP 99.2	☑ ORAL ☐ RECTAL	PULSE 99	RESP. 20	BLOOD PRESS 120/94	ALLERGIES PCN	LABS AND X-RAY	

49 y/o AAF c multiple complaints including allergy all over, redness, chills c eye irritation, coughing, sneezing & HA. Was seen in Urgent Health yesterday & given Sulfacetamide eye gtts for conjunctivitis; eyes got more red & pruritic c swelling around eyes. No known allergies. No ill contacts; cough non-productive; hasn't had flu

Dr Haney

CC/HPI: Cough/Sneeze/Eye irritation/Eye Think/Body Aches/HA/N. Quality: o/w normal

PMH: DM, HTN;

SH: Works in Dietary; ETOH, tobacco

Meds: HTN, DM

Meds Toted: Zyrtec, Albuterol, HCTZ, Eye gtts

Vitals noted

Gen: Alert, pleasant, nontoxic, 49 y/o AAF

HEENT: Sclerae very injected, periorbital edema, dFB seen; EOMI, photophobic, decreased clarity, thick discharge, PERRL, mmm

Neck: Supple; ↓ Meningismus; ↓LAN

CVR: RRR c ↓

Lungs: CTA ↓

Abd: NT ND, (+) BS

MS: ↓ C/C/E

Neuro: Alert, Oriented, MAEW, ↓ focal deficits

Skin: Warm, Dry, Erythematous

EKG: NSR

CXR: Pending

(1) Chest Pain c Cough

(2) Possible Conjunctivitis – Prob 2° Sulfacetamide

(3) Pneumonia – Prob Lower Lobe Pneumonia

VS: BP 122/89 P 95 R 19 T 98.1 O2 Sat 99% on RA

Pain: 4/10 ↓ given

Plan: Zithromax 250 mg 2 tabs po x 1 dose, then 1 tab po QD x 4 days (2) Tessalon 200 mg po TID prn cough (3) Tylenol #3 1-2 tabs po q 4-6h prn pain (4) Albuterol 2 puffs q 4h prn wheezing or other problems (5) Motrin 600 mg po TID prn aches/fever/HA (15) Claritin 10 mg po QD x 7-10d (6) F/u Dr. Felton next week

DISCHARGE INSTRUCTIONS: (1) Zithromax 250 mg 2 tabs po x 1 dose, then 1 tab po QD x 4 days (2) Tessalon 200 mg po TID prn cough (3) Tylenol #3 1-2 tabs po q 4-6h prn pain (4) Albuterol 2 puffs q 4h prn wheezing or other problems (5) Motrin 600 mg po TID prn aches/fever/HA (15) Claritin 10 mg po QD x 7-10d (6) F/u Dr. Felton next week

PATIENT'S SIGNATURE

☐ DISCHARGE ☐ OTHER ASSIST NURSE

MEETS PRUDENT LAYPERSON: YES ☐ NO ☐

PALMETTO HEALTH

EMERGENCY DEPARTMENT RECORD

FIVE RICHLAND MEDICAL PARK
COLUMBIA, S.C. 29203

PATIENT

UNIT RECORD	DATE TIME	BIRTH DATE	AGE	MOTHER'S MAIDEN NAME	SEX	MAR	RACE	PRE REG #	PATIENT NO.
009122086	02/14/04 20:59	07/04/51	52Y	FORD	F	W	B		ERR0404500202

NAME, ADDRESS: BROCKINGTON,JOANN
1208 BUSH RIVER RD APT J
COLUMBIA SC 29210

MIDDLE NAME, PHONE, SOC. SEC.: (803)750-2449 251-92-5013

FINANCIAL DATA: ALL OTHER

ADM. BY: TJW

ACCIDENT DATE AND TIME:

REGULAR PHYSICIAN:

REQUESTED PHYSICIAN: EMS,EMS

RESPONSIBLE PARTY: BROCKINGTON,JOANN
1208 BUSH RIVER RD APT J1
COLUMBIA SC 29210

PHONE: Q (803)750-2449

MODE OF ARRIVAL: EMS ✓

VALUABLES: ☐ YES ☐ NO WHERE? _____

BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER _____

CHIEF COMPLAINT: EXTREMITY COMPLAINT

DATE OF LAST VISIT: 02/10/04

LAST TETANUS:

TIME TO TREATMENT:

MD VITAL SIGNS	TEMP. 99 ☒ ORAL ☐ RECTAL	PULSE 91	RESP. 18	BLOOD PRESS. 146/	PULSE OX
RN VITAL SIGNS	TEMP. ☐ ORAL ☐ RECTAL	PULSE	RESP.	BLOOD PRESS.	PULSE OX

LMP:

NURSE'S SIGNATURE

WEIGHT:

TIME OUT:

ALLERGIES: NKDA

HISTORY:

#144307

TIME	LABS AND X-RAY
	Lt Rt Knee
	FSS
	Lt Knee

ROS: Dizziness, SOB, CP, N, V, D, Abd Pain REST OF ROS: Neg

PH: Htn, CAD SH: COOK, ☒ T, ☐ E, D

PMH / MEDS: DM, HTN, OA / Motrin, Lotensin, HCTZ, Glucophage

PHYSICAL:

Knee Films = Neg

CLINICAL IMPRESSION: ① Bilateral Knee Sprain

TREATMENT: Motrin 600mg / Tylox 1 tab PO X1

FSBS = 202

PO Fluids

DISPOSITION/SPECIAL PATIENT INSTRUCTIONS: Script Rx: Knee Sprain

Tylox #10

Walker prn

F/u w/ PMD next week prn

PRESENT AND REVIEWED WITH RESIDENT _____

CONDITION OF DISCHARGE ☐ SAME ☐ IMPROVED ☐ OTHER

EXPLAIN _____

ADMIT ROOM:

TIME SEEN BY MD: 2057

RESIDENT SIGNATURE:

MEETS PRUDENT LAYPERSON: ☐ YES ☐ NO

ATTENDING SIGNATURE:

PALMETTO HEALTH RICHLAND
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

EMERGENCY DEPARTMENT

PATIENT:	Brockington, Joann	DICT:	Benjamin Droisen, MD.
MR #:	00-91-22-08-6	DOB:	07/04/1951
ADMITTED:	02/14/2004	PT.LOC:	PD6

DATE OF VISITATION: 02/14/2004

CHIEF COMPLAINT: Extremity injury.

MODE OF ARRIVAL : EMS.

HISTORY OF PRESENT ILLNESS: The patient is a 52-year-old female presenting with a chief complaint of extremity injury. The patient reports that immediately prior to presentation, she was walking into a local pharmacy when she tripped and fell to the floor. She landed on her knees and apparently struck her head lightly during this wall. She had no loss of consciousness. She did not experience any presyncopal symptoms, chest pain, shortness of breath, or palpitations before falling to the ground.

She immediately had pain bilaterally in her knees and since then has had an off and on pain in her forehead, which is now resolved.

The patient has a prior medical history of diabetes mellitus, hypertension, and osteoarthritis. She is taking Motrin, Lotensin, hydrochlorothiazide, and Glucophage. She has otherwise been feeling well today, February 14, 2004.

REVIEW OF SYSTEMS: Review of systems is negative for syncope, shortness of breath, chest pain, nausea, vomiting, diarrhea, or abdominal pain. All other systems reviewed and otherwise negative.

FAMILY HISTORY: Family history is positive for diabetes mellitus and coronary artery disease.

SOCIAL HISTORY: The patient works as a cook in a nursing home. She does not use tobacco, alcohol, or drugs.

PAST MEDICAL HISTORY: Her medical history of hypertension, diabetes mellitus, and osteoarthritis.

MEDICATIONS:
1. Motrin.
2. Lotensin.
3. Hydrochlorothiazide.
4. Glucophage.

ALLERGIES: The patient has no known drug allergies.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 99.0, pulse 91, respiratory rate 18, blood pressure 166/107.
GENERAL APPEARANCE: Well-developed, well-nourished, 52-year-old female who is alert and oriented x3, with intact recent memory. She is very pleasant and nontoxic in appearance.
HEENT: Head, eyes, ears, nose, and throat normocephalic, atraumatic. Examination of the forehead reveals no contusion, abrasion, or laceration. Pupils equal and reactive to light. Extraocular muscles intact. Sclerae anicteric. Conjunctivae pink. Tympanic membranes and oropharynx are clear.
NECK: Neck is supple, full range of motion. There is no bony step off, tenderness, or deformity.
LUNGS: The lungs are clear to auscultation bilaterally, with equal breath sounds bilaterally. There are no adventitious noises or accessory muscle use for respirations noted on exam.
HEART: S1 and S2 with a regular rate and rhythm. Systolic ejection murmur, which the patient says she has had for her entire life. There are 2+ distal pulses and no pedal edema.
ABDOMEN: Normoactive bowel sounds, soft, nontender, and nondistended. No rebound pain or guarding.
EXTREMITIES: Extremity exam reveals no clubbing, cyanosis, edema, or deformity. There are 2+ distal pulses in all 4 extremities. They are neurovascularly intact. In particular, examination of the lower extremity reveals a limited internal-external rotation bilaterally in the hips, but otherwise there is no deformity of the hip joints and no pain or tenderness there bilaterally. There is some tenderness to palpation in the knees superior to the patella. There is no obvious effusion though the patient is somewhat obese. The knees are stable in terms of not having any laxity. The extensor mechanism is intact and the patellar tendons are palpably intact bilaterally. There is no appreciable ankle joint pathology.
SKIN: No rashes, petechia, or lesions.
NEUROLOGICAL: Cranial nerves II through XII intact. Pupils equal and reactive to light. Extraocular muscles intact. Sensation intact in all nerve distributions secondary to touch.
MUSCULOSKELETAL: There is 5/5 muscle strength in all planes. There is no obvious joint abnormality.

MEDICAL DECISION MAKING: This is a 52-year-old female presenting after she tripped and fell at a local pharmacy. As she has had no loss of consciousness and there are no presyncopal symptoms, medical workup for syncope is not indicated at this time.

She is complaining of bilateral knee pain and bilateral knee films will be obtained.

LABORATORY: Laboratory studies, right and left knee films, both revealed evidence of degenerative joint disease but otherwise, there was no acute fracture, subluxation, or effusion noted, as read by Dr. Gerard and myself.

EMERGENCY DEPARTMENT COURSE: The patient received Motrin 600 mg and Tylox 1 tablet p.o. in the emergency department. Fingerstick blood sugar was obtained and found to be 202.

She tolerated this well, along with p.o. fluids and her condition was improved upon discharge.

CLINICAL IMPRESSION: Bilateral knee pain.

DISPOSITION: The patient is discharged to home. She is given the Script Rx preprinted discharge instructions on knee sprain. She was given a work excuse, 10 tablets of Tylox #10. I gave her a prescription for a walker, which I told her to use if needed to ambulate, and she it to follow up with her primary medical doctor next week.

Attending physician, Dr. Gerard, present at the bedside and actively participating throughout evaluation and procedures of this patient.

William C Gerard, MD

Dictated by: Benjamin Droisen, MD.

:hs
D: 02/15/2004 5:23 A T: 02/15/2004 9:20 A
Job #: 000443071 T Job #: 531275 Doc #: 510167
cc : William C Gerard, MD

PALMETTO HEALTH RICHLAND Palmetto Richland Memorial Hospital 5 Richland Medical Park	**Patient Information** BROCKINGTON, JOANN 1208 BUSH RIVER RD APT J1 COLUMBIA, SC 29210 Phone: (803)750-2449	**Treating Provider** Benjamin Droisen MD 5 Richland Medical Park Phone: 803-434-6350	**Discharge Instructions** Date: 2/14/04 Time: 10:06:47 PM Chart Copy Page: 1 of 1

Patient Discharge Instructions Document: 380 Last Update: 05/06/2002

SPRAINED KNEE

Your exam shows you have an injury to the knee joint. A knee sprain is a tearing of the ligaments that hold the joint together. There are no broken bones. Sprains take from 3 to 6 weeks to heal.

Follow These Instructions Carefully:

1. Stay off the injured leg as much as possible.
2. Apply an ice pack over the injured area for 20 minutes every 2 hours for the first day. Continue this 3 to 4 times a day for the next 2 days.
3. You may take acetaminophen (Tylenol) or ibuprofen (Advil, Motrin) for pain, unless another pain medicine was prescribed.
4. If you have a plaster or fiberglass splint or cast, keep it dry. When bathing, protect the splint/cast with a large plastic bag, rubber-banded at the top end. If a fiberglass cast or splint gets wet, you can dry it with a hair-dryer.
5. If you have a Velcro knee brace, you may open the splint to apply ice. You may also remove the splint to bathe and sleep, unless told otherwise.
6. If crutches or a walker have been recommended, do not bear full weight on the injured leg until you can do so without pain. Check with your doctor before returning to sports or full work duties.

Follow up with your doctor or this facility as advised by our staff. Return sooner if you are not starting to improve within the next five days. If a cast or splint was applied, it should be checked in 24 hours to be sure it has not become too tight from swelling. Look for the warning signs listed below. (**NOTE:** If X-rays were taken, a radiologist will review them. You will be notified of any new findings that may affect your care.)

Return to this facility immediately or contact your doctor if you begin to have any of the following:

- The plaster cast or splint becomes wet or soft.
- The fiberglass cast or splint remains wet for more than 24 hours.
- Pain or swelling increases.
- Toes become cold, blue, numb or tingly.

Discharge Instructions Special Notes

IF YOU DON'T HAVE A DOCTOR CALL 434-4100 FOR USC CLINIC APPOINTMENT. I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. RETURN TO EMERGENCY DEPARTMENT IF CONDITION WORSENS OR FAILS TO IMPROVE.

JoAnn Brockington

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http://www.ScriptRx.com

PALMETTO HEALTH RICHLAND Palmetto Richland Memorial Hospital 5 Richland Medical Park	Patient Information BROCKINGTON, JOANN 1208 BUSH RIVER RD APT J1 Phone: (803)750-2449 Acct: 0404500202 Reg: 009122086	Treating Provider Benjamin Droisen MD 5 Richland Medical Park Phone: 803-434-6350	Discharge Summary Date: 2/14/04 Time: 10:06:49 PM Chart Copy

1) Your Discharge Instructions:	2) Your Prescriptions:
SPRAINED KNEE #Document: 380 (English)	

3) You should Follow Up with:

I understand that the emergency care which I received is not intended to be complete and definitive medical care and treatment. I acknowledge that I have been instructed to contact the above physician immediately for continued and complete medical diagnosis, care and treatment. EKG's, X-rays, and lab studies will be reviewed by appropriate specialists and I will be notified of significant discrepancies. I also understand that my signature authorizes this Medical Center to release all or any part of my medical record (including, if applicable, information pertaining to AIDS and/or HIV testing, mental health records, and drug and/or alcohol treatment) to the referred physician listed above.

PALMETTO HEALTH

Palmetto Health Richland
5 Richland Medical Park
Columbia, SC 29203

Patient Name: BROCKINGTON, JOANN
Patient Address:1208 BUSH RIVER RD APT J1
COLUMBIA, SOUTH CAROLINA 29210
Patient Telephone: (803) 750-2449

Gerard MD, William C
DEPT. OF EMERGENCY MED
5 RICHLAND MEDICAL PARK
COLUMBIA, SC 29203

Date of Birth: 7/4/1951
SSN:
Medical Record Number: 009122086
Account Number: 0404500202
Location: R ED Pod 6, Patient Type: ERR-Emergency Room
Room Number:
Ordering Physician: Gerard MD, William C
CC:

RADIOLOGY SERVICES

Exam:	Exam Date/Time:	Accession Number:	Ordering Physician:
CR Knee 3 Views W/ Tunnel Left	2/14/2004 10:43:35	CR-04-022140	Gerard MD, William C

Reason for Exam:

719.46-JOINT PAIN-L/LEG

Findings:

RIGHT KNEE JOINT:

Patient most likely has an old fracture of the lateral condyle of the tibia involving the posterolateral aspect. There is mild narrowing of the medial joint space. There is no evidence of any acute fracture or subluxation. There is no evidence of any joint effusion. Patella is normal.

IMPRESSION:

OLD HEALED FRACTURE OF THE LATERAL CONDYLE OF THE TIBIA.

REQUESTED IS A LEFT KNEE, BUT THE STUDY WAS DONE A RIGHT KNEE JOINT.

*** Final ***
Read by: Shah MD, Paresh P
Released By: Paresh P. Shah
on: 02/16/2004 08:31

Transcriptionist: AB
Trans Date/Time: 02/15/2004 10:21
Technologist: Devonish, Michael A

Emergency Center at
Palmetto Richland Memorial Hospital
NURSING RECORD

Triage Level: _____
Date: 2-14-04
Time: 2119

50.yr old AAM
Burlington, Susan

Temp: 99° HR: 91 RR: 18 Allergies: NKA
BP: 160/107 Pulse Ox: _____ Type of Reaction: _____

Chief Complaint: 50 yr old twisted R knee on way out of car. No LOC. Pain to knee + edema and good pulses. Swelling noted

Tetanus: ☐ UTD ☐ Unk

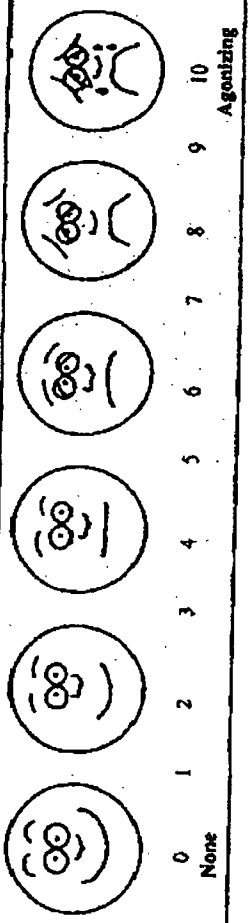
Latex Screening: ☐ No Risk ☐ Moderate Risk ☐ Low Risk ☐ High Risk

PMH: ☒ HTN ☐ SZ ☐ CAD ☒ DM ☐ RAD ☐ HIV ☐ CVA ☐ CA ☐ Chronic Pain _____
☐ Other _____
☐ Prior Surgeries _____ ☐ None

Mode of Arrival: ☐ Amb ☐ W/C ☒ EMS ☐ Stretcher ☐ Sent by PMD

Medications: ☐ OTC _____ ☐ Herbal _____ ☐ Stimulants _____
☐ Rx Klonopin, Prozac ☐ None

Pain Assessment: ☒ Yes ☐ No **Intensity:** _____ **Location:** R knee
When did your pain start? 2 hrs. Duration: _____
What words best describe the pain that bothers you the most?
☐ Dull ☐ Aching ☐ Shooting ☐ Burning ☐ Stabbing ☐ Throbbing ☐ Other _____
What makes your pain worse?
☐ Moving ☐ Heat ☐ Cold ☐ Coughing/Sneezing ☐ Sitting ☐ Lying Down ☐ Eating
☐ Other _____
What makes your pain better?
☐ Heat ☐ Cold ☐ Lying Down ☐ Medications ☐ Relaxation ☐ Magnet/Herbal Therapy
☐ Other _____
Does your pain interrupt your sleep? ☐ Yes ☐ No
Is there anything else you wish to tell us about your pain? _____



Standing Orders:
☐ X-Ray _____ ☐ Labs ☐ CBC ☐ BMP ☐ UA ☐ UPT ☐ FSBS

Prehospital Treatment: ☐ IV ☐ Other _____
☐ Meds: _____

Time	Reassessment	T	P	R	BP	P.Ox	Pain Interventions	Interventions	Initials

Barriers:
☐ Motor Impairment _____
☐ Language Impairment _____
☐ Speech or Hearing Impairment _____
☐ Visual Impairment _____
☐ Other _____

Interventions:
☐ Interpreter Contacted
☐ Unable to Locate Interpreter
☐ TDD Phone Used
☐ AT&T Operator Used

Physician: _____ Patient Called: ☐ Yes ☐ No
☐ Wants PMD Called ☐ Wants ED MD to Treat

Visual Acuity: *See Assessment
L 20/ _____ Both 20/ _____
R 20/ _____

Triaged to: ☐ Pod 1 ☐ Pod 5 ☐ Trauma Room ☐ Pod 4 ☒ Pod 6 ☐ Pod 7 ☐ Waiting Room 2405

What questions/concerns do you have about this visit: _____

Triage RN: _____

6021019 (Rev. 11/01)

Date/Time	PROGRESS NOTES
0100	Dr. Brian into room. — 0110 Medicated for
	pain. To X-ray. — 0130 Returned from X-ray.
0230	Back to X-ray. — 0240 Returned from X-ray. Sent to
	OR. — 0300 Discharge home via WC c son in no
	acute distress. Discharge instructions given, understanding of all instructions. — DO

Discharge Disposition Time: _____

☐ Home ☐ Other _____ Accompanied with ☐ Self ☒ Family ☐ EMS

Via ☒ W/C ☐ Ambulatory ☐ Stretcher ☐ Carried ☐ In Custody

Assessment of c/c: ☒ Improved ☐ N/C Pain Level _____

☒ Pt/S.O. verbalized understanding of discharge instructions _____

Admit

Time Report Called _____ Transported with:

Room # _____ ☐ Monitor ☐ O_2

Report to _____ ☐ Pulse Ox ☐ RN

Time to Floor _____

Initials	Signatures	Initials	Signatures

INTERVENTIONS

☑ Side Rails Up _____

☐ O2 @ _____

☐ Cardiac Monitor ☐ Initial Rhythm _____

☐ PSP ☐ OA ☐ C-collar _____ ☐ Backboard _____

Cleared By: _____

☐ Pulse Oximeter ☐ Spot check _____ ☐ Cont. _____

☐ NG/OG _____

☐ Restraints ☐ UE ☐ LE
*See Restraint Flowsheet

IV

Time	Gauge	Site	By	# Attempts	Time	DC'd W/O Complications	By

Labs ☐ N/A

☐ CBC
☐ BMP
☐ PTT/PTT
☐ Mg
☐ GC/Chlamydia
☐ ABG
☐ UPT
☐ U/A via ☐ Bag ☐ I/O ☐ CC ☐ Foley
☐ Redraw _____
☐ Hold Tubes: ☐ Red ☐ Green ☐ Blue ☐ Lavender

☐ Amylase/Lipase
☐ Cardiac Enz.
☐ Blood C&S
☐ T X C _____ units
☐ Troponin
☐ Other _____

EKGs ☐ N/A

☐ EKG 12 lead _____ ☐ EKG 12 lead _____
☐ EKG 12 lead _____ ☐ EKG 12 lead _____

X-Rays ☐ N/A

Time _____ Time _____

C-Spine
☐ port _____
☐ comp _____

☐ C X R
☐ port _____
☐ PA & Lat _____

☐ Abdomen _____

☐ Upper Ext. _____ ☐ Lower ext. _____

☐ CT scan
☐ Head ☐ Chest ☐ Abdomen
☐ U/S _____
☐ Special Procedure _____
☐ Other _____

Medications

Estimated Weight:

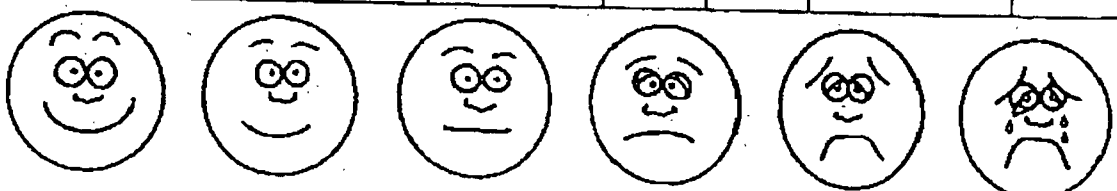
Time	Drug/Dose/Route/Site	Given By	Response
2nd Tylenol 2			
2nd Motrin 400			

Medications

Time	Drug/Dose/Route/Site	Given By	Response

PAIN ASSESSMENT

Date	Time	Pain Level	Location	Quality	Intervention	Initials	Time	Post Intervention Pain Level	Action	Initials



0 None 1 2 3 4 5 6 7 8 9 10 Agonizing

☐ See Conscious Sedation Flowsheet ☐ See Restraint Flowsheet ☐ See Suicide Observation Flowsheet ☐ See continued RN Notes

Resource Needs:
☐ None
☐ Social Worker
☐ Clinical Counselor
☐ Assistance Getting Medications
☐ Financial Counselor
☐ Assistance with ADL's
☐ Assistance with Referral
☐ Assistance with Medical Equipment
☐ Sistercare
☐ Sexual Trauma Service
☐ Other

☐ NURSING ASSESSMENT TIME _____ SIGNATURE _____

Respiratory

☐ Airway
- ☑ Clear
- ☐ Obstructed
- ☐ Oral/Nasal
- ☐ Trach

☐ Respirations
- ☑ Spontaneous
- ☐ Labored
- ☐ Assist
- ☐ Absent
- ☐ Hyperventilation
- ☐ Shallow
- ☐ Retractions
- ☐ Flaring

☐ Breath Sounds
- ☐ Clear
- ☐ Equal, Bilaterally
- ☐ Rales _____
- ☐ Rhonchi _____
- ☐ Wheezes _____
- ☐ Decreased _____
- ☐ Absent _____

☐ Cough
- ☐ Productive
- ☐ Nonproductive
- ☐ Sputum
- ☐ Nasal congestion

☐ Orthopnea
- ☐ # of pillows _____

Integumentary

☐ Temperature
- ☑ Normal
- ☐ Warm
- ☐ Cold
- ☐ Hot
- ☐ Dry
- ☐ Diaphoretic

☐ Turgor
- ☑ Elastic
- ☐ Tenting

☐ Edema
- ☐ Present
- ☑ Absent
- ☐ Pitting _____
- ☐ Location _____

☐ Mucous Membranes
- ☑ Moist
- ☐ Sticky
- ☐ Dry

☐ Skin Breakdown (REQUIRED)
- ☐ Present ☑ Absent
- Location _____
- ☐ Drainage
- Color _____

We are routinely screening for domestic violence. Have you been hit, kicked, verbally or sexually abused by a family member or significant other?
☐ Yes ☐ No

Do you want help with this today?
☐ Yes ☐ No

Cardiovascular ☐ N/A

☐ Rhythm
- ☐ Regular
- ☐ Irregular
- ☐ Paced

☐ Neck Veins
- ☑ Flat @ 45°
- ☐ Distended

Circulatory

☐ Color
- ☑ Pink
- ☐ Pale
- ☐ Mottled
- ☐ Cyanotic
- ☐ Jaundiced

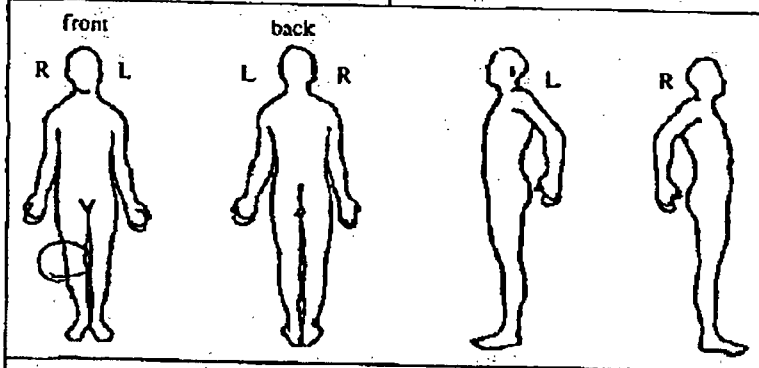
☐ Capillary Refill
- ☐ Normal
- ☐ Delayed

R	Pulses	L
_____	radial	_____
_____	pedal	_____
_____	femoral	_____

☐ AV Shunt ☑ N/A
- ☐ Location _____
- ☐ Thrill ☐ Yes ☐ No
- ☐ Bruit ☐ Yes ☐ No

Musculoskeletal ☐ N/A

1. Abrasion
2. Amputation
3. Bleeding
4. Burn
5. Fracture
6. Gunshot
7. Laceration
8. Contusion
9. Redness
10. Pain
11. Paralysis
12. Penetr. Wound
13. Sprain
14. Tenderness
15. Swelling
16. Deformity
17. Ltd. Movement
18. _____



Psychiatric

☐ Ideations
- ☐ None
- ☐ Harm to Self
- ☐ Harm to Others

☐ Security Notified
- ☐ Yes - Time _____
- ☐ No

☐ Belongings Search Done

☐ Abuses
- ☐ None
- ☐ Alcohol
- ☐ Drug
- ☐ Inhalants
- ☐ Tobacco _____/day

☐ Hallucinations
- ☐ Auditory
- ☐ Visual

Neurological

☐ LOC
- ☑ Awake
- ☑ Alert
- ☐ Drowsy
- ☐ Restless
- ☐ Lethargic
- ☐ Unresponsive

☐ Orientation
- ☑ Time
- ☑ Place
- ☑ Person

☐ Speech
- ☑ Clear
- ☐ Slurred
- ☐ Aphasic

☐ Sensory
- ☑ No Deficits
- ☐ Numbness _____
- ☐ Tingling _____

	Strong	Weak	Absent
RA			
LA			
RL			
LL			

Vision ☑ N/A

Visual Acuity
L 20/_____ R 20/_____
Both 20/_____
- ☐ Correction
- ☐ Blurred L R
- ☐ Blind L R
- ☐ Drainage Present L R

Abdominal ☐ N/A

☐ Appearance
- ☐ Flat
- ☑ Rounded
- ☐ Distended
- ☑ Soft
- ☐ Other _____

☐ Bowel Sounds
- ☐ Present
- ☐ Absent

☐ Palpation
- ☐ Mass _____
- ☐ Tender _____
- ☐ Guarding _____

☐ Last BM _____

Genitourinary ☑ N/A

☐ Flank Pain ____ L ____ R
- ☐ Dysuria
- ☐ Hematuria
- ☐ Anuria
- ☐ Frequency
- ☐ Urgency
- ☐ Penile Discharge
- Color _____

GYN ☐ N/A

☐ LMP _____
☐ Preg. _____ wks.
G _____ P _____ Ab _____
FHT: ☐ Yes ☐ No
Location _____
☐ Vag. bleed _____ pads/ _____
☐ Vag. D/C
- ☐ Color _____

Social History

☐ Eye contact
- ☐ Yes ☐ No

☐ Affect
- ☐ Flat ☐ Normal

☐ Speech
- ☐ Appropriate
- ☐ Inappropriate

☐ Appearance
- ☐ Clean ☐ Unkempt
- ☐ Other _____

☐ Motor behavior
- ☐ Cooperative
- ☐ Restless
- ☐ Agitated
- ☐ Confused
- ☐ Hostile

☐ Support Systems
- ☐ Lives alone
- ☐ Family / S.O.
- ☐ Nursing Home
- ☐ Homeless
- ☐ Assisted Living

☐ Able to: ☐ Read ☐ Write

PALMETTO HEALTH BAPTIST

EMERGENCY DEPARTMENT RECORD

FIVE ... AND MEDICAL CENTER COLUMBIA, S.C.

UR RECORD	DATE	TIME	BIRTH DATE	AGE	MOTHER'S MAIDEN NAME	SEX	MAR	RACE	PRE REG #	PATIENT NO
009122086	W	10/10/06	08:32	07/04/51	55Y COLUMBIA	F	W	B		ERR0628300

PATIENT

NAME, ADDRESS: BROCKINGTON,JOANN
1208 BUSH RIVER RD APT J
COLUMBIA SC 29210

MIDDLE NAME, PHONE, SOC. SEC.: (803)740-4497

FINANCIAL DATA: BCBS OF TENNESSEE — ADM BY: FAN — ACCIDENT DATE AN: 10/06/06 19

REGULAR PHYSICIAN: HALL,RACHEL — REQUESTED PHYSICIAN: EMS,EMS

RESPONSIBLE PARTY: BROCKINGTON,JOANN
1208 BUSH RIVER RD APT J1
COLUMBIA SC 29210

PHONE: Q (803)740-4497

MODE OF ARRIVAL: SELF DRIVEN (Ambulated to room) — S

VALUABLES: ☐ YES ☐ NO WHERE? ____

BELONGINGS: ☐ HOME ☐ WITH PATIENT OTHER ____

CHIEF COMPLAINT: RT SHOULDER PAIN

DATE OF LAST VISIT: 10/01/06

LAST TETANUS:

TIME TO TREATMENT: 0913

NURSE'S SIGNATURE: [signature]

ADM VITAL SIGNS: TEMP. 96.5 ☒ ORAL ☐ RECTAL PULSE 81 RESP. 20 BLOOD PRESS. 161/93 PULSE OX

DC VITAL SIGNS: TEMP. ____ ☐ ORAL ☐ RECTAL PULSE ____ RESP. ____ BLOOD PRESS. ____ PULSE OX ____

LMP: Hyst.

WEIGHT:

TIME OUT: 1042

ALLERGIES: NKA

TIME | LABS AND X

HISTORY: 55 yo ♀ fell 4 days ago on R shoulder (slipped on wet steps) landed on concrete. ⊖ LOC, head injury + Rt sided CP since (now resolved) (R) shoulder xra

R shoulder pain: no ↓ with Tylenol, ↑ mov't, unable to work 2° to pain, ↑ each day 8/10

ROS: no HA, AP, no fever, syncope, t.h. +n/v/d, +baseline constipation, +chills,

REST OF ROS: ____

FH: +DM

SH: A, T, Dino lives self w/ Cook

PMH / MEDS: DM, HTN, gallstones

PHYSICAL:

R shoulder: neurovasc intact ↓ROM, tender @ lat aspect
R elbow and ROM, n.t.

Xray: neg (viewed by me)

Skin: blister (1cm) at R upper back

24146885 S2

CLINICAL IMPRESSION: (1) Acute contusion to right shoulder. (2) Superficial second degree burn right upper back (3) DM (4) HTN

TREATMENT: Tylox 1 cap PO
~~Splint~~ Sling to (R) shoulder

DISPOSITION/SPECIAL PATIENT INSTRUCTIONS: D/C. Rest shoulder for 2 days in sling/remove 4x/day and move your shoulder through full ROM. Follow up with orthopedic clinic in 7-10 days. Return to ED for worsening condition.
[Work note x 2 days]
Rx: Tylox (11) / [illegible]

PRESENT AND REVIEWED WITH RESIDENT

CONDITION OF DISCHARGE: ☐ SAME ☒ IMPROVED ☐ OTHER

EXPLAIN ____

ADMIT ROOM:

TIME SEEN BY MD: 9:50

RESIDENT SIGNATURE: [signature]

MEETS PRUDENT LAYPERSON: ☐ YES ☐ NO

ATTENDING SIGNATURE: [signature]

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Elliott MD, Eric	10/10/2006 1:08:00 PM	Fuerst MD, Ronnie S	10/11/2006 11:59:34 PM

Emergency Dept
DATE OF VISITATION: 10/10/2006

ACCOUNT NUMBER: 0628300762

ATTENDING PHYSICIAN: Dr. Ron Fuerst, who was involved in the assessment and management of the patient.

PRIMARY CARE PHYSICIAN: Dr. Rachel Hall.

MODE OF ARRIVAL: Patient's daughter drove her in.

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: Patient is a 55-year-old female who states that she fell four days ago when she slipped on wet steps. She landed on concrete on her right side impacting the lateral aspect of her right shoulder. No loss of consciousness. No head impact. No fall on outstretched arm. Patient states that she had mild pain at the lateral right shoulder after the accident. However, this pain has increased over the past four days. Patient also stated that she had some tenderness and pain at the right side of her chest after the accident and this has now completely resolved. She states that her right shoulder pain is moderate but increases to severe when she attempts to move the shoulder. No relief with Tylenol. The pain has made her unable to work. She had to come home from work early yesterday secondary to the pain. The pain has seemed to get worse each day. At this point, it is rated in severity as 8 out of 10. She does not feel any weakness or numbness related to the accident.

REVIEW OF SYSTEMS: No headache. No abdominal pain. No fever. No syncope. No lightheadedness. No presyncopal symptoms. No pain at any other joint besides her right shoulder. Positive for mild nausea but no vomiting. Positive for baseline constipation. Positive for chills. All other systems negative.

FAMILY HISTORY: Positive for diabetes mellitus.

SOCIAL HISTORY: Patient states she is not using alcohol, tobacco, or drugs. She lives by herself. She works as a cook.

PAST MEDICAL HISTORY: Positive for diabetes mellitus, hypertension, and gallstones.

MEDICATIONS:
1. Metformin.
2. Zyrtec.

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Elliott MD, Eric	10/10/2006 1:08:00 PM	Fuerst MD, Ronnie S	10/11/2006 11:59:34 PM

3. Lipitor.
4. Benazepril.

5. Nifedical.

6. Hydrochlorothiazide.
7. Singulair.

ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 96.5, pulse 81, respirations 20, blood pressure 161/93.
GENERAL APPEARANCE: In general, the patient is alert and oriented x3. Nontoxic appearing.
NEUROLOGICAL: Neurologic exam shows cranial nerves 2 through 12 grossly intact. Patient moves all four extremities with 5/5 strength. Sensation to light touch is intact and symmetric bilaterally.
HEENT: Eye exam shows pupils are equally round and reactive to light. Extraocular motions are intact. Ears, nose, and throat exam shows moist mucous membranes. Oropharynx is clear. Head exam shows no evidence of trauma.
NECK: Normal range of motion with no pain.
LUNGS: Clear to auscultation bilaterally. Good bilateral symmetric chest rise. Good bilateral air movement.

CARDIOVASCULAR: Regular rate and rhythm. No murmurs, gallops, or rubs.

GASTROINTESTINAL: Abdomen soft and nontender to palpation with normal bowel sounds in all four quadrants.
ABDOMEN: Abdomen is nondistended with no palpable masses.

MUSCULOSKELETAL: Hands and feet warm and well-perfused. Capillary refill less than two seconds. Palpable pulses bilateral upper and lower extremities. The right upper extremity is neurovascularly intact with sensation to light touch intact over the entire extremity. Patient does have decreased active range of motion secondary to pain. On passive range of motion, she also has severe pain during ABduction of the right shoulder. She is tender to palpation at the lateral aspect of the right shoulder. No tenderness to palpation over the acromioclavicular joint.

SKIN: Skin exam shows a 1-cm blister at the right upper back with mild erythema surrounding this blister. The blister is intact with fluid present. Patient has full sensation surrounding this area and only is mildly tender to palpation. There is no celiac change or increased warmth surrounding the site.

MEDICAL DECISION MAKING: This 55-year-old female with a fall four days ago with impact to her right shoulder now presents with moderate-to-severe pain with decreased range of motion. At this time, we will obtain an x-ray of the right shoulder to rule out fracture or dislocation. Patient

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Elliott MD, Eric	10/10/2006 1:08:00 PM	Fuerst MD, Ronnie S	10/11/2006 11:59:34 PM

is neurovascularly intact and therefore does not need urgent treatment. Differential diagnosis would include soft tissue injury such as rotator cuff tear or contusion to the muscle and soft tissue. The blister of the patient's right upper back is secondary to applying a heat pad and falling asleep. At this time, it appears to be a superficial second degree burn which does not need any debridement.

LABORATORY AND RADIOGRAPHIC DATA: X-ray of the right shoulder shows no acute fracture and no dislocation read by me and reviewed by the attending physician.

EMERGENCY DEPARTMENT COURSE: Patient was given Tylox 1 capsule p.o. and a sling was applied to the right upper extremity with good relief of the patient's pain and discomfort. Patient verified that her daughter would drive her home after her visit here. I stated that she needed to have a followup with Orthopedic Clinic for further evaluation. At the time of discharge, the patient was in improved condition.

CLINICAL IMPRESSION:
1. Acute contusion to right shoulder.
2. Superficial second degree burn to right upper back.

3. Diabetes mellitus.
4. Hypertension.

DISPOSITION:
1. Patient was discharged home and instructed to rest her right shoulder for two days in a sling but to remove the sling four times a day and move her shoulder through full range of motion.
2. She understands she is to follow up with the Orthopedic Clinic in seven to ten days and return to the Emergency Department for any worsening in condition.

3. She is given a work note for two days off work.
4. Given a prescription for Tylox capsules, 1 p.o. q. 4 to 6 hours as needed for pain, dispensed 11 capsules and a prescription for Silvadene cream with instructions to apply to the site of her burn one time per day.

Reviewed and agree with above note

Dictated by: Eric Elliott, MD

EE:hs
D: 10/10/2006 12:48 P T: 10/10/2006 1:08 P
Job #: 000414688 T Job #: 469456 Doc #: 916676

Client Name: Palmetto Health Richland

Client Address: 5 Richland Medical Park

Columbia, SC 29203

Admitting Physician: Fuerst MD, Ronnie S
Attending Physician: Fuerst MD, Ronnie S

Patient Name: BROCKINGTON, JOANN

Patient Address: 1208 BUSH RIVER RD APT J1

COLUMBIA, SOUTH CAROLINA 29210

Age: 55 years
Date of Birth: 7/4/1951

MRN: R009122086
FIN: R0628300762
Financial Class: Blue Cross

Admit Date: 10/10/2006
Admit Time: 8:32:00 AM
Discharge Date: 10/10/2006
Discharge Time: 10:40:00 AM

Emergency Department Documentation

Performing Physician:	Performed Date/Time:	Authenticated By:	Authenticated Date/Time:
Elliott MD, Eric	10/10/2006 1:08:00 PM	Fuerst MD, Ronnie S	10/11/2006 11:59:34 PM

cc: Physcian EMS, MD
Ronnie S Fuerst, MD

Electronically Signed & Verified on 10/11/2006 23:59
by Ronnie S Fuerst MD

Orders

Order Date/Time 10/10/2006 10:45:01 AM

Mnemonic	Action	Order Status	Type of Order
acetaminophen-oxycodone	Order	Completed	Pharmacy
Ordering Physician		Order Placed By Pharmacy, Pyxis	
Review Information N/A			
Order Details 1 tab, MISC, OT, Start Date: 10/10/06 10:51:15, 1 doses, Stop date 10/10/06 10:51:15			

Order Date/Time 10/10/2006 9:45:50 AM

Mnemonic	Action	Order Status	Type of Order
CR Shoulder Ortho Right	Order	Completed	Radiology
Ordering Physician Fuerst MD, Ronnie S		Order Placed By O'toole, Ryan	
Review Information N/A			
Order Details 10/10/06 9:03:00, Stat, Reason: PAIN, Transport: Stretcher, POD 9			

Order Date/Time 10/10/2006 9:03:20 AM

Mnemonic	Action	Order Status	Type of Order
CR Shoulder 2 Views Minimum Right	Order	Canceled	Radiology
Ordering Physician Fuerst MD, Ronnie S		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details 10/10/06 9:03:00, Stat, Reason: PAIN, Transport: Stretcher, POD 9			

Order Date/Time 10/10/2006 8:53:52 AM

Mnemonic	Action	Order Status	Type of Order
Pneumovax Evaluation	Order	Ordered	Patient Care
Ordering Physician SYSTEM, SYSTEM		Order Placed By SYSTEM, SYSTEM	
Review Information N/A			
Order Details 10/10/06 8:53:52			

10/10/2006 8:53:52 AM: From Admission Form

Orders

Order Date/Time 10/10/2006 8:53:52 AM

Mnemonic	Action	Order Status	Type of Order
Influenza Evaluation	Order	Discontinued	Patient Care
Ordering Physician SYSTEM, SYSTEM		Order Placed By SYSTEM, SYSTEM	
Review Information N/A			
Order Details 10/10/06 8:53:52			

10/10/2006 8:53:52 AM: From Admission History Form

Order Date/Time 10/10/2006 8:52:50 AM

Mnemonic	Action	Order Status	Type of Order
cetirizine	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 10 mg, daily, current med (Hx)			

Order Date/Time 10/10/2006 8:52:50 AM

Mnemonic	Action	Order Status	Type of Order
metformin	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 1000 mg, PO, 2xdaily, current med (Hx)			

Order Date/Time 10/10/2006 8:52:49 AM

Mnemonic	Action	Order Status	Type of Order
montelukast	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 10 mg, qPM, current med (Hx)			

Order Date/Time 10/10/2006 8:52:49 AM

Mnemonic	Action	Order Status	Type of Order
hydrochlorothiazide	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 25 mg, PO, current med (Hx)			

Orders

Order Date/Time 10/10/2006 8:52:49 AM

Mnemonic	Action	Order Status	Type of Order
NIFEdipine	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 60 mg, PO, daily, current med (Hx)			

Order Date/Time 10/10/2006 8:52:49 AM

Mnemonic	Action	Order Status	Type of Order
benazepril	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 20 mg, PO, current med (Hx)			

Order Date/Time 10/10/2006 8:52:49 AM

Mnemonic	Action	Order Status	Type of Order
atorvastatin	Order	Ordered	Pharmacy
Ordering Physician		Order Placed By Vance RN, Arlene M	
Review Information N/A			
Order Details Dose: 20 mg, PO, current med (Hx)			

Client Name: Palmetto Health Richland

Client Address: 5 Richland Medical Park

Columbia, SC 29203

Admitting Physician: Fuerst MD, Ronnie S
Attending Physician: Fuerst MD, Ronnie S

Patient Name: BROCKINGTON, JOANN

Patient Address: 1208 BUSH RIVER RD APT J1

COLUMBIA, SOUTH CAROLINA 29210

Age: 55 years
Date of Birth: 7/4/1951

MRN: R009122086
FIN: R0628300762
Financial Class: Blue Cross

Admit Date: 10/10/2006
Admit Time: 8:32:00 AM
Discharge Date: 10/10/2006
Discharge Time: 10:40:00 AM

Radiology Reports

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Fuerst MD, Ronnie S	CR Shoulder Ortho Right	CR-06-149391	10/10/2006 9:46:25 AM

PAIN

Findings:

SHOULDER FILMS - 10/10/06:

COMPARISON: 09/15/06.

INDICATION: Pain.

FINDINGS:

Frontal radiograph of the right shoulder, one with internal and one with external humeral rotation and a "Y" view radiograph of the right shoulder is split on two cassettes and are presented. There is no evidence of an acute fracture or dislocation. A small inferior glenoid osteophyte. There are small bony spurs at the acromioclavicular joint. Visualized lung fields and adjacent elements are unremarkable.

IMPRESSION:

OSTEOARTHRITIC DISEASE. THERE IS NO EVIDENCE OF AN ACUTE INJURY.

*** Final ***
Read by: Heaton MD, Charles M
Released By: Heaton MD, Charles M
Released on: 10/10/2006 17:44

Trans On: 10/10/2006 11:0by: AJC

Technologist: Robinton, Lynn E,O'toole, Ryan

Radiology Reports

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Stacy MD, Jason J	CT Cervical Spine W/O Contrast + Recons	CT-07-052560	8/16/2007 3:17:20 PM

head trauma

Findings:

CLINICAL INDICATION: Head trauma with neck pain.

CT OF THE CERVICAL SPINE WITH MULTI-PLANAR RECONSTRUCTION: 8/16/07.

TECHNIQUE: 2.5-mm axial images obtained through the cervical spine followed by multi-planar reconstruction.

COMPARISON: None.

FINDINGS: Vertebral bodies intact with good posterior alignment. Extensive multi-level degenerative changes seen throughout the cervical spine with disc space narrowing and large bulky anterior osteophyte formation. Degenerative change also noted in C7-T1 facet joint. Spinal canal grossly unremarkable. Small posterior osteophytes noted at C3-4. Prevertebral soft tissues normal.

IMPRESSION: 1) No acute trauma.

2) Chronic degenerative changes as described above.

*** Final ***
Read by: Derek P Jakes, MD
Released By: Derek P Jakes, MD
Released on: 08/20/2007 14:30

Trans On: 08/16/2007 17:5by: BKB
Technologist: Traci T Javers

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Stacy MD, Jason J	CT Head Without Contrast	CT-07-052556	8/16/2007 3:17:31 PM

head trauma

Findings:

CT HEAD WITHOUT CONTRAST:

A noncontrasted head CT exam was performed. There is no evidence of any hydrocephalus or focal area of edema. Bilateral basal ganglia calcifications are identified. Note is made of some increased thickening and

Radiology Reports

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Stacy MD, Jason J	CT Head Without Contrast	CT-07-052556	8/16/2007 3:17:31 PM

density of the anterior and posterior falx on images 17 and 18, suspicious for a small amount of subdural blood. Just above this the dura higher between the cerebral hemispheres, this finding is prominent, but I believe this is within normal limits. A dominant finding is more inferiorly. The posterior fossa is otherwise unremarkable. The sinuses are clear.

IMPRESSION:
FINDINGS SUGGEST A SMALL AMOUNT OF BLOOD ALONG THE FALX AND BEST SEEN ON IMAGES 17 AND 18. THERE IS SOME SLIGHT THICKENING PRESENT, OTHERWISE, NO ACUTE ABNORMALITY IS SEEN. NO SUBARACHNOID BLOOD OR VENTRICULAR DILATATION OR EVIDENCE OF ANY ISCHEMIA IS SEEN.

Call report to Dr. Jason Stacy

*** Final *** Trans On: 08/16/2007 15:4by: LTR
Read by: William John Savoca, MD
Released By: William John Savoca, MD
Released on: 08/21/2007 11:00 Technologist: Traci T Javers

Radiology Reports

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Keisler MD, Brian D	MR Brain W/O Contrast	MR-07-016383	8/23/2007 5:51:00 PM

head trauma

Findings:

MRI OF THE BRAIN:

The study consists of multiplanar sequences without contrast. No prior studies but we correlate with a recent CT of head dated 08/16/2007.

On the CT scan, there was description of probable small amount of subdural blood along the posterior falx. This is recognized on the MRI as a real finding. It is along the left side of the falx abutting the occipital cortex. In fact, there is also a thin sliver of blood also seen along the left side of the anterior falx abutting the medial aspect of the left frontal cortex. Each of these is very thin, with no significant mass effect and certainly no midline shift. There are felt to present parafalcine subdural blood likely from trauma. This is likely subacute now in age. A retrospective view of the CT scan does show some minimal density anteriorly as well as posteriorly.

There is no other acute finding such as infarct, intraparenchymal hemorrhage, mass lesion, brain edema, or mass effect. The ventricles are symmetric and normal in size. There is no other extra-axial blood or fluid seen. There is no convexity subdural. Paranasal sinuses are grossly clear as visualized.

IMPRESSION:
1. VERY SMALL AND THIN PARAFALCINE SUBDURAL HEMATOMAS ON THE LEFT SIDE, SEEN BOTH ANTERIOR AND POSTERIOR. THESE CREATE NO SIGNIFICANT MASS EFFECT OR EFFACEMENT OF CORTEX. NO OTHER SUBDURAL OR EXTRA-AXIAL BLOOD OR FLUID SEEN.
2. OTHERWISE, UNREMARKABLE BRAIN MRI EXAMINATION. NO OTHER ACTIVE OR ACUTE FINDINGS.

*** Final ***
Read by: Douglas M Bull, MD
Released By: Douglas M Bull, MD
Released on: 08/24/2007 14:41

Trans On: 08/24/2007 12:3by: AMH

Technologist: Adrianne M Phillips

Radiology Reports

Ordering Provider:	Ordered Test Name:	Accession Number:	Exam Date/Time:
Morgan MD, Alan R	CT Head Without Contrast	CT-07-067569	10/22/2007 1:44:04 PM

post concussive syndrome

Findings:

CT OF THE BRAIN WITHOUT CONTRAST, 10/22/07:

HISTORY: Postconcussive syndrome.

COMMENTS: Non-contrast CT of the brain was performed. A prior study dated 8/16/07 was used for comparison.

There is no evidence of intracranial hemorrhage, mass lesion or fluid collection. Small bilateral basal ganglia calcifications are noted. Ventricles, sulci and cisterns are stable and within normal limits. There is no evidence of acute territorial infarction. Previously noted minor extraaxial hemorrhage along the falx and left tentorium is no longer visualized. The calvarium is intact.

IMPRESSION:

NO ACUTE INTRACRANIAL ABNORMALITY.

*** Final *** Trans On: 10/22/2007 14:2by: JIE
Read by: Matthew A Marcus, MD
Released By: Matthew A Marcus, MD
Released on: 10/22/2007 20:30 Technologist: Shirin M Hook

401.1 HTN
Will continue w/Adalat CC 60mg p.o. q.d. Will start HCTZ 12.5mg p.o. q.d. Pt will f/up w/Dr. Schlueter in approximately 3 months. Today we will refer pt to the eye doctor for an eye exam.

nyr
07/06/99 ERIC SCHLUETER, M.D.

SIGNED BY ERIC SCHLUETER, M.D. (151) 07/09/99
CO-SIGNED BY TRICIA WITHERSPOON, M.D. (061) 07/10/99

06/23/99 :BROCKINGTON, JOANN :42328
VISIT : : : :
145 : 045
ATTENDING:JAMEE LUCAS, MD
Dr.Lucas is the Attending Physician in the FPC and is present and available.
S:Pt. is a 47 YO female, usually seen by Dr. Eric Schlueter. She comes in today c/o HBP, HA, face pain and sinus pain. In addition to this, she is having RT back pain. HA and face pain started yesterday. Denies any kind of fever, no N&V, diarrhea, no SOB. Reports that flank pain has been present for about 3 months, occurs w/her cycle. She is not having any discharge down below. No urinary frequency or dysuria. The increased BP she had over the weekend because she had not gotten her meds refilled; also has not been taking Zyrtec allergy med.
O:
Syst. BP 158 : Diast. BP 90 : P. 80
T 98.4 : Height : Weight
R 20
Allergy:
PE: HEENT NC/AT, PERRLA, TMs w/positive light reflex, normal geography bilat.; nasal turbinates boggy, congested, clear mucus drainage; O/P erythematous, cobblestone vascularity pattern and positive clear to yellow mucus postnasal drip; neck supple w/o lymphadenopathy; lungs CTAB; heart w/RRR; abdomen soft, mildly tender in lower quadrants, no rebound, no guarding.
UA yellow/clear w/spec.gr.1.015, PH 7.5, tr.prot., otherwise, neg. microscopic and chemistries.
A: SINUSITIS
P:Given Rx for Biaxin. Cont. Zyrtec; also gave her Rx for Duratuss.

724.20 LBP.
Plan to have off work x3d. Will cont Motrin 800 mg p.o. q.6h and encouraged to use heat to the area and to stretch. F/up in 4w for evaluation of these medical problems.
km ERIC SCHLUETER, M.D.
01/07/00

SIGNED BY ERIC SCHLUETER, M.D. (151) 02/04/00
CO-SIGNED BY SCOTT MCKAY, M.D. (129) 02/08/00

11/15/99
office note
Mrs. Brockington presented to the office today for refill on BP meds. I got a bp check and it was 147/87. I increased her HCTZ to 25mg po qd and refilled her Adalat. She also c/o URI sx and I refilled her zyrtec and motrin and gave her two days off work.

SIGNED BY ERIC SCHLUETER, M.D. (151) 11/15/99

08/09/99 :BROCKINGTON, JOANN :42328
VISIT : : : :
151: 045
ATTENDING: JAMEE LUCAS, M.D.
Dr. Lucas is the attending physician in the FPC and is present and available.
SUBJECTIVE: Patient is a 48 y/o AAF who presents today w/a CC of URI symptoms which began about 4 days ago starting w/right earache, sore throat, feeling tired, decreased appetite, decreased sleep, sweats at nighttime, deep breathing producing congestion. She denies any sick contacts, any significant stressors. She has not tried any OTC medicines as of yet. She also c/o lower back pain which starts on the right lateral aspect and goes into the groin. She describes it as coming and going treated w/Motrin. Symptoms worse at the end of the day. Denies any significant heavy lifting at work however she is on her feet all day working for food services w/an 8 hour shift. Essential HTN controlled on Adalat CC 60 mg q.d. and HCTZ 12.5 mg p.o. q.d.

OBJECTIVE:
Syst BP 130 : Diast BP 74 : P 92
T 98.9 : Height : Weight 220
AL:
CRX:
PE: GEN: WDWN AAF conversive w/a congested cough. HEENT: PERRL, conjunctiva and sclera w/out erythema or DC, TMs clear bilat.. NARES: patent w/some slight clear DC. MOUTH: MMM, some slight erythema to the OP. NECK :Supple, NT, w/out palpable

02/24/04 : Brockington, Joann : Z42328
VISIT
218 : 028
ATTENDING: Lesa Bethea, M.D.

SUBJECTIVE: Dr. Lesa Bethea is the attending physician in the Family Practice Center and is present and available for consultation. The pt. is a 53 y/o AAF who is f/up today after falling on Valentine's Day. Apparently, she fell near Eckerds Drug suffering contusion to her Rt. shoulder and Rt. knee. She was seen in the ED, x-rays were neg., and she was given pain meds. and told to f/up w/her PCP. The pt. states that she is still having significant pain in her Rt. knee, not so much in her Rt. shoulder. She has been taking meds. as Rx., however, they are quite strong for her and she was hoping for something a little bit less potent. She is ambulating w/the assistance of a walker at this time. The pt. also has high BP and diabetes, which we will monitor w/this issue.
OBJECTIVE:
Allergy: Penicillin.
Syst. BP 150 : Diast. BP 83 : P 88
T : Ht. : Wt. 236
R 20
PE: HEENT: Normal. Lungs are clear. CV: RRR. Abdomen is obese, soft, nontender, nondistended w/pos. bowel sounds. Extrems.: She has mild Rt. shoulder pain w/FROM, no tenderness. She does have FROM in the joint. Rt. knee is slightly edematous, FROM, I am unable to elicit any joint laxity. No obvious signs of trauma.
LABS: BS is 258.
ASSESSMENT & PLAN:
RT. SHOULDER CONTUSION : 719.41
She is to cont. anti-inflammatories.
RT. KNEE CONTUSION : 924.1
She is to cont. the use of walker. We will also give her another few days off as she works as a cook and she has to be on her feet for the majority of that shift. We will Rx. her some Motrin and she can use her strong meds. for breakthrough pain. I told to her give another couple of weeks. If she cont. to have pain, she will need to be seen for reevaluation.

ILHS/ah.SSScott Judd, M.D.
02/25/04

SIGNED BY SCOTT JUDD, MD (218) 03/09/04
CO-SIGNED BY LESA BETHEA, M.D. (028) 04/23/04

03/05/04 : Brockington, Joann : Z42328
VISIT
238 : 028
ATTENDING: Lesa Bethea, M.D.

SUBJECTIVE: Dr. Lesa Bethea is the attending physician in the Family Practice Center and is present and available for consultation. The pt. is a 52 y/o AAF w/h/o diabetes, HTN, GERD, and recently evaluated for fall approx. two and half weeks ago. The pt. cont. to have pain in her Rt. knee w/swelling and uses a walker to ambulate. She has been soaking her Rt. ankle and Rt. knee in Epson salt and using Motrin t.i.d. The pt. states that she fell tripping on a rug two and half weeks ago, falling on her Rt. side. She also had some pain in her Rt. shoulder after the fall.
MEDS: Metformin, Levaquin for sinus infection, Lotensin, Guaifenex, Humibid for sinus infection, and Prilosec.
SH: No tobacco, alcohol, or drug use.
OBJECTIVE:
Allergy:
Syst. BP 144 : Diast. BP 86 : P 95
T : Ht. : Wt. 235

PE: General: The pt. is obese, A&O, pleasant, nontoxic, and is in NAD. MS: Examination of the Rt. knee shows swelling in the prepatellar bursa w/warmth, erythema, as well as some tenderness along the lateral joint space. The pt. has no crepitus on flexion of the knee, otherwise stable w/normal anterior and posterior drawer test. The Rt. ankle showed no swelling, erythema or warmth and is slightly tender on the lateral side.
ASSESSMENT & PLAN:
PREPATELLAR BURSITIS : 726.65
The pt. declined aspiration in the clinic. I told her to go and use ice four to five times a day for 15 min., cont. w/Motrin, and keep the knee elevated as much as possible. She may also need evaluation w/MRI or CT for meniscal tear if symptoms cont. past four more weeks.
ANKLE SPRAIN : 845.00
The pt. is recovering well from this. She is to cont. w/Epson soaks p.r.n. The pt. is to f/up in four weeks w/PCP.

ILHS/iq.QRBruce M. Easterling, M.D.
03/06/04

SIGNED BY BRUCE EASTERLING, MD (238) 03/09/04
CO-SIGNED BY LESA BETHEA, M.D. (028) 04/23/04

PATIENT CHART: VITALS PROBLEMS PROCEDURES & DX Page:
Date printed: 11/11/10

Name: JOANN BROCKINGTON ID: Z42328 Sex: F Age: 59

Major Problems

05/03/99 HTN
07/02/99 401.1 HTN
08/09/99 401.1 HTN,ESSENTIA
01/14/00 401.10 ESSENTIAL H
04/24/00 401.9 HTN
09/21/00 TYPE II. DM, H/O
02/02/01 DM TYPE II
07/02/01 DIABETES
01/22/02 DM
05/29/02 HYPERLIPIDEMIA
08/05/03 GERD

Other Problems

08/09/99 465.9 URI
12/17/99 465.90 COLD.
01/14/00 465.90 URI.
05/12/00 625.9 PELVIC PAIN
06/09/00 654.1 UTERINE FIBR
12/17/99 724.20 LBP.
05/03/99 ABDOMINAL PAIN/
05/09/03 ABNORMAL STRESS TE
03/07/02 ACUTE SINUSITIS
05/03/99 ALLERGIC RHINITIS
03/05/04 ANKLE SPRAIN
03/13/03 ARTHRITIS
06/23/99 BACK PAIN
09/09/03 CHRONIC SINUSITIS
02/02/01 DEPRESSION

Procedures

Diagnoses

Vital Signs

	03/05/04	02/24/04	02/10/04	12/09/03	09/09/03	08/05/03
Height						
Weight	235	236	239	242	233	
Temp					98.9	99.4
Pulse	95	88	95	87	99	84
Systolic	144	150	129	140	121	208
Diastol	86	83	67	87	79	126
OFC		20				
Other						

PATIENT CHART: VITALS PROBLEMS PROCEDURES & DX Page:
Date printed: 11/11/10

Name: JOANN BROCKINGTON ID: Z42328 Sex: F Age: 59

Major Problems

Other Problems

05/14/03 DISCHARGE
09/21/00 F/UP
05/03/99 GLUCOSE
05/24/99 GLUCOSE INTOLERANC
09/09/03 H. PYLORI POS
05/03/99 HEALTH MAINT
04/24/00 HM
07/02/01 HOSPITAL F/UP VISI
08/13/01 HRT
05/24/99 HTN.
06/26/00 LAB
05/04/99 LAB NOTE
05/09/03 LEG PAIN
08/09/99 LOWER BACK PAIN
07/21/03 MEDICAL RECORDS

Procedures

Diagnoses

RECEIVED
FEB 22 2012
SECOND INJURY FUND

Vital Signs

	05/09/03	04/14/03	03/13/03	10/03/02	05/29/02	04/05/02
Height						
Weight	243	236	236	230	234	229
Temp		99	99.4			
Pulse	99	98	88	88	82	82
Systolic	154	160	149	168	144	150
Diastol	85	95	84	100	100	90
OFC			18			
Other						

Name: JOANN BROCKINGTON ID: Z42328 Sex: F Age: 59

Major Problems

Other Problems

05/24/99 MS PAIN, RT FOOT.
05/03/99 MUSCULOSKELETAL
05/17/99 MUSCULOSKELETAL PA
05/03/99 NN
11/15/99 OFFICE NOTE
06/02/00 OVARIAN CYST
09/22/00 PERITONSILLAR CELL
05/12/99 PHONE NOTE
03/05/04 PREPATELLAR BURSIT
12/07/01 RASH
02/24/04 RT. KNEE CONTUSION
02/24/04 RT. SHOULDER CONTU
06/23/99 SINUSITIS
10/03/02 URI
02/02/01 URI SYMPTOMS

Procedures

Diagnoses

Vital Signs

	03/07/02	02/26/02	01/22/02	12/07/01	08/13/01	07/02/01
Height				5'4"		
Weight	226	236	227	229	217	219
Temp	99.2		99.3	90.8		98.6
Pulse	82	86	78	88	82	86
Systolic	130	172	152	150	132	150
Diastol	80	96	100	100	90	94
OFC						
Other						

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

03/30/2004 - Office Visit
Provider: Scott D Judd MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **234** lbs. P: **83** Rhythm: **regular** R: **20** BP: **160/106** **Blood sugar:** 346
Blood sugar is: Random

Body Mass Index in-lb

Height (in): 64
Weight (lb): 234

Patient is here to day for a F/U

Continuity Provider is Dr. scott judd
Practice Partner #: z42328
Are you experiencing any pain or discomfort? Yes

Race: Undetermined

Risk Factors

Tobacco use: never
Passive smoke exposure: no
Alcohol use: no
Drug use: no
HIV high risk behavior: no
Caffeine use (drinks/day): 0
Exercise (times/week): 5
Type of exercise: walking
Seatbelt use: 100 %
Sun exposure: frequently

Pain Assessment

Are you experiencing pain:

Yes

Description:

Subjective Sharp, Throbbing
Non-Verbal Cues Other
Duration of pain: always
What relieves your pain? medication
Are you taking pain medications? Yes
Name of Medication: motrin 800
Nursing Intervention: MD notified

Latex Screening Tool

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

1. Do you have or think you have an allergy to natural rubber latex? (Examples: balloons,condoms,pacifiers) No
2. Do you have spina bifida* or bowel/bladder problems that have required you to have any surgeries or procedures? No
3. If your work requires you to wear rubber gloves or to handle rubber products, have you had any problems? No
4. Did you have more than 3 operations or medical procedures before you were 1 year old? No
5. Have you ever had an allergic reaction during a medical or dental procedure? No
6. Do you have an allergic reaction to any of the following foods: Avocado, banana, potato, peach, kiwi, chestnut, or tomato? No
Above information entered by: mrobinson/lpn
.....Maureen E Robinson LPN March 30, 2004 1:13 PM

Attending Participation: Present and Available
Dr Damon Daniels was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up

Chief Complaint: knee pain.
PCP: scott judd

General History:
52 yo AAF with h/o htn, dm, with right knee pain after a fall in mid feb. Cont to be painful, swelling only minimally improved. Also, the ankle swells, unsure if this is related. BP also up, not taken any anti-inflamm. today and did take BP meds. BS up secondary to a lapse in dietary restraint(she had a cinnamon bub and some orange juice for lunch)

Past Medical History:

Hx of type 2 diabetes
Hx of hypertension

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Percussion:	no dullness
Palpation:	normal fremitus
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Palpation:	no thrill or displacement of PMI
Auscultation:	normal S1 and S2; no murmur, rub, or gallop
Carotid artery:	pulses 2+ and symmetric; no bruits
Abd. aorta:	no enlargement or bruits
Femoral artery:	pulses 2+ and symmetric; no bruits
Pedal pulses:	pulses 2+ and symmetric
Peripheral circ:	no cyanosis, clubbing, or edema

Musculoskeletal:

Gait/station:	normal gait; no ataxia
RUE:	mild edema, tender jt. line, no crep. no ankle edema
RLE:	normal range of motion and strength

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: Will increase Procardia XL to 90 qd, re-eval BP in 6 weeks.
The patient was started on the following medications:
Procardia Xl 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Lotensin Hct 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tablet bid

Problem: KNEE PAIN (ICD-719.46)
Assessment: Ortho referral, vioxx for pain.
.....Scott D Judd MD March 30, 2004 1:34 PM

Signed by Damon Daniels MD on 03/30/2004 at 4:32 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

05/25/2004 - Office Visit
Provider: Damon Daniels MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **233** lbs. P: **109** Rhythm: **regular** R: **20** BP: **145/82**
Above BP taken with L Adult cuff
Blood sugar: 109
Blood sugar is: Fasting

Body Mass Index in-lb

Height (in): 64
Weight (lb): 233
BMI (in-lb) 40.14

Patient is here to day for a F/U

Continuity Provider is: scott judd
Practice Partner #: z42328
Are you experiencing any pain or discomfort? Yes

Latex Risk: no latex allergy 5/25/04
Race: Black

Pain Assessment

Are you experiencing pain:

Yes
Location: headache

Description:

Subjective Intermittently, Other
Duration of pain: intermittent
What relieves your pain? sinus meds
Are you taking pain medications? No
Nursing Intervention: MD notified
.....Maureen E Robinson LPN May 25, 2004 3:04 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr Damon Daniels was present and available for consultation while the patient was in the clinic.

History of Present Illness:

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Visit Type: Routine follow up
PCP: scott judd

General History:
follow up for BP-recent increase in medication and for refills for nasal spray and decongestants-chronic sinus trouble.Otherwise doing well. Also needs refills on diabetes meds.

Review of Systems

General
Denies fever and chills.

ENT
Complains of nasal congestion.

CV
Denies chest pains and palpitations.

Resp
Denies cough and dyspnea at rest.

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Ears, Nose, Throat:

External:	no significant lesions or deformities noted
Otoscopic:	canals clear; tympanic membranes intact with normal light reflex
Hearing:	grossly intact
Nasal:	mucosa, septum, and turbinates normal
Dental:	good dentition
Pharynx:	tongue normal; posterior pharynx without erythema or exudate

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Percussion:	no dullness
Palpation:	normal fremitus
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Palpation:	no thrill or displacement of PMI
Auscultation:	normal S1 and S2; no murmur, rub, or gallop
Carotid artery:	pulses 2+ and symmetric; no bruits
Abd. aorta:	no enlargement or bruits
Femoral artery:	pulses 2+ and symmetric; no bruits

Pedal pulses:	pulses 2+ and symmetric
Peripheral circ:	no cyanosis, clubbing, or edema

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: new medication regiment doing well, no changes today.
Her updated medication list for this problem includes:
Procardia Xl 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Lotensin Hct 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tablet bid

Problem: SINUSITIS, CHRONIC (ICD-473.9)
Assessment: not likely sinusitis, just congestion, will refill nasonex and suggested OTC sudafed.
.....Scott D Judd MD May 25, 2004 3:30 PM

Signed by Damon Daniels MD on 05/31/2004 at 11:47 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female, DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

08/17/2004 - Office Visit
Provider: D Lindsie Cone MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **228** lbs. P: **90** BP: **131/74**
Above BP taken with L Adult cuff
Blood sugar: 243
Blood sugar is: 1 hr PP

Body Mass Index in-lb

Height (in): 64
Weight (lb): 228
BMI (in-lb) 39.28

Patient is here to day for a F/U

Continuity Provider is: Steen
Team: 10

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

.....Dale L Reaves LPN August 17, 2004 3:16 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr David Lindsie Cone was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up
PCP: Steen

General History:
C/o chronic right knee pain, elevated BS, sinusitis, and yeast infection. BS running higher than usual (150-200). Taking Glucotrol/Glucophage without SE. Needs med refill. Knee has been evaluated by Moore Ortho with MRI and dx'd with OA and menescal tear. Pt declined steroid injection. Pain worse with stairs. Sinus pressure and HA x 2 weeks. On flonase.

Family History:

FH of Diabetes:
FH of Hypertension:

FH of Breast Cancer: GM

Review of Systems

General
Denies fever, weakness, and weight loss.

ENT
Complains of nasal congestion.
Others: Sinus pressure/pain

CV
Denies chest pains and palpitations.

GI
Denies change in bowel habits.

GU
Complains of vaginal discharge.
Others: yeast infection

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Head:
Inspection: normocephalic without obvious abnormalities

Eyes:
External: conjunctiva and lids normal

Ears, Nose, Throat:
maxillary sinus pressure/pain on palp bilateraly

Neck:
Neck: supple; no masses; trachea midline
Thyroid: no nodules, masses, tenderness, or enlargement

Respiratory:
Resp. effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular:
Auscultation: normal S1 and S2; no murmur, rub, or gallop

Prescriptions:
KNEE BRACE () wear daily 08/17/2004 #1 x 0
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

LEVAQUIN 500 MG TABS (LEVOFLOXACIN) () one tablet daily 08/17/2004 #10 x 0
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
PROCARDIA XL 90 MG TBCR (NIFEDIPINE) One tablet daily 08/17/2004 #30 x 3
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
DIFLUCAN 200 MG TABS (FLUCONAZOLE) one tablet daily 08/17/2004 #1 x 0
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
BENAZEPRIL-HCTZ 10-12.5 MG TABS (BENAZEPRIL-HCTZ) one tab bid 08/17/2004 #62 x 5
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

Assessment & Plan:

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: Continue Gluctrol and Glucophage. Check A1C, Creat, K+, and FLP. Need to check microalb at next visit. If A1C not below 7.0, we discussed possiblility of adding Lantus to regimine for better control.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid

Problem: KNEE PAIN (ICD-719.46)
Assessment: Pt's knee felt cool today without swelling. Recommend conservative treatment with knee brace and NSAID's and refer for PT for strengthening and stretching exercises.

Problem: HYPERTENSION (ICD-401.1)
Assessment: Continue Benazepril and Procardia XL.
The patient was started on the following medications:
Benazepril-hctz 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tab bid

Her updated medication list for this problem includes:
Procardia Xl 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Lotensin Hct 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tablet bid
Benazepril-hctz 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tab bid

Problem: FAMILY HISTORY BREAST CANCER (ICD-V16.3)
Assessment: Screening mammo scheduled.

Problem: SINUSITIS, CHRONIC (ICD-473.9)
Assessment: Levoquin for sinusitis. Continue flonase.
.....Bruce M Easterling MD August 17, 2004 5:02 PM

Signed by D Lindsie Cone MD on 08/23/2004 at 10:53 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

11/23/2004 - Office Visit
Provider: Scott A McKay MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **230** lbs. P: **94** Rhythm: **regular** BP: **136/90**
Above BP taken with L Adult cuff
Blood sugar: 322
Blood sugar is: Random

Body Mass Index in-lb

Height (in): 64
Weight (lb): 230
BMI (in-lb) 39.62

Continuity Provider is: Christian Steen
Team: 10

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

.....Linda D Searles PCA November 23, 2004 3:25 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr Scott McKay was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up
PCP: Christian Steen

General History:
Right knee pain and bump on superior side. RUQ abd pain, intermittent, not associated with anything, sometimes food, worse with deep breath and movement. H/o of "gall stones removed", not sure if GB removed. Does have constipation (BM q34 days) and improvement of RUQ pain with BM.

Prescriptions:

COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid 11/23/2004 #30 x 2
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
INSULIN SYRINGE AND NEEDLES () bid dosing 11/23/2004 #1 month x 2
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
INSULIN NPH () 5 units SC bid 11/23/2004 #1 month x 2

Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) one tablet daily 11/23/2004 #30 x 2
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily 11/23/2004 #30 x 1
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

NASONEX 50 MCG/ACT SUSP (MOMETASONE FUROATE) 1 spray per nostril QD 11/23/2004 #1 x 6
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

BENAZEPRIL-HCTZ 10-12.5 MG TABS (BENAZEPRIL-HCTZ) one tab bid 11/23/2004 #62 x 5
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID 11/23/2004 #60 x 6
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

PROCARDIA XL 90 MG TBCR (NIFEDIPINE) One tablet daily 11/23/2004 #30 x 3
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

Review of Systems

General
Complains of fatigue and weakness.
Denies fever, chills, malaise, weight loss, and sleep disorder.

CV
Denies chest pains and palpitations.

GI
Complains of constipation, abdominal pain, gas/bloating, and indigestion/heartburn.
Denies nausea, vomiting, diarrhea, melena, and hematochezia.

GU
Complains of urinary frequency.

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Neck:

Neck:	supple; no masses; trachea midline
Thyroid:	no nodules, masses, tenderness, or enlargement

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses
Liver/spleen:	normal to percussion; no enlargement or nodularity
Other:	Surgical scar

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: Continue metoprolol, procardia xl, and lisinopril/hctz. Check creat, K.
The patient was advised to stop the following medications:
Lotensin Hct 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tablet bid

Her updated medication list for this problem includes:
Procardia XI 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Benazepril-hctz 10-12.5 Mg Tabs (Benazepril-hctz) ..... One tab bid

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: Poorly controlled on Glucophage bid (A1c of 13). Will start on insulin NPH 5 units bid and check FSBS tid. Return in 2 weeks for increasing insulin. May benefit from 70/30. Reviewed sx of hypoglycemia.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid

Problem: ABDOMINAL PAIN, RIGHT UPPER QUADRANT (ICD-789.01)
Assessment: Pt with probably hx of GB removed. I feel that pain is related to constipation given h/o relief with BM, h/o constipation, h/o poorly controlled DM with polyuria, polydipsia and probable poor hydration. Start on colace. Expect sx to improve once DM is better controlled.
.....Bruce M Easterling MD November 23, 2004 5:43 PM

Signed by Scott A McKay MD on 11/24/2004 at 10:37 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

01/11/2005 - Office Visit
Provider: Bruce M Easterling MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **227** lbs. T: **99.3** Deg F. T site: **oral** P: **101** Rhythm: **regular** R: **20** BP: **141/100**
Above BP taken with L Adult cuff

Body Mass Index in-lb

Height (in): 64
Weight (lb): 227
BMI (in-lb) 39.11

Patient is here today with a New Complaint
Continuity Provider is: Christian Steen
Team: Blue
Are you experiencing any pain or discomfort? Yes

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

Pain Assessment

Are you experiencing pain:

Yes
Location: diarrhea

Description:

Subjective Constant
Duration of pain: started this am
What relieves your pain? N/A
Are you taking pain medications? No
Nursing Intervention: MD notified
.....Maureen E Robinson LPN January 11, 2005 3:57 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr Damon Daniels was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up
PCP: Christian Steen

JOANN BROCKINGTON Home (803)740-4497 Office (803)939-0026
Female DOB 07/04/1951 R009122086 Ins. SELF-PAY (0600)

General History:
Pt c/o URI progressing to diarrhea x 1 week. Seen in LMC ER on Friday with normal lab work and given decongestant rx. Has not started until seen by me. FSBS elevated since illness.

Review of Systems

General
Complains of fever, fatigue, and weakness.

ENT
Complains of nasal congestion.

CV
Complains of chest pains.
Denies syncope and dyspnea on exertion.

Resp
Denies cough, hemoptysis, and wheezing.

GI
Complains of vomiting and diarrhea.

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Ears, Nose, Throat:

Nasal:	inflamed mucosa
Pharynx:	mild pharyngeal erythema

Neck:

Neck:	supple; no masses; trachea midline
Thyroid:	no nodules, masses, tenderness, or enlargement

Respiratory:

Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Assessment & Plan:

Problem: UPPER RESPIRATORY INFECTION (URI) (ICD-465.9)
Assessment: OK for pt to take oral decongestants for few days but no nasal spray (Neosenephrine). BMP, CBC from LMC wnl on Friday. Will not recheck.

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: Last A1c improved, but still 10ish. Will increase NPH to 10units bid.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid

Problem: HYPERTENSION (ICD-401.1)
Assessment: Increase combo to 20/25 bid from 10/12.5.
The patient was started on the following medications:
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

Her updated medication list for this problem includes:
Procardia XI 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

.....Bruce M Easterling MD January 11, 2005 6:20 PM

Signed by Damon Daniels MD on 01/13/2005 at 9:43 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

03/10/2005 - Office Visit: nasal congestion,poss sinusitis
Provider: Susan A Werner, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **222** lbs. T: **99.2** Deg F. P: **95** BP: **150/83**
Above BP taken with M Adult cuff
Blood sugar: 3hrpp---286

Body Mass Index in-lb

Height (in): 64
Weight (lb): 222
BMI (in-lb) 38.24

Patient is here today with a New Complaint
Comments: nasal congestion,poss sinusitis
Continuity Provider is: Christian Steen
Team: Blue

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

Risk Factors

Seatbelt use: 100 %
.....Margie E Gunter, PCA March 10, 2005 2:07 PM

Attending Participation: Present and Available
Dr Thomas D Armsey II was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Est. pt.--problem only

Chief Complaint: Cold & URI symptoms.
PCP: Christian Steen

General History:
Pt presents to FPC with c/o congestion x 1 week, getting worse. She c/o that the congestion is worse on the left side of her face, in the maxillary area, and worsens when she leans forward. She also c/o a cough, productive of yellow sputum. She c/o post-nasal drip. Subjective fevers. Occassional left ear fullness, but no otalgia or decreased hearing. Has h/o sinus problems. Has been taking Mucinex with little relief.

She is also asking for refills of her chronic medications.

Prescriptions:

MUCINEX 600 MG TBCR (GUAIFENESIN) one PO tablet bid 03/10/2005 #20 x 0

Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
LEVAQUIN 500 MG TABS (LEVOFLOXACIN) one tab daily x 10 days 03/10/2005 #10 x 0
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid 03/10/2005 #30 x 5
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily 03/10/2005 #30 x 5
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
BENAZEPRIL-HYDROCHLOROTHIAZIDE 20-25 MG TABS (BENAZEPRIL-HYDROCHLOROTHIAZIDE) one tab bid 03/10/2005 #60 x 5
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID 03/10/2005 #60 x 5
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient
PROCARDIA XL 90 MG TBCR (NIFEDIPINE) One tablet daily 03/10/2005 #30 x 5
Entered, Authorized and Signed by: Susan Ashton, MD
Method used: Print then Give to Patient

Current Problems:
HYPERTENSION (ICD-401.1)
DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
KNEE PAIN (ICD-719.46)
SINUSITIS, CHRONIC (ICD-473.9)
FAMILY HISTORY OF DIABETES (ICD-V18.0)
FAMILY HISTORY OF HYPERTENSION (ICD-V17.4)
FAMILY HISTORY BREAST CANCER (ICD-V16.3)

Social History:
non-smoker

Review of Systems
See HPI

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Eyes:
External: conjunctiva and lids normal
Pupils: equal, round, and reactive to light and accommodation

RECEI FEB SECOND

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Ears, Nose, Throat:

External:	no significant lesions or deformities noted
Otoscopic:	canals clear; tympanic membranes intact with normal light reflex
Hearing:	grossly intact
Nasal:	edematous mucosa
Pharynx:	post-nasal drip
Other:	pressure/pain - left maxiallary sinus with leaning forward and with percussion

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses

Lymphatic:

Neck:	no cervical adenopathy

Assessment & Plan:

Problem: SINUSITIS, ACUTE (ICD-461.9)
Assessment: Has h/o sinus infections. Not sure if any work-up has been done. Could be predisposed with allergies, but also consider nasal polyps or need for CT. Will treat with Levaquin, as pt has PCN allergy.

Problem: UPPER RESPIRATORY INFECTION (URI) (ICD-465.9)
Assessment: For the congestion, I refilled her Mucinex. Encourage PO fluids.

The patient was started on the following medications:
Levaquin 500 Mg Tabs (Levofloxacin) ..... One tab daily x 10 days

Pt instructed to return to FPC if symptoms worsen or do not improve after course of abx.

As far as her chronic medical problems, I have scheduled her an appointment for later this month. Refilled her meds in the meantime.

.....Susan Ashton, MD March 13, 2005 2:08 PM

Signed by Thomas D Armsey MD on 03/16/2005 at 10:45 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

03/29/2005 - Office Visit: Routine Follow Up. Problems with Pollen
Provider: D Lindsie Cone MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **222.5** lbs. P: **96** BP: **148/86**
Above BP taken with L Adult cuff
Blood sugar: 129-4hpp
Blood sugar is: Random

Body Mass Index in-lb

Height (in): 64
Weight (lb): 222.5
BMI (in-lb) 38.33

Comments: Routine Follow Up. Having problems with pollen; c/o HA. On Zyrtec.
Continuity Provider is: Christian Steen
Team: Blue
Are you experiencing any pain or discomfort? Yes

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

Pain Assessment

Are you experiencing pain:

Yes
Location: Head

Pain Scale Used:

Wong Baker
Intensity: 3

Description:

Subjective Aching, Intermittently
Non-Verbal Cues Facial Expressions
Duration of pain: Today
What relieves your pain? Nothing
Are you taking pain medications? Yes
Name of Medication: Zyrtec
Nursing Intervention: MD notified
.....Sandra D McLean LPN March 29, 2005 1:12 PM

Risk Factors

Seatbelt use: 100 %

Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient
BLOOD PRESSURE MONITOR () check daily 03/29/2005 #1 x 0
Entered, Authorized and Signed by: Bruce M Easterling MD
Method used: Print then Give to Patient

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Neck:

Neck:	supple; no masses; trachea midline
Thyroid:	no nodules, masses, tenderness, or enlargement

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop
Pedal pulses:	pulses 2+ and symmetric
Peripheral circ:	no cyanosis, clubbing, or edema

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses
Liver/spleen:	normal to percussion; no enlargement or nodularity

Assessment & Plan:

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: May need to add TZD. Will check A1c, creat and consider starting Avandia. DM foot exam wnl.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid

Problem: HYPERTENSION (ICD-401.1)
Assessment: Rx for home BP monitor to r/o white coat HTN. Check K+, Na
Her updated medication list for this problem includes:
Procardia XI 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

Problem: HYPERCHOLESTEROLEMIA (ICD-272.0)
Assessment: Check FLP. Have tried 6 months of diet changes. May need to start statin.

Problem: FAMILY HISTORY BREAST CANCER (ICD-V16.3)

Attending Participation: Present and Available
Dr David Lindsie Cone was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up
PCP: Christian Steen

General History:
C/o allergies with pollen. FSBS in 150's bid, improved with walking. Eating sensibly. O/w doing well, no complaints.

Past Medical History:

S/P Total Abdominal Hysterectomy
Hx of type 2 diabetes
Hx of hypertension
Hx of prior gynecological surgery
S/P Total Abdominal Hysterectomy and Bilateral Salpingo-oopherectomy 1993 for fibroids.
S/p BTL 1979
S/P Cholecystectomy 1980's

Family History:

FH of Diabetes:
FH of Hypertension:
FH of Breast Cancer: GM
FH of Colon Cancer: sister s/p resection at age 46

Review of Systems

General
Denies fever and chills.

ENT
Complains of nasal congestion.

CV
Denies chest pains, palpitations, syncope, and peripheral edema.

Resp
Denies cough and wheezing.

GI
Denies nausea, vomiting, change in bowel habits, and melena.

Prescriptions:

ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily 03/29/2005 #30 x 5

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Assessment: Screening mammogram.

Problem: FAMILY HISTORY OF COLON CANCER (ICD-V16.0)
Assessment: Screening colonoscopy.
.....Bruce M Easterling MD March 29, 2005 1:45 PM

Signed by D Lindsie Cone MD on 03/29/2005 at 5:03 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

06/27/2005 - Office Visit
Provider: Christian C Steen, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **222** lbs. P: **72** R: **20** BP: **158/98**
Above BP taken with L Adult cuff
Blood sugar: 241
Blood sugar is: Random

Body Mass Index in-lb

Height (in): 64
Weight (lb): 222
BMI (in-lb) 38.24

Patient is here to day for a F/U

Continuity Provider is: Christian Steen
Team: Blue

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

Prescriptions:

GLYBURIDE 5 MG TABS (GLYBURIDE) One tablet BID 06/27/2005 #60 x 5
Entered, Authorized and Signed by: Christian C Steen, MD
Method used: Print then Give to Patient
BENAZEPRIL-HYDROCHLOROTHIAZIDE 20-25 MG TABS (BENAZEPRIL-HYDROCHLOROTHIAZIDE) one tab bid 06/27/2005 #60 x 5
Entered, Authorized and Signed by: Christian C Steen, MD
Method used: Print then Give to Patient
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID 06/27/2005 #60 x 5
Entered, Authorized and Signed by: Christian C Steen, MD
Method used: Print then Give to Patient
PROCARDIA XL 90 MG TBCR (NIFEDIPINE) One tablet daily 06/27/2005 #30 x 5
Entered, Authorized and Signed by: Christian C Steen, MD
Method used: Print then Give to Patient
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 1 tablet daily at bedtime. 06/27/2005 #30 x 3
Entered, Authorized and Signed by: Christian C Steen, MD
Method used: Print then Give to Patient

.....Dale L Reaves LPN June 27, 2005 4:25 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr Rachel Hall was present and available for consultation while the patient was in the clinic.

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins. SELF-PAY (0600)

History of Present Illness:

Visit Type: Routine follow up

Chief Complaint: Diabetes Management and Hypertension Management.
PCP: Christian Steen

General History:
Patient presents today for routine followup and continued management of her HTN and DM. She notes that she recently ran out of all of her medications and was unable to obtain refills. She notes that since being out of her medications she has had some elevated FSBS notesd on her regular FSBS checks. She has also had some recent headaches which she attributes to her elevated BP since being out of her medications. She denies any other hypertensive sx. Pt. tolerating all of her medications well when she has them to take.

Diabetes Management History:
The patient is a 53 year old female who comes in for evaluation of non-insulin dependent diabetes. She has not been enrolled in the "Diabetic Education Program". She states understanding of dietary principles but she is not following the appropriate diet. No sensory loss is reported. Self foot exams are being performed. She is checking home blood sugars. She says that she is not exercising regularly.
Reported hypoglycemic symptoms include sweats and weakness. Frequency of hypoglycemic symptoms are reported to be occasionally. Hyperglycemic symptoms include polyuria and polydipsia. Frequency of hyperglycemic symptoms are reported to be occasionally.
There are no symptoms to suggest diabetic complications. Since her last visit, no infections have occurred. No changes have been made to her treatment plan since last visit.

Hypertension History:
She denies headache, chest pain, palpitations, dyspnea with exertion, orthopnea, peripheral edema, neurologic problems, and side effects from treatment. She notes no problems with any antihypertensive medication side effects.
Positive major cardiovascular risk factors include diabetes, hyperlipidemia, and hypertension. Negative major cardiovascular risk factors include female age < 55 years old.

Family History:

Reviewed and no changes required:
FH of Diabetes:
FH of Hypertension:
FH of Breast Cancer: GM
FH of Colon Cancer: sister s/p resection at age 46

Social History:

Reviewed and no changes required:
non-smoker

Review of Systems

General

Denies fever, chills, fatigue, and weakness.

Eyes
Denies blurring and eye pain.

CV
Denies chest pains, palpitations, dyspnea on exertion, and peripheral edema.

Resp
Denies cough, dyspnea at rest, and wheezing.

GI
Denies nausea, vomiting, diarrhea, constipation, and abdominal pain.

MS
Denies arthritis.

Neuro
Complains of frequent headaches.

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Eyes:

External:	conjunctiva and lids normal
Pupils:	equal, round, and reactive to light and accommodation

Respiratory:

Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop
Carotid artery:	pulses 2+ and symmetric; no bruits
Pedal pulses:	pulses 2+ and symmetric
Peripheral circ:	no cyanosis, clubbing, or edema

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses
Liver/spleen:	normal to percussion; no enlargement or nodularity

Diabetes Management Exam:
Foot Exam:
Sensory-Pinprick/Light touch:
Left medial foot (L-4): normal
Left dorsal foot (L-5): normal
Left lateral foot (S-1): normal
Right medial foot (L-4): normal
Right dorsal foot (L-5): normal

Right lateral foot (S-1): normal
Sensory-Monofilament:
Left foot: normal
Right foot: normal
Inspection:
Left foot: normal
Right foot: normal

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: BP much elevated today but no hypertensive sx currently. Pt. out of medications. Will give refills on all meds and follow for improvement. If continued elevation when back on all medications will then consider adjusting dosage. Will check renal fx on next clinic visit.
Her updated medication list for this problem includes:
Procardia XI 90 Mg Tbcr (Nifedipine) ..... One tablet daily
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: FSBS elevated today and last few visits. Pt. given refills on all meds and encouraged to continue dietary compliance. Pt. to check am fasting bs and eat a small breakfast since she has been having some hypoglycemic sx during the middle of the day prior to taking her second dosage of both meds. Will consider dosage adjustment if cont. sx. Will recheck HgbA1c on next visit.
The patient was started on the following medications:
Glyburide 5 Mg Tabs (Glyburide) ..... One tablet bid

Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid
Glyburide 5 Mg Tabs (Glyburide) ..... One tablet bid

Problem: HYPERCHOLESTEROLEMIA (ICD-272.0)
Assessment: tolerating med well. Will check FLP on next visit.
The patient was started on the following medications:
Lipitor 20 Mg Tabs (Atorvastatin calcium) ..... Take 1 tablet daily at bedtime.

.....Christian C Steen, MD June 27, 2005 4:59 PM

Signed by Rachel E Hall MD on 06/28/2005 at 10:51 AM

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

11/03/2005 - Office Visit: Injection-clonidine
Provider: Maureen E Robinson LPN
Location of Care: Palmetto Health Richland Family Medicine Center

Injections Today:

Clonidine 0.1mg PO
Given By: Maureen Robinson LPN
Time: 2:45pm

.....Maureen E Robinson LPN November 3, 2005 3:05 PM

Signed by Maureen E Robinson LPN on 11/03/2005 at 3:05 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

11/03/2005 - Office Visit
Provider: Christian C Steen, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Nursing Intake

Vital Signs

Ht: **64** in. Wt: **220** lbs. P: **88** Rhythm: **regular** BP: **172/100**
Above BP taken with L Adult cuff
Blood sugar: 279
Blood sugar is: Fasting

Body Mass Index in-lb

Height (in): 64
Weight (lb): 220
BMI (in-lb) 37.90

Patient is here today with a New Complaint
Continuity Provider is: Christian Steen
Team: Blue

Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)
Race: Black

.....Maureen E Robinson LPN November 3, 2005 1:50 PM

Risk Factors

Seatbelt use: 100 %

Attending Participation: Present and Available
Dr Brian Keisler was present and available for consultation while the patient was in the clinic.

History of Present Illness:

Visit Type: Routine follow up

Chief Complaint: Diabetes Management, Hypertension Management, and Lipid Management.
PCP: Christian Steen

General History:
Patient presents today for routine followup and continued managment of her HTN, DM and cholesterol. Pt. doing well since last seen except for recent develpment of URI/cold sx. Pt. with nasal/sinus congestion, cough, yellow phlegm production and rhinorrhea for last 5 days. Pt. attempting no meds to help. Pt. with no fevers or chills. Pt. also complaining of some mild hypertensive sx such as occ. headaches and mild visual blurring. Pt. notes recent increased social stressor of family and employment. Just cam off 7 day work stretch. Recent poor DM dietary compliance. FSBS subjectively running in 100s since last visit. Pt. with no problems tolerating lipitor and attempting some dietary chol changes.

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Diabetes Management History:

The patient is a 54 year old female who comes in for evaluation of non-insulin dependent diabetes. She has not been enrolled in the "Diabetic Education Program". She states understanding of dietary principles but she is not following the appropriate diet. No sensory loss is reported. Self foot exams are being performed. She is checking home blood sugars. She says that she is not exercising regularly.

Hypoglycemic symptoms are not occurring. No hyperglycemic symptoms are reported.

There are no symptoms to suggest diabetic complications. The following treatment plan problems are reported: diet problems. No changes have been made to her treatment plan since last visit.

Hypertension History:

She complains of headache, but denies chest pain, palpitations, dyspnea with exertion, orthopnea, peripheral edema, neurologic problems, and side effects from treatment. She notes no problems with any antihypertensive medication side effects.

Positive major cardiovascular risk factors include diabetes, hyperlipidemia, and hypertension. Negative major cardiovascular risk factors include female age < 55 years old.

Lipid Management History:

Positive NCEP/ATP III risk factors include diabetes, HDL cholesterol less than 40, and hypertension. Negative NCEP/ATP III risk factors include female age < 55 years old.

The patient states that she knows about the "Therapeutic Lifestyle Change" diet. Her compliance with the TLC diet is fair. The patient expresses understanding of adjunctive measures for cholesterol lowering. Adjunctive measures started by the patient include aerobic exercise, fiber, ASA, limit alcohol consumpton, and weight reduction. She expresses no side effects from her lipid-lowering medication. The patient denies any symptoms to suggest myopathy or liver disease from her "statin" therapy.

Past Medical History:

PMH reviewed. No changes required:
S/P Total Abdominal Hysterectomy
Hx of type 2 diabetes
Hx of hypertension
Hx of prior gynecological surgery
S/P Total Abdominal Hysterectomy and Bilateral Salpingo-oopherectomy 1993 for fibroids.
S/p BTL 1979
S/P Cholecystectomy 1980's

Social History:

Reviewed and no changes required:
non-smoker

Review of Systems

General

Denies fever, chills, weakness, and malaise.

ENT

Complains of nasal congestion.
Denies sore throat.

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

CV
Denies chest pains, palpitations, dyspnea on exertion, and peripheral edema.

Resp
Denies cough, dyspnea at rest, and wheezing.

GI
Denies nausea, vomiting, diarrhea, constipation, and abdominal pain.

MS
Complains of arthritis.

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Head:
Inspection: normocephalic without obvious abnormalities

Eyes:
External: conjunctiva and lids normal
Pupils: equal, round, and reactive to light and accommodation
Fundus: a-v nicking

Ears, Nose, Throat:
External: no significant lesions or deformities noted
Otoscopic: canals clear; tympanic membranes intact with normal light reflex
Hearing: grossly intact
Nasal: edematous mucosa
Dental: good dentition
Pharynx: post-nasal drip

Neck:
Neck: supple; no masses; trachea midline
Thyroid: no nodules, masses, tenderness, or enlargement

Respiratory:
Resp. effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular:
Auscultation: normal S1 and S2; no murmur, rub, or gallop
Carotid artery: pulses 2+ and symmetric; no bruits
Pedal pulses: pulses 2+ and symmetric
Peripheral circ: no cyanosis, clubbing, or edema

Gastrointestinal:
Abdomen: soft and non-tender with normal bowel sounds; no masses
Liver/spleen: normal to percussion; no enlargement or nodularity

Musculoskeletal:

Gait/station:	normal gait; no ataxia
Digits/nails:	no cyanosis, clubbing, or petechiae
Head/neck:	normal alignment and mobility
Trunk:	normal alignment and mobility; no deformity
RUE:	normal range of motion and strength
RLE:	normal range of motion and strength
LUE:	normal range of motion and strength
LLE:	normal range of motion and strength

Lymphatic:

Neck:	no cervical adenopathy

Skin:

Inspection:	no rashes, suspicious lesions, or ulcerations

Diabetes Management Exam:

Foot Exam:

Sensory-Pinprick/Light touch:
- Left medial foot (L-4): normal
- Left dorsal foot (L-5): normal
- Left lateral foot (S-1): normal
- Right medial foot (L-4): normal
- Right dorsal foot (L-5): normal
- Right lateral foot (S-1): normal

Sensory-Monofilament:
- Left foot: normal
- Right foot: normal

Inspection:
- Left foot: normal
- Right foot: normal

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: Poor control on current med regimen which is maxed out on multiple agents. Pt. will likely need for additional agent to help control. Pt. with some improvement in BP while resting in clinic and after give 0.1 of clonidine. Will consider adding beta blocker or arb to regimen
Her updated medication list for this problem includes:
Procardia Xl 60 Mg Tb24 (Nifedipine) ..... Take 2 tabs daily
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: FSBS elevated today due to poor lunch diet. Pt. to be better about dietary compliance. Continue current regimen and recheck A1c on future visit. Urine dip in clinic with >1000 glu but no protein and micral neg.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Glyburide 5 Mg Tabs (Glyburide) ..... One tablet bid

Problem: HYPERCHOLESTEROLEMIA (ICD-272.0)
Assessment: tolerating med well. Recheck lipids on next visit.
Her updated medication list for this problem includes:
Lipitor 20 Mg Tabs (Atorvastatin calcium) ..... Take 1 tablet daily at bedtime.

Problem: VIRAL URI (ICD-465.9)
Assessment: Pt. with likely viral URI. Pt. to use OTC cough suppressant and decongestant. To return if lack of improvement over next week or if worsening sx.

.....Christian C Steen, MD November 3, 2005 2:30 PM

Signed by Brian D Keisler, MD on 11/07/2005 at 10:13 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

04/20/2006 - Office Visit: Multi-Problem Visit
Provider: Rukhsana Mirza
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Christian Steen
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 223.80 lb. **Height:** 64 in.
Temperature: 98.4 deg F. **Temp Site:** oral
Pulse rate: 80 **Pulse rhythm:** regular **Respirations:** 16
BP: 162/98
BMI: 38.55 **BSA:** 2.05 **Wt chg:** -1.20 since 03/23/2006

Pain Assessment
The patient is currently experiencing pain.
Location: thumb **Intensity (1-10):** 8 **Description:** sharp **Duration:** intermittant
Vitals updated by: Sharon E Hopkins RN on April 20, 2006 2:17 PM

Laboratory Results
Glucose (random): 187 mg/dL

Patient Information
Continuity Provider: Christian Steen
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Attending Participation: Seen and discussed
Dr Holbrook Raynal saw and discussed patient with me during clinic.

History of Present Illness
History from: patient
Chief Complaint: follow up for hyperlipidemia,pain in the right thumb for the past 1 week.

Hyperlipidemia
Date of diagnosis or first concern: 04/01/2005
Basis for diagnosis: previous HX
Denies: myalgias, fatigue, abdominal pain, diarrhea, constipation, flatulence, headache, nausea, rash
Compliance with tx: good
Comments: patient is already on simvastatin 20 mg/day,she is unable to excercise to a satisfactory

degree due to OA of the knees.she has never attended a class for dietary management for DM,HTN,or Hyperlipdemia .

History of Present Illness

History from: patient
Chief Complaint: follow up for hyperlipidemia,pain in the right thumb for the past 1 week.

General HPI

patient whose past med Hx significant for HTN,DM and Hypercholestrolemia is here today for a routine follow up .She also has a new complaint of acute ,severe pain in the right thumb for the past 1 week.

Patient is already on Lipitor 20 mg for the past one year.Her lipid profile ordered a month ago showed a satisfectory Cholestrol ,and a moderately raised LDL.patient has no active physical complaints right now and her HTN is well controlled.

The patient today also has a new ,unrelated problem of severe acute pain in the right thumb.she has had experienced pain due to carpel tunnel syndrome years ago ,and got relief by using a splint.she has used the splint during the past week along with Tylenol and Ibuprofen,but nothing has provided significant relief.the pain is mostly arond the MCP joint of the thumb ,but she can feel it throughout the thumb and it shoots upto the middle fo the forearm.The pain is sharp,very severe,intermittent ,is mostly induced by movement but can occur at rest,is relieved some what by raising the hand,is accompanied by some tingling and numbness and is worse than the pain she experienced the fist time with carper tunnel synd.she is able to move the other fingers of the right hand without difficulty and pain,but the movements of the thumb are severely restriced .there is no obvious swelling right now ,but according to the patient the hand was swollen initially.she is a cook by profession and uses the right hand for heavy work quite frequently.

Past History

Past Medical History (reviewed - no changes required): S/P Total Abdominal Hysterectomy
Hx of type 2 diabetes
Hx of hypertension
Hx of prior gynecological surgery
S/P Total Abdominal Hysterectomy and Bilateral Salpingo-oopherectomy 1993 for fibroids.
S/p BTL 1979
S/P Cholecystectomy 1980's

Family History (reviewed - no changes required): FH of Diabetes:
FH of Hypertension:
FH of Breast Cancer: GM
FH of Colon Cancer: sister s/p resection at age 46

Social History (reviewed - no changes required): non-smoker

Review of Systems

General: denies fevers, chills, sweats, anorexia, fatigue, malaise, weight loss.patient winces in pain frequently from the pain in her right hand.
Eyes: denies blurring, diplopia, irritation, discharge, vision loss, eye pain, photophobia
Ear/Nose/Throat: denies ear pain or discharge, tinnitus, decreased hearing, nasal obstruction or discharge, nosebleeds, sore throat, hoarseness, dysphagia
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema

Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, melena, hematochezia, jaundice
Genitourinary: denies vaginal discharge, incontinence, dysuria, hematuria, urinary frequency, amenorrhea, menorrhagia, abnormal vaginal bleeding, pelvic pain
Musculoskeletal: See HPI
Skin: denies rash, itching, dryness, suspicious lesions
Neurologic: denies transient paralysis, weakness, paresthesias, seizures, syncope, tremors, vertigo

Physical Exam
General Appearance: moderately overweight AA female in obvious distress due to the pain in the right hand.

Eyes
External: conjunctivae and lids normal

Ear, Nose &Throat
Hearing: grossly intact

Neck
Neck Exam: supple, no masses, trachea midline
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal, can undergo exercise testing and/or participate in exercise program
Digits and nails: no clubbing, cyanosis, petechiae, or nodes
RUE: normal ROM and strength, no joint enlargement or tenderness
LUE: normal ROM and strength, no joint enlargement or tenderness
RLE: normal ROM and strength, no joint enlargement or tenderness
LLE: normal ROM and strength, no joint enlargement or tenderness

Neurologic
Cranial Nerves: II - XII grossly intact
Reflexes: 2+, symmetric, no pathological reflexes

Sensation: intact to touch, pin, vibration, and position

Review of Lab Results

Random Blood Sugar: 177 (03/23/2006 9:52:40 AM)
Serum Cholesterol 202 (03/23/2006 11:03:00 AM)
LDL: 146 (03/23/2006 11:03:00 AM)
HDL: 36 (03/23/2006 11:03:00 AM)
BUN: 21 (03/23/2006 11:03:00 AM)
Creatinine: 0.6 (03/23/2006 11:03:00 AM)

Patient Education

Education was provided to: patient
Patient Response: Expressed understanding

Topics Discussed:
Medical Condition, Workup Risks & Benefits, Treatment Options, Medication Use, Health Promotion, Diet & Nutrition, Diabetes Management, Low Cholesterol Diet, Low Salt Diet, High Fiber Diet, Cardiovascular Exercise, patient will attend groups for management of DM,HTN for better and more effective control .At present patient has a very poor understanding of the role diet and exercise play in the management of these chronic disorders and how they are interrelated..
Informed How: Verbally

Assessment and Plan

Problem 1: S/P TOTAL ABDOMINAL HYSTERECTOMY (CPT-58150)
patient will now take 40 mg of Lipitor a day ,and will attend groups for DM and HTN control.(previously patient was on 20 mg of Lipitor a day for 1 year).Lipid profile will be evaluated at next routine visit.
Problem 2: ARTHROPATHY NOS HAND (ICD-716.94)
patient was prescribed Naprosyn,500 BID for 10 days and Percocet(2.5/325) q 6 hrs for break through pain.she was advised strict hand rest with elevation through the use of a sling.excuse from work as a cook was provided till monday.Patient will report back if the pain dose not improve by the 3 days.

Current Orders
Lipid Panel [CPT-80061]
Potassium [CPT-84132]
BMP [CPT-80048]

Prescriptions:

PERCOCET2.5/325 MG TABS (OXYCODONE-ACETAMINOPHEN) One tablet q6h ,for severe break throgh pain ,as reqd. #20 x 0
Entered and Authorized by: Rukhsana Mirza
Signed by: Rukhsana Mirza on 04/20/2006
Method used: Print then Give to Patient
Handout requested.

JOANN BROCKINGTON Home (803)740-4497 Office (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

NAPROSYN 250 MG TABS (NAPROXEN) 2 tablets BID for 10 days ,with food. #20 x 0
Entered and Authorized by: Rukhsana Mirza
Signed by: Rukhsana Mirza on 04/20/2006
Method used: Print then Give to Patient
Handout requested.

.....Rukhsana Mirza April 20, 2006 2:06 PM.

Signed by Holbrook W Raynal, MD on 04/20/2006 at 3:40 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

08/24/2006 - Office Visit: Multi-Problem Visit - F/U DM and HTN; Script Refills
Provider: Rachel E Hall MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Christian Steen
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 225 lb. **Height:** 64 in.
Temperature: 98.91 deg F. **Temp Site:** oral
Pulse rate: 70

Blood Pressure #1: 138/98
Blood Pressure #2: 146/100
BMI: 38.76 **BSA:** 2.06 **Wt chg:** 1.20 since 04/20/2006

Pain Assessment
The patient is currently experiencing pain.
Location: Right Arm **Intensity (1-10):** 5 **Description:** When Lifting **Duration:** intermittant
Vitals entered by: Sandra D McLean LPN on August 24, 2006 1:31 PM
Urine Dip: Done today.
Finger stick: Done today.
Comments: C/O Arm Pain and SInus complaints. Need Refills

Laboratory Results

Microalbumin (urine): 20 mg/L
Glucose (random): 213 mg/dL

.....Sandra D McLean LPN August 24, 2006 1:36 PM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Diabetes

Blood Sugar checks: Yes

Self Foot Exam: no
Eye Exam within last 12 months: yes
Location of Exam: Referral to Ophthalmologist

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Date of Exam: 1/2006

Exam
Complete Diabetic Foot Exam within last 12 months: Done
Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses
DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact, callus present
Skin (Left Foot): Intact, callus present
Nails: no clubbing, cyanosis, petechiae, or nodes
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) one po daily
ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
GLYBURIDE 5 MG TABS (GLYBURIDE) One tablet BID
NASONEX 50 MCG/ACT SUSP (MOMETASONE FUROATE)
MUCINEX D 60-600 MG TB12 (PSEUDOEPHEDRINE-GUAIFENESIN) 1-2 po q12 h with plenty of fluids
SINGULAIR 10 MG TABS (MONTELUKAST SODIUM) One tablet qhs

History of Present Illness

Diabetes History
Dilated Eye Exam: yes

History of Present Illness

General HPI
says she has been doing well, hasn't needed to come in. Fastings are 90-110, says her randoms are around a 100 too and will get some down into the 50's and 60's, is over 200 today and says took last of her DM meds yesterday, none this AM. Last A1c long ago was 13.3. Pt states she was suppossed to have gone to DM education classes but noone called her. Have discussion with pt about her needing to take responsibility for her care. She needs to come in for regularly scheduled chronic care visits to deal with her chronic illnesses, and to take action by calling herself about the classes.

Past History
Past Medical History: Hx of type 2 diabetes
Hx of hypertension
allergies

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Surgical History: BTL 1979
Chole 1980
Total abd Hysterectomy and BSO for fibroids 1993

Review of Systems
General: denies fever
Eyes: co watery, itching
Ear/Nose/Throat: co congestion for the last several days, not taking zyrtec daily, uses nasonex.
Cardiovascular: denies cp, edma
Respiratory: denies sob
Gastrointestinal: co nausea when sugars are low
Skin: denies rash
Endocrine: pos sx of hypoglycemia when getting low
Allergic/Immunologic: co lots of allergy sx

Physical Exam
General Appearance: obese

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: mild serous effusion L>R
Hearing: grossly intact
Nasal: large boggy blue hued turbinates, thick dc seen from behind
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: pos cobblestoning

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Peripheral Circulation: no cyanosis, clubbing, or edema

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal

Gait and Station: normal gait, no ataxia
Digits and nails: no clubbing, cyanosis, petechiae, or nodes

Neurologic
Cranial Nerves: II - XII grossly intact

Mental Status
Judgement, insight: fair
Mood and affect: no appearance depression, anxiety, or agitation

Assessment and Plan
Problem 1: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
pt has little insight into her disease, review she needs to do nightly foot checks, how and why, ask her to keep a log of her sugars and bring them to her appts to help us adjust her meds. Will do long overdue A1c today and make decision on meds after I get that back, may go to half tab daily of glucotrol. Encouraged she come to classes, schedule given and aksed her to call Diane and set up schedule to come to appts and learn. May benefit from a visit with Sharm or Elizabeth. To f/u in 3mo with PCP
Problem 2: HYPERTENSION (ICD-401.1)
not at goal, was on ACE-HCTZ combo twice a day, changed to ACE alone and can add back in HCTZ in the am in the future if need be, recheck 3mo
Problem 3: ALLERGIC RHINITIS SEASONAL (ICD-477.9)
added singulair and mucinex, encourage fluids, avoid triggers/limit time outside this fall
Problem 4: HYPERCHOLESTEROLEMIA (ICD-272.0)
restart lipitor, advised she much f/u in 3mo for LFTs will recheck lipids then.

Current Orders
HgbA1C [CPT-83036]
BMP [CPT-80048]

Prescriptions:
SINGULAIR 10 MG TABS (MONTELUKAST SODIUM) One tablet qhs #30 x 5
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient
MUCINEX D 60-600 MG TB12 (PSEUDOEPHEDRINE-GUAIFENESIN) 1-2 po q12 h with plenty of fluids #40 x 2
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient
ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily #30 x 12
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) one po daily #60 x 5

Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient

LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime. #30 x 5
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient

PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily #60 x 5
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient

GLYBURIDE 5 MG TABS (GLYBURIDE) One tablet BID #60 x 5
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 08/24/2006
Method used: Print then Give to Patient

Signed by Rachel E Hall MD on 08/24/2006 at 3:25 PM

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

09/26/2006 - Office Visit: Multi-Problem Visit
Provider: Lisa M Pomranky MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Laboratory Results

Date/Time Collected: 0945

Routine Urinalysis
Color: lt. yellow
Appearance: clear
Leukocytes: mod
Nitrite: negative
Urobilinogen: 0.2
Protein: negative
pH: 5.0
Blood: negative
Spec. Gravity: 1.010
Ketone: trace (5)
Bilirubin: negative
Glucose: negative
Date/Time Collected: 0954
Glucose (random): 76 mg/dL
large b/p cuff

Vital Signs

Weight: 224.30 lb. **Height:** 65 in.
Temperature: 98.1 deg F. **Temp Site:** oral
Pulse rate: 76 **Respirations:** 20
BP: 158/100
BMI: 37.46 **BSA:** 2.08 **Wt chg:** -1.89 since 09/15/2006

Pain Assessment
The patient is currently experiencing pain.
Location: R shoulder **Intensity (1-10):** 4 **Duration:** intermittant
The patient does not experience chronic pain.
Vitals entered by: Sharon E Hopkins RN on September 26, 2006 9:54 AM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Available
Dr David Greenhouse

History of Present Illness

General HPI

Pt presents today for sinus headache and facial pressure. She also c/o ear pressure. She denies fevers at this time. Denies pain into her teeth. C/o drainage from her nose that she subsequently coughs up. She has had these symptoms for over 2 weeks now.

As far as her shoulder she has no improvement. She hasn't been to physical therapy yet but has appt scheduled. She states the shot lasted only 2-3 days and she is still very hindered at work although she does have better range of motion.

She didn't see dm educator yet. Her meter is broken and needs a new script so she can't comment on her blood sugars.

Review of Systems

General: denies fevers, chills, sweats, weight loss
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Gastrointestinal: Denies nausea, vomiting
Genitourinary: denies urinary frequency
Musculoskeletal: see hpi
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Physical Exam

General Appearance: well nourished, well hydrated, no acute distress

Eyes

External: conjunctivae and lids normal

Ear, Nose &Throat

External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck

Neck Exam: supple, no masses, trachea midline

Respiratory
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
RUE: lateral abduction/forward flexion to only 160 degrees and painful, painful internal rotation at S1, + hawkins and neers, neg cross chest, weak supraspinatus and external rotators, very painful for her to resist tension, no swelling/ecchymosis, tender to palp of supraspinatus insertion and along external rotator insertion
LUE: normal ROM and strength, no joint enlargement or tenderness

Mental Status
Orientation: oriented to time, place, and person

Other Physical Exam Findings
xray report revealed signs of impingement -unable to pull images - will try later

Review of Lab Results
HgbA1C 9.8 (08/24/2006 2:30:00 PM)
Serum Cholesterol 202 (03/23/2006 11:03:00 AM)
LDL: 146 (03/23/2006 11:03:00 AM)
HDL: 36 (03/23/2006 11:03:00 AM)
BUN: 19 (08/24/2006 2:30:00 PM)
Creatinine: 0.7 (08/24/2006 2:30:00 PM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition.
Informed How: Verbally
Minutes spent on education: 25

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Assessment and Plan

Problem 1: SHOULDER PAIN RIGHT (ICD-719.41)
follow up after physical therapy. change from naprosyn to tylenol due to blood pressure and be very consistent with icing

Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
wrote for glucometer and test strips. she will record and f/u with pcp. her bs today was 78. she is taking the new dose of glyburide. f/u 2 weeks with pcp. lipids not at goal either based on previous labs - likely needs increase in lipitor - will hold off on too many changes today.

Problem 3: SINUSITIS ACUTE NOS (ICD-461.9)
z pack b/c of pcn allergy.

Problem 4: HYPERTENSION (ICD-401.1)
added hctz 25 mg. f/u in 2w with pcp.

Prescriptions:

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 5
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/26/2006
Method used: Print then Give to Patient

ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 x 0
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/26/2006
Method used: Print then Give to Patient

.....Lisa M Pomranky MD September 26, 2006 5:00 PM
reviewed and agree with above resident note DLG

Signed by David L Greenhouse MD on 10/10/2006 at 9:02 AM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

02/14/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Laboratory Results - Normals in ()
Date/Time Collected: 2/14/07
Glucose (random): 81 mg/dL (70-125 mg/dL)

Vital Signs
Entered weight: 231 lb., 7 oz.
Calculated Weight: 231.44 lb.
Temperature: 98.91 deg F. **Temp Site:** oral
Pulse rate: 80 **Pulse rhythm:** regular
BP: 152/90
BMI: 38.65 **BSA:** 2.11 **Wt chg:** 8.44 since 12/04/2006
Vitals entered by: Maureen E Robinson LPN on February 14, 2007 4:16 PM
.....Maureen E Robinson LPN February 14, 2007 4:17 PM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information

No passive smoke exposure

Attending Participation: Present and Available
Dr Patricia Witherspoon

Diabetes

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance fair

Self Foot Exam: yes
Eye Exam within last 12 months: yes

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Location of Exam: Referral to Ophthalmologist
Last eye exam: 1/2006
Results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam
Complete Diabetic Foot Exam within last 12 months: Done
Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses
DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
ZYRTEC 10 MG TABS (CETIRIZINE HCL) One tablet daily
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
GLYBURIDE 5 MG TABS (GLYBURIDE) Two tablet BID
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily

Medication Hx:
ACE: yes
Statin: yes

History of Present Illness
History from: patient
Chief Complaint: f/u HTN,DM

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: good

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Glucose Monitoring
Glucose Home Monitoring reviewed: yes

Diet Management
ADA diet, low fat, low cholesterol
Diet compliance: good
Insulin Management: no
Dilated Eye Exam: yes
Comments: fasting AM sugar-avg 110's
pp in pm 90's?

Hypertension
Basis for diagnosis: previous history of HTN
Denies: headache, visual disturbance, vertigo, syncope/presyncope, fatigue, edema, diaphoresis, dyspnea, chest pain, palpitations

Current Status
Home BP monitoring: no
Non-pharmacologic treatment: dietary modification
Compliance with tx: fair
Comments: Compliant with meds. Denies any side effects of meds. Denies any symptoms associated with elevated BP.

History of Present Illness
Chief Complaint: f/u HTN,DM

Orthopedic / Injury
Current symptoms: pain
Denies: numbness, tingling, radicular symptoms
Current Treatment: rest, acetaminophen
Comments: generalized joint pain worse with activity

Past History
Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: denies fevers, chills, sweats, anorexia, fatigue, malaise
Eyes: denies irritation, discharge
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Respiratory: Denies cough, dyspnea, excessive sputum, wheezing
Gastrointestinal: Denies nausea, vomiting
Musculoskeletal: joint pain
Skin: denies rash, itching, dryness, suspicious lesions

Neurologic: denies weakness, paresthesias

Physical Exam
General Appearance: obese, nad

Eyes
External: conjunctivae and lids normal

Ear, Nose &Throat
Hearing: grossly intact

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+ and symmetric
Peripheral Circulation: trace edema

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: fair
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Review of Lab Results

HgbA1C 9.8 (08/24/2006 2:30:00 PM)
Potassium: 3.9 (08/24/2006 2:30:00 PM)
BUN: 19 (08/24/2006 2:30:00 PM)
Creatinine: 0.7 (08/24/2006 2:30:00 PM)

Patient Education

Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Treatment Options, Medication Use, Diabetes Management, Use of Glucometer, Compliance with Medication, Low Cholesterol Diet, Low Salt Diet.
Informed How: Verbally

Assessment and Plan

Problem 1: HYPERTENSION (ICD-401.1)
BP elevated today. States its white coat HTN and pretty adamant about not increasing meds. Cont same meds for now but if elevated at next visit, will increase meds.
Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Fastings reported in 110's. Check A1c today.
Problem 3: DEGENERATIVE JOINT DISEASE (ICD-715.90)
Start scheduled ibuprofen.

Current Orders
BMP [CPT-80048]
HgbA1C [CPT-83036]

Prescriptions:

IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain #90 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/14/2007
Method used: Print then Give to Patient

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/14/2007
Method used: Print then Give to Patient

DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose #1 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/14/2007
Method used: Print then Give to Patient

SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day #3 mL bottle x 11

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female, DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/14/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD February 25, 2007 4:55 PM

Signed by Patricia W Witherspoon MD on 02/27/2007 at 6:06 PM

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

03/22/2007 - Office Visit: Group Visit One
Provider: Sandra C Payne CFNP
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 232.50 lb. **Height:** 65 in.
Pulse rate: 80

Blood Pressure #1: 148/86
Blood Pressure #2: 146/94
Wt chg: 1.06 since 02/14/2007

Pain Assessment
The patient is not currently experiencing pain.
Vitals entered by: Sandra D McLean LPN on March 22, 2007 8:17 AM
.....Sandra D McLean LPN March 22, 2007 8:17 AM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Diabetes

HPI 55 year old female in for diabetes group visitl. She is on glucopahge and glyburide. her aic 2/14 was 9.1 and her 1 hr pp blood sugar today ia 168. Says that she is trying to do better with her blood sugar readings. Having trouble with her allergies and feels like zyrtec is no longer working

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Exercise: yes

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 02/14/2007
Last eye exam: 1/2006
Last exam results: Normal

Exam

Complete Diabetic Foot Exam within last 12 months: Done

Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses
DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
GLYBURIDE 5 MG TABS (GLYBURIDE) Two tablet BID
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
ALLEGRA 180 MG TABS (FEXOFENADINE HCL) Take one tablet po daily for seasonal allergies

Medication Hx:
ACE: yes
Statin: yes
ASA: yes

History of Present Illness

Diabetes History
Dilated Eye Exam: yes

History of Present Illness

General HPI
Pt comes in today for their comprehensive diabetes group visit. The patient has no issues to report that made their management difficult. Since the last visit the patient has checked their glucose 2 a day/wk.
Physical activity 3times per__.
Food Groups: Pt has eaten 2 fruits/veg servings a day.
pt has limited fat intake to 5 times per day/week
Pt has not noticed no changes in their foot exam.
We have reviewed the chart for labs, medication and maintenance items.

Review of Systems
General: no fever or fatigue
Eyes: no visual change
Cardiovascular: no chest pain
Respiratory: no cough or wheezing
Gastrointestinal: no abdominal pain
Neurologic: no neuropathy
Psychiatric: no depression
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Physical Exam
General Appearance: obese, nad

Eyes
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
Hearing: grossly intact

Neck
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Carotid arteries: pulses 2+, symmetric, no bruits
Abdominal aorta: no enlargement or bruits
Femoral arteries: pulses 2+, symmetric, no bruits
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal
Liver and Spleen: no enlargement or nodularity

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal

Mental Status
Mood and affect: no appearance depression, anxiety, or agitation

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Other Physical Exam Findings

Assessment and Plan

Problem 1: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
This is diabetes group visit # __1__. The patient's focus physical exam is within normal limits.
There were no changes made to exisiting regimine. Maintenance is up to date with the exception of flp, and lfts._.
30 mins of the 90 min visit was spent face to face counseling on ABC's of diabetes, discussed AIC, ACE, blood sugars, foot exam, blood sugar monitoring. eye exam, aspirin.
Self management goals we established and listed .
Next visit will be in ONE MONTH

Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
uncontrolled
Problem 3: HYPERCHOLESTEROLEMIA (ICD-272.0)
flp, lfts. up to date on aic, foot exam today
Problem 4: HYPERTENSION (ICD-401.1)
uncontrolled. She is on procardia xl 120, Benazapril 40 bid, hctz.
schedule for echo. visit with Sharm to review meds, carbs and recommendations
Dr. Venn's patient .
DC the zyrtec and begin allegra.

Current Orders
Echocardiogram [CPT-93325]
Hepatic Function [CPT-80076]
Lipid Panel [CPT-80061]
Refer to Diabetes Education [*]
.....Sandra C Payne CFNP March 22, 2007 11:49 AM

Prescriptions:

ALLEGRA 180 MG TABS (FEXOFENADINE HCL) Take one tablet po daily for seasonal allergies #30 x 4
Entered by: Jeffrey M McDaniel, MD
Authorized by: Patricia W Witherspoon MD
Signed by: Jeffrey M McDaniel, MD on 03/22/2007
Method used: Print then Give to Patient

Signed by Patricia W Witherspoon MD on 03/22/2007 at 2:14 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

05/17/2007 - Office Visit: Group Visit 3
Provider: Patricia W Witherspoon MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 228 lb. **Height:** 65 in.
Temperature: 98.4 deg F. **Pulse rate:** 89

Blood Pressure #1: 136/88
Blood Pressure #2: 160/90
BMI: 38.08 **BSA:** 2.09 **Wt chg:** -4.50 since 03/22/2007

Pain Assessment
The patient is currently experiencing pain.
Location: Head **Intensity (1-10):** 3 **Description:** Ache **Duration:** intermittant
Vitals entered by: Sandra D McLean LPN on May 17, 2007 8:21 AM
Comments: Woke up this morning with right eye reddened. C/O Ear Ache and Sinus drainage "can taste infection"
FSBS via lab per Dr. Witherspoon's Orders.

Fat Intake: Medium
Fruit <2 servings daily

Laboratory Results - Normals in ()

Microalbumin (urine): 0 mg/L (15-20 mg/L)
HGBA1C 7.5 % (5.0% - 12.8%)
.....Sandra D McLean LPN May 17, 2007 8:22 AM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors

Smoking Information
Non-Smoker
HIV and Drug Use Information
Drug Use: none
Health Factor Information
Exercise (times/week): 3 to 4 times a week

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

Type of exercise: Walk
Seatbelt use: 100 %
Sun exposure: occasionally

Diabetes

HPI In for Diabetes Group Visit #3. Doing ok with her blood sugars and diet. Most of her blood are around 110, 120. Occasionally one over 200. Having low blood sugars around 2 in the afternoon: 50,60. Is on glucophage 1000 bid and glucotrol 5 one bid.

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms nervous, sweaty
Blood Sugar checks: Yes
Diet Compliance good
Exercise: yes
Patient exercises 3 to 4 times a week times per week spending approximately 30 minutes per day exercising.

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 04/04/2007
Last eye exam: 02/14/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no

Exam

Complete Diabetic Foot Exam within last 12 months: Done

Pulses

DP (R): normal
DP (L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins: SELF-PAY (0600)

ALLEGRA 180 MG TABS (FEXOFENADINE HCL) Take one tablet po daily for seasonal allergies

History of Present Illness

Diabetes History
Dilated Eye Exam: yes

History of Present Illness

General HPI
Pt comes in today for their comprehensive diabetes group visit. The patient has no issues to report that made their management difficult. Since the last visit the patient has checked their glucose 10 a day/wk.
Physical activity __ times per__.
Food Groups: Pt has eaten __ fruits/veg servings a __.
pt has limited fat intake to__ times per day/week
Pt has not noticed any changes in their foot exam.
We have reviewed the chart for labs, medication and maintenance items.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA

Review of Systems
General: no fever or fatigue
Eyes: no visual changes
Ear/Nose/Throat: recent uri
Cardiovascular: no chest pain
Respiratory: some coughing from uri
Gastrointestinal: no abdominal pain
Neurologic: no neuropathy
Psychiatric: no depression
Endocrine: some low blood sugar reactions

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

Ear, Nose &Throat
Hearing: grossly intact

Neck
Neck Exam: supple, no masses, trachea midline

Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Carotid arteries: pulses 2+, symmetric, no bruits
Abdominal aorta: no enlargement or bruits
Femoral arteries: pulses 2+, symmetric, no bruits
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal
Liver and Spleen: no enlargement or nodularity

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal

Mental Status
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings

Assessment and Plan
Problem 1: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
This is diabetes group visit # __3__. The patient's focus physical exam is within normal limits.
. Maintenance is up to date with the exception of micral.
30 mins of the 90 min visit was spent face to face counseling on medications, action and side effects. .
We reviewed nutritional choices and physical activity.
Self management goals we established and listed .
Next visit will be in June

Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Problem 3: HYPERCHOLESTEROLEMIA (ICD-272.0)
labs ordered
stop the glucotrol, monitor blood sugars and fu with Dr.Vann-- having some low blood sugars: 45, 50
Up to date on eye and foot exam. micral today
Blood pressure up today. has been stressful week and weekend. Has not exercised this week.
has appt with Dr. Venn in 2 weeks for fu of hypertension and low blood sugars. told her to hold the glucotrol. labs ordered.

Current Orders
CMP [CPT-80053]
Lipid Panel [CPT-80061]
Hgb A1C (Glyco-Hgb) [CPT-83036]
.....Sandra C Payne CFNP May 17, 2007 11:07 AM

Prescriptions:

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime. #30 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID #60 x 3
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily #60 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

Self Management

Eating
Diet Plan: Portion Control
Importance: High
Confidence: High
Comments: Eat more fruits and vegetables while paying attention to portion control.

Current Weight (in lbs): 228

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home (803)740-4497 Office (803)939-0026
Female DOB 07/04/1951 R009122086 Ins. SELF PAY (0600)

Follow-up Call Date: 05/31/2007

Signed by Patricia W Witherspoon MD on 05/29/2007 at 3:05 PM

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

05/29/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Latex Screening Tool
1. Do you have or think you have an allergy to natural rubber latex? (Examples: balloons,condoms,pacifiers) No
2. Do you have spina bifida* or bowel/bladder problems that have required you to have any surgeries or procedures? No
3. If your work requires you to wear rubber gloves or to handle rubber products, have you had any problems? No
4. Did you have more than 3 operations or medical procedures before you were 1 year old? No
5. Have you ever had an allergic reaction during a medical or dental procedure? No
6. Do you have an allergic reaction to any of the following foods: Avocado, banana, potato, peach, kiwi, chestnut, or tomato? No

Vital Signs
Entered weight: 226 lb., 4 oz.
Calculated Weight: 226.25 lb.
Pulse rate: 84 **Respirations:** 20
BP: 122/70
BMI: 37.79 **BSA:** 2.09 **Wt chg:** -1.75 since 05/17/2007

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 2 **Description:** nagging **Duration:** intermittant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on May 29, 2007 4:27 PM
.....Avis N Jackson, LPN May 29, 2007 4:28 PM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R009122086 Ins. SELF-PAY (0600)

Previous HIV and Drug Use Information
Drug Use: none (data entered on 05/17/2007)

Attending Participation: Present and Available
Dr Damon Daniels

Diabetes

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance good

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 04/04/2007
Last eye exam: 04/04/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam

Complete Diabetic Foot Exam within last 12 months: Done
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed

Medication Hx:

ACE: yes
Statin: yes

History of Present Illness

History from: patient

Ambulatory Services
1801 Sunset Drive Columbia, SC 29203
803-434-2173 Fax: 803

March 3, 2008

Chart Document

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Chief Complaint: sinus problems

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: good
Glucose Monitoring
Glucose Home Monitoring reviewed: no
Diet Management
ADA diet, low fat, low cholesterol
Diet compliance: good
Insulin Management: no
Dilated Eye Exam: yes

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache, cough
Denies: visual disturbance, epistaxis, vertigo, syncope/presyncope, fatigue, edema, dyspnea, chest pain, palpitations
Current Status
Compliance with tx: good
Medication Tolerance: no complaints
Comments: Compliant with meds. Denies any side effects of meds. Denies any symptoms associated with elevated BP.

History of Present Illness
History from: patient
Chief Complaint: sinus problems

URI Symptoms
Cough: productive, worse in the morning for the past 2 weeks
Sore throat: with swollen glands, with dysphagia for the past 2 weeks
Nasal congestion: yellow, white, thick, facial pressure for the past 2 weeks
Ear pain: right side, pressure/fullness, with drainage, with ringing/roaring, with popping for the past 2 weeks
Eye discharge: right eye, matting, tearing, swelling, painful for the past 2 weeks
Trends/Treatment
# of URI in the past year: 3
Comments: has tried Mucinex, Zyrtec, Aleve

white, yellow thick nasal discharge

nausea/vomiting

subjective low grade fever

lots of pressure around right eye

JOANN BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: SELF-PAY (0600)

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: subjective low-grade fever; no chills, sweats
Eyes: denies blurring, irritation
Ear/Nose/Throat: c/o nasal congestion, sore throat, sinus pressure
Cardiovascular: denies CP, palps, DOE, edema
Respiratory: productive cough
Gastrointestinal: c/o nausea, vomiting; denies diarrhea
Skin: denies rash, itching, dryness, suspicious lesions
Psychiatric: denies depression, anxiety
Allergic/Immunologic: See HPI

Physical Exam

General Appearance: well nourished, well hydrated, no acute distress

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat

External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: dull appearance to right tm
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: mild pharyngeal erythema

Neck

Neck Exam: supple, no masses, trachea midline
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal

Lymphatic
Neck: mildly tender submandibular LAD

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
ttp right maxillary and right frontal sinuses

Review of Lab Results
HgbA1C 8.0 (05/17/2007 11:00:00 AM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use, Diabetes Management, Use of Glucometer, Compliance with Medication.

Assessment and Plan
Problem 1: SINUSITIS ACUTE NOS (ICD-461.9)
History and physical c/w acute sinusitis. Z-pack due to PCN allergy. Cont OTC Mucinex.
Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
A1c down to 8.0 from 9.1. Gluc 85 today. Cont current regimen. Recheck A1c in 3 months.
Problem 3: HYPERTENSION (ICD-401.1)
Pt's blood pressure is stable and under good control with current medications. Will continue to monitor.

Prescriptions:

ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily #30 x 3
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient

ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD May 31, 2007 3:20 PM

Signed by Damon Daniels MD on 06/07/2007 at 1:46 PM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

General Medical Physical Exam:

General Appearance:
Well developed, well nourished, in no acute distress

Head:

Inspection:	normocephalic without obvious abnormalities

Eyes:

External:	conjunctiva and lids normal
Pupils:	equal, round, and reactive to light and accommodation
Fundus:	a-v nicking

Ears, Nose, Throat:

External:	no significant lesions or deformities noted
Otoscopic:	canals clear; tympanic membranes intact with normal light reflex
Hearing:	grossly intact
Nasal:	edematous mucosa
Dental:	good dentition
Pharynx:	post-nasal drip

Neck:

Neck:	supple; no masses; trachea midline
Thyroid:	no nodules, masses, tenderness, or enlargement

Respiratory:

Resp. effort:	no intercostal retractions or use of accessory muscles
Auscultation:	no rales, rhonchi, or wheezes

Cardiovascular:

Auscultation:	normal S1 and S2; no murmur, rub, or gallop
Carotid artery:	pulses 2+ and symmetric; no bruits
Pedal pulses:	pulses 2+ and symmetric
Peripheral circ:	no cyanosis, clubbing, or edema

Gastrointestinal:

Abdomen:	soft and non-tender with normal bowel sounds; no masses
Liver/spleen:	normal to percussion; no enlargement or nodularity

Musculoskeletal:

Gait/station:	normal gait; no ataxia
Digits/nails:	no cyanosis, clubbing, or petechiae
Head/neck:	normal alignment and mobility
Trunk:	normal alignment and mobility; no deformity
RUE:	normal range of motion and strength
RLE:	normal range of motion and strength
LUE:	normal range of motion and strength
LLE:	normal range of motion and strength

Lymphatic:
Neck: no cervical adenopathy

Skin:
Inspection: no rashes, suspicious lesions, or ulcerations

Diabetes Management Exam:
Foot Exam:
Sensory-Pinprick/Light touch:
Left medial foot (L-4): normal
Left dorsal foot (L-5): normal
Left lateral foot (S-1): normal
Right medial foot (L-4): normal
Right dorsal foot (L-5): normal
Right lateral foot (S-1): normal
Sensory-Monofilament:
Left foot: normal
Right foot: normal
Inspection:
Left foot: normal
Right foot: normal

Assessment & Plan:

Problem: HYPERTENSION (ICD-401.1)
Assessment: Poor control on current med regimen which is maxed out on multiple agents. Pt. will likely need for additional agent to help control. Pt. with some improvement in BP while resting in clinic and after give 0.1 of clonidine. Will consider adding beta blocker or arb to regimen
Her updated medication list for this problem includes:
Procardia Xl 60 Mg Tb24 (Nifedipine) ..... Take 2 tabs daily
Benazepril-hydrochlorothiazide 20-25 Mg Tabs (Benazepril-hydrochlorothiazide) ..... One tab bid

Problem: DIABETES MELLITUS, NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Assessment: FSBS elevated today due to poor lunch diet. Pt. to be better about dietary compliance. Continue current regimen and recheck A1c on future visit. Urine dip in clinic with >1000 glu but no protein and micral neg.
Her updated medication list for this problem includes:
Glucophage 1000 Mg Tabs (Metformin hcl) ..... One tablet bid
Glyburide 5 Mg Tabs (Glyburide) ..... One tablet bid

Problem: HYPERCHOLESTEROLEMIA (ICD-272.0)
Assessment: tolerating med well. Recheck lipids on next visit.
Her updated medication list for this problem includes:
Lipitor 20 Mg Tabs (Atorvastatin calcium) ..... Take 1 tablet daily at bedtime.

Problem: VIRAL URI (ICD-465.9)
Assessment: Pt. with likely viral URI. Pt. to use OTC cough suppressant and decongestant. To return if

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

History of Present Illness

General HPI

Pt presents today for sinus headache and facial pressure. She also c/o ear pressure. She denies fevers at this time. Denies pain into her teeth. C/o drainage from her nose that she subsequently coughs up. She has had these symptoms for over 2 weeks now.

As far as her shoulder she has no improvement. She hasn't been to physical therapy yet but has appt scheduled. She states the shot lasted only 2-3 days and she is still very hindered at work although she does have better range of motion.

She didn't see dm educator yet. Her meter is broken and needs a new script so she can't comment on her blood sugars.

Review of Systems

General: denies fevers, chills, sweats, weight loss
Cardiovascular: Denies chest pain, palpitations, syncope, dyspnea on exertion, orthopnea, PND, peripheral edema
Gastrointestinal: Denies nausea, vomiting
Genitourinary: denies urinary frequency
Musculoskeletal: see hpi
Endocrine: denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change

Physical Exam

General Appearance: well nourished, well hydrated, no acute distress

Eyes

External: conjunctivae and lids normal

Ear, Nose &Throat

External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck

Neck Exam: supple, no masses, trachea midline

Respiratory

Auscultation: no rales, rhonchi, or wheezes

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Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
RUE: lateral abduction/forward flexion to only 160 degrees and painful, painful internal rotation at S1, + hawkins and neers, neg cross chest, weak supraspinatus and external rotators, very painful for her to resist tension, no swelling/ecchymosis, tender to palp of supraspinatus insertion and along external rotator insertion
LUE: normal ROM and strength, no joint enlargement or tenderness

Mental Status
Orientation: oriented to time, place, and person

Other Physical Exam Findings
xray report revealed signs of impingement -unable to pull images - will try later

Review of Lab Results
HgbA1C 9.8 (08/24/2006 2:30:00 PM)
Serum Cholesterol 202 (03/23/2006 11:03:00 AM)
LDL: 146 (03/23/2006 11:03:00 AM)
HDL: 36 (03/23/2006 11:03:00 AM)
BUN: 19 (08/24/2006 2:30:00 PM)
Creatinine: 0.7 (08/24/2006 2:30:00 PM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition.
Informed How: Verbally
Minutes spent on education: 25

Assessment and Plan
Problem 1: SHOULDER PAIN RIGHT (ICD-719.41)
follow up after physical therapy. change from naprosyn to tylenol due to blood pressure and be very consistent with icing

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
wrote for glucometer and test strips. she will record and f/u with pcp. her bs today was 78. she is taking the new dose of glyburide. f/u 2 weeks with pcp. lipids not at goal either based on previous labs - likely needs increase in lipitor - will hold off on too many changes today.
Problem 3: SINUSITIS ACUTE NOS (ICD-461.9)
z pack b/c of pcn allergy.
Problem 4: HYPERTENSION (ICD-401.1)
added hctz 25 mg. f/u in 2w with pcp.

Prescriptions:

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 5
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/26/2006
Method used: Print then Give to Patient
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 x 0
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/26/2006
Method used: Print then Give to Patient

.....Lisa M Pomranky MD September 26, 2006 5:00 PM
reviewed and agree with above resident note DLG

Signed by David L Greenhouse MD on 10/10/2006 at 9:02 AM

09/15/2006 - Office Visit: Multi-Problem Visit/rt shoulder pain
Provider: Lisa M Pomranky MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Entered weight: 226 lb., 3 oz.
Calculated Weight: 226.19 lb. (102.81 kg.)
Temperature: 98.8 deg F. (37.11 deg C.) **Temp Site:** oral
Pulse rate: 84 **Pulse rhythm:** regular **Respirations:** 20
BP: 160/94

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BMI: 37.78 **BSA:** 2.09 **Wt chg:** 2.19 since 08/29/2006

Pain Assessment
The patient is currently experiencing pain.
Location: right shoulder **Intensity (1-10):** 5 **Description:** sharp **Duration:** intermittant
Vitals entered by: Betty S Grant RN on September 15, 2006 9:04 AM

Laboratory Results
Date/Time Collected: 9/15/2006
Glucose (2 hour PP): 328 mg/dL
.....Betty S Grant RN September 15, 2006 9:05 AM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Available
Dr Rachel Brown

History of Present Illness

General HPI
Pt presents for f/u of her shoulder. She has only been icing before she goes to bed at night. She is taking the naprosyn bid and it helps a little. She states she is still working as a cook and lifting things in and out of ovens.

Also c/o nasal congestion and some rhinorrhea for 2-3 days. + h/o allergies.

BS was 328 today in the office. She has been taking her oral meds. She states it has been running in the 200's at home.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
allergies

Social History (reviewed - no changes required): non-smoker

Review of Systems
General: denies fevers, chills, sweats, weight loss
Eyes: denies irritation, discharge
Ear/Nose/Throat: see hpi
Cardiovascular: Denies chest pain, palpitations, dyspnea on exertion, orthopnea, PND, peripheral edema
Respiratory: Denies cough, dyspnea, excessive sputum, hemoptysis, wheezing

Musculoskeletal: see hpi
Neurologic: denies weakness, paresthesias

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

Eyes
External: conjunctivae and lids normal

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
RUE: lateral abduction/forward flexion to only 90 degrees and painful, painful external rotation, painful internal rotation at S1, + hawkins and neers, neg cross chest, weak supraspinatus and external rotators, very painful for her to resist tension, no swelling/ecchymosis, tender to palp of supraspinatus insertion and along external rotator insertion

Other Physical Exam Findings
Procedure:
cleansed with povidone x 3
injected posteriorly just below acromion
2cc lidocaine
2cc bupivicaine
1cc depo medrol
cleansed and bandage applied

improvement in her pain with rom

Review of Lab Results
HgbA1C 9.8 (08/24/2006 2:30:00 PM)
Serum Cholesterol 202 (03/23/2006 11:03:00 AM)
LDL: 146 (03/23/2006 11:03:00 AM)
HDL: 36 (03/23/2006 11:03:00 AM)
BUN: 19 (08/24/2006 2:30:00 PM)
Creatinine: 0.7 (08/24/2006 2:30:00 PM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition.
Informed How: Verbally

Assessment and Plan
Problem 1: SHOULDER PAIN RIGHT (ICD-719.41)
s/p injection. sent for PT. d/c naprosyn as bp is rising. please ice at least 20 min tid. f/u after PT
Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
increased glyburide to 10 bid. advised adding lantus at night would likely be to her benefit, but she refuses at this time - advised f/u with her pcp for her further dm management in 2 weeks. referred to the dm educator.
Problem 3: HYPERTENSION (ICD-401.1)
uncontrolled - d/c naprosyn and decongestants. f/u pcp
Problem 4: VIRAL URI (ICD-465.9)
may try coriciden and facial steams. if symptoms persist for more than 2 weeks or if she has fever/teeth pain to return. continue with flonase and zyrtec.

Prescriptions:
GLYBURIDE 5 MG TABS (GLYBURIDE) Two tablet BID #120 x 3
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/15/2006
Method used: Print then Give to Patient
GLYBURIDE 5 MG TABS (GLYBURIDE) Two tablet BID #120 x 3
Entered and Authorized by: Lisa M Pomranky MD
Signed by: Lisa M Pomranky MD on 09/15/2006
Method used: Print then Give to Patient

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November 10, 2010

Chart Document

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Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Vitals entered by: Avis N Jackson, LPN on August 14, 2007 11:28 AM
patient presents with complaints of head pain from a fall @ work on last Wednesday, rates pain level @ 5 on scale of 0-10. Patient states she is experiencing blurry vision unable to open mouth wide without hurting. Patient state she had a knot in base of head the is smaller now. Patient went to Lexington ER

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Available
Dr Jason Stacy

History of Present Illness
Chief Complaint: f/u fall

History of Present Illness
History from: patient
Chief Complaint: f/u fall

General HPI
Presents to clinic today after suffering fall 7 days ago. Pt was at work and slipped on concrete floor. Hit head and blacked out afterwards. Went to LMC ED where she had plain films of neck and right hip performed which ruled out fracture. No CT performed per pt. Since then has experienced blurred vision, constant headache primarily in left temporal and occipital regions. 5/10 on pain scale today. Has been taking 800mg Motrin with mild relief of pain and minimal relief of pain with Flexeril as well. Unable to work since this has happened.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: denies weight or appetite change
Eyes: c/o blurred vision
Cardiovascular: denies CP, palps, DOE, edema
Musculoskeletal: denies shoulder pain
Neurologic: c/o headache-see hpi; denies dizziness lately

Physical Exam
General Appearance: moderate discomfort due to headache

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Palpation: no thrill or palpable murmurs, no displacement of PMI
Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Musculoskeletal
Gait and Station: normal
Head and neck: mild decreased ROM due to pain, bilateral paracervical muscle spasms
RUE: normal ROM and strength, no joint enlargement or tenderness
LUE: normal ROM and strength, no joint enlargement or tenderness

Neurologic
Cranial Nerves: II - XII grossly intact
Reflexes: 2+, symmetric, no pathological reflexes in UE
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Snellen: 20/70 right and 20/50 left

Patient Education
Education was provided to: patient

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use.
Informed How: Verbally

Assessment and Plan

Problem 1: HEAD TRAUMA (ICD-959.01)
Mechanical fall resulting in trauma to head. Pt reports no CT performed at LMC. Since pt experiencing headaches and blurred vision, will refer for CT head and neck to r/o any pathology. Cont Motrin for pain control. Will keep pt out of work for one week.

Current Orders
CT Head w/o Contrast [CPT-70450]

Prescriptions:

IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain #90 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/14/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 14, 2007 1:22 PM

Signed by Jason J Stacy MD on 08/28/2007 at 10:45 AM

05/29/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Latex Screening Tool

1. Do you have or think you have an allergy to natural rubber latex?
(Examples: balloons,condoms,pacifiers) No
2. Do you have spina bifida* or bowel/bladder problems that have required you to have any

surgeries or procedures? No
3. If your work requires you to wear rubber gloves or to handle rubber products, have you had any problems? No
4. Did you have more than 3 operations or medical procedures before you were 1 year old? No
5. Have you ever had an allergic reaction during a medical or dental procedure? No
6. Do you have an allergic reaction to any of the following foods: Avocado, banana, potato, peach, kiwi, chestnut, or tomato? No

Vital Signs
Entered weight: 226 lb., 4 oz.
Calculated Weight: 226.25 lb.
Pulse rate: 84 **Respirations:** 20
BP: 122/70
BMI: 37.79 **BSA:** 2.09 **Wt chg:** -1.75 since 05/17/2007

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 2 **Description:** nagging **Duration:** intermittant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on May 29, 2007 4:27 PM
.....Avis N Jackson, LPN May 29, 2007 4:28 PM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure
Previous HIV and Drug Use Information
Drug Use: none (data entered on 05/17/2007)

Attending Participation: Present and Available
Dr Damon Daniels

Diabetes

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance good

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 04/04/2007
Last eye exam: 04/04/2007

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Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam
Complete Diabetic Foot Exam within last 12 months: Done
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed

Medication Hx:
ACE: yes
Statin: yes

History of Present Illness
History from: patient
Chief Complaint: sinus problems

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: good
Glucose Monitoring
Glucose Home Monitoring reviewed: no
Diet Management
ADA diet, low fat, low cholesterol
Diet compliance: good
Insulin Management: no
Dilated Eye Exam: yes

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache, cough

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Denies: visual disturbance, epistaxis, vertigo, syncope/presyncope, fatigue, edema, dyspnea, chest pain, palpitations

Current Status
Compliance with tx: good
Medication Tolerance: no complaints
Comments: Compliant with meds. Denies any side effects of meds. Denies any symptoms associated with elevated BP.

History of Present Illness
History from: patient
Chief Complaint: sinus problems

URI Symptoms
Cough: productive, worse in the morning for the past 2 weeks
Sore throat: with swollen glands, with dysphagia for the past 2 weeks
Nasal congestion: yellow, white, thick, facial pressure for the past 2 weeks
Ear pain: right side, pressure/fullness, with drainage, with ringing/roaring, with popping for the past 2 weeks
Eye discharge: right eye, matting, tearing, swelling, painful for the past 2 weeks

Trends/Treatment
# of URI in the past year: 3
Comments: has tried Mucinex, Zyrtec, Aleve

white, yellow thick nasal discharge

nausea/vomiting

subjective low grade fever

lots of pressure around right eye

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: subjective low-grade fever; no chills, sweats
Eyes: denies blurring, irritation
Ear/Nose/Throat: c/o nasal congestion, sore throat, sinus pressure
Cardiovascular: denies CP, palps, DOE, edema
Respiratory: productive cough
Gastrointestinal: c/o nausea, vomiting; denies diarrhea

Skin: denies rash, itching, dryness, suspicious lesions
Psychiatric: denies depression, anxiety
Allergic/Immunologic: See HPI

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: dull appearance to right tm
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: mild pharyngeal erythema

Neck
Neck Exam: supple, no masses, trachea midline
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal

Lymphatic
Neck: mildly tender submandibular LAD

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

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Mental Status
Judgement, insight: intact
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
ttp right maxillary and right frontal sinuses

Review of Lab Results
HgbA1C 8.0 (05/17/2007 11:00:00 AM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use, Diabetes Management, Use of Glucometer, Compliance with Medication.

Assessment and Plan
Problem 1: SINUSITIS ACUTE NOS (ICD-461.9)
History and physical c/w acute sinusitis. Z-pack due to PCN allergy. Cont OTC Mucinex.
Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
A1c down to 8.0 from 9.1. Gluc 85 today. Cont current regimen. Recheck A1c in 3 months.
Problem 3: HYPERTENSION (ICD-401.1)
Pt's blood pressure is stable and under good control with current medications. Will continue to monitor.

Prescriptions:
ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily #30 x 3
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD May 31, 2007 3:20 PM

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Signed by Damon Daniels MD on 06/07/2007 at 1:46 PM

05/17/2007 - Office Visit: Group Visit 3
Provider: Patricia W Witherspoon MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 228 lb. **Height:** 65 in.
Temperature: 98.4 deg F. **Pulse rate:** 89

Blood Pressure #1: 136/88
Blood Pressure #2: 160/90
BMI: 38.08 **BSA:** 2.09 **Wt chg:** -4.50 since 03/22/2007

Pain Assessment
The patient is currently experiencing pain.
Location: Head **Intensity (1-10):** 3 **Description:** Ache **Duration:** intermittant
Vitals entered by: Sandra D McLean LPN on May 17, 2007 8:21 AM
Comments: Woke up this morning with right eye reddened. C/O Ear Ache and Sinus drainage "can taste infection"
FSBS via lab per Dr. Witherspoon's Orders.

Fat Intake: Medium
Fruit <2 servings daily

Laboratory Results - Normals in ()

Microalbumin (urine): 0 mg/L (15-20 mg/L)
HGBA1C 7.5 % (5.0% - 12.8%)
.....Sandra D McLean LPN May 17, 2007 8:22 AM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors

Smoking Information

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Non-Smoker

HIV and Drug Use Information
Drug Use: none

Health Factor Information
Exercise (times/week): 3 to 4 times a week
Type of exercise: Walk
Seatbelt use: 100 %
Sun exposure: occasionally

Diabetes

HPI In for Diabetes Group Visit #3. Doing ok with her blood sugars and diet. Most of her blood are around 110, 120. Occasionally one over 200. Having low blood sugars around 2 in the afternoon: 50,60. Is on glucophage 1000 bid and glucotrol 5 one bid.

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms nervous, sweaty
Blood Sugar checks: Yes
Diet Compliance good
Exercise: yes
Patient exercises 3 to 4 times a week times per week spending approximately 30 minutes per day exercising.

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 04/04/2007
Last eye exam: 02/14/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no

Exam

Complete Diabetic Foot Exam within last 12 months: Done

Pulses

DP (R): normal
DP (L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal

Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily

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SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
ALLEGRA 180 MG TABS (FEXOFENADINE HCL) Take one tablet po daily for seasonal allergies

History of Present Illness

Diabetes History
Dilated Eye Exam: yes

History of Present Illness

General HPI
Pt comes in today for their comprehensive diabetes group visit. The patient has no issues to report that made their management difficult. Since the last visit the patient has checked their glucose 10 a day/wk.
Physical activity __ times per__.
Food Groups: Pt has eaten _ _ fruits/veg servings a __.
pt has limited fat intake to__ times per day/week
Pt has not noticed any changes in their foot exam.
We have reviewed the chart for labs, medication and maintenance items.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA

Review of Systems
General: no fever or fatigue
Eyes: no visual changes
Ear/Nose/Throat: recent uri
Cardiovascular: no chest pain
Respiratory: some coughing from uri
Gastrointestinal: no abdominal pain
Neurologic: no neuropathy
Psychiatric: no depression
Endocrine: some low blood sugar reactions

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

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Ear, Nose &Throat
Hearing: grossly intact

Neck
Neck Exam: supple, no masses, trachea midline
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Carotid arteries: pulses 2+, symmetric, no bruits
Abdominal aorta: no enlargement or bruits
Femoral arteries: pulses 2+, symmetric, no bruits
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal
Liver and Spleen: no enlargement or nodularity

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal

Mental Status
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings

Assessment and Plan
Problem 1: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
This is diabetes group visit # __3__. The patient's focus physical exam is within normal limits.
. Maintenance is up to date with the exception of micral.
30 mins of the 90 min visit was spent face to face counseling on medications, action and side effects. .
We reviewed nutritional choices and physical activity.
Self management goals we established and listed .
Next visit will be in June

Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
Problem 3: HYPERCHOLESTEROLEMIA (ICD-272.0)
labs ordered
stop the glucotrol, monitor blood sugars and fu with Dr.Vann-- having some low blood sugars: 45, 50

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Up to date on eye and foot exam. micral today
Blood pressure up today. has been stressful week and weekend. Has not exercised this week. has appt with Dr. Venn in 2 weeks for fu of hypertension and low blood sugars. told her to hold the glucotrol. labs ordered.

Current Orders
CMP [CPT-80053]
Lipid Panel [CPT-80061]
Hgb A1C (Glyco-Hgb) [CPT-83036]
.....Sandra C Payne CFNP May 17, 2007 11:07 AM

Prescriptions:

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime. #30 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID #60 x 3
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily #60 x 5
Entered by: Sandra D McLean LPN
Authorized by: Patricia W Witherspoon MD
Signed by: Sandra C Payne CFNP on 05/17/2007
Method used: Print then Give to Patient

Self Management

Eating
Diet Plan: Portion Control
Importance: High
Confidence: High
Comments: Eat more fruits and vegetables while paying attention to portion control.

Current Weight (in lbs): 228

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History of Present Illness
Chief Complaint: f/u CT results

History of Present Illness
History from: patient
Chief Complaint: f/u CT results

General HPI
Presents to clinic today for f/u on CT head/neck results for her recent head trauma. Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative.

Pt states headache now worse, now located along both parietal regions. Constant baseline HA with intermittent flares of sharp pain. Worst headache of her life. States vision worse as well. Also c/o dizziness at times and imbalance when walking or standing up.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: subjective low-grade fever; no chills, sweats
Eyes: c/o blurred vision
Cardiovascular: denies CP, palps, DOE, edema
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures

Physical Exam
General Appearance: moderate discomfort due to pain

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation
Ophthalmoscopic: some a/v nicking present, no hemorrhages, or exudates noted

Ear, Nose &Throat
Hearing: grossly intact

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Palpation: no thrill or palpable murmurs, no displacement of PMI
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: no cervical adenopathy

Musculoskeletal
Gait and Station: normal
Digits and nails: no clubbing, cyanosis, petechiae, or nodes
Head and neck: mild decreased ROM due to pain
Spine, ribs, pelvis: normal alignment and mobility, no deformity
RUE: normal ROM and strength, no joint enlargement or tenderness
LUE: normal ROM and strength, no joint enlargement or tenderness
RLE: normal ROM and strength, no joint enlargement or tenderness
LLE: normal ROM and strength, no joint enlargement or tenderness

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Snellen: 20/70 bilaterally

Romberg with slight drift to the right

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Results, Workup Options, Treatment Options, Medication Use.
Informed How: Verbally

Assessment and Plan

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Problem 1: HEAD TRAUMA (ICD-959.01)
MRI without contrast to check if collection of blood has resolved. Refer to ophthalmology as well. Tylox for pain. Needs to remain out of work for at least two weeks due to intense symptoms of HA, blurred vision, imbalance.
Problem 2: VISUAL IMPAIRMENT (ICD-368.10)
Vision worse per pt. Refer to ophthalmology.

Current Orders
MRI Head [CPT-70546]
Refer to Ophthalmology [*]

Prescriptions:
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/21/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 21, 2007 10:29 AM

Signed by Brian D Keisler, MD on 08/21/2007 at 1:20 PM

08/14/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs
Entered weight: 223 lb., 7 oz.
Calculated Weight: 223.44 lb.
Pulse rate: 84 **Respirations:** 20
BP: 164/108
BMI: 37.32 **BSA:** 2.08 **Wt chg:** -2.81 since 05/29/2007

Pain Assessment
The patient is currently experiencing pain.
Location: head **Intensity (1-10):** 5 **Description:** stabbing **Duration:** constant
The patient does not experience chronic pain.

Sensation: intact to touch

Mental Status
Judgement, insight: intact
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Romberg with slight drift to the right

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Medication Use.
Informed How: Verbally

Assessment and Plan
Problem 1: HEAD TRAUMA (ICD-959.01)
Suspect postconcussion syndrome but seems to be prolonged course. Will refer to neurology as pt's symptoms of HA, diplopia, blurred vision, imbalance still persist and have not improved at all. Toradol given for pain today.
Problem 2: VISUAL IMPAIRMENT (ICD-368.10)
Cleared by ophtho.

Current Orders
Refer to Neurology [*]

Prescriptions:
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient
CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po daily #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007

Method used: Print then Give to Patient
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 29, 2007 9:32 PM

Signed by Elizabeth G Baxley MD on 09/09/2007 at 7:11 PM

08/21/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 222 lb.
Temperature: 100 deg F. **Temp Site:** oral
Pulse rate: 102 **Pulse rhythm:** regular **Respirations:** 22
BP: 150/100
BMI: 37.08 **BSA:** 2.07 **Wt chg:** -4.25 since 05/29/2007
Vitals entered by: Linda D Searles PCA on August 21, 2007 9:44 AM
.....Linda D Searles PCA August 21, 2007 9:44 AM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Discussed
Dr Brian Keisler

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 220 lb. (100.00 kg.)
Pulse rate: 88 **Pulse rhythm:** regular **Respirations:** 20
BP: 160/110
BMI: 36.74 **BSA:** 2.06 **Wt chg:** -2 since 08/21/2007

Pain Assessment
The patient is currently experiencing pain.
Location: posterior R head **Intensity (1-10):** 10 **Description:** sharp **Duration:** 21 days
Vitals entered by: Virginia R Prevost LPN on August 29, 2007 10:50 AM

Other Medications
Toradol IM
Dose: 60 mg
Site: IM L deltoid
Given by: Virginia Prevost LPN
Notes: Per order of Dr. Venn at 10:50am.

.....Virginia R Prevost LPN August 29, 2007 10:50 AM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Discussed
Dr Elizabeth G Baxley

History of Present Illness
Chief Complaint: f/u head trauma

History of Present Illness
History from: patient
Chief Complaint: f/u head trauma

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R009122086

Home: (803)740-4497 Work: (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

General HPI

Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative. MRI ordered and showed very small and thin parafalcine subdural hematomas on left side, both anterior and posterior causing NO mass effect.

Pt still complaining of HA, no localized to ocipital regions, right worse than left. Went to ophtho last Saturday and he cleared her, stating that symptoms probably related to concussion. Pt still with double and blurred vision. Has short-term memory loss. Taking Tylox and ibuprofen which provide mild relief but do not completely take HA away. Also still has dizziness when she gets up.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: poor appetite
Cardiovascular: denies CP
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures

Physical Exam

General Appearance: moderate discomfort due to pain

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation
Ophthalmoscopic: some a/v nicking present, no hemorrhages, or exudates noted

Neck

Neck Exam: supple, no masses, trachea midline

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop

Musculoskeletal

Gait and Station: normal
Head and neck: mild decreased ROM due to pain

Neurologic

Cranial Nerves: II - XII grossly intact

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings

Review of Lab Results
HgbA1C 8.0 (05/17/2007 11:00:00 AM)
AST: 21 (05/17/2007 11:00:00 AM)
Alt: 16 (05/17/2007 11:00:00 AM)
Serum Cholesterol 231 (05/17/2007 11:00:00 AM)
LDL: 172 (05/17/2007 11:00:00 AM)
HDL: 43 (05/17/2007 11:00:00 AM)
Potassium: 4.2 (05/17/2007 11:00:00 AM)
BUN: 19 (05/17/2007 11:00:00 AM)
Creatinine: 0.6 (05/17/2007 11:00:00 AM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Treatment Options, Medication Use, Health Promotion, Diabetes Management, Compliance with Medication.
Informed How: Verbally

Assessment and Plan
Problem 1: HYPERTENSION (ICD-401.1)
Elevated today. Suspect pain component as well. Cont same meds and if still elevated once postconcussive syndrome has resolved, then will change med regimen.
Problem 2: DIABETES MELLITUS TYPE II UNCONTROLLED (ICD-250.02)
A1c 10.8 today, 8.0 in May. Micral neg. Recent ophtho appt neg for DM retinopathy. Switched from Avandia to Actos. Cont Glucophage 1000mg bid. Believe that once postconcussion syndrome resolved, pt would be more willing to check blood sugars and tend to her overall health better.
Problem 3: POSTCONCUSSION SYNDROME (ICD-310.2)
Still with headache. Followed by neuro and cleared by ophtho. Cont Tylox and ibuprofen for pain and flexeril for muscle relaxer. Repeat head CT in 6 weeks per neuro. Amitriptyline 25mg per neuro.
Problem 4: SUBDURAL HEMATOMA (ICD-432.1)

Secondary to head trauma. Monitor.

Prescriptions:

ACTOS 30 MG TABS (PIOGLITAZONE HCL) one tablet by mouth daily #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

STEP ONE TEST STRIPS one months supply of Step One test strips #qs x 1 month x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day #3 mL bottle x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

ERYTHROMYCIN OINT (ERYTHROMYCIN OINT) ophthalmic ointment-apply twice a day to both eyes #3.5gram x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain #90 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD September 19, 2007 11:25 PM

Signed by Christian C Steen, MD on 10/01/2007 at 7:59 AM

08/29/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

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R009122086 Ins: BLUE CRO (0534) Grp: 111148

Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Entered weight: 219 lb., 8 oz.
Calculated Weight: 219.50 lb.
Pulse rate: 96 **Pulse rhythm:** regular
BP: 162/90
BMI: 36.66 **BSA:** 2.06 **Wt chg:** -0.50 since 08/29/2007

Pain Assessment
The patient is not currently experiencing pain.
The patient has chronic pain.
Location: leg/feet **Duration:** intermittant
Vitals entered by: Maureen E Robinson LPN on September 17, 2007 2:07 PM

Laboratory Results - Normals in ()

Date/Time Collected: 9/17/07 at 1:15pm

Routine Urinalysis
Color: yellow
Appearance: clear
Leukocytes: negative (Negative)
Nitrite: negative (Negative)
Urobilinogen: 0.2 (Adult 0.1 or 1) (Peds 0.2 or 1.0)
Protein: negative (Negative)
pH: 5.0 (5-7.5)
Blood: negative (Negative)
Spec. Gravity: 1.005 (Adult 1.010-1.025)(Peds 1.002-1.025,Infant 1.002-1.006,Newborn 1.012)
Ketone: negative (Negative)
Bilirubin: negative (Negative)
Glucose: negative (Negative)
Microalbumin (urine): 0 mg/L (15-20 mg/L)
Date/Time Collected: 9/17/07
HGBA1C 10.8 % (5.0% - 12.8%)
.....Maureen E Robinson LPN September 17, 2007 2:07 PM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors

Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

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No passive smoke exposure

Attending Participation: Present and Available
Dr Christian Steen

Diabetes

HPI was told to stop glyburide 5 months ago by DM educators due to hypoglycemia

states she has not been checking her sugars like she should or eating correctly ever since her head trauma a couple months ago; sometimes misses meds as well

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance fair
Exercise: no

Self Foot Exam: yes
Eye Exam within last 12 months: performed within the last 12 months
Last eye exam: 04/04/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam

Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses

DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po daily
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain
CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms
GLYBURIDE 5 MG TABS (GLYBURIDE) one po bid
ACTOS 30 MG TABS (PIOGLITAZONE HCL) one tablet by mouth daily
ERYTHROMYCIN OINT (ERYTHROMYCIN OINT) ophthalmic ointment-apply twice a day to both eyes
* STEP ONE TEST STRIPS one months supply of Step One test strips
AMITRIPTYLINE HCL 25 MG TABS (AMITRIPTYLINE HCL) one tab po qhs-Rx'd by neuro

Medication Hx:
ACE: yes
Statin: yes

History of Present Illness
History from: patient
Chief Complaint: f/u DM, HTN, concussion

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: fair
Glucose Monitoring
Glucose Home Monitoring reviewed: no
Diet Management
ADA diet
Diet compliance: fair
Insulin Management: no
Dilated Eye Exam: performed within the last 12 months

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache, visual disturbance
Denies: vertigo, syncope/presyncope, fatigue, edema, dyspnea, chest pain
Current Status
Home BP monitoring: no
Compliance with tx: fair
Medication Tolerance: no complaints
Comments: HA and occ blurred vision all due to recent concussion

History of Present Illness
Chief Complaint: f/u DM, HTN, concussion

General HPI
Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative. MRI ordered and showed very small and thin parafalcine subdural hematomas on left side, both anterior and posterior causing NO mass effect.

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010
Chart Document

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R009122086 Ins: BLUE CRO (0534) Grp: 111148

Pt still complaining of HA, now localized to temporo-occipital regions, left worse than right. Went to ophtho and he cleared her, stating that symptoms probably related to concussion. Pt still with double and blurred vision. Has short-term memory loss. Taking Tylox and ibuprofen which provide mild relief but do not completely take HA away. Also still has dizziness when she gets up. Was referred to neurology and diagnosed with postconcussion syndrome. Prescribed amitriptyline 25mg at bedtime to help with sleep. This works.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: poor appetite
Eyes: c/o blurred vision
Cardiovascular: denies CP
Respiratory: denies cough, sob
Gastrointestinal: denies n/v/d/c, abd pain, blood in stool
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures
Psychiatric: denies depression, anxiety

Physical Exam

General Appearance: mild discomfort due to HA

Eyes

External: conjunctivae and lids normal

Ear, Nose &Throat

Hearing: grossly intact

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric

Musculoskeletal

Gait and Station: normal
Digits and nails: Normal
Head and neck: mild decreased ROM due to pain

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History of Present Illness
History from: patient
Chief Complaint: f/u DM, HTN, postconcussive syndrome

General HPI
Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor. Followed by neurology. On Neurontin now for headaches which seem to have helped. Repeat CT head recently showed no signs of sudural hematoma anymore.

C/o eyes bloodshot, sinus pressure, thick and yellow drainage from nose. Has h/o AR and h/o sinus infections in past. Reports low grade fever as well. Pressure/pain worsens when she leans her head forward.

Past History
Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: c/o low grade fever-exact temp unknown
Eyes: vision has improved; c/o eye irritation
Ear/Nose/Throat: c/o nasal congestion, sinus pressure (see hpi)
Cardiovascular: denies CP
Respiratory: denies cough, sob
Gastrointestinal: denies n/v/d/c, abd pain, blood in stool
Neurologic: HA improved
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema

Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal
Head and neck: normal alignment and mobility; ROM improved compared to last visit

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch pedal

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
ttp frontal and maxillary sinuses R>L

Review of Lab Results
HgbA1C 10.8 (09/17/2007 2:05:05 PM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

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November 10, 2010

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Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use, Diabetes Management, Compliance with Medication.
Informed How: Verbally

Assessment and Plan

Problem 1: DIABETES MELLITUS TYPE II UNCONTROLLED (ICD-250.02)
Pt met with Dr. Steadman today and glucometer printout showed that blood sugars have greatly improved and there are more readings within our target fasting and postprandial goals. Cont metformin, Actos, Amaryl regimen. Pt adamant about avoiding needles and insulin therapy as much as possible. Next A1c due in December.
Problem 2: HYPERTENSION (ICD-401.1)
BP better than previous visits but not ideal. Will max out ACEI dose at 80mg daily.
Problem 3: SINUSITIS ACUTE NOS (ICD-461.9)
History and exam c/w acute sinusitis picture. Pt given Z-pack.
Problem 4: SUBDURAL HEMATOMA (ICD-432.1)
Resolved per latest CT scan.
Problem 5: POSTCONCUSSION SYNDROME (ICD-310.2)
Still with mild headaches. Followed by neuro. Now takes Neurontin 300mg tid.

Prescriptions:

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 11/07/2007
Method used: Print then Give to Patient
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 11/07/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD November 7, 2007 11:37 AM

Signed by Holbrook W Raynal, MD on 11/12/2007 at 3:51 PM

09/17/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: dietary modification
Treatment compliance: Fair
Medication tolerance: no complaints

History of Present Illness
History from: patient
Chief Complaint: multiple complaints

Ortho/Injury

Location: Left finger

Current Symptoms: swelling, pain, weakness
Denies:
Current Treatment: rest, ibuprofen

Comments: 2 week h/o left thumb pain; no other associated finger pain; mild swelling; no trauma; Motrin without much relief; difficult to hold objects due to pain

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor. Followed by neurology with last appt this week. On Neurontin now for headaches which seems to have helped but still has dull baseline HA. Repeat CT head recently showed no signs of sudural hematoma anymore.

C/o sinus pressure, thick and yellow drainage from nose. Has h/o AR and h/o sinus infections in past. Reports low grade fever as well. Pressure/pain worsens when she leans her head forward.

Past Medical History
Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History
Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:

3 to 4 times a week (05/17/2007 8:20:27 AM)
Other Social History: unemployed since concussion, summer 2007

Review of Systems
General: c/o low grade fever-exact temp unknown
Eyes: vision has improved; c/o eye irritation
Ear/Nose/Throat: c/o nasal congestion, sinus pressure (see hpi)
Cardiovascular: denies CP
Respiratory: denies cough, sob
Genitourinary: denies urinary frequency
Genitourinary: denies urinary frequency
Musculoskeletal: Complains of see HPI, joint pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam
General
General: well nourished, well hydrated, no acute distress

Eyes
External Eye: conjunctivae and lids normal

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/Teeth/Gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
LUE: ttp in anatomic snuffbox; limited ROM of left thumb; mild swelling

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

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November 10, 2010

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Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Dr C Scott Lamar

History of Present Illness
History from: patient
Chief Complaint: HA

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last June. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head as well as neck pain. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

History of Present Illness
History from: patient
Chief Complaint: HA

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:

Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: no glucometer readings brought in today; does c/o nausea at times; has BM every other day

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: fatigue, headache
Denies: chest pain, edema, palpitations, syncope/presyncope, visual disturbances

Status:
Home BP monitoring: No
Management:
Treatment compliance: Good
Medication tolerance: no complaints

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Comments: states she is compliant with her meds and has not run out

Past Medical History

Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Complains of fatigue, malaise. Denies fevers, chills, sweats.
Eyes: vision has improved
Cardiovascular: denies CP
Respiratory: denies cough, sob
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Musculoskeletal: Denies back pain.
Neurologic: c/o HA, see HPI
Endocrine: denies polydipsia or polyuria recently

Physical Exam

General

General: well nourished, well hydrated, no acute distress

Eyes

External Eye: conjunctivae and lids normal

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop
Peripheral Circulation: Negative Findings: no edema.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: Negative Findings: normal alignment, normal mobility.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results:

Assessment & Plan Summary

POSTCONCUSSION SYNDROME (ICD-310.2) - Unchanged. Still with occasional headaches. Almost one year since concussion occurred. No longer followed by neurology. Was on neurontin and amitriptyline Rx'd by them, but has stopped taking these as they did not help. Cont narcotic as this seems to be only thing that has helped. Consider repeat head CT if still continuing to have HA.
Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

NAUSEA (ICD-787.02). Try Reglan as nausea may be DM related.
Medications: Metoclopramide hcl 10 mg tabs one tab po bid prn nausea.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Will increase beta-blocker dose. Cont ACEI and HCTZ.
Medications: Metoprolol tartrate 100 mg tabs one tab po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. Pt cannot afford A1c or any other labs as she is self-pay. Will keep on current regimen as I am unaware of what her blood sugars are at home.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 1 mg tabs one tablet daily with first meal of the day; Glyburide 5 mg tabs one tab daily for diabetes.

Prescriptions:

METOCLOPRAMIDE HCL 10 MG TABS (METOCLOPRAMIDE HCL) one tab po bid prn nausea #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987989559390
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987869559390
OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987869159390
METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) one tab po bid #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987810009390

.....Tad A Venn, MD May 21, 2008 11:01 AM

Signed by C Scott Lamar MD on 06/06/2008 at 6:58 PM

01/18/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 228 lb., 2 oz.
Calculated Weight: 228.13 lb.

Pain Assessment
The patient is currently experiencing pain.

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Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 233 lb., 0 oz.
Calculated Weight: 233 lb.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 5 **Description:** throbbing
Vitals entered by: Avis N Jackson, LPN on June 12, 2008 10:17 AM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC
Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated, presents with complaints of headaches and sinus problems.
.....Avis N Jackson, LPN June 12, 2008 10:19 AM

Risk Factors

Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness

History from: patient
Chief Complaint: f/u HA, HTN, DM; sinus complaint

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last June. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head which has been the usual location for her HA since the concussion. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

Also c/o over one week h/o thick, yellow sinus drainage, ear congestion, frontal HA, no dental pain. H/o

sinus infections at least once or twice a year.

History of Present Illness
History from: patient
Chief Complaint: f/u HA, HTN, DM; sinus complaint

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:
FSBS testing: No
Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: does not check sugars very often

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: headache
Denies: chest pain, palpitations, syncope/presyncope

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Good
Medication tolerance: no complaints

Comments: Compliant with meds. Denies any side effects of meds. C/o frontal HA today.

Past Medical History
Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

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Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Social History
Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems
General: Complains of malaise. Denies fevers.
Eyes: Denies blurring, irritation.
Ear/Nose/Throat: Complains of see HPI.
Cardiovascular: Denies chest pains, peripheral edema.
Respiratory: Denies cough, excessive sputum.
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Negative Findings: normal canals, tympanic membranes intact, No exudates, No fluid.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: inflamed mucosa, purulent discharge.
Lip/Teeth/Gums: Negative Findings: normal dentition, no gingival inflammation, no labial lesions, no buccal lesions.
Pharynx: Negative Findings: normal tongue, normal posterior pharynx, no pharyngeal erythema, no pharyngeal exudates.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory

distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no edema.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: Positive Findings: lt paracervical muscle spasms. Negative Findings: normal alignment, normal mobility.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results:

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Increase metoprolol to 150mg bid. Maxed on ACEI and HCTZ.
Medications: Metoprolol tartrate 100 mg tabs one tab po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Metoprolol tartrate 50 mg tabs one tab po twice a day.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. A1c 10.6, up from 7.7 in January. Will increase Amaryl to 4mg daily. Suspect will need insulin at some point. Would like to see pt monthly but she is self-pay.
Medications: Glucophage 1000 mg tabs One tablet BID; Benazepril hcl 40 mg tabs Take two po daily; Pravastatin sodium 40 mg tabs one tablet at bedtime for cholesterol; Amaryl 4 mg tabs Take one (1) tablet daily.

POSTCONCUSSION SYNDROME (ICD-310.2) - Stable. Percocet helps with recurrent HA. Refilled today. Neurology has signed off re: this issue. Pt cannot afford repeat CT head.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

SINUSITIS, ACUTE NOS (ICD-461.9) - New. s/s c/w acute sinusitis. Z-pack today.
Medications: Zithromax z-pak 250 mg tabs take as directed.

Prescriptions:

METOPROLOL TARTRATE 50 MG TABS (METOPROLOL TARTRATE) one tab po twice a day #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888881158770

ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888851158770

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888791608770

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888791058770

PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888761258770

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888761158770

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888761058770

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

RxID: 1528888551658770

.....Tad A Venn, MD June 23, 2008 4:44 PM

Signed by Brian D Keisler, MD on 06/25/2008 at 8:14 AM

05/21/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 233 lb., 8 oz.
Calculated Weight: 233.50 lb.
Pulse rate: 72 **Respirations:** 20
BP: 170/110
BMI: 39.00 **BSA:** 2.11 **Wt chg:** 5.37 since 01/18/2008

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 7 **Description:** pressure **Duration:** conastant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on May 21, 2008 10:54 AM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC
Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated, presents with complaints of headache times two weeks, complains of blurry vision as well.
.....Avis N Jackson, LPN May 21, 2008 10:55 AM

Attending Participation: Present and Available

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Attending Participation: Present and Discussed
Dr Ramon Ylanan

History of Present Illness

History from: patient
Chief Complaint: elevated blood pressure

Other HPI: At work this morning did not feel well and presented to company nurse who checked blood pressure where found to be 222/138 and advised to present to MD. Patient states symptoms prompting presentation were headache and bodyache, general malaise. Has history of headaches according to chart and patients states current headache is exactly like usual headaches, same location and level of intensity. Patient takes percocet and ibuprofen for headaches. Denies chest pain, palpitations, transient paralysis, seizures, syncope, paresthesias, dysarthria, dysphagia.

Past Medical History

Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Complains of see HPI, malaise.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.
Pupils: Negative Findings: no aniscoria, no cataracts, normal light reaction.

Ear, Nose, Throat

External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Hearing: Negative Findings: Grossly normal hearing.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
RUE: Negative Findings: normal strength.
LUE: Negative Findings: normal strength.
RLE: Negative Findings: normal strength.
LLE: Negative Findings: normal strength.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.
Sensation: Negative Findings: normal light touch.

Mental Status
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results
HgbA1C Collected: January 15, 2009 10:46 AM **HgbA1C:** 8.4% (4.0%-6.9% normal) (7.0%-13.0% high)
Test performed by: Dale L Reaves LPN

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0). hypertensive urgency. looking through chart it appears patient has history of poorly controlled blood pressure, she has no abnormal neurologic findings currently, her headache is chronic and unchanged. I discussed potential admission to hospital for treatment of blood pressure but patient does not want admission if it can be avoided, she states she will follow whatever is recommended in order to avoid admission. Will add calcium channel blocker to current regimen and ask to return tomorrow for blood pressure check. Advised to stop NSAID.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Diltiazem hcl 60 mg tabs Take one (1) tablet twice a day..

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). HbA1C not at goal. will need to adjust

meds but will attempt to treat blood pressure before adjusting meds.
Medications: Glucophage 1000 mg tabs One tablet BID.

Follow up in 1 days.

Prescriptions:

DILTIAZEM HCL 60 MG TABS (DILTIAZEM HCL) Take one (1) tablet twice a day. #60 x 2
Entered and Authorized by: Samuel J Crutcher MD
Signed by: Samuel J Crutcher MD on 01/15/2009
Method used: Print then Give to Patient
RxID: 1547635234157410

.....Samuel J Crutcher MD January 15, 2009 6:29 PM

Signed by Ramon C Ylanan, MD on 01/16/2009 at 8:19 AM

08/12/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 234 lb., 1 oz.
Calculated Weight: 234.06 lb.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 5 **Description:** sharp
Vitals entered by: Avis N Jackson, LPN on August 12, 2008 1:36 PM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated with patient today, presents with complaints of headache and sinus problems.
.....Avis N Jackson, LPN August 12, 2008 1:39 PM

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness
History from: patient
Chief Complaint: f/u HAs

Headache
This patient with a history of presents to clinic today with complaints of onset occipital headache which began on .
Headache is described to have been present for .
Headache pain is most severe and is given a out of 10 in severity by the patient.
Assoc. Symptoms: visual disturbance
Management:
Comments: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last August. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head (occipital) which has been the usual location for her HA since the concussion. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

Today HA is 10/10. Narcotic decreases it to 4-5/10. Occ blurred vision. Uses narc tid.

History of Present Illness
History from: patient
Chief Complaint: Diabetes, HTN maintenance

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Status:
FSBS testing: Yes
Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: fasting 180 this AM per pt
no glucometer readings today
last POC A1c 10.6 (prev 7.7)

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: headache, visual disturbances
Denies: chest pain, cough, dyspnea, edema, palpitations, syncope/presyncope

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Fair
Medication tolerance: no complaints

Past Medical History
Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History
Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)

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Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Denies fatigue, weight loss.
Eyes: Complains of see HPI, blurring.
Cardiovascular: Denies chest pains, peripheral edema.
Respiratory: Denies cough, excessive sputum.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: conjunctivae and lids normal

Ear, Nose, Throat

Hearing: Negative Findings: Grossly normal hearing.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no edema.

Musculoskeletal

Gait and Station: Negative Findings: normal gait.
Head and Neck: Positive Findings: lt paracervical muscle spasms. Negative Findings: normal alignment, normal mobility.
Spine, Ribs, Pelvis: normal alignment and mobility, no deformity

Neurologic

Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status

Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

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November 10, 2010

Chart Document

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Female DOB: 07/04/1951

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R009122086 Ins: BLUE CRO (0534) Grp: 111148

Assessment & Plan Summary

POSTCONCUSSION SYNDROME (ICD-310.2) - Unchanged. Still with headaches after one year of injury. Unable to work. Lost health plan. Neurology has essentially signed off stating that she may continue to have headaches. Pt unable to afford CT scan. Cont Percocet as this is only med that has allowed her to dull the HAs. Restart neurontin as well.
Medications: Neurontin 300 mg caps one cap po tid-per neuro; Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Increase beta blocker dose. HAs may be aggravated by her uncontrolled BP.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. Last POC A1c 10.6 (not in flowsheet). No glucometer readings today. Wonder if pt is testing like she says. Suspect will need insulin at some point. Would like to see pt monthly but she is self-pay. Can't afford labs either. Will meet with financial counselor today.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 4 mg tabs Take one (1) tablet daily.

Prescriptions:

NEURONTIN 300 MG CAPS (GABAPENTIN) one cap po tid-per neuro #90 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/12/2008
Method used: Print then Give to Patient
RxID: 1534169736557100

METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) two tabs po bid #120 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/12/2008
Method used: Print then Give to Patient
RxID: 1534169736157100

.....Tad A Venn, MD August 12, 2008 2:16 PM

Signed by Brian D Keisler, MD on 08/18/2008 at 9:07 AM

06/12/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.
Liver and Spleen: Negative Findings: no liver enlargement, no spleen enlargement, no liver nodularity.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Spine, Ribs, Pelvis: Negative Findings: normal alignment, normal mobility, no deformity, no tenderness, negative straight leg raise bilaterallly.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Reference range in parenthesis.
Microalbumin (urine): 20 mg/L (0-20 mg/L)

Assessment & Plan Summary

RIB PAIN, RIGHT SIDED (ICD-786.50) - Uncontrolled.
Unsure of etiology of R side/back pain and its relationship to her daily vomiting. CXR neg. Pt has a MRI of her spine ordered by the neurologist. Is stooling regularly. Has pain meds. RUQ u/s neg and pt has an absent gallbladder. Will CT chest/abd to see if she has a tumor lesion. Will get xrays to eval for osteoporosis or vertebral frx.

Upon pt leaving, she noted to a nurse that this was all related to an injury and she was going to give the orders to her lawyer. I was told this after the fact and am unsure about the initial incident.

.....Rachel L Callis MD March 30, 2009 1:24 PM

Signed by C Scott Lamar MD on 03/31/2009 at 7:53 PM

02/25/2009 - Office Visit: FMC Adult Visit/ follow up and micral
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 240.90 lb.
Pulse rate: 74 **Pulse rhythm:** regular **Respirations:** 18
BP: 140/100
Wt chg: 0.59 since 01/15/2009
Vitals entered by: Karen A Churchill on February 25, 2009 3:20 PM
Vitals updated by: Karen A Churchill on February 25, 2009 3:20 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC

Pain Assessment
The patient is currently experiencing pain.
Location: right side **Intensity (1-10):** 4 **Description:** sharp, stabbing **Duration:** months
The patient has chronic pain.
Intensity (1-10): 10
Comment: pt. states that she has been having pain on her right side. seems to be in-between her ribs she has taken her pain med and it has not helpd. she also says that sometimes when she breathes it hurts also
.....Karen A Churchill February 25, 2009 3:20 PM

Risk Factors

Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Jeffrey Hall

History of Present Illness

History from: patient
Chief Complaint: headaches, f/u HTN, DM

Headache

This patient with a history of presents to clinic today with complaints of sudden onset throbbing generalized headache which began on .
Headache is described to have been present for .

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Headache pain is most severe and is given a 10-worst ever out of 10 in severity by the patient.
Assoc. Symptoms: visual disturbance, neck pain
Aggrevating Factors: bright light, stress
Management:
Comments: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor Aug 2007. Was followed by Dr. Alan Morgan at the SC Neurological Clinic but is no longer seeing them. Diagnosis for her headches was postconcussive headaches. Was on Neurontin and amitriptyline per neurology for her headaches but she stopped these as they did not seem to help.Repeat CT head late 2007 showed no signs of sudural hematoma anymore. Pt c/o generalized HA today. States that she has a headache more days than not out of the week. Has associated blurred vision and photophobia. Has been evaluated by ophthalmology as well and no further intervention suggested. Only thing that truly has helped HA in past has been oxycodone-APAP. Pt did not work from 8/07 to 1/09 due to impairment s/p concussion andhad been self-pay for all of her meds and treatments. She is now working light duty at her previous job.

Today HA is 10/10. Narcotic decreases it to 4-5/10.

Desires referral to different neurologist re: second opinion about headaches.

Other HPI: also c/o right sided rib pain, basically ever since head trauma in 2007- no SOB, resp symptoms, fever

History of Present Illness
History from: patient
Chief Complaint: headaches, f/u HTN, DM

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:
FSBS testing: Yes
Self foot Exam: Yes

Last A1c :
8.4 (01/15/2009 9:41:58 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: states recent fasting blood sugars have been in the low 100's

Hypertension
Basis for Diagnosis: Previous History of HTN

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JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Current symptoms: edema, headache, visual disturbances
Denies: chest pain, dyspnea, fatigue, palpitations, syncope/presyncope, vertigo

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Fair
Comments: out of ACEI x 1 week

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Social History
non-smoker
currently back at work, light duty

Review of Systems

General: Denies fevers, weight loss.
Eyes: Complains of see HPI, blurring, photophobia. Denies vision loss.
Cardiovascular: Complains of peripheral edema. Denies chest pains, palpitations, dyspnea on exertion.
Respiratory: Denies cough, dyspnea.
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: Negative Findings: conjunctivae normal, lids normal.

Ear, Nose, Throat

Hearing: Negative Findings: Grossly normal hearing.

Neck

Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Positive Findings: trace bilateral pedal edema.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: ttp bitemporal and occipital regions; ttp bilateral cervical muscles

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Orientation: oriented to time, place, and person
Memory: Negative Findings: intact recent recall, intact remote recall.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results
Microalbumin Collected: February 25, 2009 3:20 PM **Microalbumin Resulted:** February 25, 2009 3:26 PM
Reference range in parenthesis.
Microalbumin (urine): 20 mg/L (0-20 mg/L)

Assessment & Plan Summary

RIB PAIN, RIGHT SIDED (ICD-786.50) - New. Check CXR to r/o any pulm pathology. Former smoker.

h/o POSTCONCUSSION SYNDROME (ICD-310.2). Pt still with headaches despite head injury back in Aug 2007. At that time had subdural hematoma which over serial imaging had resolved. Now that pt has insurance again, will refer to USC neurology per pt request for second opinion. Formerly seen by SC Neurological Clinic. They stated pt may continue to have HA and told her to cont amitriptyline and neurontin. Pt states these do not help. Percocet is only thing that helps. Pt has been appropriate with all refill requests and has not abused our narcotics policy. Pt formerly worked full-time and was active in her community. This has been limited since the injury due to the headaches. Pt would like to get back to her old lifestyle.
Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Out of ACEI x 1 week. Will refill today. F/u after neuro appt or in one month, whichever is sooner.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po

daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Diltiazem hcl 60 mg tabs Take one (1) tablet twice a day..

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. A1c 8.4 in January. Pt states blood sugars have been in low 100's fasting recently. Will give pt benefit of the doubt and not change any meds today. Recheck A1c in April.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 4 mg tabs Take one (1) tablet daily.

Follow up as previously scheduled.

Prescriptions:

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197168059190

SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day #3 mL bottle x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138609190

DILTIAZEM HCL 60 MG TABS (DILTIAZEM HCL) Take one (1) tablet twice a day. #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138509190

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138409190

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197108359190

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197078059190

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

RxID: 1551197048359190

.....Tad A Venn, MD March 1, 2009 3:08 PM

Signed by Jeffery W Hall , MD on 03/09/2009 at 3:00 PM

01/15/2009 - Office Visit: FMC Adult Visit
Provider: Samuel J Crutcher MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 240 lb., 5 oz.
Calculated Weight: 240.31 lb.
Pulse rate: 72 **Pulse rhythm:** regular **Respirations:** 20
BP: 224/120
BMI: 40.13 **BSA:** 2.14 **Wt chg:** 6.25 since 08/12/2008
Vitals entered by: Avis N Jackson, LPN on January 15, 2009 9:42 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 4 **Description:** sharp
The patient does not experience chronic pain.
Patient presents with complaints of elevated BP and blurry vision. BP at work this AM was 222/138. Needs refill on meds.
.....Avis N Jackson, LPN January 15, 2009 9:44 AM

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951 R009122086

Home: (803)740-4497 Work: (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 237 lb., 3 oz.
Calculated Weight: 237.19 lb.
Pulse rate: 70 **Respirations:** 18
BP: 160/88
Wt chg: -3.71 since 02/25/2009
Vitals entered by: Jeanette Randolph CMA on March 30, 2009 11:14 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Level Low Risk

Pain Assessment
The patient is currently experiencing pain.
The patient has chronic pain.
Location: Lower R side **Intensity (1-10):** 7 **Description:** sharp **Duration:** Months

Attending Participation: Seen and discussed
Dr C Scott Lamar

History of Present Illness

History from: patient

Abdominal Pain

This patient presents today with complaints of abdominal pain present since .
The pain is described as a dull aching right flank constant pain which is in duration.
The pain is noted to be a out of 10 on a 10 point pain scale.
The pain is described to have .
The patient describes having loose stools associated with the abdominal discomfort.

Comments: Says pain is on the back side, but other on the R side pain. Says she is having stomach swelling. Pain is there daily. Sometimes pain lasts all day. Sometimes she wakes up in the night nauseated, throwing up yellowish, thick, with a nasty bitter taste. Throws up about every morning. Even if she drinks water. Sometimes she wakes in the morning with it, lasting all day, then goes to bed with it.

Aching pain. Sometimes pain travels under her backbone, but otherwise no radiation. for several months. Stools twice a day, sometimes not at all.. Lately more with diarrhea. Stooled this am. Denies bloody, tarry stools. Denies dysuria. Had a BTL and hysterectomy. When she leans over and sits back up pain is worse. When she is working, notices she is sweating more. Sex drive is down. Had hysterectomy 6-7 yrs ago.

Other HPI: Neurologist wants to see her back in 6 wks,. She has an rxn for MRI of the lumbar spine for low back pain, a script for lamictal 25mg #90 for 2 wks, then 50mg x2 wks then 75mg daily. Then wants a sleep study for obstructive sleep apnea. She said she doesn't know what he thinks is going.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Surgical History (reviewed - no changes required): BTL 1979
Chole 1980
Total abd Hysterectomy and BSO for fibroids 1993
Family History (reviewed - no changes required): FH of Diabetes:
FH of Hypertension:
FH of Breast Cancer: GM
FH of Colon Cancer: sister s/p resection at age 46
DVT - Aunt, sister (after surgeries)
PE - daughter (after childbirth)
Social History (reviewed - no changes required): non-smoker
currently back at work, light duty

Review of Systems

General: Denies fevers, chills.
Musculoskeletal: Complains of see HPI.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Pedal Pulses: Negative Findings: symmetrical normal dorsalis pedis pulses, symmetrical normal post tibial pulses.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

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JOANN M BROCKINGTON
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Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 240 lb., 5 oz.
Calculated Weight: 240.31 lb.
Temperature: 98.2 deg F. **Temp Site:** oral
Pulse rate: 68 **Pulse rhythm:** regular **Respirations:** 20
BP: 150/92
Wt chg: 3.12 since 03/30/2009
Vitals entered by: Avis N Jackson, LPN on April 29, 2009 2:47 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 7 **Description:** ache **Duration:** 1 Days
The patient does not experience chronic pain.
patient presents with complaints of headache and cough for about a day.
.....Avis N Jackson, LPN April 29, 2009 2:48 PM

Patient/caregiver Teaching

History of Present Illness

Chief Complaint: HA

Headache

This patient with a history of Sinus headaches presents to clinic today with complaints of sudden onset throbbing frontal headache which began on 04/29/2009.
Headache is described to have been present for <1 days.
Headache pain is most severe in the morning and is given a out of 10 in severity by the patient.
Assoc. Symptoms: nausea, sinus pressure
Aggrevating Factors: bright light
Management:
Comments: yesterday her L eye was hurting, this AM took at goody powder and it didn't help. She also had a bad episode of night sweats last night. Last year fell and hit head and had a concussion, has had hx of HAs since and has been started on Lamictal per Neuro. Has been out of her flonase for a couple of months.

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JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History
Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Denies fevers.
Neurologic: Complains of headaches. Denies dizziness, transient paralysis, weakness, paresthesias.
Allergic/Immunologic: Complains of hay fever.

Physical Exam
General
General: Positive Findings: obese. Negative Findings: Well appearing, no acute distress.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Positive Findings: serous L otitis.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: pale mucosa. enlarged turbinates
Pharynx: Positive Findings: mild pharyngeal erythema. Negative Findings: no pharyngeal exudates.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: no extra heart sounds.

Lymphatic

Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: no appearance of depression, anxiety or agitation

Reference range in parenthesis.
Microalbumin (urine): 20 (0-20 mg/L)

Assessment & Plan Summary

HEADACHE (ICD-784.0).
ALLERGIC RHINITIS, SEASONAL (ICD-477.9).
POSTCONCUSSION SYNDROME (ICD-310.2). Restart flonase, Mucinex D advised as well, plenty of water.

Prescriptions:
MUCINEX D 60-600 MG TB12 (PSEUDOEPHEDRINE-GUAIFENESIN) one or two po q12h with plenty of water #40 x 1
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 04/29/2009
Method used: Print then Give to Patient
RxID: 1556636595157500

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 04/29/2009
Method used: Print then Give to Patient
RxID: 1556636535407500

Signed by Rachel E Hall MD on 04/29/2009 at 3:33 PM

03/30/2009 - Office Visit: FMC Adult Visit
Provider: Rachel L Callis MD
Location of Care: Palmetto Health Richland Family Medicine Center

Review of Systems
General: Complains of sweats, fatigue, weight loss. Denies fevers, chills. sweats daily.
Eyes: Complains of blurring, eye pain.
Cardiovascular: Complains of palpitations, dyspnea on exertion, peripheral edema. Denies chest pains, syncope.
Respiratory: Complains of cough, wheezing. SOB
Gastrointestinal: Complains of vomiting, diarrhea. Denies nausea, constipation. Vomiting monday morning
Genitourinary: Complains of vaginal discharge. Denies incontinence, urinary frequency.
Genitourinary: Complains of vaginal discharge. Denies incontinence, urinary frequency.
Neurologic: Complains of headaches, dizziness, tremors. Denies paresthesias, seizures.
Psychiatric: Complains of anxiety. Denies depression, memory loss, paranoia.
Allergic/Immunologic: Denies seasonal allergies.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Positive Findings: pericardial friction rub.
Carotid Arteries: Negative Findings: symmetrical 2+ pulses, no bruits.
Pedal Pulses: Negative Findings: symmetrical normal dorsalis pedis pulses, symmetrical normal post tibial pulses.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis, no abnormal lesions.

Neurologic

Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status

Judgement/Insight: Negative Findings: intact.
Mood and Affect: Positive Findings: slightly anxious.

Assessment & Plan Summary

PALPITATIONS (ICD-785.1).
pt with new sx of palpitations. Will check EKG now and give 24 hour holter for monitoring to return tomorrow.. Pt to keep event journal. Will follow up in 2 weeks or will call if any abnormality noted.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
Pt maxed out on most bp meds.. will increase Diltiazem to 120 bid

POSTCONCUSSION SYNDROME (ICD-310.2).
continues to have headaches- is following at neuro for this... has apt on 6/17. Please send referral letter.

PREVENTIVE HEALTH CARE (ICD-V70.0).
will sched mammo and eye exam

.....Kathryn W Dudas, MD June 10, 2009 11:43 AM

Prescriptions:

DILTIAZEM HCL CR 120 MG CP12 (DILTIAZEM HCL) take one tab BID #60 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 06/10/2009
Method used: Print then Give to Patient
RxID: 1560250673158510

Signed by Jason J Stacy MD on 06/10/2009 at 12:04 PM

04/29/2009 - Office Visit: FMC Adult Visit
Provider: Rachel E Hall MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Carotid Arteries: Negative Findings: symmetrical 2+ pulses, no bruits.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.
Liver and Spleen: Negative Findings: no liver enlargement, no spleen enlargement, no liver nodularity.

Genitourinary
External Genitalia: Negative Findings: no deformity, no skin lesions, no edema, no discharge.
Vagina: Positive Findings: discharge. Negative Findings: normal mucosa, no lesions, no rectocele, no cystocele.
Urethra: Negative Findings: no discharge.
Bladder: Negative Findings: no cystocele, no tenderness.
Cervix: Positive Findings: discharge. Negative Findings: no lesions, normal mucosa, no tenderness.
Uterus: Negative Findings: normal size, normal position, normal mobility, no tenderness.
Adnexa: Negative Findings: no masses, no tenderness.

Lymphatic
Groin: Negative Findings: no inguinal lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Digits and Nails: Negative Findings: no clubbing, no cyanosis, no deformity, no tenderness.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results
Wet prep/KOH Resulted: June 30, 2009 2:37 PM
Source: vag
WM: 1+ bacteria, 3+ WBCs, Clue Cells absent, Yeast absent, Trichomonas present
KOH: Negative Whiff
Test performed by: Rachel L Callis MD

Palmetto Health Richland Family Medicine Center
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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled.
BP up today. Pt is on diltiazem and BB. WIll d/c dilt to get her off of two rate controllers. Start norvasc instead. Want her to keep track of her bp and return if it continues to be too high.

TRICHOMONAL VAGINITIS (ICD-131.01) - New.
Wet pre positive for trich. Will treat with flagyl. Discussed using protection during intercourse and not to have intercourse with her partner after she was treated until he is treated. Noted they both needed to be treated 7 days before resuming intercourse. Will test pt for GCC and HIV and syphilis.

Follow up 1-2 weeks

Prescriptions:

METRONIDAZOLE 500 MG TABS (METRONIDAZOLE) take 4 tabs at one time #4 x 0
Entered and Authorized by: Rachel L Callis MD
Signed by: Rachel L Callis MD on 06/29/2009
Method used: Print then Give to Patient
RxID: 1561909700156850

NORVASC 5 MG TABS (AMLODIPINE BESYLATE) one tab po daily #30 x 6
Entered and Authorized by: Rachel L Callis MD
Signed by: Rachel L Callis MD on 06/29/2009
Method used: Print then Give to Patient
RxID: 1561908194756900

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 6
Entered and Authorized by: Rachel L Callis MD
Signed by: Rachel L Callis MD on 06/29/2009
Method used: Print then Give to Patient
RxID: 1561908104156900

METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) two tabs po bid #120 x 6
Entered and Authorized by: Rachel L Callis MD
Signed by: Rachel L Callis MD on 06/29/2009
Method used: Print then Give to Patient
RxID: 1561908074056900

Present during pelvic exam. Wet prep and GCC collected.
.....Ontrelle L Young, CMA June 29, 2009 5:56 PM

.....Rachel L Callis MD June 30, 2009 2:39 PM

Signed by Brian D Keisler, MD on 07/01/2009 at 2:01 PM

06/10/2009 - Office Visit: FMC Adult Visit/ followup HTN/DM
Provider: Kathryn W Dudas, MD

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 235 lb.
Pulse rate: 68 **Respirations:** 18
BP: 158/80
Wt chg: -5.31 since 04/29/2009
Vitals entered by: Maxine M Hedges LPN on June 10, 2009 10:25 AM

Fall Risk Assessment
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.
EKG: Done today. Print out given to provider.

Pain Assessment
The patient is currently experiencing pain.
Location: head **Intensity (1-10):** 3 **Description:** dull **Duration:** Days
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Jason Stacy
Dr Jason Stacy

History of Present Illness

History from: patient
Chief Complaint: heart palpation

Other HPI: States she is have some palpitations x 3 days, which is new for her. Started after the sleep study last month.
last couple of days 2-3 times per day. Has a little chest pain with palpation but it comes and goes. Worst for the lats three days. Last about 5 min. Nothing make it better or worst. Woke up in her sleep last night and could not go back to sleep. Denied heart murmur.

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Basis of Diagnosis: Previous history

FSBS testing: Yes **High** 201 **Low:** 91 **Avg:** 130

Non-pharmacologic tx: Low Sodium diet

Comments: Need eye exam.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 232 lb., 9 oz.
Calculated Weight: 232.56 lb.
Pulse rate: 76 **Respirations:** 20
BP: 122/80
BMI: 38.84 **BSA:** 2.11 **Wt chg:** -1.94 since 06/29/2009
Vitals entered by: Susan Jackson, CMA on July 13, 2009 1:54 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr C Scott Lamar

Back Pain

This patient presents today with complaints of back pain present since 08/08/2008.
The pain which is reportedly is described to be a pain of the lower back region present for . The patient reports the pain to be a out of 10 on a 10 point pain scale and have .
Associated symptoms:
Aggrevating factors:
Alleviating factorsComments: low back pain from a fall

History of Present Illness

Chief Complaint: Hypertension maintenance

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Comments: Patient states that blood sugar has been relatively well controlled with levels below 120 mg/dL. One time it was above 300 mg/dL

Basis for Diagnosis: Previous History of HTN

Frequency(x/week) 1
Systolic Range: 200
Diastolic Range: 120

Current Diet: low fat/low cholesterol
Treatment compliance: Good
Comments: pt B/P was 200/100 a wk ago; usual blood pressures have been 120s/80s

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Denies fevers, chills, sweats.
Cardiovascular: Denies chest pains, palpitations.
Respiratory: Denies dyspnea.
Gastrointestinal: Complains of nausea. Denies vomiting, diarrhea, constipation.
Genitourinary: Denies vaginal discharge.

Genitourinary: Denies vaginal discharge.
Musculoskeletal: Complains of back pain.
Psychiatric: Complains of depression, anxiety. Denies suicidal ideation.
Heme/Lymphatic: Denies abnormal bruising, bleeding.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Respiratory
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Diabetic Foot Exam
Diabetes Foot Exam: Negative Findings: Normal DP pulse bilaterally, Skin intact bilaterally, No fungal nail changes.

.....Thomas W Morris, Medical Student July 13, 2009 2:13 PM
Acting as scribe for Dr. Dudas

Laboratory Results
HgbA1C Collected: July 13, 2009 2:50 PM **HgbA1C Resulted:** July 13, 2009 3:51 PM
HgbA1C: 11.7% (4.0%-6.9% normal) (7.0%-13.0% high)
Test performed by: Susan Jackson, CMA

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
on Amilodipine, metoprolol and benzapril... looks like bp is controlled. Will cont to follow.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02).
Glycolsylated hemoglobin was elevated. However, blood glucose measured today was in the normal range. Glimerpiride was increased to 6mg q day. Pt counseled to lose weight. Will continue to follow.

OBESITY (ICD-278.00).
Pt dieting- using south beach; will decrease drinking sugary drinks; decrease fried foods.... pt not currently exercising.... will start walking 5Xper week for 30 minutes. has back pain but will start exercising.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

TRICHOMONAL VAGINITIS (ICD-131.01).
improved sx

DEGENERATIVE JOINT DISEASE (ICD-715.90).
will continue vicoprofen and wean as tolerated

.....Kathryn W Dudas, MD July 13, 2009 5:17 PM

Prescriptions:
OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #90 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563114102408370
GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs #30 x 4
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563114012158370
OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #90 x 0
Entered by: Thomas W Morris, Medical Student
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563113832058370

Signed by C Scott Lamar MD on 07/14/2009 at 4:56 PM

06/29/2009 - Office Visit: FMC Adult Visit/Fu with dm and hypertension/vaginal discharge
Provider: Rachel L Callis MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Vital Signs

Weight: 234.50 lb.
Pulse rate: 68 **Pulse rhythm:** regular
BP: 150/90
Wt chg: -0.50 since 06/10/2009
Vitals entered by: Ontrelle L Young, CMA on June 29, 2009 3:01 PM

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.
BP with large cuff
.....Ontrelle L Young, CMA June 29, 2009 3:07 PM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness

History from: patient
Chief Complaint: vag infection

Other HPI: Pain vaginally. Uncomfortable. x 2-3 wks. + discharge. Had an odor at first, but not now. Denies dysuria, hematuria. No rashes, or skin changes. Is sexually active, just one partner. Last 2 months ago. Stopped having periods, age 5 yrs ago had hysterectomy for menorrhagia. Is having sweats. Her partner is not in the same town. Had trichomonas in the past.

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Hypertension

Basis for Diagnosis: Previous History of HTN

Denies: abdominal pain, chest pain, cough, dyspnea, headache, vomiting

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Good
Medication tolerance: no complaints

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Complains of see HPI.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Patient PT: 17.2 (09/21/2009 9:45:00 AM)
INR: 1.3 (09/21/2009 9:45:00 AM)
Target INR Range: 2.0-3.0
Duration Tx: indefinitely
New Coumadin Regimen
Friday: 10
Saturday: 10
Sunday : 10
Monday: 10
Tuesday: 10
Wed: 10
Thurs: come in

Provider Instructions
Advise patient: PT/INR is too low and the dose of coumadin needs to be increased.
Comments: Called pt and gave these instructions. Unsure why INR is not increasing... will give 10mg q day and check on thursday. Pt not eating green veges per her.
Results reviewed by: Kathryn W Dudas, MD on September 21, 2009 1:40 PM

.....Kathryn W Dudas, MD September 21, 2009 1:40 PM

Signed by C Scott Lamar MD on 09/21/2009 at 2:02 PM

09/18/2009 - Office Visit: Coumadin Management
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Coumadin Management
Indication for Coumadin Therapy: Deep Vein Thrombosis

Patient PT: 17.1 (09/16/2009 9:33:00 AM)
INR: 1.3 (09/16/2009 9:33:00 AM)
Target INR Range: 2.0-3.0
Duration Tx: indefinitely
New Coumadin Regimen Friday 10mg
Saturday 10mg
SUnday 10mg

(last week took 10mg Mon and Tues and 5 Wed... then had checked 1.3; will recheck on monday

Provider Instructions
Advise patient: PT/INR is too low and the dose of coumadin needs to be increased.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Comments: Come in for recheck on Monday am. Go to ER if any s/sx of SOB/ leg pain or swelling.
Results reviewed by: Kathryn W Dudas, MD on September 18, 2009 12:35 PM

.....Kathryn W Dudas, MD September 18, 2009 12:35 PM

Signed by C Scott Lamar MD on 09/21/2009 at 2:01 PM

09/14/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 233 lb., 2 oz.
Calculated Weight: 233.13 lb.
Pulse rate: 70 **Respirations:** 18
BP: 130/70
BMI: 38.94 **BSA:** 2.11 **Wt chg:** 2.75 since 08/31/2009
Vitals entered by: Jeanette Randolph CMA on September 14, 2009 2:01 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Level Low Risk
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available

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Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Dr Brian Keisler

History of Present Illness

History from: patient
Chief Complaint: Follow up visit

Other HPI: Patient is a 58 yr old female seen in clinic today for f/u visit for bld clots. Pt states that she is still having diarrhea since hospital discharge 4-5 times per day. denies nausea , vomiting,chills or fevers. Not taking meds for diarrhea.
Stopped taking Nifidepine bc thought was causing diarrhea X several days but did not stop.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Denies see HPI.
Eyes: Complains of blurring, eye pain.
Ear/Nose/Throat: Complains of earache, nasal congestion.
Cardiovascular: Denies chest pains, palpitations.
Respiratory: Complains of cough. Denies wheezing.
Gastrointestinal: Denies see HPI.
Genitourinary: Denies vaginal discharge, urinary frequency, pelvic pain.
Genitourinary: Denies vaginal discharge, urinary frequency, pelvic pain.
Musculoskeletal: Complains of back pain, joint pain. Denies arthritis.
Skin: Denies rash.
Neurologic: Complains of headaches. Denies dizziness.
Psychiatric: Complains of depression. Denies anxiety.
Endocrine: Complains of heat intolerance. Denies cold intolerance.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
Otoscopic: Negative Findings: normal canals, tympanic membranes intact, tympanic membranes w/ normal mobility, No exudates, No fluid.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Positive Findings: trace bilateral LE edema, mild varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis, no abnormal lesions.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary 296-6135

PULMONARY EMBOLISM, HX OF (ICD-V12.51).
checking PT/INR today- taking 5mg coumadin daily--INR today 1.1. Pt denies eating any green veges. Will take additional dose today and tomorrow: New schedule: Monday and Tuesday 10mg; Wed 5mg; thursday am return for repeat PT/INR. WIll likely need around 7.5 mg q day. Pt advised to go to ER if has

lower ext pain or SOB.

COUMADIN THERAPY (ICD-V58.61).
as above

DIARRHEA (ICD-787.91).
pt having diarrhea X 2 weeks since leaving hospital. Watery, nonbloody. 4-5 times per day. Will give culture kit and have pt return to hospital lab today or tomorrow. Pt to use immodium for relief of diarrhea. Continue drinking plenty of water and eat bland foods.

.....Kathryn W Dudas, MD September 14, 2009 4:37 PM

.....Kathryn W Dudas, MD September 14, 2009 2:42 PM

Signed by Brian D Keisler, MD on 09/15/2009 at 1:46 PM

08/31/2009 - Office Visit: FMC Adult Visit
Provider: John M Ferguson, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 230 lb., 6 oz.
Calculated Weight: 230.38 lb.
Pulse rate: 68 **Respirations:** 18
BP: 120/80
Wt chg: -1.42 since 08/25/2009
Vitals entered by: Jeanette Randolph CMA on August 31, 2009 2:25 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Fall Risk Level Low Risk
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: L leg **Intensity (1-10):** 6 **Description:** pressure **Duration:** 2Days
The patient does not experience chronic pain.

Patient/caregiver Teaching

Dr C Scott Lamar
Attending Participation: Present and Discussed
Dr C Scott Lamar

Other HPI: JOANN BROCKINGTON complains of some SOB that began Friday
-recent history of DVT and PE, hospitalized at LMC
-second DVT, so requiring Coumadin for life
-SOB associated with dry cough and worse with exertiion
-denies fevers
-also complains of L leg swelling (DVT in L leg previosly)

JOANN BROCKINGTON has also had loose stools over the weekend
-describes them as "dark"

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Alcohol use: no
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

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November 10. 2010

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Anticoagulation Therapy
Indication for Anticoagulation Therapy: Deep Vein Thrombosis
Target INR: 2.0-3.0
Duration of Treatment indefinitely

Side Effects
Comments: no side effects/ pt denies eating green veges and states that she takes her meds daily. Side effects were reviewed and the patient denies having any problems or issues since their last visit.

Vitamin K Intake
Number of servings consumed per week: 1
Is this amount a change? no

Patient's Knowledge of Dosing
Patient is able to correctly state the dosing scheme: yes
Patient denies missing any doses.

Medication Changes
Has the patient had any medication changes? no

Previous Dosing Scheme
Sunday: 5 mg
Monday: 5 mg
Tuesday: 5 mg
Wednesday: 5 mg
Thursday: 5 mg
Friday: 5 mg
Saturday: 5 mg
Total Dose: 35 mg over the week

New Dosing Scheme
Sunday: 12.5 mg
Monday: 12.5 mg
Tuesday: 12.5 mg
Wednesday: 12.5 mg
Thursday: 12.5 mg
Friday: 12.5 mg
Saturday: 12.5 mg
Total Dose: 87.50 mg over the week

Changes
Comments: pt was on 10mg q day X 1 week- INR 1.4; will increase to 12.5 daily and recheck in 1 week

Prescriptions:
COUMADIN 10 MG TABS (WARFARIN SODIUM) take one tab daily with half tab of 5mg. #30 x 2
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 09/25/2009
Method used: Print then Give to Patient

RxID: 1569502324156710
COUMADIN 5 MG TABS (WARFARIN SODIUM) take 1/2 tab daily with 10mg coumadin tab: total 12.5 mg daily #30 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 09/25/2009
Method used: Print then Give to Patient
RxID: 1569502294106710

Active Medications:
METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) two tabs po bid
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily
PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily
STEP ONE TEST STRIPS () one months supply of Step One test strips
OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours
PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth
LAMICTAL TABS (LAMOTRIGINE TABS) per neuro-see 3/27/09 note
METRONIDAZOLE 500 MG TABS (METRONIDAZOLE) take 4 tabs at one time
GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs
COUMADIN 5 MG TABS (WARFARIN SODIUM) take 1/2 tab daily with 10mg coumadin tab: total 12.5 mg daily
COUMADIN 10 MG TABS (WARFARIN SODIUM) take one tab daily with half tab of 5mg.

Current Allergies:
! PCN

.....Kathryn W Dudas, MD September 25, 2009 1:27 PM

Signed by C Scott Lamar MD on 09/30/2009 at 1:04 PM

09/21/2009 - Office Visit: Coumadin Management
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Coumadin Management
Indication for Coumadin Therapy: Deep Vein Thrombosis
Coumadin Management Provider: Kathryn W Dudas MD

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Complains of chills. Denies fevers.
Eyes: Complains of blurring. Denies eye pain.
Ear/Nose/Throat: Complains of earache.
Cardiovascular: Denies chest pains.
Respiratory: Complains of dyspnea.
Gastrointestinal: Complains of diarrhea. Denies nausea, vomiting.
Musculoskeletal: Complains of back pain.
Skin: Complains of rash.
Neurologic: Complains of headaches, dizziness.
Heme/Lymphatic: Denies abnormal bruising, bleeding.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal

Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic

Neck: Negative Findings: no cervical lymphadenopathy.

Skin

Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis, no abnormal lesions.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary

COUMADIN THERAPY (ICD-V58.61). pt taking 12.5 M-Thurs and 15mg Fri-Sun; will increase to 12.5 Monday/Tuesday and 15mg Wed-Sunday. Will need to recheck in 1 week.
Medications: Glucophage 1000 mg tabs One tablet BID.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth. BP 138/88 today...will continue home meds and if remains elevated will need to adjust regimen.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02).
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs.
Will assess diabetes at next visit. Pt is trying to lose weight. WIll meet next week and discuss diabetes regimen-- A1C 7.7- pt will need a tighter regimen.

pt with vaginal concerns- will do pap at next visit and address diabetes... Pt with much stress due to mothers cancer and work. Encourage weight loss.

.....Kathryn W Dudas, MD November 1, 2009 6:15 PM

.....Kathryn W Dudas, MD October 30, 2009 3:30 PM

Signed by Brian D Keisler, MD on 11/02/2009 at 2:15 PM

10/09/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 236.10 lb.
Pulse rate: 68 **Pulse rhythm:** regular
BP: 158/886
BMI: 39.43 **BSA:** 2.12 **Wt chg:** 2.97 since 09/14/2009
Vitals entered by: Karen M Springfield, RN on October 9, 2009 2:36 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: head **Intensity (1-10):** 5 **Description:** ache **Duration:** 2 days
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Brian Keisler

Other HPI: pt here to follow up coumadin mgt. Having some SOB and leg swelling occasionally. INR 2.0 today. Pt on 12.5mg Mon- Sat and 15mg on Sunday.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

DVT x 2
PE

Social History
Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Complains of fatigue, malaise. Denies fevers, chills, sweats, anorexia.
Eyes: Complains of blurring, diplopia.
Ear/Nose/Throat: Denies earache.
Cardiovascular: Complains of chest pains, dyspnea on exertion, peripheral edema. Denies palpitations, syncope, orthopnea, PND.
Respiratory: Complains of dyspnea. Denies cough.
Musculoskeletal: Complains of back pain.
Neurologic: Complains of headaches, weakness. Denies dizziness, seizures, syncope.
Endocrine: Denies cold intolerance, heat intolerance.
Allergic/Immunologic: Denies urticaria, hay fever.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.

Mental Status
Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary

PULMONARY EMBOLISM, HX OF (ICD-V12.51).

COUMADIN THERAPY (ICD-V58.61).
INR is 2.0; currently on 90mg per week. WIll increase to 95 mg per week and recheck in 2 weeks. Pt to take 15mg q day on Friday, Sat and SUnday and take 12.5 Mon-Thurs.

pt to return in 2 weeks with diet log and exercise log... will get A1C at that time.. pt wants to lose wt.
HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth. and Amilodipine 5mg q day. BP high today. WIll recheck in 2 weeks and increase as needed.

.....Kathryn W Dudas, MD October 10, 2009 3:59 PM

Prescriptions:
COUMADIN 5 MG TABS (WARFARIN SODIUM) take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday #120 x 3
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/09/2009
Method used: Print then Give to Patient
RxID: 1570719521158560

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/09/2009
Method used: Print then Give to Patient
RxID: 1570719461058560

GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs #30 x 4
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/09/2009
Method used: Print then Give to Patient
RxID: 1570719431058560

Signed by Brian D Keisler, MD on 10/12/2009 at 10:28 AM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

10/02/2009 - Office Visit: Coumadin Management
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Coumadin Management

Indication for Coumadin Therapy: Deep Vein Thrombosis
Coumadin Management Provider: Kathryn W Dudas MD

Patient PT: 23.0 (10/01/2009 9:32:00 AM)
INR: 1.9 (10/01/2009 9:32:00 AM)
Target INR Range: 2.0-3.0
Duration Tx: indefinitely
Current Coumadin Regimen
Friday: 10
Saturday: 10
Sunday : 10
Monday: 10
Tuesday: 10
Wed: 10
Thurs: come in
New Coumadin Regimen Friday: 12.5
Sat: 12.5
Sunday: 15
Monday: 12.5
Tuesday: 12.5
Wed: 12.5
Thurs: 12.5

Provider Instructions

Advise patient: PT/INR is too low and the dose of coumadin needs to be increased.
Comments: INR increased from 1.4- 1.9. Will cont. 12.5 q day except sunday-- will increase to 15. Pt understands this plan. Will recheck in 1 week. If theraputic- will recheck in 1 mo.

Results reviewed by: Kathryn W Dudas, MD on October 2, 2009 2:23 PM

Signed by Johan Hernandez MD on 10/02/2009 at 2:48 PM

09/24/2009 - Office Visit: Coumadin Update and Orders
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 232.80 lb.
Pulse rate: 84 **Pulse rhythm:** regular **Respirations:** 14
BP: 118/80
Wt chg: -0.50 since 10/30/2009
Vitals entered by: Karen S Grimball, RN on November 5, 2009 9:09 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.
.....Karen S Grimball, RN November 5, 2009 9:13 AM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness
History from: patient

Other HPI: 58 AAF presents today for f/u on DM and routine pap. Unsure if partner is faithful-- has had discharge- wants to be checked. Exercising daily... diet improving. DId not bring bs log.

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Social History
Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Denies fevers, chills, sweats.
Eyes: Denies blurring, diplopia.
Cardiovascular: Denies chest pains, palpitations.
Respiratory: Denies cough, dyspnea.
Genitourinary: Complains of vaginal discharge. Denies incontinence, dysuria, hematuria, abnormal vaginal bleeding.
Genitourinary: Complains of vaginal discharge. Denies incontinence, dysuria, hematuria, abnormal vaginal bleeding.
Musculoskeletal: Denies back pain, joint pain, joint swelling.
Endocrine: Denies cold intolerance, heat intolerance.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Genitourinary
External Genitalia: Negative Findings: no deformity, no skin lesions, no edema, no discharge.
Vagina: Negative Findings: normal mucosa, no discharge, no lesions, no rectocele, no cystocele.
Urethra: Negative Findings: no discharge.

Bladder: Negative Findings: no cystocele, no tenderness.
Cervix: Positive Findings: discharge. s/p total hysterectomy

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.

Laboratory Results
Wet prep/KOH Resulted: November 5, 2009 9:56 AM
WM: 2+ bacteria, Clue Cells present, Yeast absent, Trichomonas absent
Test performed by: Kathryn W Dudas, MD

Assessment & Plan Summary

COUMADIN THERAPY (ICD-V58.61). will check inr today and call with results-- may need to adjust dose
Medications: Coumadin 5 mg tabs take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday. INR 2.7- will continue current regimen and recheck in 2 weeks.

SEXUAL ACTIVITY, HIGH RISK (ICD-V69.2). wet prep done today for discharge-- bv noted. WIll treat.

VAGINITIS, BACTERIAL (ICD-616.10).
will treat wtih metronidazole X 7 days

OBESITY (ICD-278.00). pt exercising-- last A1C 7.7; wants to try to lose weight before switching regimens- if A1C increases above 8 will need to change regimen-- pt plans to lose 5 lbs prior to next visit in 1 mo.

.....Kathryn W Dudas, MD November 5, 2009 9:55 AM

Prescriptions:
FLAGYL 500 MG TABS (METRONIDAZOLE) one tab bid X 7 days #14 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 11/05/2009
Method used: Print then Give to Patient
RxID: 1573033030157110

Signed by Brian D Keisler, MD on 11/06/2009 at 8:24 AM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

10/30/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 233.30 lb. (106.05 kg.)
Pulse rate: 72 **Pulse rhythm:** regular **Respirations:** 16
BP: 138/88
BMI: 38.96 **BSA:** 2.11 **Wt chg:** -2.80 since 10/09/2009
Vitals entered by: Erin G Adams LPN on October 30, 2009 2:51 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.
Assessment done at: 1453
.....Erin G Adams LPN October 30, 2009 2:53 PM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness

History from: patient

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Other HPI: Patient presents to clinic today with c/o dizziness since Wednesday night. Pt has been missing meals. She also states that she is also having intermittant diarrhea since 08/23/2009. Diarrhea X 1 day; had in past happened 3 weeks ago-- last 1/2 day. She states that it has been difficult with the weight management. She has been staying at the hospital with her mother who has been diagnosed with cancer. Patient also states that she is having problems with her "sex drive".

Basis of Diagnosis: Previous history

FSBS testing: Yes **High** 200 **Low:** 65 **Avg:** 130

Comments: working on exercising--- mom in hospital.... new cancer diagnosis.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Musculoskeletal: Complains of back pain, joint pain.
Skin: Denies rash.
Neurologic: Complains of headaches, dizziness, weakness.
Psychiatric: Complains of depression, anxiety.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Spine, Ribs, Pelvis: Positive Findings: mild decreased ROM, L-Spine tenderness.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Positive Findings: mildly depressed mood, slightly anxious.

Assessment & Plan Summary

COUMADIN THERAPY (ICD-V58.61). will check INR today- and adjust coumadin dose as needed. INR: 2.3... will continue current treatment. 12.5mg Mon-Thurs and 15mg Fri-Sun.

DEPRESSION (ICD-311). Pt with depression/anxiety- mother with cancer. Pt overwhelmed. Will refer to Dr. Orr for psychotherapy and counsleing. Will start Zoloft and encourage to exercise and watch caloric intake. Zoloft does not interact with coumadin, thus this is why i am choosing. If pt has good response

but beings to gain weight, will consider changing to effexor. Effexor has some interaction with Coumadin so will not start there. Also could change to Welbutrin if anxiety improves. Will not use Paxil/Prozac as there is most interation with Coumadin.
Medications: Zoloft 50 mg tabs take one tab po q day.

DEGENERATIVE JOINT DISEASE (ICD-715.90). pt with DJD- has spinal osteophytes in C spine that cause some back pain.. Only takes as needed. Pt on Coumadin-- can't take NSAIDS for pain. WIll give 30 tabs Oxyc/apap- for severe pain. Pt states she is unable to exercise due to back pain.
Medications: Oxycodone-acetaminophen 5-500 mg caps take one tab po q 6 hours prn pain.

.....Kathryn W Dudas, MD December 4, 2009 2:45 PM

Prescriptions:

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) take one tab po q 6 hours prn pain #30 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 12/04/2009
Method used: Print then Give to Patient
RxID: 1575542268158590

PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 5
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 12/04/2009
Method used: Print then Give to Patient
RxID: 1575541878058590

ZOLOFT 50 MG TABS (SERTRALINE HCL) take one tab po q day #30 x 3
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 12/04/2009
Method used: Print then Give to Patient
RxID: 1575541378158430

Signed by Christian C Steen, MD on 12/08/2009 at 8:49 AM

11/05/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Depression

Basis for diagnosis: Previous diagnosis

Current Symptoms:feeling depressed
Denies:suicidal plan

Status:
The patients symptoms are reported to be better
The patient reports previous episodes of depression.
The patient reports no history of anxiety disorders.

Management:
The patient is currently using anti-depressants.

Comments: Patient states that her mood swings are not as bed anymore. She has an appt. scheduled with Dr Orr in January. Last week uncle passed away so feeling sad at times about that. Mother sick- out of hospital. Pt noticing a difference in mood with Zoloft- started 3 weeks ago. Will continue- no side effects.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

Ear/Nose/Throat: Complains of earache, nasal congestion. Denies sore throat.
Cardiovascular: Denies chest pains, palpitations, peripheral edema. Patient states she has swelling in her ankles when she is on her feet alot.
Respiratory: Denies cough, dyspnea.
Gastrointestinal: Complains of diarrhea. Denies nausea, vomiting, constipation.
Genitourinary: Denies dysuria, hematuria.
Genitourinary: Denies dysuria, hematuria.
Skin: Denies rash.
Neurologic: Complains of headaches, dizziness.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Physical Exam

General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Mood and Affect: Positive Findings: mildly depressed mood.

Assessment & Plan Summary

DEPRESSION (ICD-311). pt seeing some improvement with Zoloft noted after 3 weeks. Pt having all family together for christmas and is excited about that. Will see Dr. Orr in January. Continue Zoloft.
Medications: Zoloft 50 mg tabs take one tab po q day.

COUMADIN THERAPY (ICD-V58.61). Taking 12.5mg Mon-Thurs and Fri-Sun 15mg- INR 2.3 at last check. Will recheck today.

DEGENERATIVE JOINT DISEASE (ICD-715.90). controlled currently- pt has oxycod/apap prn unbearable pain. Trying to exercise--- will increase to 30 min walking q day.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0). pt bp elevated today; pt to keep bp log and bring to next visit. If remains greater than 140/90 pt to call. may need to add additional med at next visit. Pt feeling stressed today, could cause some elevation.
Medications: Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Benazepril hcl 40 mg tabs Take two po daily; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

At next visit: evaluate diabetes/htn. ?last mammo

.....Kathryn W Dudas, MD December 22, 2009 1:01 PM

Signed by Christian C Steen, MD on 12/22/2009 at 1:43 PM

12/04/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 234.50 lb.
Pulse rate: 78 **Pulse rhythm:** regular
BP: 140/96
Wt chg: 1.70 since 11/05/2009
Vitals entered by: Tamica L West, CMA on December 4, 2009 9:51 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.

Pain Assessment

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

The patient is not currently experiencing pain.
The patient does not experience chronic pain.
.....Tamica L West, CMA December 4, 2009 9:52 AM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Christian Steen

History of Present Illness

History from: patient
Chief Complaint: follow up weight...

Other HPI: Patient is here to f/u with weight and is concerned about a dent in her left leg and across her left fourth toe she states it feels tender and sore.

Mother in hospital again; pt feeling very stressed out. Desires help with depression. having dizzy spells with going to Charleston.

INR 3.6 at last check... here for recheck.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Denies fevers, chills, sweats.
Eyes: Denies blurring, diplopia, irritation.
Cardiovascular: Complains of dyspnea on exertion. Denies chest pains, palpitations, syncope.
Respiratory: Complains of dyspnea. Denies cough.
Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation.

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Signed by Ramon C Ylanan, MD on 03/05/2010 at 9:50 AM

12/22/2009 - Office Visit: FMC Adult Visit/ f/u depression
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 240.70 lb.
Pulse rate: 78 **Pulse rhythm:** regular
BP: 158/90
BMI: 40.20 **BSA:** 2.14 **Wt chg:** 6.20 since 12/04/2009
Vitals entered by: Karen M Springfield, RN on December 22, 2009 9:34 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall Risk Assessment: done today. No changes noted.

Suicide Screening

Are you having any problems with depression or feelings of hopelessness? Yes
Has there been any recent life situational changes that are affecting your ability to cope? Yes
Do you have thoughts of harming yourself? No
Comments: Recent unexpected death of uncle. Mother has been hospitalized recently with cancer & is not doing well.

Evaluation

Actions taken: Provider notified

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.
BP with large cuff.....Karen M Springfield, RN December 22, 2009 9:47 AM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Christian Steen

Other HPI: On coumadin therapy for dvt-- will check level today.
no bleeding/brusing.

Back pain- tolerable-- gave oxycod/apap at last visit-- pt has only used one time. Has a heating pad that she uses at times.

History of Present Illness
History from: spouse

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Management:
The patient is currently using anti-depressants, herbal products.

Comments: Pt has been doing much better since last visit until 2 weeks ago when her mother was put on hospice.. Pt has not been exercising and has been gaining weight since that time. Prior to 2 weeks ago she had lost 5 lbs per her. States that Zoloft has helped- she notices a difference from previously.

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History
Tobacco use: never
Drug Use: No
General Health Information
Exercise (x/wk): 2
Min/day: 30
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Denies fevers, chills, sweats.
Eyes: Complains of blurring, irritation. Denies vision loss, eye pain.
Ear/Nose/Throat: Complains of earache, hoarseness. Denies decreased hearing, sore throat.
Cardiovascular: Complains of chest pains, palpitations, dyspnea on exertion. Denies syncope.
Respiratory: Complains of cough, dyspnea, excessive sputum.
Gastrointestinal: Complains of nausea, diarrhea. Denies vomiting.
Genitourinary: Denies vaginal discharge, urinary frequency.
Genitourinary: Denies vaginal discharge, urinary frequency.
Musculoskeletal: Complains of muscle cramps. Denies back pain, joint pain.
Skin: Complains of itching, dryness. Denies rash.
Neurologic: Complains of headaches, dizziness, weakness.
Psychiatric: Complains of depression, anxiety. Denies memory loss.
Endocrine: Complains of weight change. Denies cold intolerance, heat intolerance.
Heme/Lymphatic: Denies abnormal bruising.
Allergic/Immunologic: Denies seasonal allergies, HIV exposure.

Physical Exam
General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Positive Findings: trace bilateral LE edema.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis, no abnormal lesions.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Positive Findings: mildly depressed mood.

Assessment & Plan Summary

COUMADIN THERAPY (ICD-V58.61). will check inr today; and continue current regimen- will call with results.
Medications: Coumadin 5 mg tabs take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday.

DEPRESSION (ICD-311).
Pt improving clinically-- relapse in past 2 weeks with mother declining. Will increase Zoloft to 100qday. Saw another physician who began Lexapro and vicaprofen? Pt has not taken and advised to not take. Will follow closely.
Medications: Zoloft 100 mg tabs take one tab po q day.

HEADACHE (ICD-784.0). seen by Dr. Ogburu-- taking maxalt at first sign of HA and Topamax daily-- continue.

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). Pt still does not desire insulin. Explained that if her A1C today is greater than 8 she will need insulin. Pt adamently against, has fear of needles. Will continue current regimen and get labs. Will see in 2 weeks and reevaluate.
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs; Amaryl 4 mg tabs Take one (1) tablet daily.

.....Kathryn W Dudas, MD March 2, 2010 12:44 PM

Prescriptions:

METOPROLOL SUCCINATE 200 MG XR24H-TAB (METOPROLOL SUCCINATE) take on tab po q day #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583149262609410

PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol #30 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148540159550

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148540059550

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148510659550

GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148510559550

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148510459550

ZOLOFT 100 MG TABS (SERTRALINE HCL) take one tab po q day #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 03/02/2010
Method used: Print then Give to Patient
RxID: 1583148360159550

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall risk screening: done today. No changes noted.

Suicide Screening

Comments: Pt does not meet criteria for screening.

Pain Screening

The patient is not currently experiencing pain.

The patient does not experience chronic pain.
Assessment done at: 1540

.....Erin G Adams LPN April 19, 2010 3:42 PM

Patient/caregiver Teaching

Attending Participation: Seen and discussed
Dr C Scott Lamar

History of Present Illness

History from: patient
Chief Complaint: f/u

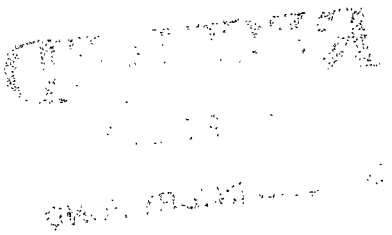
Other HPI: Patient presents to clinic today for a f/u of depression and coumadin therapy.

Hypertension

Basis for Diagnosis: Previous History of HTN

Denies: abdominal pain, chest pain, cough, diaphoresis

Status:
Home BP monitoring: No
Management:
Comments: bp cuff broke at home; will refill.



Palmetto Health Richland Family Medicine Center
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803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Depression

Basis for diagnosis: Previous diagnosis

Denies:feeling depressed, sadness, crying spells, concentration problems, short temper

Status:
The patients symptoms are reported to be better
The patient reports previous episodes of depression.
The patient reports a past history of anxiety.

Management:
The patient is currently using anti-depressants, relaxation techniques, exercise.

Comments: pt started doing puzzle books to help with anxiety; exercising- 3-4 times per week walking; doing upper body exercises.

Appears happier than i have ever seen.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Marital Status: Widowed

Review of Systems

General: Denies fevers, chills, sweats.
Eyes: Denies blurring, diplopia.
Cardiovascular: Denies chest pains, palpitations, syncope.
Respiratory: Complains of cough. Denies dyspnea, wheezing.
Gastrointestinal: Complains of diarrhea. Denies nausea, vomiting, constipation.
Genitourinary: Denies vaginal discharge, dysuria.
Genitourinary: Denies vaginal discharge, dysuria.
Neurologic: Denies headaches, dizziness.
Psychiatric: Denies depression, anxiety.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Palpation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal

Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic

Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal

Gait and Station: Negative Findings: normal gait.

Mental Status

Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary

COUMADIN THERAPY (ICD-V58.61) - Stable. will check INR today
Medications: Coumadin 5 mg tabs take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday.

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

DEPRESSION (ICD-311) - Improved. mood better than ever; continue zoloft. Cont exercise.
Medications: Zoloft 100 mg tabs take one tab po q day.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). will check A1C today; pt has lost 5 lbs- encouraged to continue exercising and eating healthy.
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs; Amaryl 4 mg tabs Take one (1) tablet daily; Benazepril hcl 40 mg tabs Take two po daily.

OBESITY (ICD-278.00). losing weight; exercising.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
Medications: Benazepril hcl 40 mg tabs Take two po daily; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth; Lopressor 50 mg tabs Take one tablet by mouth twice daily; Norvasc 5 mg tabs Take one (1) tablet daily by mouth.

Printing error-- pt did not recieve vicoprofen!

.....Kathryn W Dudas, MD April 19, 2010 4:46 PM

Prescriptions:

LOPRESSOR 50 MG TABS (METOPROLOL TARTRATE) Take one tablet by mouth twice daily #60 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587312005058950

ZOLOFT 100 MG TABS (SERTRALINE HCL) take one tab po q day #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975758950

PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol #30 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975658950

PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 5
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975558950

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 11
Entered and Authorized by: Kathryn W Dudas, MD

Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975458950

METOPROLOL SUCCINATE 200 MG XR24H-TAB (METOPROLOL SUCCINATE) take on tab po q day #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975358950

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975258950

GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311975058950

COUMADIN 5 MG TABS (WARFARIN SODIUM) take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday #120 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311855058950

PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 2
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311825558950

NORVASC 5 MG TABS (AMLODIPINE BESYLATE) Take one (1) tablet daily by mouth #30 x 6
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Print then Give to Patient
RxID: 1587311825358950

B2 100 MG TABS (RIBOFLAVIN) Take four tablets by mouth per day #100 x 8
Entered by: Erin G Adams LPN
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Historical
RxID: 1587310838158950

PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 2
Entered by: Erin G Adams LPN
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Historical
RxID: 1587310718158950

VICOPROFEN 7.5-200 MG TABS (HYDROCODONE-IBUPROFEN) Take one tablet by mouth every 6 hours as needed for pain. Max 5 tablets daily. #100 x 0
Entered by: Erin G Adams LPN
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010

Method used: Historical
RxID: 1587310688158950
NORVASC 5 MG TABS (AMLODIPINE BESYLATE) Take one (1) tablet daily by mouth #30 x 0
Entered by: Erin G Adams LPN
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 04/19/2010
Method used: Historical
RxID: 1587310658158950

Signed by C Scott Lamar MD on 04/19/2010 at 4:50 PM

03/02/2010 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Latex Screening Tool
1. Do you have or think you have an allergy to natural rubber latex? (Examples: balloons,condoms,pacifiers) No
2. Do you have spina bifida* or bowel/bladder problems that have required you to have any surgeries or procedures? No
3. If your work requires you to wear rubber gloves or to handle rubber products, have you had any problems? No
4. Did you have more than 3 operations or medical procedures before you were 1 year old? No
5. Have you ever had an allergic reaction during a medical or dental procedure? No
6. Do you have an allergic reaction to any of the following foods: Avocado, banana, potato, peach, kiwi, chestnut, or tomato? No
Above information entered by: Lasharen Carter, CMA

Vital Signs

Weight: 239.90 lb. **Height:** 65 in.
Pulse rate: 80 **Respirations:** 20
BP: 146/80

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

BMI: 40.07 **BSA:** 2.14 **Wt chg:** -0.80 since 12/22/2009
Vitals entered by: Lasharen D Carter, CMA on March 2, 2010 10:52 AM

Medication Reconcilliation
Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall risk screening: done today. No changes noted.

Suicide Screening

Are you having any problems with depression or feelings of hopelessness? Yes
Has there been any recent life situational changes that are affecting your ability to cope? No
Do you have thoughts of harming yourself or others? No

Pain Screening
The patient is currently experiencing pain.
Location: head Intensity (1-10): 4 Description: pressure Duration: 7Days
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Ramon Ylanan

Other HPI: F/u coumadin management-- taking same dose-- not checked inr in 3 month-- explained that this needs checking every month. No bleeding; +leg swelling, improved today.

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: abdominal pain, chest pain, cough, diaphoresis
Denies: dyspnea

Status:
Home BP monitoring: No

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3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10. 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Management:
Current Diet: low fat/low cholesterol
Comments: has been exercising until 2 weeks ago--- found out mom needed hospice-- has melonoma. Had been more depressed and staying at the hospital

Basis of Diagnosis: Previous history

FSBS testing: Yes **High** 150 **Low:** 60 **Avg:** 125

Comments: pt on metformin and glimipride.. Refuses insulin at this time. Will recheck A1C today and address at next visit.

Depression

Basis for diagnosis: Previous diagnosis

Current Symptoms:feeling depressed, sadness, crying spells, concentration problems, trouble sleeping

Status:
The patients symptoms are reported to be better
The patient reports previous episodes of depression.
The patient reports a past history of anxiety.

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3209 Colonial Drive Columbia, SC 29203
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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Denies fevers, chills, sweats.
Eyes: Denies blurring, diplopia.
Cardiovascular: Denies chest pains, palpitations, syncope.
Respiratory: Denies cough, dyspnea.
Gastrointestinal: Complains of nausea, diarrhea. Denies vomiting, constipation.
Genitourinary: Denies vaginal discharge, incontinence.
Genitourinary: Denies vaginal discharge, incontinence.
Musculoskeletal: Complains of back pain. Denies joint pain.
Skin: Denies rash, itching.
Psychiatric: Denies depression, anxiety.
Endocrine: Denies cold intolerance, heat intolerance.
Allergic/Immunologic: Complains of seasonal allergies. Denies urticaria.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Neck

Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Palpatation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal

Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic

Neck: Negative Findings: no cervical lymphadenopathy.

Skin

Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis, no abnormal lesions.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.

Mental Status
Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary 939-0026

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). Pt has not been exercising. Has been eating better and bs have been in 100's most of the time. Will start exercising. Will walk 10 min 2 times per day. Plan to lose 4 lbs by next visit.
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs; Amaryl 4 mg tabs Take one (1) tablet daily.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Stable. controlled; continue current regimen.
Medications: Metoprolol succinate 200 mg xr24h-tab take on tab po q day; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Benazepril hcl 40 mg tabs Take two po daily; Norvasc 5 mg tabs Take one (1) tablet daily by mouth; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

PULMONARY EMBOLISM, HX OF (ICD-V12.51). will check INR today and change regimen as needed. Would like to give pt one tab per day but is req about 13.5 mg per day.... will reeval after labs.
Medications: Coumadin 5 mg tabs take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday.

DEPRESSION (ICD-311) - Improved. Mother doing bad- pts mood much improved. WIll cont Zoloft.
Medications: Zoloft 100 mg tabs take one tab po q day.

.....Kathryn W Dudas, MD July 14, 2010 4:21 PM

Prescriptions:
VICOPROFEN 7.5-200 MG TABS (HYDROCODONE-IBUPROFEN) Take one tablet by mouth every 6 hours as needed for pain. Max 5 tablets daily. #100 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/14/2010
Method used: Print then Give to Patient
RxID: 1594743921058940
STEP ONE TEST STRIPS one months supply of Step One test strips #qs x 1 month x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/14/2010
Method used: Print then Give to Patient

RxID: 1594743861058940
COUMADIN 5 MG TABS (WARFARIN SODIUM) take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday #120 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/14/2010
Method used: Print then Give to Patient
RxID: 1594743831158940
PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 5
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/14/2010
Method used: Print then Give to Patient
RxID: 1594743831058940

]

Signed by Tan J Platt MD on 07/15/2010 at 12:11 AM

04/19/2010 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 235 lb. (106.82 kg.)
Pulse rate: 72 **Pulse rhythm:** regular **Respirations:** 16
BP: 130/82
Wt chg: -4.90 since 03/02/2010
Vitals entered by: Erin G Adams LPN on April 19, 2010 3:42 PM

Medication Reconcilliation
Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History
Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Complains of fevers, sweats, fatigue, malaise. Denies chills.
Eyes: Complains of blurring. Denies diplopia.
Ear/Nose/Throat: Complains of nasal congestion, sore throat, hoarseness. Denies earache, ear discharge, tinnitus.
Cardiovascular: Denies chest pains, palpitations, syncope.
Respiratory: Complains of cough, dyspnea, wheezing. Denies excessive sputum, hemoptysis.
Gastrointestinal: Complains of nausea. Denies vomiting, diarrhea, constipation.
Musculoskeletal: Complains of back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness.
Skin: Denies rash, itching.
Neurologic: Complains of headaches, dizziness, weakness. Denies paresthesias, seizures.
Psychiatric: Complains of depression, anxiety.
Heme/Lymphatic: Denies abnormal bruising.

Physical Exam
General
General: Negative Findings: well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.

External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Negative Findings: normal canals, tympanic membranes intact, tympanic membranes w/ normal mobility, No exudates, No fluid.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: edematous mucosa.
Lip/Teeth/Gums: Negative Findings: normal dentition.
Pharynx: Positive Findings: mild pharyngeal erythema.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpatation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Lymphatic
Neck: Positive Findings: shotty cervical adenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: decreased range of motion turning head left to 30degrees; right 60degrees; chin to chest 40 degrees;
Spine, Ribs, Pelvis: Positive Findings: bilateral paravertebral spasm, mild decreased ROM.
LUE: pain with overhead abduction, normal adduction, decreased strength over head

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Assessment & Plan Summary

HEADACHE, TENSION (ICD-307.81). will refer for PT; recommends massage. Will give vicodin for musc spasm. PT advised to only take as needed. Has much stress in her life currently. Advised personal time, walking daily and rest. Will send to PT and follow up in 1 mo. Ibuprofen for headaches.

COUMADIN THERAPY (ICD-V58.61). PT/INR checked today.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Stable. bp finally controlled; will continue current mgt.
Medications: Metoprolol succinate 200 mg xr24h-tab take on tab po q day; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Benazepril hcl 40 mg tabs Take two po daily; Norvasc 5 mg tabs Take one (1) tablet daily by mouth; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

.....Kathryn W Dudas, MD October 7, 2010 9:51 AM

Prescriptions:
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/06/2010
Method used: Print then Give to Patient
RxID: 1602000285609450
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 11
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/06/2010
Method used: Print then Give to Patient
RxID: 1602000285509450
VICODIN ES 7.5-750 MG TABS (HYDROCODONE-ACETAMINOPHEN) take one tab po q 8 hours prn muscle spasm. Do not drive. #20 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/06/2010
Method used: Print then Give to Patient
RxID: 1602000255159450
COUMADIN 5 MG TABS (WARFARIN SODIUM) take 3 pills Mon- Fri 2 pills Sat-Sunday #120 x 3
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/06/2010
Method used: Print then Give to Patient
RxID: 1601999481659450

]

Signed by Patricia W Witherspoon MD on 10/08/2010 at 12:44 PM

08/16/2010 - Office Visit: FMC Adult Visit Coughing
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: No latex allergy 08/16/2010
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)
.....Sharese L Reames August 16, 2010 3:30 PM

Vital Signs
Entered weight: 232 lb., 0 oz.
Calculated Weight: 232 lb. (105.45 kg.)
Temperature: 99.39 deg F. (37.44 deg C.) **Temp Site:** oral
Pulse rate: 80 **Pulse rhythm:** regular **Respirations:** 18
BP: 122/62
Wt chg: -6.70 since 07/14/2010
Vitals entered by: Sharese L Reames on August 16, 2010 3:25 PM
Vitals updated by: Sharese L Reames on August 16, 2010 3:25 PM

Medication Reconcilliation
Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall risk screening: done today. No changes noted.

Suicide Screening

Are you having any problems with depression or feelings of hopelessness? No
Has there been any recent life situational changes that are affecting your ability to cope? No
Do you have thoughts of harming yourself or others? No
Comments: Pt does not meet criteria for screening.

Pain Screening
The patient is currently experiencing pain.
Location: Lower abd Intensity (1-10): 7 Description: pressure Duration: Weeks
The patient does not experience chronic pain.

Pain Reassessment
The patient is currently experiencing pain.
Location: Lower abd.Intensity (1-10): 6Description: pressureDuration: Weeks
.....Sharese L Reames August 16, 2010 3:28 PM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr C Scott Lamar

History of Present Illness
History from: patient
Chief Complaint: pain

Headache
This patient with a history of Tension headaches presents to clinic today with complaints of onset squeezing left side headache which began on .
Headache is described to have been present for 10 days.
Headache pain is most severe no timing pattern and is given a 6 out of 10 in severity by the patient.
Assoc. Symptoms: nausea, neck pain, weakness
Aggrevating Factors: stress
Aleviating Factors: quiet room, dark room

Management:
Comments: Taking vicoprofen as needed for pain-- helps pt to sleep.

URI
Date of onset: 08/02/2010
Duration: 3 weeks
Current Symptoms:
Cough: productive
Congestion: yellow

Status:
URIs in last year: 0
Management:
Treatment: antihistamines, antibiotics

Other HPI: URI/Larangitis dx in ER at LMC 8/4-- PT given hydrocodone cough syrup, and z pack x 5 days.
Having pain around upper abdomen and back. Aching in nature. +cough, yellow thick mucous in the am. +diarrhea.
Works at NHC, lexington-- everyone is sick.

Also needs coumadin checked. Taking as perscribed.
.....Sharese L Reames August 16, 2010 3:29 PM

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History
Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Complains of fevers, chills, sweats, anorexia, fatigue, malaise, weight loss.
Eyes: Complains of blurring, eye pain. Denies diplopia.
Ear/Nose/Throat: Complains of earache, nasal congestion, nosebleeds, sore throat, hoarseness.
Cardiovascular: Denies chest pains, palpitations, syncope.
Respiratory: Complains of cough, dyspnea, excessive sputum, wheezing.
Gastrointestinal: Complains of nausea, diarrhea, abdominal pain. Denies vomiting, constipation, melena.
Genitourinary: Denies vaginal discharge, incontinence.
Genitourinary: Denies vaginal discharge, incontinence.
Musculoskeletal: Complains of back pain, joint pain, stiffness.
Skin: Denies rash.
Neurologic: Complains of headaches, dizziness. Denies syncope, tremors, vertigo.
Psychiatric: Denies depression, anxiety.

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.
Pupils: Negative Findings: no aniscoria, no cataracts, normal light reaction, normal accomodation.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Negative Findings: normal canals, tympanic membranes intact, tympanic membranes w/ normal mobility, No exudates, No fluid.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: edematous mucosa, inflamed mucosa.
Lip/Teeth/Gums: Negative Findings: normal dentition.
Pharynx: Positive Findings: pharyngeal erythema. Negative Findings: normal tongue.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.
Thyroid: Negative Findings: no masses.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Percussion: Negative Findings: no hyperresonance, no dullness.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Palpatation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Positive Findings: trace bilateral pedal edema.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Skin
Skin Inspection: Negative Findings: no rash.

Mental Status
Judgement/Insight: Negative Findings: intact.

Assessment & Plan Summary

ACUTE SINUSITIS, UNSPECIFIED (ICD-461.9). Pt with sx of sinusitis x 2-3 weeks. Has failed tx with Zpack. Sx persist-- fevers/chills. WIll retreat with augmentin x 10 days. PT to call if sx worsen or no improvment in 10 days. Encouraged to get neti pot or nasal saline irrigation. States nasal sprays are too expensive and her insurance does not cover. Tylenol for fever/chills.
Medications: Augmentin 500-125 mg tabs one tab po bid.

COUMADIN THERAPY (ICD-V58.61). will check INR today and call pt with results.
Medications: Pravastatin sodium 40 mg tabs one tablet at bedtime for cholesterol; Coumadin 5 mg tabs take 2.5 pills Mon- Thurs and Three pills Fri/Sat/Sunday.

OBESITY (ICD-278.00). lost 6 lbs-- encouraged to continue diet and exercise.

.....Kathryn W Dudas, MD August 16, 2010 3:57 PM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Prescriptions:

AUGMENTIN 500-125 MG TABS (AMOXICILLIN-POT CLAVULANATE) one tab po bid #20 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 08/16/2010
Method used: Print then Give to Patient
RxID: 1597593050159210

]

Signed by C Scott Lamar MD on 08/16/2010 at 3:58 PM

07/14/2010 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 238.70 lb.
Pulse rate: 84 **Pulse rhythm:** regular **Respirations:** 16
BP: 122/76
Wt chg: 3.70 since 04/19/2010
Vitals entered by: Karen S Grimball, RN on July 14, 2010 3:51 PM

Medication Reconcilliation

Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Additional Risk Factor(s): Medications affecting B/P or LOC
Fall risk screening: done today. No changes noted.

Suicide Screening

Comments: Pt does not meet criteria for screening.

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Pain Screening

The patient is not currently experiencing pain.

The patient does not experience chronic pain.

.....Karen S Grimball, RN July 14, 2010 3:58 PM

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr Tan Platt

Other HPI: Pt just returned from Florida for her birthday. Mood is much better. Her mother is on hospice. Had a great trip.
Has not been watching diet during trip.

Hx of PE-- on coumadin- 12.5mg Monday-Thurs
15mg Fri- Sunday
Hasn't missed any doses.

Comments: Checks bp at walmart occasionally- Usually 110-130/80-90

Basis of Diagnosis: Previous history

FSBS testing: Yes **High** 190 **Low:** 120 **Avg:** 160

Comments: Pt feels that diabetes is doing better. Besides last few days, diet has been better. Eating baked foods.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Depression
Basis for diagnosis: Previous diagnosis

Denies:feeling depressed, sadness, crying spells, concentration problems, short temper, decreased appetite, increased appetite, trouble sleeping, increased sleep, feeling worthless, feeling hopeless, feeling helpless, anxious, palpitations

Status:
The patients symptoms are reported to be better
The patient reports previous episodes of depression.
The patient reports a past history of anxiety.

Management:
The patient is currently using anti-depressants.

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History
Tobacco use: never

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Language Preference: English
Latex Risk: No latex allergy 08/16/2010 (08/16/2010 3:21:51 PM)

Vital Signs

Weight: 230 lb. (104.55 kg.)
Pulse rate: 72 **Respirations:** 20
BP: 120/64
BMI: 38.41 **BSA:** 2.10 **Wt chg:** -2 since 08/16/2010
Vitals entered by: Susan Jackson, CMA on October 6, 2010 3:25 PM

Medication Reconcilliation

Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall risk screening: done today. No changes noted.

Suicide Screening

Pain Screening

The patient is currently experiencing pain.
Location: headaches Intensity (1-10): 7 Description: ache Duration: Weeks
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Discussed
Dr Patricia Witherspoon

Headache

This patient with a history of Tension headaches presents to clinic today with complaints of onset constant occipital headache which began on 09/07/2010.
Headache is described to have been present for >60 minutes.
Headache pain is most severe int the afternoon and is given a 7 out of 10 in severity by the patient.
Assoc. Symptoms: nausea, sinus pressure, neck pain, back pain, speech disturbance
Aggrevating Factors: noise, bright light, valsalva
Aleviating Factors: sleep, quiet room, dark room

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Management:
Prophylactic treatment:beta blocker**Comments:** constant stabbing pain. Has been taking Lortab as needed- helps for 2 hrs then returns. Comes and goes, most of the time comes on in the afternoon. Worse with stress.
pain from left occiput area down left side of neck.
Has been hoarse -worse at night.

Granddaughter attempted suicide recently- at baptist rehab now.
Mother with cancer - on hospice.

Pulled muscle in back 8/8- fell and hit head- had headache since that time.. Had CT scan at Richland.

Also fell recently at work and pulled lower back- seeing ortho about that per her job.

Hypertension
Basis for Diagnosis: Previous History of HTN

Denies: abdominal pain, chest pain

Status:
Home BP monitoring: No
Management:
Current Diet: 2gm Sodium
Treatment compliance: Good
Comments: Pt doing well. No complaints.

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr C Scott Lamar

Headache

This patient with a history of Tension headaches presents to clinic today with complaints of gradual onset stabbing occipital headache which began on .
Headache is described to have been present for 5 minutes.
Headache pain is most severe no timing pattern and is given a out of 10 in severity by the patient.
Assoc. Symptoms: aura, sinus pressure, neck pain, radicular sx
Aggrevating Factors: noise, bright light, stress
Aleviating Factors: sleep, quiet room, dark room

Management:
Aleviating Factors:NSAIDs/Tylenol**Comments:** Patient states that she take Hydrocod/Ibu for both back pain and headaches. She does not know if it is effective; however, it makes her tired.

Ortho/Injury

Location: Bilateral neck
Mechanism of injury: Patient still has muscle spasm locate in her neck. Patient complains of decreased range of movement.
Current Symptoms: pain
Denies: swelling, erythema, weakness, numbness, tingling

Comments: Patient is currently taking Vicodin for neck pain. States that medication makes her sleep and decrease pain for 1 hr. Patient also had a massage which helped for 1 day.

Diabetes

Type: Non-insulin dependent

Hyperglycemic Symptoms: polydipsia
Hypoglycemic Symptoms: nervous, sweaty

Status:
FSBS testing: Yes **High** 200 **Low:** 40 **Avg:** 170
Self foot Exam: Yes

Last A1c :

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

8.3 (07/14/2010 4:00:00 PM)

Management:
Dietary Compliance: Fair
Medication Compliance: Good
ACEi: yes **ARB:** no **Statin:** yes **ASA:** no

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Complains of fatigue. Denies fevers, chills, sweats.
Eyes: Denies blurring, irritation, discharge, vision loss.
Ear/Nose/Throat: Complains of nasal congestion. Denies earache, ear discharge, sore throat, hoarseness.
Cardiovascular: Complains of palpitations, orthopnea. Denies chest pains, dyspnea on exertion, peripheral edema. Sleeps on 2 pillows.
Respiratory: Denies cough, dyspnea.

Gastrointestinal: Complains of diarrhea, abdominal pain. Denies nausea, vomiting, constipation, melena, hematochezia.
Genitourinary: Denies dysuria, hematuria, urinary frequency.
Genitourinary: Denies dysuria, hematuria, urinary frequency.
Musculoskeletal: Complains of back pain. Denies joint pain, muscle cramps, muscle weakness.
Skin: Denies rash, itching, dryness.
Neurologic: Complains of see HPI, headaches. Denies dizziness, weakness, syncope.
Psychiatric: Complains of depression, anxiety.
Endocrine: Denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change.
Heme/Lymphatic: Denies abnormal bruising, bleeding, enlarged lymph nodes.

Physical Exam

Assessment & Plan Summary

HEADACHE, TENSION (ICD-307.81) - Unchanged. still having tension headaches. Had massage and had some improvement. Some improvement with vicoprofen. Neck spasms continue. Will treat with flexeril. Pt has soo much stress in life, less concerned for intracranial pathology, and more with overall stress picture. Will reeval in 1 mo.

ACUTE SINUSITIS, UNSPECIFIED (ICD-461.9) - Improved.

COUMADIN THERAPY (ICD-V58.61). INR elevated at last check 3.6. Taking 15 mg M-W and 10mg Th-Sun. Will check INR today. If OK will give 12.5 daily to equal 87.5 per week. Will call with results.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Stable.
Medications: Metoprolol succinate 200 mg xr24h-tab take on tab po q day; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Benazepril hcl 40 mg tabs Take two po daily; Norvasc 5 mg tabs Take one (1) tablet daily by mouth; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). will check A1C today.
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs; Amaryl 4 mg tabs Take one (1) tablet daily.

DEGENERATIVE JOINT DISEASE (ICD-715.90). back pain continues to be an issue--- pt starting PT again in 1 week. Working with lawyers over previous work injuries... Advised exercise/stretching PT best treatment.

.....Kathryn W Dudas, MD October 20, 2010 3:25 PM

Prescriptions:

FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) take one tab po q 8 hours prn muscle spasm #30 x 1

Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/20/2010
Method used: Print then Give to Patient
RxID: 1603205968159120

]

Signed by C Scott Lamar MD on 10/20/2010 at 3:49 PM

10/20/2010 - Append: FMC Adult Visit
Provider: C Scott Lamar MD
Location of Care: Ambulatory Services

Physical Exam

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: No latex allergy 08/16/2010 (08/16/2010 3:21:51 PM)

Vital Signs

Medication Reconcilliation

Fall Risk Screening

Suicide Screening

Pain Screening

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

10/20/2010 - Office Visit: FMC Adult Visit/FU muscle spasms
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: No latex allergy 08/16/2010 (08/16/2010 3:21:51 PM)

Vital Signs

Weight: 228.60 lb. (103.91 kg.)
Pulse rate: 74 **Pulse rhythm:** regular
BP: 140/90
Wt chg: -1.40 since 10/06/2010
Vitals entered by: Ontrelle L Young, CMA on October 20, 2010 2:34 PM
Vitals updated by: Ontrelle L Young, CMA on October 20, 2010 2:34 PM

Medication Reconcilliation

Medication list reviewed by nursing staff with pt/caregiver today.

Fall Risk Screening

Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: No
Fall risk screening: done today. No changes noted.

Suicide Screening

Comments: Pt does not meet criteria for screening.

Pain Screening

The patient is currently experiencing pain.
Location: lower abdomen Intensity (1-10): 6 Description: pressure Duration: 1 week
The patient does not experience chronic pain.

Comment: Patient states that the pressure she feels in her lower abdomen comes and goes.
.....Ontrelle L Young, CMA October 20, 2010 2:38 PM
BP with large cuff

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr C Scott Lamar

Headache

This patient with a history of Tension headaches presents to clinic today with complaints of gradual onset stabbing occipital headache which began on .
Headache is described to have been present for 5 minutes.
Headache pain is most severe no timing pattern and is given a out of 10 in severity by the patient.
Assoc. Symptoms: aura, sinus pressure, neck pain, radicular sx
Aggrevating Factors: noise, bright light, stress
Aleviating Factors: sleep, quiet room, dark room

Management:
Aleviating Factors:NSAIDs/Tylenol**Comments:** Patient states that she take Hydrocod/Ibu for both back pain and headaches. She does not know if it is effective; however, it makes her tired.

Ortho/Injury

Location: Bilateral neck
Mechanism of injury: Patient still has muscle spasm locate in her neck. Patient complains of decreased range of movement.
Current Symptoms: pain
Denies: swelling, erythema, weakness, numbness, tingling

Comments: Patient is currently taking Vicodin for neck pain. States that medication makes her sleep and decrease pain for 1 hr. Patient also had a massage which helped for 1 day.

Diabetes

Type: Non-insulin dependent

Hyperglycemic Symptoms: polydipsia
Hypoglycemic Symptoms: nervous, sweaty

Status:
FSBS testing: Yes **High** 200 **Low:** 40 **Avg:** 170
Self foot Exam: Yes

Last A1c :

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

8.3 (07/14/2010 4:00:00 PM)

Management:
Dietary Compliance: Fair
Medication Compliance: Good
ACEi: yes **ARB:** no **Statin:** yes **ASA:** no

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History

Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Complains of fatigue. Denies fevers, chills, sweats.
Eyes: Denies blurring, irritation, discharge, vision loss.
Ear/Nose/Throat: Complains of nasal congestion. Denies earache, ear discharge, sore throat, hoarseness.
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Genitourinary: Denies dysuria, hematuria, urinary frequency.
Genitourinary: Denies dysuria, hematuria, urinary frequency.
Musculoskeletal: Complains of back pain. Denies joint pain, muscle cramps, muscle weakness.
Skin: Denies rash, itching, dryness.
Neurologic: Complains of see HPI, headaches. Denies dizziness, weakness, syncope.
Psychiatric: Complains of depression, anxiety.
Endocrine: Denies cold intolerance, heat intolerance, polydipsia, polyphagia, polyuria, weight change.
Heme/Lymphatic: Denies abnormal bruising, bleeding, enlarged lymph nodes.

Physical Exam

Assessment & Plan Summary

HEADACHE, TENSION (ICD-307.81) - Unchanged. still having tension headaches. Had massage and had some improvement. Some improvement with vicoprofen. Neck spasms continue. Will treat with flexeril. Pt has soo much stress in life, less concerned for intracranial pathology, and more with overall stress picture. Will reeval in 1 mo.

ACUTE SINUSITIS, UNSPECIFIED (ICD-461.9) - Improved.

COUMADIN THERAPY (ICD-V58.61). INR elevated at last check 3.6. Taking 15 mg M-W and 10mg Th-Sun. Will check INR today. If OK will give 12.5 daily to equal 87.5 per week. Will call with results.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Stable.
Medications: Metoprolol succinate 200 mg xr24h-tab take on tab po q day; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Benazepril hcl 40 mg tabs Take two po daily; Norvasc 5 mg tabs Take one (1) tablet daily by mouth; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). will check A1C today.
Medications: Glucophage 1000 mg tabs One tablet BID; Glimepiride 2 mg tabs take one tab q day, take with 4mg tabs; Amaryl 4 mg tabs Take one (1) tablet daily.

DEGENERATIVE JOINT DISEASE (ICD-715.90). back pain continues to be an issue--- pt starting PT again in 1 week. Working with lawyers over previous work injuries... Advised exercise/stretching PT best treatment.

.....Kathryn W Dudas, MD October 20, 2010 3:25 PM

Prescriptions:
FLEXERIL 10 MG TABS (CYCLOBENZAPRINE HCL) take one tab po q 8 hours prn muscle spasm #30 x 1

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 10/20/2010
Method used: Print then Give to Patient
RxID: 1603205968159120

]

Signed by C Scott Lamar MD on 10/20/2010 at 3:49 PM

10/20/2010 - Append: FMC Adult Visit
Provider: C Scott Lamar MD
Location of Care: Ambulatory Services

Physical Exam

Patient Information
Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: No latex allergy 08/16/2010 (08/16/2010 3:21:51 PM)

Vital Signs

Medication Reconcilliation

Fall Risk Screening

Suicide Screening

Pain Screening

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November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Patient/caregiver Teaching

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
DVT x 2
PE

Social History
Tobacco use: never
Drug Use: No
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Lip/Teeth/Gums: Negative Findings: normal dentition.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.
Thyroid: Negative Findings: no masses, no nodules, non-tender, no enlargement.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory

distress.

Cardiovascular
Palpatation: Negative Findings: no thrill, normal PMI, no parasternal heave.
Auscultation: Negative Findings: normal S1 & S2, no murmurs, no rubs, no gallop.
Carotid Arteries: Negative Findings: symmetrical 2+ pulses, no bruits.
Abdominal Aorta: Negative Findings: no enlargement, no burits.
Femoral Arteries: Negative Findings: no bruits.
Pedal Pulses: Negative Findings: symmetrical normal post tibial pulses.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

Gastrointestinal
Abdomen: Positive Findings: tenderness R lower quadrant, tenderness L lower quadrant. Negative Findings: soft, no masses, normal bowel sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash, no petechiae, no ecchymosis.

Musculoskeletal
Head and Neck: Positive Findings: mild decreased ROM, bilateral paracervical muscle spasms.

Mental Status
Judgement/Insight: Negative Findings: intact.

]

Signed by C Scott Lamar MD on 10/20/2010 at 4:49 PM

PALMETTO HEALTH

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
OFFICE: 803-434-6113 FAX: 803-434-7231

10/26/2010

Name: JOANN M BROCKINGTON

DOB: 07/04/1951

To whom it may concern:
Mrs. Brockington has been under my care and suffered an injury at work on 9/27/10. Since that time, she has not been able to perform the duties that her job requires due to pain in her back and neck. She will see orthopedic surgery in early November and her return to work will be determined at that time by the orthopedist. Please excuse her from work from 9/27 until 11/5/2010. I am hopeful that she will be able to return to work soon.

Thank you,

Kathryn Dudas, MD

Signed by Kathryn W Dudas, MD on 10/26/2010 at 3:23 PM

JOANN M BROCKINGTON Home: (803)740-4497 Work: (803)939-0026
Female DOB: 07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

Richland Family Medicine Center
3209 Colonial Drive
Columbia, SC 29203 USA
Phone: 803-434-6113

October 27, 2010

JOANN BROCKINGTON
1208 BUSH RIVER RD APT J1
COLUMBIA, SC 29210
IMPORTANT APPOINTMENT INFORMATION

RE: REFERRAL

Dear Ms. BROCKINGTON,

This letter is to confirm that you have been scheduled for an appointment. Please make every effort to keep this appointment. If you cannot keep this appointment, please call the Office Phone Number listed below to reschedule.

Type of referral: Testing
Diagnostic Study: Sleep Study
Scheduled With: Palmetto Health Richland
Your appointment is scheduled on 10/31/2010 **at** 8:00
Office Location: 3 Medical park, ste 250
Office Phone: 434-4488
Referring Resident: Katie Dudas
Referring Attending: Scott Lamar
Reason for test: OSA

Appointment made by:

Karen S Grimball RN

Patient / Significant Other/Caregiver verbalized understanding.

10/27/2010 - Append: Sleep Study with Titration auth not required. gn
Provider: Glenda C Nelson RN
Location of Care: Palmetto Health Richland Family Medicine Center

Phone Note

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
803-434-6113 Fax: 803-434-7231

November 10, 2010

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951

Home: (803)740-4497 Work: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 111148

Outgoing Call
Call placed by: Glenda C Nelson RN, October 27, 2010 10:38 AM
Call placed to: 800-924-7141 BCBS TN
Details for Reason:
is pt. covered?
is authorization required for sleep study (95811)?
Summary of Call:
per IVRS:
effective date of coverage 01/01/2009
network Blue network P
transferred to service representative
spoke with April
tax id - 57-0969833
call back # 803-434-2469
do you participate with the local PPO network? yes
no pre-existing
no exclusion rider
procedure code 95811 does not require prior authorization but must meet medical criteria for medical necessity.

Signed by Glenda C Nelson RN on 10/27/2010 at 10:46 AM

PALMETTO HEALTH

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
OFFICE: 803-434-6113 FAX: 803-434-7231

Name: JOANN M BROCKINGTON

DOB: 07/04/1951

To whom it may concern:
Mrs. Brockington has been under my care and suffered an injury at work on 9/27/10. Since that time, she has been able to perform the duties that her job requires due to pain in her back and neck. She will see orthopedic surgery in early November and her return to work will be determined at that time by the orthopedist. Please excuse her from work from 9/27 until 11/5/2010. I am hopeful that she will be able to return to work soon.

Thank you,

Kathryn Dudas, MD

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PALMETTO HEALTH

Palmetto Health Richland Family Medicine Center
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CERTIFICATE TO RETURN TO SCHOOL OR WORK

JOANN BROCKINGTON has been under the care of Kathryn Dudas, MD from September 7, 2010 to and is able to return to school/work on September 8, 2010.

Limitations/Remarks:

Jada M Sumter,CMA

Palmetto Health Richland Family Medicine Center

PALMETTO HEALTH

Palmetto Health Richland Family Medicine Center
3209 Colonial Drive Columbia, SC 29203
OFFICE: 803-434-6113 FAX: 803-434-7231

CERTIFICATE TO RETURN TO SCHOOL OR WORK

JOANN BROCKINGTON has been under the care of Kathryn Dudas, MD on July 14, 2010 and is able to return to school/work.

Limitations/Remarks:

Karen S Grimball, RN

Palmetto Health Richland Family Medicine Center

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female, DOB: 02/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148 Home: (803)740-4497 Office: (803)939-0026

05/29/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Latex Screening Tool
1. Do you have or think you have an allergy to natural rubber latex? (Examples: balloons,condoms,pacifiers) No
2. Do you have spina bifida* or bowel/bladder problems that have required you to have any surgeries or procedures? No
3. If your work requires you to wear rubber gloves or to handle rubber products, have you had any problems? No
4. Did you have more than 3 operations or medical procedures before you were 1 year old? No
5. Have you ever had an allergic reaction during a medical or dental procedure? No
6. Do you have an allergic reaction to any of the following foods: Avocado, banana, potato, peach, kiwi, chestnut, or tomato? No

Vital Signs
Entered weight: 226 lb., 4 oz.
Calculated Weight: 226.25 lb.
Pulse rate: 84 **Respirations:** 20
BP: 122/70
BMI: 37.79 **BSA:** 2.09 **Wt chg:** -1.75 since 05/17/2007

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 2 **Description:** nagging **Duration:** intermittant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on May 29, 2007 4:27 PM
.....Avis N Jackson, LPN May 29, 2007 4:28 PM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1965
R009122086
Home: (803) 7[illegible] Office: (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

Previous HIV and Drug Use Information
Drug Use: none (data entered on 05/17/2007)

Attending Participation: Present and Available
Dr Damon Daniels

Diabetes

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance good

Self Foot Exam: yes
Eye Exam within last 12 months: yes
Date of Exam: 04/04/2007
Last eye exam: 04/04/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam

Complete Diabetic Foot Exam within last 12 months: Done
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po BID
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
DIFLUCAN 150 MG TABS (FLUCONAZOLE) one tablet by mouth x 1 dose
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed

Medication Hx:

ACE: yes
Statin: yes

History of Present Illness

History from: patient

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female, DOB:0/04/1961 R009122086 Ins: BLUE CRO (0634) Grp:111148

Chief Complaint: sinus problems

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: good
Glucose Monitoring
Glucose Home Monitoring reviewed: no
Diet Management
ADA diet, low fat, low cholesterol
Diet compliance: good
Insulin Management: no
Dilated Eye Exam: yes

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache, cough
Denies: visual disturbance, epistaxis, vertigo, syncope/presyncope, fatigue, edema, dyspnea, chest pain, palpitations
Current Status
Compliance with tx: good
Medication Tolerance: no complaints
Comments: Compliant with meds. Denies any side effects of meds. Denies any symptoms associated with elevated BP.

History of Present Illness
History from: patient
Chief Complaint: sinus problems

URI Symptoms
Cough: productive, worse in the morning for the past 2 weeks
Sore throat: with swollen glands, with dysphagia for the past 2 weeks
Nasal congestion: yellow, white, thick, facial pressure for the past 2 weeks
Ear pain: right side, pressure/fullness, with drainage, with ringing/roaring, with popping for the past 2 weeks
Eye discharge: right eye, matting, tearing, swelling, painful for the past 2 weeks
Trends/Treatment
# of URI in the past year: 3
Comments: has tried Mucinex, Zyrtec, Aleve

white, yellow thick nasal discharge

nausea/vomiting

subjective low grade fever

lots of pressure around right eye

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home (803)740-4297 Office (803)939-0026
Ins: BLUECRO (0534) Grp: 111148

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA

Social History (reviewed - no changes required): non-smoker

Review of Systems

General: subjective low-grade fever; no chills, sweats
Eyes: denies blurring, irritation
Ear/Nose/Throat: c/o nasal congestion, sore throat, sinus pressure
Cardiovascular: denies CP, palps, DOE, edema
Respiratory: productive cough
Gastrointestinal: c/o nausea, vomiting; denies diarrhea
Skin: denies rash, itching, dryness, suspicious lesions
Psychiatric: denies depression, anxiety
Allergic/Immunologic: See HPI

Physical Exam

General Appearance: well nourished, well hydrated, no acute distress

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat

External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: dull appearance to right tm
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: mild pharyngeal erythema

Neck

Neck Exam: supple, no masses, trachea midline
Thyroid Exam: no nodules, masses, tenderness, or enlargement

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop

Gastrointestinal
Abdomen: soft, non-tender, no masses, bowel sounds normal

Lymphatic
Neck: mildly tender submandibular LAD

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
ttp right maxillary and right frontal sinuses

Review of Lab Results
HgbA1C 8.0 (05/17/2007 11:00:00 AM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use, Diabetes Management, Use of Glucometer, Compliance with Medication.

Assessment and Plan
Problem 1: SINUSITIS ACUTE NOS (ICD-461.9)
History and physical c/w acute sinusitis. Z-pack due to PCN allergy. Cont OTC Mucinex.
Problem 2: DIABETES MELLITUS NONINSULIN DEPENDENT (NIDDM) (ICD-250.00)
A1c down to 8.0 from 9.1. Gluc 85 today. Cont current regimen. Recheck A1c in 3 months.
Problem 3: HYPERTENSION (ICD-401.1)
Pt's blood pressure is stable and under good control with current medications. Will continue to monitor.

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(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 6/7/1981 R0091220[illegible] Home: (803)740-4497 Office: (803)939-0026
Ins: BLUE GRO (0534) Grp: 111148

Prescriptions:
ZYRTEC 10 MG TABS (CETIRIZINE HCL) one tablet daily #30 x 3
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/29/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD May 31, 2007 3:20 PM

Signed by Damon Daniels MD on 06/07/2007 at 1:46 PM

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB:07/24/1961 R009122086 Home:(803)740-4497 Office:(803)939-0026 Ins:BLUE CRO (0034) Grp: 111148

08/14/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs
Entered weight: 223 lb., 7 oz.
Calculated Weight: 223.44 lb.
Pulse rate: 84 **Respirations:** 20
BP: 164/108
BMI: 37.32 **BSA:** 2.08 **Wt chg:** -2.81 since 05/29/2007

Pain Assessment
The patient is currently experiencing pain.
Location: head **Intensity (1-10):** 5 **Description:** stabbing **Duration:** constant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on August 14, 2007 11:28 AM
patient presents with complaints of head pain from a fall @ work on last Wednesday, rates pain level @ 5 on scale of 0-10. Patient states she is experiencing blurry vision unable to open mouth wide without hurting. Patient state she had a knot in base of head the is smaller now. Patient went to Lexington ER

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Available
Dr Jason Stacy

History of Present Illness
Chief Complaint: f/u fall

History of Present Illness
History from: patient
Chief Complaint: f/u fall

General HPI
Presents to clinic today after suffering fall 7 days ago. Pt was at work and slipped on concrete floor. Hit head and blacked out afterwards. Went to LMC ED where she had plain films of neck and right hip performed which ruled out fracture. No CT performed per pt. Since then has experienced blurred vision, constant headache primarily in left temporal and occipital regions. 5/10 on pain scale today. Has been taking 800mg Motrin with mild relief of pain and minimal relief of pain with Flexeril as well. Unable to work

since this has happened.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: denies weight or appetite change
Eyes: c/o blurred vision
Cardiovascular: denies CP, palps, DOE, edema
Musculoskeletal: denies shoulder pain
Neurologic: c/o headache-see hpi; denies dizziness lately

Physical Exam

General Appearance: moderate discomfort due to headache

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat

External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck

Neck Exam: supple, no masses, trachea midline

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Palpation: no thrill or palpable murmurs, no displacement of PMI
Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Musculoskeletal

Gait and Station: normal
Head and neck: mild decreased ROM due to pain, bilateral paracervical muscle spasms
RUE: normal ROM and strength, no joint enlargement or tenderness
LUE: normal ROM and strength, no joint enlargement or tenderness

Neurologic
Cranial Nerves: II - XII grossly intact
Reflexes: 2+, symmetric, no pathological reflexes in UE
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Snellen: 20/70 right and 20/50 left

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use.
Informed How: Verbally

Assessment and Plan
Problem 1: HEAD TRAUMA (ICD-959.01)
Mechanical fall resulting in trauma to head. Pt reports no CT performed at LMC. Since pt experiencing headaches and blurred vision, will refer for CT head and neck to r/o any pathology. Cont Motrin for pain control. Will keep pt out of work for one week.

Current Orders
CT Head w/o Contrast [CPT-70450]

Prescriptions:
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain #90 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/14/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 14, 2007 1:22 PM

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female, DOB 07/04/1951 R009122086 Home (803)740-4497 Office (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

Signed by Jason J Stacy MD on 08/28/2007 at 10:45 AM

Children's Hospital Outpatient Center
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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB:07/04/1951 [illegible] R009122086 Home: (803)740-4497 Office: (803)699-6026
Ins:BLUE GRO (0534) Grp: 111148

08/21/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 222 lb.
Temperature: 100 deg F. **Temp Site:** oral
Pulse rate: 102 **Pulse rhythm:** regular **Respirations:** 22
BP: 150/100
BMI: 37.08 **BSA:** 2.07 **Wt chg:** -4.25 since 05/29/2007
Vitals entered by: Linda D Searles PCA on August 21, 2007 9:44 AM
.....Linda D Searles PCA August 21, 2007 9:44 AM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Attending Participation: Present and Discussed
Dr Brian Keisler

History of Present Illness
Chief Complaint: f/u CT results

History of Present Illness
History from: patient
Chief Complaint: f/u CT results

General HPI
Presents to clinic today for f/u on CT head/neck results for her recent head trauma. Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 03/04/1954 R009122086 Home: (803)740-4497 Office: (803)939-0026
Ins: BLUECRO (6534) Grp: 111148

Pt states headache now worse, now located along both parietal regions. Constant baseline HA with intermittent flares of sharp pain. Worst headache of her life. States vision worse as well. Also c/o dizziness at times and imbalance when walking or standing up.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: subjective low-grade fever; no chills, sweats
Eyes: c/o blurred vision
Cardiovascular: denies CP, palps, DOE, edema
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures

Physical Exam

General Appearance: moderate discomfort due to pain

Eyes

External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation
Ophthalmoscopic: some a/v nicking present, no hemorrhages, or exudates noted

Ear, Nose &Throat

Hearing: grossly intact

Neck

Neck Exam: supple, no masses, trachea midline

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Palpation: no thrill or palpable murmurs, no displacement of PMI
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic

Neck: no cervical adenopathy

Musculoskeletal

Gait and Station: normal

Digits and nails: no clubbing, cyanosis, petechiae, or nodes
Head and neck: mild decreased ROM due to pain
Spine, ribs, pelvis: normal alignment and mobility, no deformity
RUE: normal ROM and strength, no joint enlargement or tenderness
LUE: normal ROM and strength, no joint enlargement or tenderness
RLE: normal ROM and strength, no joint enlargement or tenderness
LLE: normal ROM and strength, no joint enlargement or tenderness

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Snellen: 20/70 bilaterally

Romberg with slight drift to the right

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Results, Workup Options, Treatment Options, Medication Use.
Informed How: Verbally

Assessment and Plan
Problem 1: HEAD TRAUMA (ICD-959.01)
MRI without contrast to check if collection of blood has resolved. Refer to ophthalmology as well. Tylox for pain. Needs to remain out of work for at least two weeks due to intense symptoms of HA, blurred vision, imbalance.
Problem 2: VISUAL IMPAIRMENT (ICD-368.10)
Vision worse per pt. Refer to ophthalmology.

Current Orders
MRI Head [CPT-70546]
Refer to Ophthalmology [*]

Prescriptions:

Children's Hospital Outpatient Center
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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1951 R009122086 Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CRO (0534) Grp: 11149

TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/21/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 21, 2007 10:29 AM

Signed by Brian D Keisler, MD on 08/21/2007 at 1:20 PM

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: BLUE CRG (0534) Grp: 111149

08/29/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 220 lb. (100.00 kg.)
Pulse rate: 88 **Pulse rhythm:** regular **Respirations:** 20
BP: 160/110
BMI: 36.74 **BSA:** 2.06 **Wt chg:** -2 since 08/21/2007

Pain Assessment
The patient is currently experiencing pain.
Location: posterior R head **Intensity (1-10):** 10 **Description:** sharp **Duration:** 21 days
Vitals entered by: Virginia R Prevost LPN on August 29, 2007 10:50 AM

Other Medications
Toradol IM
Dose: 60 mg
Site: IM L deltoid
Given by: Virginia Prevost LPN
Notes: Per order of Dr. Venn at 10:50am.

.....Virginia R Prevost LPN August 29, 2007 10:50 AM

Patient Referral
Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Discussed
Dr Elizabeth G Baxley

History of Present Illness

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB:07/04/1951 R009122086 Home:(803)740-4497 Office:(803)939-0026 Ins: BLUE GRO (0534) Grp: 111148

Chief Complaint: f/u head trauma

History of Present Illness
History from: patient
Chief Complaint: f/u head trauma

General HPI
Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative. MRI ordered and showed very small and thin parafalcine subdural hematomas on left side, both anterior and posterior causing NO mass effect.

Pt still complaining of HA, no localized to ocipital regions, right worse than left. Went to ophtho last Saturday and he cleared her, stating that symptoms probably related to concussion. Pt still with double and blurred vision. Has short-term memory loss. Taking Tylox and ibuprofen which provide mild relief but do not completely take HA away. Also still has dizziness when she gets up.

Past History
Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: poor appetite
Cardiovascular: denies CP
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures

Physical Exam
General Appearance: moderate discomfort due to pain

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation
Ophthalmoscopic: some a/v nicking present, no hemorrhages, or exudates noted

Neck
Neck Exam: supple, no masses, trachea midline

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Musculoskeletal

Gait and Station: normal
Head and neck: mild decreased ROM due to pain

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Orientation: oriented to time, place, and person
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
Romberg with slight drift to the right

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Medication Use.
Informed How: Verbally

Assessment and Plan
Problem 1: HEAD TRAUMA (ICD-959.01)
Suspect postconcussion syndrome but seems to be prolonged course. Will refer to neurology as pt's symptoms of HA, diplopia, blurred vision, imbalance still persist and have not improved at all. Toradol given for pain today.
Problem 2: VISUAL IMPAIRMENT (ICD-368.10)
Cleared by ophtho.

Current Orders
Refer to Neurology [*]

Prescriptions:
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient
CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms #60 x 0
Entered and Authorized by: Tad A Venn, MD

Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po daily #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/29/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD August 29, 2007 9:32 PM

Signed by Elizabeth G Baxley MD on 09/09/2007 at 7:11 PM

JOANN M BROCKINGTON
Female DOB:07/04/1951 R009122088 Home: (803)240-4497 Office: (803)939-0026
Ins: BLUE CRO (0534)Grp: FH148

09/17/2007 - Office Visit: Multi-Problem Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Entered weight: 219 lb., 8 oz.
Calculated Weight: 219.50 lb.
Pulse rate: 96 **Pulse rhythm:** regular
BP: 162/90
BMI: 36.66 **BSA:** 2.06 **Wt chg:** -0.50 since 08/29/2007

Pain Assessment
The patient is not currently experiencing pain.
The patient has chronic pain.
Location: leg/feet **Duration:** intermittant
Vitals entered by: Maureen E Robinson LPN on September 17, 2007 2:07 PM

Laboratory Results - Normals in ()

Date/Time Collected: 9/17/07 at 1:15pm

Routine Urinalysis
Color: yellow
Appearance: clear
Leukocytes: negative (Negative)
Nitrite: negative (Negative)
Urobilinogen: 0.2 (Adult 0.1 or 1) (Peds 0.2 or 1.0)
Protein: negative (Negative)
pH: 5.0 (5-7.5)
Blood: negative (Negative)
Spec. Gravity: 1.005 (Adult 1.010-1.025)(Peds 1.002-1.025,Infant 1.002-1.006,Newborn 1.012)
Ketone: negative (Negative)
Bilirubin: negative (Negative)
Glucose: negative (Negative)
Microalbumin (urine): 0 mg/L (15-20 mg/L)
Date/Time Collected: 9/17/07
HGBA1C 10.8 % (5.0% - 12.8%)
.....Maureen E Robinson LPN September 17, 2007 2:07 PM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors

Previous smoking information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Christian Steen

Diabetes

HPI was told to stop glyburide 5 months ago by DM educators due to hypoglycemia

states she has not been checking her sugars like she should or eating correctly ever since her head trauma a couple months ago; sometimes misses meds as well

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance fair
Exercise: no

Self Foot Exam: yes
Eye Exam within last 12 months: performed within the last 12 months
Last eye exam: 04/04/2007
Results: Normal
Last exam results: Normal

Depression Screen
Little interest or pleasure in doing things? no
Feeling down, depressed or hopeless? no
Results: Negative for depression

Exam

Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses

DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal

Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take one po daily
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain
CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms
GLYBURIDE 5 MG TABS (GLYBURIDE) one po bid
ACTOS 30 MG TABS (PIOGLITAZONE HCL) one tablet by mouth daily
ERYTHROMYCIN OINT (ERYTHROMYCIN OINT) ophthalmic ointment-apply twice a day to both eyes
* STEP ONE TEST STRIPS one months supply of Step One test strips
AMITRIPTYLINE HCL 25 MG TABS (AMITRIPTYLINE HCL) one tab po qhs-Rx'd by neuro

Medication Hx:
ACE: yes
Statin: yes

History of Present Illness
History from: patient
Chief Complaint: f/u DM, HTN, concussion

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: fair
Glucose Monitoring
Glucose Home Monitoring reviewed: no
Diet Management
ADA diet
Diet compliance: fair
Insulin Management: no
Dilated Eye Exam: performed within the last 12 months

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache, visual disturbance
Denies: vertigo, syncope/presyncope, fatigue, edema, dyspnea, chest pain
Current Status
Home BP monitoring: no
Compliance with tx: fair
Medication Tolerance: no complaints
Comments: HA and occ blurred vision all due to recent concussion

History of Present Illness

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB:07/04/1951 [redacted] R009122086 Home: (803)740-4497 Office: (803)939-0026
Ins: BLUE CRO (053) Emp: 111148

Chief Complaint: f/u DM, HTN, concussion

General HPI

Again, pt slipped and fell onto concrete floor, striking her head. Reported that only plain films of neck and hip performed at LMC. CT of head showed small amt of blood noticed along falx; amount was within normal limits. CT neck negative. MRI ordered and showed very small and thin parafalcine subdural hematomas on left side, both anterior and posterior causing NO mass effect.

Pt still complaining of HA, now localized to temporo-occipital regions, left worse than right. Went to ophtho and he cleared her, stating that symptoms probably related to concussion. Pt still with double and blurred vision. Has short-term memory loss. Taking Tylox and ibuprofen which provide mild relief but do not completely take HA away. Also still has dizziness when she gets up. Was referred to neurology and diagnosed with postconcussion syndrome. Prescribed amitriptyline 25mg at bedtime to help with sleep. This works.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
Social History (reviewed - no changes required): non-smoker

Review of Systems

General: poor appetite
Eyes: c/o blurred vision
Cardiovascular: denies CP
Respiratory: denies cough, sob
Gastrointestinal: denies n/v/d/c, abd pain, blood in stool
Musculoskeletal: c/o intermittent neck pain
Neurologic: c/o severe HA; denies paresthesias, seizures
Psychiatric: denies depression, anxiety

Physical Exam

General Appearance: mild discomfort due to HA

Eyes

External: conjunctivae and lids normal

Ear, Nose &Throat

Hearing: grossly intact

Respiratory

Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal
Head and neck: mild decreased ROM due to pain

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings

Review of Lab Results
HgbA1C 8.0 (05/17/2007 11:00:00 AM)
AST: 21 (05/17/2007 11:00:00 AM)
Alt: 16 (05/17/2007 11:00:00 AM)
Serum Cholesterol 231 (05/17/2007 11:00:00 AM)
LDL: 172 (05/17/2007 11:00:00 AM)
HDL: 43 (05/17/2007 11:00:00 AM)
Potassium: 4.2 (05/17/2007 11:00:00 AM)
BUN: 19 (05/17/2007 11:00:00 AM)
Creatinine: 0.6 (05/17/2007 11:00:00 AM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Treatment Options, Medication Use, Health Promotion, Diabetes Management, Compliance with Medication.
Informed How: Verbally

Assessment and Plan
Problem 1: HYPERTENSION (ICD-401.1)
Elevated today. Suspect pain component as well. Cont same meds and if still elevated once postconcussive syndrome has resolved, then will change med regimen.
Problem 2: DIABETES MELLITUS TYPE II UNCONTROLLED (ICD-250.02)

A1c 10.8 today, 8.0 in May. Micral neg. Recent ophtho appt neg for DM retinopathy. Switched from Avandia to Actos. Cont Glucophage 1000mg bid. Believe that once postconcussion syndrome resolved, pt would be more willing to check blood sugars and tend to her overall health better.

Problem 3: POSTCONCUSSION SYNDROME (ICD-310.2)

Still with headache. Followed by neuro and cleared by ophtho. Cont Tylox and ibuprofen for pain and flexeril for muscle relaxer. Repeat head CT in 6 weeks per neuro. Amitriptyline 25mg per neuro.

Problem 4: SUBDURAL HEMATOMA (ICD-432.1)

Secondary to head trauma. Monitor.

Prescriptions:

ACTOS 30 MG TABS (PIOGLITAZONE HCL) one tablet by mouth daily #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

STEP ONE TEST STRIPS one months supply of Step One test strips #qs x 1 month x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day #3 mL bottle x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

ERYTHROMYCIN OINT (ERYTHROMYCIN OINT) ophthalmic ointment-apply twice a day to both eyes #3.5gram x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain #90 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain #60 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 09/17/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD September 19, 2007 11:25 PM

Signed by Christian C Steen, MD on 10/01/2007 at 7:59 AM

Children's Hospital Outpatient Center
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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home (803)740-4497 Office (803)939-0026
Ins. BLUE CRO (0534) Grp# 111148

Children's Hospital Outpatient Center
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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female, DOB 07/04/1959 R009122086 Home (803)740-4497 Office (803)939-0026
Ins BLUE CRO(0534)Grp 111148

11/07/2007 - Office Visit: Multi-Problem Visit-diabetes/sinus
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007
Latex Risk: no latex allergy 5/25/04 (05/25/2004 3:01:40 PM)

Vital Signs

Weight: 226.60 lb. (103.00 kg.)
Temperature: 97.59 deg F. (36.44 deg C.)**Pulse rate:** 84 **Respirations:** 20
BP: 150/100
BMI: 37.84 **BSA:** 2.09 **Wt chg:** 7.10 since 09/17/2007

Pain Assessment
The patient is currently experiencing pain.
Location: headache-sinus **Intensity (1-10):** 4 **Description:** pressure **Duration:** constant
The patient does not experience chronic pain.
Vitals entered by: Betty S Grant RN on November 7, 2007 11:08 AM
.....Betty S Grant RN November 7, 2007 11:08 AM

Patient Referral

Patient Information JOANN BROCKINGTON
Medical Record #: R009122086

Risk Factors

Previous smoking information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Holbrook Raynal

Diabetes

Hyperglycemia Symptoms: None
Hypoglycemia Symptoms None
Blood Sugar checks: Yes
Diet Compliance good
Exercise: no

JOANN M BROCKINGTON
Female DOB: 07/04/1951 R00912208 Home: (803)740-4497 Office: (803)939-0025
Ins: BLUE CRO (0534) Grp: 111148

Self Foot Exam: yes
Date of Exam: 04/04/2007
Last eye exam: 04/04/2007
Results: Normal
Last exam results: Normal

Exam

Complete Diabetic Foot Exam within last 12 months: Done
Intact Monofiliament (Left): yes
Intact Monofilament (Right): yes

Pulses

DP (R): normal
DP (L): normal
Post Tib(R): normal
Post Tib(L): normal
Skin (Right foot): Intact
Skin (Left Foot): Intact
Nails: Normal
Current Medications
PROCARDIA XL 60 MG TB24 (NIFEDIPINE) Take 2 tabs daily
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily
COLACE 100 MG CAPS (DOCUSATE SODIUM) one capsule bid
LIPITOR 20 MG TABS (ATORVASTATIN CALCIUM) Take 2 tablets daily at bedtime.
HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily
SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day
FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day
IBUPROFEN 800 MG TABS (IBUPROFEN) one tablet up to three times a day as needed for pain
POTASSIUM CHLORIDE 20 MEQ PACK (POTASSIUM CHLORIDE) one tab daily
TYLOX 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap every 6 hours prn pain
CYCLOBENZAPRINE HCL 10 MG TABS (CYCLOBENZAPRINE HCL) one tab three times a day prn spasms
AMARYL 1 MG TABS (GLIMEPIRIDE) one tablet daily with first meal of the day
ACTOS 30 MG TABS (PIOGLITAZONE HCL) one tablet by mouth daily
ERYTHROMYCIN OINT (ERYTHROMYCIN OINT) ophthalmic ointment-apply twice a day to both eyes
* STEP ONE TEST STRIPS one months supply of Step One test strips
AMITRIPTYLINE HCL 25 MG TABS (AMITRIPTYLINE HCL) one tab po qhs-Rx'd by neuro
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed
NEURONTIN 300 MG CAPS (GABAPENTIN) one cap po tid-per neuro

Medication Hx:

ACE: yes
Statin: yes

History of Present Illness

History from: patient
Chief Complaint: f/u DM, HTN, postconcussive syndrome

JOANN M BROCKINGTON
Female, DOB 07/04/1951 R009122086 Home: (803) 740-4497 Office: (803) 939-0026
Ins: BLUE CROSS (0534) Grp: 111148

Diabetes History
Type: Type II: Non-insulin dependent
Patient's compliance with treatment plan: good
Glucose Monitoring
Diet Management
ADA diet
Diet compliance: good
Comments: fastings improved per meter download-to be scanned into chart

Hypertension
Basis for diagnosis: previous history of HTN
Current symptoms: headache
Denies: visual disturbance, syncope/presyncope, fatigue, edema, dyspnea, chest pain, palpitations
Current Status
Home BP monitoring: no
Non-pharmacologic treatment: none
Compliance with tx: good
Medication Tolerance: no complaints

History of Present Illness
History from: patient
Chief Complaint: f/u DM, HTN, postconcussive syndrome

General HPI
Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor. Followed by neurology. On Neurontin now for headaches which seem to have helped. Repeat CT head recently showed no signs of sudural hematoma anymore.

C/o eyes bloodshot, sinus pressure, thick and yellow drainage from nose. Has h/o AR and h/o sinus infections in past. Reports low grade fever as well. Pressure/pain worsens when she leans her head forward.

Past History
Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Social History (reviewed - no changes required): non-smoker

Review of Systems
General: c/o low grade fever-exact temp unknown
Eyes: vision has improved; c/o eye irritation
Ear/Nose/Throat: c/o nasal congestion, sinus pressure (see hpi)
Cardiovascular: denies CP
Respiratory: denies cough, sob

Gastrointestinal: denies n/v/d/c, abd pain, blood in stool
Neurologic: HA improved
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam
General Appearance: well nourished, well hydrated, no acute distress

Eyes
External: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose &Throat
External Ears: normal, no lesions or deformities
External Nose: normal, no lesions or deformities
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact
Nasal: bilateral turbinate enlargement and erythema
Lip/teeth/gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Neck
Neck Exam: supple, no masses, trachea midline

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop
Pedal pulse: pulses 2+, symmetric
Peripheral Circulation: no cyanosis, clubbing, edema, or varicosities

Lymphatic
Neck: no cervical adenopathy

Skin
Inspection: no rashes, lesions, or ulcerations

Musculoskeletal
Gait and Station: normal
Digits and nails: Normal
Head and neck: normal alignment and mobility; ROM improved compared to last visit

Neurologic
Cranial Nerves: II - XII grossly intact
Sensation: intact to touch pedal

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14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home (803)749-4497 Office (803)939-0026
Female DOB 07/04/1951 R009122086 Ins=BLUE CRO (0534) Grp=H1148

Mental Status
Judgement, insight: intact
Mood and affect: no appearance depression, anxiety, or agitation

Other Physical Exam Findings
ttp frontal and maxillary sinuses R>L

Review of Lab Results
HgbA1C 10.8 (09/17/2007 2:05:05 PM)

Patient Education
Education was provided to: patient
Patient Response: Expressed understanding, Receptive

Topics Discussed:
Medical Condition, Workup Options, Treatment Options, Medication Use, Diabetes Management, Compliance with Medication.
Informed How: Verbally

Assessment and Plan
Problem 1: DIABETES MELLITUS TYPE II UNCONTROLLED (ICD-250.02)
Pt met with Dr. Steadman today and glucometer printout showed that blood sugars have greatly improved and there are more readings within our target fasting and postprandial goals. Cont metformin, Actos, Amaryl regimen. Pt adamant about avoiding needles and insulin therapy as much as possible. Next A1c due in December.
Problem 2: HYPERTENSION (ICD-401.1)
BP better than previous visits but not ideal. Will max out ACEI dose at 80mg daily.
Problem 3: SINUSITIS ACUTE NOS (ICD-461.9)
History and exam c/w acute sinusitis picture. Pt given Z-pack.
Problem 4: SUBDURAL HEMATOMA (ICD-432.1)
Resolved per latest CT scan.
Problem 5: POSTCONCUSSION SYNDROME (ICD-310.2)
Still with mild headaches. Followed by neuro. Now takes Neurontin 300mg tid.

Prescriptions:
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 11/07/2007
Method used: Print then Give to Patient
ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB 07/04/1951 R008122066 Ins: BLUE CRO (053A) Grp: 111148

Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 11/07/2007
Method used: Print then Give to Patient

.....Tad A Venn, MD November 7, 2007 11:37 AM

Signed by Holbrook W Raynal, MD on 11/12/2007 at 3:51 PM

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14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female, DOB 07/04/1957 R009122086 Ins: Blue E GRO (0534) Grp:111148 Home: (803)240-4497 Office: (803)939-0026

01/18/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 228 lb., 2 oz.
Calculated Weight: 228.13 lb.

Pain Assessment
The patient is currently experiencing pain.
Location: left thumb, headaches **Intensity (1-10):** 7 **Description:** stabbing **Duration:** intermittant
Vitals entered by: Avis N Jackson, LPN on January 18, 2008 9:26 AM

Laboratory Results - Normals in ()
Microalbumin (urine): 20 mg/L (15-20 mg/L)
patient presents with complaints of pain in left thumb and headaches but not @ this time.

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure
Previous HIV and Drug Use Information
Drug Use: none (data entered on 05/17/2007)

Attending Participation: Present and Available
Dr Jason Stacy

History of Present Illness
History from: patient
Chief Complaint: multiple complaints

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home (803)740-1497 Office (803)939-0026
Ins: BLUECROS (0534) Grp: 111148

Status:
FSBS testing: Yes
Self foot Exam: Yes

Last A1c :
10.8 (09/17/2007 2:05:05 PM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEI: yes **Statin:** yes **ASA:** yes

Comments: states fastings 128-130's; 2 hr PP 120's; no actual numbers today; out of glucophage and Actos for last two weeks

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: headache
Denies: chest pain, dyspnea, edema, fatigue, palpitations, syncope/presyncope, visual disturbances

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: dietary modification
Treatment compliance: Fair
Medication tolerance: no complaints

History of Present Illness
History from: patient
Chief Complaint: multiple complaints

Ortho/Injury

Location: Left finger

Current Symptoms: swelling, pain, weakness
Denies:
Current Treatment: rest, ibuprofen

Comments: 2 week h/o left thumb pain; no other associated finger pain; mild swelling; no trauma; Motrin without much relief; difficult to hold objects due to pain

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor. Followed by neurology with last appt this week. On Neurontin now for headaches which seems to have helped but still has dull baseline HA. Repeat CT head recently showed no signs of sudural hematoma anymore.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female | DOB: 6/4/1951 | Home: (803) 740-4487 | Office: (803)939-0026
R0091220867 | Ins: BLUE CRO (0534) | Grp: 101148

C/o sinus pressure, thick and yellow drainage from nose. Has h/o AR and h/o sinus infections in past. Reports low grade fever as well. Pressure/pain worsens when she leans her head forward.

Past Medical History

Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: c/o low grade fever-exact temp unknown
Eyes: vision has improved; c/o eye irritation
Ear/Nose/Throat: c/o nasal congestion, sinus pressure (see hpi)
Cardiovascular: denies CP
Respiratory: denies cough, sob
Genitourinary: denies urinary frequency
Genitourinary: denies urinary frequency
Musculoskeletal: Complains of see HPI, joint pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam

General

General: well nourished, well hydrated, no acute distress

Eyes

External Eye: conjunctivae and lids normal

Ear, Nose, Throat

External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: canals clear, tympanic membranes intact with good movement, no fluid
Hearing: grossly intact

Nasal: bilateral turbinate enlargement and erythema
Lip/Teeth/Gums: normal dentition, no gingival inflammation, no labial lesions
Pharynx: tongue normal, posterior pharynx without erythema or exudate

Respiratory
Respiratory Effort: no intercostal retractions or use of accessory muscles
Auscultation: no rales, rhonchi, or wheezes

Cardiovascular
Auscultation: S1, S2, no murmur, rub, or gallop

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
LUE: ttp in anatomic snuffbox; limited ROM of left thumb; mild swelling

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.
Sensation: Positive Findings: impaired light touch.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: no appearance depression, anxiety, or agitation

Laboratory Results:

Assessment & Plan Summary

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. Out of Actos and metformin x 2 weeks. Cont metformin on max dose, change from Actos to Glyburide b/c of formulary, and cont Amaryl. A1c today (last was 10.8 in 9/07).
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 1 mg tabs one tablet daily with first meal of the day; Glyburide 5 mg tabs one tab daily for diabetes.

HYPERTENSION (ICD-401.1) - Uncontrolled. Maxed on ACEI and no benefit from increasing HCTZ dose to 50mg. Add beta blocker.
Medications: Metoprolol tartrate 50 mg tabs one tablet twice a day for high blood pressure; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily.

POSTCONCUSSION SYNDROME (ICD-310.2) - Stable. HA's not resolved. Followed by neurology. Cont ibuprofen, amitriptyline, neurontin.
Medications: Ibuprofen 800 mg tabs one tablet up to three times a day as needed for pain; Amitriptyline hcl 25 mg tabs one tab po qhs-Rx'd by neuro; Neurontin 300 mg caps one cap po tid-per neuro.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0826
Female DOB 02/04/1951 R009122086 His BLUE CRO(0534) Grp: 114148

SINUSITIS, ACUTE NOS (ICD-461.9). S/S c/w sinusitis. Due to duration of over two weeks, may be bacterial in etiology. Try Z-pack as she is PCN allergic. Advised about copious irrigation with warm salt water.
Medications: Zithromax z-pak 250 mg tabs take as directed.

THUMB PAIN, LEFT (ICD-729.5) - New. X-ray as pain in anatomic snuffbox.

Prescriptions:

ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

GLYBURIDE 5 MG TABS (GLYBURIDE) one tab daily for diabetes #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol #30 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

METOPROLOL TARTRATE 50 MG TABS (METOPROLOL TARTRATE) one tablet twice a day for high blood pressure #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 01/18/2008
Method used: Print then Give to Patient

.....Tad A Venn, MD January 18, 2008 9:28 AM

Signed by Jason J Stacy MD on 01/30/2008 at 9:54 AM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)929-3026
Female DOB: 02/04/1953 R009122086 Ins: BLUE CRO (0534) Grp: EH1148

JOANN M BROCKINGTON
Female DOB:07/04/1951 R009122086 Home:(803)740-4497 Office:(803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

05/21/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 233 lb., 8 oz.
Calculated Weight: 233.50 lb.
Pulse rate: 72 **Respirations:** 20
BP: 170/110
BMI: 39.00 **BSA:** 2.11 **Wt chg:** 5.37 since 01/18/2008

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 7 **Description:** pressure **Duration:** conastant
The patient does not experience chronic pain.
Vitals entered by: Avis N Jackson, LPN on May 21, 2008 10:54 AM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC
Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated, presents with complaints of headache times two weeks, complains of blurry vision as well.

.....Avis N Jackson, LPN May 21, 2008 10:55 AM

Attending Participation: Present and Available
Dr C Scott Lamar

History of Present Illness
History from: patient
Chief Complaint: HA

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last June. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head as

well as neck pain. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

History of Present Illness

History from: patient
Chief Complaint: HA

Diabetes

Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:

Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: no glucometer readings brought in today; does c/o nausea at times; has BM every other day

Hypertension

Basis for Diagnosis: Previous History of HTN

Current symptoms: fatigue, headache
Denies: chest pain, edema, palpitations, syncope/presyncope, visual disturbances

Status:
Home BP monitoring: No
Management:
Treatment compliance: Good
Medication tolerance: no complaints

Comments: states she is compliant with her meds and has not run out

Past Medical History

Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home: (803)740-4492 Office: (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Complains of fatigue, malaise. Denies fevers, chills, sweats.
Eyes: vision has improved
Cardiovascular: denies CP
Respiratory: denies cough, sob
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Musculoskeletal: Denies back pain.
Neurologic: c/o HA, see HPI
Endocrine: denies polydipsia or polyuria recently

Physical Exam

General

General: well nourished, well hydrated, no acute distress

Eyes

External Eye: conjunctivae and lids normal

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: S1, S2, no murmur, rub, or gallop
Peripheral Circulation: Negative Findings: no edema.

Lymphatic

Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal

Gait and Station: Negative Findings: normal gait.
Head and Neck: Negative Findings: normal alignment, normal mobility.

JOANN M BROOKINGTON Home: (803)740-4492 Office: (803)939-9026
Female DOB: 07/01/1951 R009122086 Ins: BLUE CRO(0554)Grp: 111148

Neurologic

Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status

Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results:

Assessment & Plan Summary

POSTCONCUSSION SYNDROME (ICD-310.2) - Unchanged. Still with occasional headaches. Almost one year since concussion occurred. No longer followed by neurology. Was on neurontin and amitriptyline Rx'd by them, but has stopped taking these as they did not help. Cont narcotic as this seems to be only thing that has helped. Consider repeat head CT if still continuing to have HA.
Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

NAUSEA (ICD-787.02). Try Reglan as nausea may be DM related.
Medications: Metoclopramide hcl 10 mg tabs one tab po bid prn nausea.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Will increase beta-blocker dose. Cont ACEI and HCTZ.
Medications: Metoprolol tartrate 100 mg tabs one tab po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. Pt cannot afford A1c or any other labs as she is self-pay. Will keep on current regimen as I am unaware of what her blood sugars are at home.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 1 mg tabs one tablet daily with first meal of the day; Glyburide 5 mg tabs one tab daily for diabetes.

Prescriptions:

METOCLOPRAMIDE HCL 10 MG TABS (METOCLOPRAMIDE HCL) one tab po bid prn nausea #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987989559390

BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987869559390

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987869159390

METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) one tab po bid #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 05/21/2008
Method used: Print then Give to Patient
RxID: 1526987810009390

.....Tad A Venn, MD May 21, 2008 11:01 AM

Signed by C Scott Lamar MD on 06/06/2008 at 6:58 PM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148

06/12/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 233 lb., 0 oz.
Calculated Weight: 233 lb.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 5 **Description:** throbbing
Vitals entered by: Avis N Jackson, LPN on June 12, 2008 10:17 AM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC
Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated, presents with complaints of headaches and sinus problems.
.....Avis N Jackson, LPN June 12, 2008 10:19 AM

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness
History from: patient
Chief Complaint: f/u HA, HTN, DM; sinus complaint

Other HPI: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last June. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT

head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head which has been the usual location for her HA since the concussion. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

Also c/o over one week h/o thick, yellow sinus drainage, ear congestion, frontal HA, no dental pain. H/o sinus infections at least once or twice a year.

History of Present Illness

History from: patient
Chief Complaint: f/u HA, HTN, DM; sinus complaint

Diabetes

Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:
FSBS testing: No
Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: does not check sugars very often

Hypertension

Basis for Diagnosis: Previous History of HTN

Current symptoms: headache
Denies: chest pain, palpitations, syncope/presyncope

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Good
Medication tolerance: no complaints

Comments: Compliant with meds. Denies any side effects of meds. C/o frontal HA today.

Past Medical History

Other Past Medical History: Hx of type 2 diabetes

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home (803)740-4497 Office (803)939-0026
Ins: BLUE CRO (0534) Grp# 11148

Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Complains of malaise. Denies fevers.
Eyes: Denies blurring, irritation.
Ear/Nose/Throat: Complains of see HPI.
Cardiovascular: Denies chest pains, peripheral edema.
Respiratory: Denies cough, excessive sputum.
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: conjunctivae and lids normal
Pupils: equal, round, reactive to light and accommodation

Ear, Nose, Throat

External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Negative Findings: normal canals, tympanic membranes intact, No exudates, No fluid.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: inflamed mucosa, purulent discharge.
Lip/Teeth/Gums: Negative Findings: normal dentition, no gingival inflammation, no labial lesions, no buccal lesions.
Pharynx: Negative Findings: normal tongue, normal posterior pharynx, no pharyngeal erythema, no pharyngeal exudates.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no edema.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Skin
Skin Inspection: Negative Findings: no rash.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: Positive Findings: lt paracervical muscle spasms. Negative Findings: normal alignment, normal mobility.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results:

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Increase metoprolol to 150mg bid. Maxed on ACEI and HCTZ.
Medications: Metoprolol tartrate 100 mg tabs one tab po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Metoprolol tartrate 50 mg tabs one tab po twice a day.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. A1c 10.6, up from 7.7 in January. Will increase Amaryl to 4mg daily. Suspect will need insulin at some point. Would like to see pt monthly but she is self-pay.
Medications: Glucophage 1000 mg tabs One tablet BID; Benazepril hcl 40 mg tabs Take two po daily; Pravastatin sodium 40 mg tabs one tablet at bedtime for cholesterol; Amaryl 4 mg tabs Take one (1)

tablet daily.

POSTCONCUSSION SYNDROME (ICD-310.2) - Stable. Percocet helps with recurrent HA. Refilled today. Neurology has signed off re: this issue. Pt cannot afford repeat CT head.
Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

SINUSITIS, ACUTE NOS (ICD-461.9) - New. s/s c/w acute sinusitis. Z-pack today.
Medications: Zithromax z-pak 250 mg tabs take as directed.

Prescriptions:

METOPROLOL TARTRATE 50 MG TABS (METOPROLOL TARTRATE) one tab po twice a day #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888881158770

ZITHROMAX Z-PAK 250 MG TABS (AZITHROMYCIN) take as directed #1 pack x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888851158770

AMARYL 4 MG TABS (GLIMEPIRIDE) Take one (1) tablet daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888791608770

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888791058770

PRAVASTATIN SODIUM 40 MG TABS (PRAVASTATIN SODIUM) one tablet at bedtime for cholesterol #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888761258770

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888761158770

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient

RxID: 1528888761058770
GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 06/12/2008
Method used: Print then Give to Patient
RxID: 1528888551658770

.....Tad A Venn, MD June 23, 2008 4:44 PM

Signed by Brian D Keisler, MD on 06/25/2008 at 8:14 AM

JOANN M BROCKINGTON
Female DOB 07/01/1951 Home (803)240-4497 Office (803)939-0026
R009122086 Ins: BLUE CRO (0544) Grp: 111148

08/12/2008 - Office Visit: FMC Adult Visit
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 234 lb., 1 oz.
Calculated Weight: 234.06 lb.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 5 **Description:** sharp
Vitals entered by: Avis N Jackson, LPN on August 12, 2008 1:36 PM

Fall Risk
Additional Risk Factors: Medications affecting B/P or LOC
Fall Risk Level: Low Risk
Verbal patient and/or family education provided: yes
Fall Risk Assessment: done today. No changes noted.

Med reconcilliation initated with patient today, presents with complaints of headache and sinus problems.
.....Avis N Jackson, LPN August 12, 2008 1:39 PM

Risk Factors
Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Brian Keisler

History of Present Illness
History from: patient
Chief Complaint: f/u HAs

Headache
This patient with a history of presents to clinic today with complaints of onset occipital headache which began on .

Children's Hospital Outpatient Center
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(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1961 R009122080 Home (803)740-4497 Office (803)939-9026
Ins. BLUE CRO (0537) Grp. 111148

Headache is described to have been present for .
Headache pain is most severe and is given a out of 10 in severity by the patient.
Assoc. Symptoms: visual disturbance
Management:
Comments: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor last August. Was followed by neurology but is no longer. Was on Neurontin and amitriptyline for headaches but she stopped these as they did not seem to help.Repeat CT head late last yr showed no signs of sudural hematoma anymore. Pt c/o HA today in left side of head (occipital) which has been the usual location for her HA since the concussion. Only thing that truly has helped HA in past has been oxycodone-APAP. Has not worked since concussion and thus has lost her insurance.

Today HA is 10/10. Narcotic decreases it to 4-5/10. Occ blurred vision. Uses narc tid.

History of Present Illness
History from: patient
Chief Complaint: Diabetes, HTN maintenance

Diabetes
Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:
FSBS testing: Yes
Self foot Exam: Yes

Last A1c :
7.7 (01/18/2008 10:46:00 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair
ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: fasting 180 this AM per pt
no glucometer readings today
last POC A1c 10.6 (prev 7.7)

Hypertension
Basis for Diagnosis: Previous History of HTN

Current symptoms: headache, visual disturbances
Denies: chest pain, cough, dyspnea, edema, palpitations, syncope/presyncope

Status:

JOANN M BROCKINGTON
Female DOB:07/04/1951 R009122086 Home (803)740-4497 Office (803)939-0026 Ins: BLUE CRO (6534) Grp:111148

Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Fair
Medication tolerance: no complaints

Past Medical History
Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History
Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems
General: Denies fatigue, weight loss.
Eyes: Complains of see HPI, blurring.
Cardiovascular: Denies chest pains, peripheral edema.
Respiratory: Denies cough, excessive sputum.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety
Endocrine: denies polydipsia or polyuria recently

Physical Exam
General
General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes
External Eye: conjunctivae and lids normal

Ear, Nose, Throat
Hearing: Negative Findings: Grossly normal hearing.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 [illegible] Home: (803)740-4497 Office: (803)939-0026
R009122086 Ins: BLUE CRO (0534) Grp: 11148

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no acessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no edema.

Musculoskeletal

Gait and Station: Negative Findings: normal gait.
Head and Neck: Positive Findings: lt paracervical muscle spasms. Negative Findings: normal alignment, normal mobility.
Spine, Ribs, Pelvis: normal alignment and mobility, no deformity

Neurologic

Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status

Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Assessment & Plan Summary

POSTCONCUSSION SYNDROME (ICD-310.2) - Unchanged. Still with headaches after one year of injury. Unable to work. Lost health plan. Neurology has essentially signed off stating that she may continue to have headaches. Pt unable to afford CT scan. Cont Percocet as this is only med that has allowed her to dull the HAs. Restart neurontin as well.
Medications: Neurontin 300 mg caps one cap po tid-per neuro; Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Increase beta blocker dose. HAs may be aggravated by her uncontrolled BP.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. Last POC A1c 10.6 (not in flowsheet). No glucometer readings today. Wonder if pt is testing like she says. Suspect will need insulin at some point. Would like to see pt monthly but she is self-pay. Can't afford labs either. Will meet with financial counselor today.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 4 mg tabs Take one (1) tablet daily.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home (803)740-4497 Office (803)939-0026
Ins: BLUE CRO (0534) Grp: 111148

Prescriptions:

NEURONTIN 300 MG CAPS (GABAPENTIN) one cap po tid-per neuro #90 x 5
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/12/2008
Method used: Print then Give to Patient
RxID: 1534169736557100

METOPROLOL TARTRATE 100 MG TABS (METOPROLOL TARTRATE) two tabs po bid #120 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 08/12/2008
Method used: Print then Give to Patient
RxID: 1534169736157100

.....Tad A Venn, MD August 12, 2008 2:16 PM

Signed by Brian D Keisler, MD on 08/18/2008 at 9:07 AM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4407 Office: (803)939-0026
Female DOB: 07/04/1951 R009122088 Ins: BLUE CRO (0534) Grp: 111148

01/15/2009 - Office Visit: FMC Adult Visit
Provider: Samuel J Crutcher MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 240 lb., 5 oz.
Calculated Weight: 240.31 lb.
Pulse rate: 72 **Pulse rhythm:** regular **Respirations:** 20
BP: 224/120
BMI: 40.13 **BSA:** 2.14 **Wt chg:** 6.25 since 08/12/2008
Vitals entered by: Avis N Jackson, LPN on January 15, 2009 9:42 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 4 **Description:** sharp
The patient does not experience chronic pain.
Patient presents with complaints of elevated BP and blurry vision. BP at work this AM was 222/138. Needs refill on meds.
.....Avis N Jackson, LPN January 15, 2009 9:44 AM

Attending Participation: Present and Discussed
Dr Ramon Ylanan

History of Present Illness
History from: patient
Chief Complaint: elevated blood pressure

Other HPI: At work this morning did not feel well and presented to company nurse who checked blood pressure where found to be 222/138 and advised to present to MD. Patient states symptoms prompting presentation were headache and bodyache, general malaise. Has history of headaches according to chart and patients states current headache is exactly like usual headaches, same location and level of intensity.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 9/04/1951 Home: (803)740-4497 Office: (803)939-9026
R009122086 Ins: BLUE CRO (0604)Grp: 111148

Patient takes percocet and ibuprofen for headaches. Denies chest pain, palpitations, transient paralysis, seizures, syncope, paresthesias, dysarthria, dysphagia.

Past Medical History

Other Past Medical History: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco Use
never (05/17/2007 8:20:27 AM)
Drug use:
none (05/17/2007 8:20:27 AM)
Caffeinated drink consumption daily:
0 (03/30/2004 1:08:05 PM)
Exercise amount weekly:
3 to 4 times a week (05/17/2007 8:20:27 AM)
Marital Status: Widowed
Other Social History: unemployed since concussion, summer 2007

Review of Systems

General: Complains of see HPI, malaise.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.
Pupils: Negative Findings: no aniscoria, no cataracts, normal light reaction.

Ear, Nose, Throat

External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Hearing: Negative Findings: Grossly normal hearing.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no

gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
RUE: Negative Findings: normal strength.
LUE: Negative Findings: normal strength.
RLE: Negative Findings: normal strength.
LLE: Negative Findings: normal strength.

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.
Sensation: Negative Findings: normal light touch.

Mental Status
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results
HgbA1C Collected: January 15, 2009 10:46 AM **HgbA1C:** 8.4% (4.0%-6.9% normal) (7.0%-13.0% high)
Test performed by: Dale L Reaves LPN

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0). hypertensive urgency. looking through chart it appears patient has history of poorly controlled blood pressure, she has no abnormal neurologic findings currently, her headache is chronic and unchanged. I discussed potential admission to hospital for treatment of blood pressure but patient does not want admission if it can be avoided, she states she will follow whatever is recommended in order to avoid admission. Will add calcium channel blocker to current regimen and ask to return tomorrow for blood pressure check. Advised to stop NSAID.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Diltiazem hcl 60 mg tabs Take one (1) tablet twice a day..

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02). HbA1C not at goal. will need to adjust meds but will attempt to treat blood pressure before adjusting meds.
Medications: Glucophage 1000 mg tabs One tablet BID.

Follow up in 1 days.

Prescriptions:
DILTIAZEM HCL 60 MG TABS (DILTIAZEM HCL) Take one (1) tablet twice a day. #60 x 2
Entered and Authorized by: Samuel J Crutcher MD
Signed by: Samuel J Crutcher MD on 01/15/2009

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122086 Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CRO (0534) Grp: 111148

Method used: Print then Give to Patient
RxID: 1547635234157410

.....Samuel J Crutcher MD January 15, 2009 6:29 PM

Signed by Ramon C Ylanan, MD on 01/16/2009 at 8:19 AM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB 07/04/1951 R009122080 Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CRO (6534) Grp: 111148

02/25/2009 - Office Visit: FMC Adult Visit/ follow up and micral
Provider: Tad A Venn, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 240.90 lb.
Pulse rate: 74 **Pulse rhythm:** regular **Respirations:** 18
BP: 140/100
Wt chg: 0.59 since 01/15/2009
Vitals entered by: Karen A Churchill on February 25, 2009 3:20 PM
Vitals updated by: Karen A Churchill on February 25, 2009 3:20 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC

Pain Assessment
The patient is currently experiencing pain.
Location: right side **Intensity (1-10): 4** **Description:** sharp, stabbing **Duration:** months
The patient has chronic pain.
Intensity (1-10): 10
Comment: pt. states that she has been having pain on her right side. seems to be in-between her ribs she has taken her pain med and it has not helpd. she also says that sometimes when she breathes it hurts also
.....Karen A Churchill February 25, 2009 3:20 PM

Risk Factors

Previous smoking Information
Non-Smoker (data entered on: 05/17/2007)

No passive smoke exposure

Attending Participation: Present and Available
Dr Jeffrey Hall

History of Present Illness

History from: patient

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB [illegible] Home: (803)740-4497 Office: (803)939-0026
R009122086[illegible] Ins: BLUE CRO(0534) Grp: 111148

Chief Complaint: headaches, f/u HTN, DM

Headache

This patient with a history of presents to clinic today with complaints of sudden onset throbbing generalized headache which began on .
Headache is described to have been present for .
Headache pain is most severe and is given a 10-worst ever out of 10 in severity by the patient.
Assoc. Symptoms: visual disturbance, neck pain
Aggrevating Factors: bright light, stress
Management:
Comments: Had small subdural hematoma and subsequent postconcussive syndrome following a fall with strike to head onto concrete floor Aug 2007. Was followed by Dr. Alan Morgan at the SC Neurological Clinic but is no longer seeing them. Diagnosis for her headches was postconcussive headaches. Was on Neurontin and amitriptyline per neurology for her headaches but she stopped these as they did not seem to help.Repeat CT head late 2007 showed no signs of sudural hematoma anymore. Pt c/o generalized HA today. States that she has a headache more days than not out of the week. Has associated blurred vision and photophobia. Has been evaluated by ophthalmology as well and no further intervention suggested. Only thing that truly has helped HA in past has been oxycodone-APAP. Pt did not work from 8/07 to 1/09 due to impairment s/p concussion andhad been self-pay for all of her meds and treatments. She is now working light duty at her previous job.

Today HA is 10/10. Narcotic decreases it to 4-5/10.

Desires referral to different neurologist re: second opinion about headaches.

Other HPI: also c/o right sided rib pain, basically ever since head trauma in 2007- no SOB, resp symptoms, fever

History of Present Illness

History from: patient
Chief Complaint: headaches, f/u HTN, DM

Diabetes

Type: Non-insulin dependent
Basis of Diagnosis: Previous history

Hyperglycemic Symptoms: None
Hypoglycemic Symptoms: None

Status:
FSBS testing: Yes
Self foot Exam: Yes

Last A1c :
8.4 (01/15/2009 9:41:58 AM)

Management:
Dietary Compliance: Fair
Medication Compliance: Fair

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/04/1961 R009122086 Home (803)740-4494 Office (803)939-0026
Ins: BLUE GRO(0534) Grp#111148

ACEi: yes **ARB:** no **Statin:** yes **ASA:** yes

Comments: states recent fasting blood sugars have been in the low 100's

Hypertension

Basis for Diagnosis: Previous History of HTN

Current symptoms: edema, headache, visual disturbances
Denies: chest pain, dyspnea, fatigue, palpitations, syncope/presyncope, vertigo

Status:
Home BP monitoring: No
Management:
Non-pharmacologic treatment: none
Treatment compliance: Fair
Comments: out of ACEI x 1 week

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Social History
non-smoker
currently back at work, light duty

Review of Systems

General: Denies fevers, weight loss.
Eyes: Complains of see HPI, blurring, photophobia. Denies vision loss.
Cardiovascular: Complains of peripheral edema. Denies chest pains, palpitations, dyspnea on exertion.
Respiratory: Denies cough, dyspnea.
Gastrointestinal: Denies change in bowel habits, abdominal pain.
Neurologic: c/o HA, see HPI
Psychiatric: denies depression, anxiety

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: Negative Findings: conjunctivae normal, lids normal.

Ear, Nose, Throat

Hearing: Negative Findings: Grossly normal hearing.

Neck

Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory
Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Positive Findings: trace bilateral pedal edema.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.
Head and Neck: ttp bitemporal and occipital regions; ttp bilateral cervical muscles

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status
Judgement/Insight: Negative Findings: intact.
Orientation: oriented to time, place, and person
Memory: Negative Findings: intact recent recall, intact remote recall.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Laboratory Results
Microalbumin Collected: February 25, 2009 3:20 PM **Microalbumin Resulted:** February 25, 2009 3:26 PM
Reference range in parenthesis.
Microalbumin (urine): 20 mg/L (0-20 mg/L)

Assessment & Plan Summary

RIB PAIN, RIGHT SIDED (ICD-786.50) - New. Check CXR to r/o any pulm pathology. Former smoker.

h/o POSTCONCUSSION SYNDROME (ICD-310.2). Pt still with headaches despite head injury back in Aug 2007. At that time had subdural hematoma which over serial imaging had resolved. Now that pt has insurance again, will refer to USC neurology per pt request for second opinion. Formerly seen by SC Neurological Clinic. They stated pt may continue to have HA and told her to cont amitriptyline and neurontin. Pt states these do not help. Percocet is only thing that helps. Pt has been appropriate with all refill requests and has not abused our narcotics policy. Pt formerly worked full-time and was active in her community. This has been limited since the injury due to the headaches. Pt would like to get back to her old lifestyle.

JOANN M BROCKINGTON
Female DOB:07/07/1961 R009122086 Home:(803)746-4497 Office:(803)929-0026 Ins: BLUE CRO (0554) Grp: 111148

Medications: Oxycodone-acetaminophen 5-500 mg caps one cap po every 6 hours.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0) - Uncontrolled. Out of ACEI x 1 week. Will refill today. F/u after neuro appt or in one month, whichever is sooner.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Diltiazem hcl 60 mg tabs Take one (1) tablet twice a day..

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02) - Uncontrolled. A1c 8.4 in January. Pt states blood sugars have been in low 100's fasting recently. Will give pt benefit of the doubt and not change any meds today. Recheck A1c in April.
Medications: Glucophage 1000 mg tabs One tablet BID; Amaryl 4 mg tabs Take one (1) tablet daily.

Follow up as previously scheduled.

Prescriptions:

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197168059190

SYSTANE 0.4-0.3 % SOLN (POLYETHYL GLYCOL-PROPYL GLYCOL) one drop in each eye twice a day #3 mL bottle x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138609190

DILTIAZEM HCL 60 MG TABS (DILTIAZEM HCL) Take one (1) tablet twice a day. #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138509190

GLUCOPHAGE 1000 MG TABS (METFORMIN HCL) One tablet BID #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197138409190

HYDROCHLOROTHIAZIDE 25 MG TABS (HYDROCHLOROTHIAZIDE) 1 tab orally daily #30 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197108359190

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #120 x 0
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009

Method used: Print then Give to Patient
RxID: 1551197078059190
BENAZEPRIL HCL 40 MG TABS (BENAZEPRIL HCL) Take two po daily #60 x 11
Entered and Authorized by: Tad A Venn, MD
Signed by: Tad A Venn, MD on 02/25/2009
Method used: Print then Give to Patient
RxID: 1551197048359190

.....Tad A Venn, MD March 1, 2009 3:08 PM

Signed by Jeffery W Hall , MD on 03/09/2009 at 3:00 PM

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female DOB: 07/02/1954 R009122086 Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CROSS (0584) Grp: 111148

03/30/2009 - Office Visit: FMC Adult Visit
Provider: Rachel L Callis MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 237 lb., 3 oz.
Calculated Weight: 237.19 lb.
Pulse rate: 70 **Respirations:** 18
BP: 160/88
Wt chg: -3.71 since 02/25/2009
Vitals entered by: Jeanette Randolph CMA on March 30, 2009 11:14 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Level Low Risk

Pain Assessment
The patient is currently experiencing pain.
The patient has chronic pain.
Location: Lower R side **Intensity (1-10):** 7 **Description:** sharp **Duration:** Months

Attending Participation: Seen and discussed
Dr C Scott Lamar

History of Present Illness
History from: patient

Abdominal Pain
This patient presents today with complaints of abdominal pain present since .
The pain is described as a dull aching right flank constant pain which is in duration.
The pain is noted to be a out of 10 on a 10 point pain scale.
The pain is described to have .
The patient describes having loose stools associated with the abdominal discomfort.

Comments: Says pain is on the back side, but other on the R side pain. Says she is having stomach swelling. Pain is there daily. Sometimes pain lasts all day. Sometimes she wakes up in the night

nauseated, throwing up yellowish, thick, with a nasty bitter taste. Throws up about every morning. Even if she drinks water. Sometimes she wakes in the morning with it, lasting all day, then goes to bed with it. Aching pain. Sometimes pain travels under her backbone, but otherwise no radiation. for several months. Stools twice a day, sometimes not at all.. Lately more with diarrhea. Stooled this am. Denies bloody, tarry stools. Denies dysuria. Had a BTL and hysterectomy. When she leans over and sits back up pain is worse. When she is working, notices she is sweating more. Sex drive is down. Had hysterectomy 6-7 yrs ago.

Other HPI: Neurologist wants to see her back in 6 wks,. She has an rxn for MRI of the lumbar spine for low back pain, a script for lamictal 25mg #90 for 2 wks, then 50mg x2 wks then 75mg daily. Then wants a sleep study for obstructive sleep apnea. She said she doesn't know what he thinks is going.

Past History

Past Medical History (reviewed - no changes required): Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007
Surgical History (reviewed - no changes required): BTL 1979
Chole 1980
Total abd Hysterectomy and BSO for fibroids 1993
Family History (reviewed - no changes required): FH of Diabetes:
FH of Hypertension:
FH of Breast Cancer: GM
FH of Colon Cancer: sister s/p resection at age 46
DVT - Aunt, sister (after surgeries)
PE - daughter (after childbirth)
Social History (reviewed - no changes required): non-smoker
currently back at work, light duty

Review of Systems

General: Denies fevers, chills.
Musculoskeletal: Complains of see HPI.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Respiratory

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Pedal Pulses: Negative Findings: symmetrical normal dorsalis pedis pulses, symmetrical normal post tibial pulses.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema.

Gastrointestinal

Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.
Liver and Spleen: Negative Findings: no liver enlargement, no spleen enlargement, no liver nodularity.

Musculoskeletal

Gait and Station: Negative Findings: normal gait.
Spine, Ribs, Pelvis: Negative Findings: normal alignment, normal mobility, no deformity, no tenderness, negative straight leg raise bilaterallly.

Neurologic

Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Mental Status

Judgement/Insight: Negative Findings: intact.
Mood and Affect: Negative Findings: no depression, no anxiety, no agitation.

Reference range in parenthesis.
Microalbumin (urine): 20 mg/L (0-20 mg/L)

Assessment & Plan Summary

RIB PAIN, RIGHT SIDED (ICD-786.50) - Uncontrolled.
Unsure of etiology of R side/back pain and its relationship to her daily vomiting. CXR neg. Pt has a MRI of her spine ordered by the neurologist. Is stooling regularly. Has pain meds. RUQ u/s neg and pt has an absent gallbladder. Will CT chest/abd to see if she has a tumor lesion. Will get xrays to eval for osteoporosis or vertebral frx.

Upon pt leaving, she noted to a nurse that this was all related to an injury and she was going to give the orders to her lawyer. I was told this after the fact and am unsure about the initial incident.

.....Rachel L Callis MD March 30, 2009 1:24 PM

Signed by C Scott Lamar MD on 03/31/2009 at 7:53 PM

Children's Hospital Outpatient Center
14 Richland Medical Park Drive Suite 400 Columbia, SC 29203
(803) 434-6155 Fax: (803) 434-6979

October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB: 07/04/1951 R009122088 Ins: BLUE CRO (0534) Grp: 111148

04/29/2009 - Office Visit: FMC Adult Visit
Provider: Rachel E Hall MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information
Continuity Provider: Tad Venn
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs
Entered weight: 240 lb., 5 oz.
Calculated Weight: 240.31 lb.
Temperature: 98.2 deg F. **Temp Site:** oral
Pulse rate: 68 **Pulse rhythm:** regular **Respirations:** 20
BP: 150/92
Wt chg: 3.12 since 03/30/2009
Vitals entered by: Avis N Jackson, LPN on April 29, 2009 2:47 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Additional Risk Factor(s): Medications affecting B/P or LOC
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is currently experiencing pain.
Location: headache **Intensity (1-10):** 7 **Description:** ache **Duration:** 1 Days
The patient does not experience chronic pain.
patient presents with complaints of headache and cough for about a day.
.....Avis N Jackson, LPN April 29, 2009 2:48 PM

Patient/caregiver Teaching

History of Present Illness
Chief Complaint: HA

Headache
This patient with a history of Sinus headaches presents to clinic today with complaints of sudden onset throbbing frontal headache which began on 04/29/2009.
Headache is described to have been present for <1 days.
Headache pain is most severe in the morning and is given a out of 10 in severity by the patient.

JOANN M BROCKINGTON
Female DOB 04/04/1951 R009122086 Ins: BLUE CRO (0534) Grp: 111148
Home: (803)740-4497 Office: (803)939-0026

Assoc. Symptoms: nausea, sinus pressure
Aggrevating Factors: bright light
Management:
Comments: yesterday her L eye was hurting, this AM took at goody powder and it didn't help. She also had a bad episode of night sweats last night. Last year fell and hit head and had a concussion, has had hx of HAs since and has been started on Lamictal per Neuro. Has been out of her flonase for a couple of months.

Past Medical History
Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History
Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems
General: Denies fevers.
Neurologic: Complains of headaches. Denies dizziness, transient paralysis, weakness, paresthesias.
Allergic/Immunologic: Complains of hay fever.

Physical Exam
General
General: Positive Findings: obese. Negative Findings: Well appearing, no acute distress.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
External Nose: Negative Findings: no discharge, no deformity, no skin lesions.
Otoscopic: Positive Findings: serous L otitis.
Hearing: Negative Findings: Grossly normal hearing.
Nasal: Positive Findings: pale mucosa. enlarged turbinates
Pharynx: Positive Findings: mild pharyngeal erythema. Negative Findings: no pharyngeal exudates.

Neck
Neck Exam: Negative Findings: supple, no masses, trachea midline.

Respiratory

JOANN M BROCKINGTON
Female DOB 02/04/1954 R000122086 Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CRO (0534) Grp: PI1148

Respiratory Effort: Negative Findings: no intercostal retractions, no accessory muscle use, no respiratory distress.
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: no extra heart sounds.

Lymphatic
Neck: Negative Findings: no cervical lymphadenopathy.

Musculoskeletal
Gait and Station: Negative Findings: normal gait.

Mental Status
Judgement/Insight: Negative Findings: intact.
Mood and Affect: no appearance of depression, anxiety or agitation

Reference range in parenthesis.
Microalbumin (urine): 20 (0-20 mg/L)

Assessment & Plan Summary

HEADACHE (ICD-784.0).
ALLERGIC RHINITIS, SEASONAL (ICD-477.9).
POSTCONCUSSION SYNDROME (ICD-310.2). Restart flonase, Mucinex D advised as well, plenty of water.

Prescriptions:
MUCINEX D 60-600 MG TB12 (PSEUDOEPHEDRINE-GUAIFENESIN) one or two po q12h with plenty of water #40 x 1
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 04/29/2009
Method used: Print then Give to Patient
RxID: 1556636595157500

FLONASE 50 MCG/ACT SUSP (FLUTICASONE PROPIONATE) 2 sprays in each nostril once a day #1 x 11
Entered and Authorized by: Rachel E Hall MD
Signed by: Rachel E Hall MD on 04/29/2009
Method used: Print then Give to Patient
RxID: 1556636535407500

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
Female, DOB 07/04/1951 [illegible] R009122086 [illegible] Home: (803)740-4497 Office: (803)939-0026 Ins: BLUE CRD (0534) Grp: 111148

Signed by Rachel E Hall MD on 04/29/2009 at 3:33 PM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-9026
Female DOB: 10/04/1951 R009122086 Ins: BLUE CRO(0534) Grp: 113148

07/13/2009 - Office Visit: FMC Adult Visit
Provider: Kathryn W Dudas, MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Entered weight: 232 lb., 9 oz.
Calculated Weight: 232.56 lb.
Pulse rate: 76 **Respirations:** 20
BP: 122/80
BMI: 38.84 **BSA:** 2.11 **Wt chg:** -1.94 since 06/29/2009
Vitals entered by: Susan Jackson, CMA on July 13, 2009 1:54 PM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Level Low Risk
Verbal patient and/or family education provided: Yes
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient is not currently experiencing pain.
The patient does not experience chronic pain.

Patient/caregiver Teaching

Attending Participation: Present and Available
Dr C Scott Lamar

Back Pain

This patient presents today with complaints of back pain present since 08/08/2008.
The pain which is reportedly is described to be a pain of the lower back region present for . The patient reports the pain to be a out of 10 on a 10 point pain scale and have .
Associated symptoms:
Aggrevating factors:
Alleviating factorsComments: low back pain from a fall

History of Present Illness

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)749-4497 Office: (803)939-0026
Female, DOB: 07/04/1951 R009122088 Ins: BLUECRO (0534) Grp: 111148

Chief Complaint: Hypertension maintenance

Comments: Patient states that blood sugar has been relatively well controlled with levels below 120 mg/dL. One time it was above 300 mg/dL

Basis for Diagnosis: Previous History of HTN

Frequency(x/week) 1
Systolic Range: 200
Diastolic Range: 120

Current Diet: low fat/low cholesterol
Treatment compliance: Good
Comments: pt B/P was 200/100 a wk ago; usual blood pressures have been 120s/80s

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

General: Denies fevers, chills, sweats.

Cardiovascular: Denies chest pains, palpitations.
Respiratory: Denies dyspnea.
Gastrointestinal: Complains of nausea. Denies vomiting, diarrhea, constipation.
Genitourinary: Denies vaginal discharge.
Genitourinary: Denies vaginal discharge.
Musculoskeletal: Complains of back pain.
Psychiatric: Complains of depression, anxiety. Denies suicidal ideation.
Heme/Lymphatic: Denies abnormal bruising, bleeding.

Physical Exam

General

General: Negative Findings: Well appearing, well hydrated, no acute distress.

Eyes

External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.

Respiratory

Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular

Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.
Peripheral Circulation: Negative Findings: no cyanosis, no clubbing, no edema, no varicosities.

Gastrointestinal

Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Diabetic Foot Exam

Diabetes Foot Exam: Negative Findings: Normal DP pulse bilaterally, Skin intact bilaterally, No fungal nail changes.

.....Thomas W Morris, Medical Student July 13, 2009 2:13 PM
Acting as scribe for Dr. Dudas

Laboratory Results

HgbA1C Collected: July 13, 2009 2:50 PM **HgbA1C Resulted:** July 13, 2009 3:51 PM
HgbA1C: 11.7% (4.0%-6.9% normal) (7.0%-13.0% high)
Test performed by: Susan Jackson, CMA

Assessment & Plan Summary

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0).
on Amilodipine, metoprolol and benzapril... looks like bp is controlled. Will cont to follow.

DIABETES MELLITUS, TYPE II, UNCONTROLLED (ICD-250.02).
Glycolsylated hemoglobin was elevated. However, blood glucose measured today was in the normal range. Glimerpiride was increased to 6mg q day. Pt counseled to lose weight. Will continue to follow.

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October 19, 2009

Chart Document

JOANN M BROCKINGTON
female DOB 07/04/1951 #R009122086 Home:(803)740-4497 Office:(803)939-0026
Ins:BLUE CRO (0534)Grp:111148

OBESITY (ICD-278.00).
Pt dieting- using south beach; will decrease drinking sugary drinks; decrease fried foods.... pt not currently exercising.... will start walking 5Xper week for 30 minutes. has back pain but will start exercising.

TRICHOMONAL VAGINITIS (ICD-131.01).
improved sx

DEGENERATIVE JOINT DISEASE (ICD-715.90).
will continue vicoprofen and wean as tolerated

.....Kathryn W Dudas, MD July 13, 2009 5:17 PM

Prescriptions:

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #90 x 0
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563114102408370

GLIMEPIRIDE 2 MG TABS (GLIMEPIRIDE) take one tab q day, take with 4mg tabs #30 x 4
Entered and Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563114012158370

OXYCODONE-ACETAMINOPHEN 5-500 MG CAPS (OXYCODONE-ACETAMINOPHEN) one cap po every 6 hours #90 x 0
Entered by: Thomas W Morris, Medical Student
Authorized by: Kathryn W Dudas, MD
Signed by: Kathryn W Dudas, MD on 07/13/2009
Method used: Print then Give to Patient
RxID: 1563113832058370

Signed by C Scott Lamar MD on 07/14/2009 at 4:56 PM

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October 19, 2009

Chart Document

JOANN M BROCKINGTON [redacted] Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 [redacted] R009122086 [redacted] BLUE CRD(0534) Grp:110148

08/25/2009 - Office Visit: FMC Adult Visit
Provider: Johan Hernandez MD
Location of Care: Palmetto Health Richland Family Medicine Center

Patient Information

Continuity Provider: Kathryn Dudas
Team: Blue
Ethnicity: Not Hispanic or Latino (08/29/2007 10:43:41 AM)
Race: Black
Language Preference: English
Latex Risk: none 11-7-2007 (11/07/2007 11:05:02 AM)

Vital Signs

Weight: 231.80 lb. (105.36 kg.)
Pulse rate: 76 **Pulse rhythm:** regular **Respirations:** 16
LMP: Menopause/hysterectomy
BP: 140/90
BMI: 38.71 **BSA:** 2.11 **Wt chg:** -0.76 since 07/13/2009
Vitals entered by: Virginia R Prevost LPN on August 25, 2009 8:27 AM

Medication Reconcilliation: Medication list reviewed by nursing staff with pt/caregiver today. List given to provider to reconcile.

Fall Risk Assessment
Fall Risk Assessment: done today. No changes noted.

Pain Assessment
The patient has chronic pain.
.....*Virginia R Prevost LPN August 25, 2009 8:27 AM*

Patient/caregiver Teaching

History of Present Illness

History from: patient
Chief Complaint: hospital f/u

Other HPI: Patient is a 58 yo AAF with PMH significant for HTN, DVT, DM and PE who is here today for hospital f/u from Providence. She was admitted 8/14 adn discharged on 8/24 with LLE DVT and PE. She was sent out therapeutic with INR 2.1. She was admitted when was having leg pain and swelling which made her go to the ER. Last episode of PE and DVT 2 years ago where she took coumadin for 6 month and had been of it for 1.5 years. Today she comes because she took her last coumadin dose yesterday of 15mg . She states that she feel fatigued and tired. Is here because she need her coumadin regimen.

History of Present Illness

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October 19, 2009

Chart Document

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female, DOB: 07/04/1951 R0091220086 Ins: BLUE CROSS (0534) Grp: 114148

History from: patient
Chief Complaint: Hypertension maintenance

Hypertension

Basis for Diagnosis: Previous History of HTN

Current symptoms: dyspnea
Denies: chest pain, cough, diaphoresis, edema

Status:
Home BP monitoring: Yes
Management:
Non-pharmacologic treatment: none
Treatment compliance: Good
Medication tolerance: no complaints

Comments: Did not take BP pills today.

Past Medical History

Other: Hx of type 2 diabetes
Hx of hypertension
hyperlipidemia
allergies
OA
postconcussive syndrome-summer 2007

Social History

Tobacco use: never
Drug Use: none
Type of exercise: Walk
Employment/Family:
Marital Status: Widowed

Review of Systems

JOANN M BROCKINGTON Home: (803)740-4497 Office: (803)939-0026
Female DOB:07/04/1951 R009122086 Ins: BLUE CRO (0534) Grp:1 11148

General: Denies fevers, chills.
Eyes: Denies blurring.
Ear/Nose/Throat: Denies earache, nosebleeds.
Cardiovascular: Complains of dyspnea on exertion. Denies chest pains, palpitations.
Respiratory: Denies cough, wheezing.
Gastrointestinal: Denies vomiting, diarrhea.
Musculoskeletal: Denies joint pain.
Skin: Denies rash.

Physical Exam

General
General: Positive Findings: obese. Negative Findings: Well appearing,well hydrated,no acute distress.

Eyes
External Eye: Negative Findings: conjunctivae normal, lids normal, no icterus, corneas normal.
Pupils: Negative Findings: normal light reaction, normal accomodation.

Ear, Nose, Throat
External Ears: Negative Findings: normal pinna, no skin lesions, no deformity.
Hearing: Negative Findings: Grossly normal hearing.
Pharynx: Negative Findings: normal tongue, normal posterior pharynx, no pharyngeal erythema, no pharyngeal exudates.

Respiratory
Auscultation: Negative Findings: no rales, no rhonchi, no wheezes, symetrical air movement.

Cardiovascular
Auscultation: Negative Findings: normal S1 & S2, no extra heart sounds, no murmurs, no rubs, no gallop.

Gastrointestinal
Abdomen: Negative Findings: soft, non-tender, no masses, normal bowel sounds.

Skin
Skin Inspection: Negative Findings: no rash.

Musculoskeletal
RLE: 39cm
LLE: 41cm

Neurologic
Cranial Nerves: Negative Findings: CN II-XII grossly intact.

Assessment & Plan Summary

DEEP VENOUS THROMBOPHLEBITIS, LEG, LEFT (ICD-453.40). Patient with second DVT episode.

Will need coumadin indefinetely. Her INR on dscharge was 2.1. She took 15mg yesterday. Will start on 5mg po daily and check INR on Thursday.
Medications: Coumadin 5 mg tabs Take one (1) tablet daily by mouth.

PULMONARY EMBOLISM (ICD-415.19). Had PE episode in Hospital last week. Will need to be on Coumadin. On 5mg po daily and check INR in 2 days. PE is normal . No SOB or chest pain a this time.
Medications: Coumadin 5 mg tabs Take one (1) tablet daily by mouth.

HYPERTENSION, MALIGNANT, UNCONTROLLED (ICD-401.0). BP elevated, but did not take her medication today at all. Prescription written today and handed to patient.
Medications: Metoprolol tartrate 100 mg tabs two tabs po bid; Benazepril hcl 40 mg tabs Take two po daily; Hydrochlorothiazide 25 mg tabs 1 tab orally daily; Procardia xl 90 mg xr24h-tab Take one (1) tablet daily by mouth.

OBESITY (ICD-278.00). Weight loss, diet and exercise.

Prescriptions:
PROCARDIA XL 90 MG XR24H-TAB (NIFEDIPINE) Take one (1) tablet daily by mouth #30 x 5
Entered and Authorized by: Johan Hernandez MD
Signed by: Johan Hernandez MD on 08/25/2009
Method used: Print then Give to Patient
RxID: 1566808894558460

Signed by Johan Hernandez MD on 08/25/2009 at 11:07 AM

The Moore Orthopaedic Clinic, P.A.
14 Medical Park, Suite 200
Columbia, SC 29203
(803)-227-8000 Fax: (803) 749-9627

Venn

October 24, 2006 **Joanne M. Brockington 192522** **Irmo Office**

HISTORY: Joanne is a pleasant 55-year-old black female, who has had some pain in her right shoulder going on for a few months. She then fell about three weeks ago and the pain has just gotten tremendously worse. She was seen by Dr. Batson, who got an MRI that shows a significant rotator cuff tear with some retraction. She denies any previous problems with her shoulder.

She is a non-insulin-dependent diabetic and has hypertension.

PHYSICAL EXAMINATION: Clinical exam reveals passively, she has excellent range of motion, but actively she is only able to come up to about 90 degrees and she is just hurting real bad. She has marked impingement findings. I cannot evaluate the strength to supraspinatus testing mainly because she is just hurting too badly.

PLAN: I reviewed the MRI. She is going to need to have right shoulder arthroscopy, acromioplasty, and Mumford with rotator cuff repair. We will make sure she has preoperative x-rays of her shoulder. I have given her literature on the topic and explained this to her in detail. **When she comes back in for the next appointment, I will also get two views of her right shoulder**.

Earl B. McFadden, Jr., M.D.

EBM:hsj
cc: Rachel E. Hall, M.D.
DD: 10/24/06, DT: 10/25/06

Vean

The Moore Orthopaedic Clinic, P.A.
14 Medical Park, Suite 200
Columbia, SC 29203
(803)-227-8000 Fax: (803) 749-9627

November 06, 2006 **Joanne M. Brockington 192522** **Richland Office**

Joanne is here for history and physical for a right shoulder arthroscopy with acromioplasty and Mumford and rotator cuff repair. She understands risks and complications including bleeding, nerve damage, infection, failure of the repair, recurrent tear, and possibility of not being able to completely repair it, and she signs her permit. Also, we got two views of her right shoulder that show a huge spur in the front, significant degenerative changes in the AC joint, and a prominent greater tuberosity.

Earl B. McFadden, Jr., M.D.

EBM:sps
cc: Rachel E. Hall, M.D.
DD: 11/06/06, DT: 11/07/06

iv

The Moore Orthopaedic Clinic, P.A.
14 Medical Park, Suite 200
Columbia, SC 29203
(803)-227-8000 Fax: (803) 749-9627

December 14, 2006 **Joanne M. Brockington 192522** **Irmo Office**

HISTORY: Joanne is five weeks out from a large rotator cuff repair and she has been coming with an immobilizer on. She has been using her arm. So, I have instructed her not to be using her arm, keep it by her side for another week. At that point, she can start using it actively, no sudden jerky motion or any new exercises. Today, her range of motion is excellent.

PLAN: I gave her prescription of Vicodin for pain. I will see her back after the first of year and start her on general strengthening exercises when she is at least eight to nine weeks out. I am going to let her go back to work beginning of the year keeping work below chest height.

Earl B. McFadden, Jr., M.D.

EBM:swy
cc: Rachel E. Hall, M.D.
DD: 12/14/06, DT: 12/15/06

The Moore Orthopaedic Clinic, P.A.
14 Medical Park, Suite 200
Columbia, SC 29203
(803)-227-8000 Fax: (803) 749-9627

January 24, 2007 **Joanne M. Brockington 192522** **Richland Office**

HISTORY: Joanne lacks about 10 degrees of full forward flexion. She is about 10 weeks' out.

PHYSICAL EXAMINATION: She has good internal and external rotation. She has a little bit of weakness to supraspinatus testing, but not bad.

PLAN: I am going to start her on some gentle rotator cuff strengthening exercises. I will let her go on back to work. I do not want her do any sudden jerky motions until she is 12 weeks' out. I will see her back in six to eight weeks for one final exam.

Earl B. McFadden, Jr., M.D.

EBM:swy
cc: Rachel E. Hall, M.D.
DD: 01/24/07, DT: 01/25/07

Moore Orthopaedics
104 Saluda Pointe Drive
Lexington, South Carolina 29072
(803) 227-8000 Phone / (803) 227-8015 Fax

October 30, 2008 **Joanne M. Brockington 192522** **Lexington Office**

CHIEF COMPLAINT: LOW BACK PAIN AND BILATERAL HIP PAIN

HISTORY OF PRESENT ILLNESS: Ms. Brockington is a 57-year-old female here for independent medical evaluation. She works as a cook. Her injury dates back to August 2007 when she was at work and she slipped in the kitchen falling directly on her back. She did get seen at Richland Hospital and she was given some medications for her back. She has not been back to work since this injury occurred. She complains of low back pain that is fairly constant. The pain radiates down all the way down to her ankles. She really has not had a history consistent with tingling and numbness in her legs. She has had no treatment for the back. There has been no physical therapy, MRI imaging, or other radiographic imaging done to this point. She denies any previous problems of the back or similar symptoms prior to this injury. She has not been to work since the accident. She has had treatment for her head. They did a CAT scanning and other treatment by neurology and now she is here just to try to sort out her back and hip situation.

REVIEW OF SYSTEMS: The patient's medical history form is reviewed with the patient, signed, and is included in the chart.

PHYSICAL EXAMINATION: Neurological examination of the lower extremities reveals there are 2+ deep tendon reflexes at the knees and ankles that are symmetrical. EHL, anterior tibialis, peroneal tendon, posterior tibial tendon and gastrocnemius strength are 5/5 bilaterally. Quadriceps strength is 5/5 bilaterally. There is normal sensation to light touch diffusely throughout both lower extremities. Babinski sign is negative bilaterally. There is no clonus present to the bilateral feet. There is 2+ dorsalis pedis pulse and 2+ posterior artery pulse to palpation bilaterally. Gait is normal. She has no effusion of her knee. She has 0 to 130 degrees of range of motion of bilateral knees. Short leg raise is negative bilaterally. Hip bursa is nontender bilaterally. She has 45 degrees internal and external rotation of bilateral hips. She has palpable pulses in both feet. She has 70 degrees of lumbar spinal flexion; afterwards she gets a little bit of discomfort. She points to pain along the sacral region of the lumbar spine. This is slightly tender diffusely across the low back but no point tenderness today. There are no abnormalities to inspection.

RADIOGRAPHS: Imaging is not available today. I do have reports of AP pelvis, which are normal.

Continued

Moore Orthopaedics
104 Saluda Pointe Drive
Lexington, South Carolina 29072
(803) 227-8000 Phone / (803) 227-8015 Fax

October 30, 2008 **Joanne M. Brockington 192522** **Lexington Office**
Continued

IMPRESSION:

1. MECHANICAL LOW BACK PAIN WITH LUMBAR STRAIN
2. POSSIBLE SPINAL STENOSIS WITH REFERRED RADICULAR PAIN WITHOUT NEUROLOGIC DEFICIT

PLAN: I counseled her about the options. I think a course of physical therapy to be given to the patient. Should she not respond to physical therapy, I think an MRI will be appropriate. We could try an epidural steroid injection pending progress. I think I would not recommend she do any heavy lifting at this point just given the nature of the problem, so she could do light duty, which will not involve any significant bending, stooping, or lifting. I think this will be reasonable. She does not have frequent breaks. If it is unavailable, I guess she probably should stay out of work until she has at least completed her course of physical therapy. I will see her back on a p.r.n. basis.

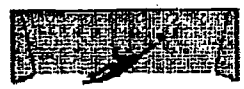
I did speak with the case manager today, Ms. Cindy Taylor, who is independent of my examination of Ms. Brockington. We talked about the findings and general treatment recommendations. Although I do not have the imaging today, I do not see evidence of any significant structural damage to the spine or any neurologic compromise.

Frank K. Noojin, M.D.

FKN:jpy
DD: 10/30/08, DT: 10/31/08



MOORE
— Orthopaedics —



Name: Joanne Brockington Date: 10/31/08

Diagnoses: 724.2 LBP

Appointment Date: _____ Time: _____

Occupational/Physical Therapy: To be seen _____ times per week for _____ weeks.

Protocol: X Eval and Treat __ Cont PT/OT

KNEE

ACL pre-op___
ACL autograft___
ACL allograft___
ACL HS___
ACL deficient___
PCL PTG___
MCL___
ACL&PCL recon___
Lateral ret release___
Carticel___
Meniscus repair___
Patella Protection___
Menisectomy___
Fulkerson___
PF Program___

SHOULDER

Impingement acute___
Impingement subacute___
Impingement strength___
Impingement advanced___
Rot Cuff repair type 1___
Rot Cuff repair 2___
Rot Cuff repair 3___
Bankart repair___
SLAP repair___
Bristow procedure___
Fulkerson___
Anterior Capsular shift___
Posterior Capsular shift___
Thermal assist capsulorraphy___
Anterior shoulder instability___
AC joint stabilization___
Total shoulder arthroplasty___
Frozen shoulder protocol___
Rotator Cuff Exercises___

ELBOW

Ulnar nerve trans___
UCL sprain___
UCL recon___
Elbow arthrolysis___

ANKLE

Ankle Sprain I__
Ankle Sprain II__
Ankle Sprain III__

SPINE

Lumbar Stabilization X
SIJ__
Spondylolysis__

MODALITIES

_____Cold
_____Heat
_____Ultrasound
_____Phonophores
_____E-stim
_____Iontophores
_____TENS
_____Edema Control
_____FCE

Other: _____

Special Considerations: _____

Weight Bearing Status: NWB:____ PWB:____ TTWB:____ WBAT:___

ROM: PROM:____ AAROM:____ AROM:___ LIMITS:____

_____ _____
Doctor Signature(Dispense as written) Doctor Signature(Substitution permitted

Moore Orthopaedics
104 Saluda Pointe Drive
Lexington, South Carolina 29072
(803) 227-8000 Phone / (803) 227-8015 Fax

April 2, 2009 **Joanne Brockington 192522** **Lexington Office**

PRESENT CONDITION: Ms. Brockington returns for her lumbar spine and right leg. She has had low back pain and hip pain for quite some time. The pain goes down the leg somewhat. It has been going on for over a year and a half. She has no significant imaging studies other than some plain films that have been performed. She was able to go back to light duty after I saw her in October. She also has some neck and thoracic back pain as well.

REVIEW OF SYSTEMS: Refer to sheet.

PHYSICAL EXAMINATION: Physical exam shows 1+ deep tendon reflexes at knees and ankles. I see no neurologic deficit in the lower extremities. Straight leg raise is positive on the right, negative on the left. She has no trochanteric bursal tenderness. Her ROM is normal and symmetric without pain. I do not see anything to suggest she has a hip problem per se.

IMPRESSION:

1. DEGENERATIVE DISEASE, LUMBAR SPINE, MECHANICAL BACK PAIN
2. LUMBAR RADICULITIS, RIGHT LEG

PLAN: At this time, I am going to go ahead and proceed with an MRI scan of the lumbar spine. I would like to see if Dr. Van Dam can see her for possible an epidural steroid injection if he thinks this is indicated to give her some pain relief. I have counseled her, but I am not sure what else she can really do at this point. I do not think she meets indication for surgical referral for this problem at this time. I did speak with her case manager today, Ms. Sammy Guiness, who was present for the examination. I am going to keep her at light duty with no lifting and mostly sedentary duties at work.

Frank K. Noojin, M.D.

FKN: ats32
cc: Ted Venn, MD
DD: 04/02/09 DT: 04/03/09

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THE MOORE ORTHOPAEDIC CLINIC
FOUNDED 1928

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Kim J. Chillag, M.D.
Total Hip & Total Knee Replacement
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David B. Fulton, M.D.
Hand, Upper Extremity Surgery & General Orthopaedics
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Sports Medicine, Arthroscopy & General Orthopaedics
William H. Kirkley, M.D.
General Orthopaedics
Mark D. Locke, M.D., FAAP
Pediatric Orthopaedics
Earl B. McFadden, Jr., M.D.
Hand & Upper Extremity Surgery
Frank K. Noojin, III, M.D.
Sports Medicine, Arthroscopy & General Orthopaedics
Bradley P. Presnal, M.D.
Total Joint Replacement, Arthroscopy & General Orthopaedics
W. Alaric Van Dam, M.D.
Musculoskeletal Medicine & Electrodiagnostics

REPORT OF MEDICAL EXAMINATION

JOANNE BROCKINGTON
Employee's Name

XXX-XX
Social Security Number

BCBS-TN: BCBS OF TENNESSEE (PPO)
Employer/Carrier

04/02/2009
Date of Office Visit

FRANK NOOJIN III MD
Physician/Provider

Signature of Physician

RETURN TO WORK STATUS:

Regular Duties	/	Date to Return:
Light Duties		Date to Return:
Remain Out of Work		Duration:

PHYSICAL LIMITATIONS:

	None		Pushing and pulling limit lbs.
	No Walking or climbing	/	Lifting and carrying limit lbs.
	No standing		Sedentary duties only
	No prolonged standing		No kneeling, squatting, crawling
	No sitting		No work involving arm/hand
/	No bending or stooping		No overhead work
	No twisting or stretching		No work at heights
	No change from previous status		Other:

FOLLOW UP:

to AVD

	Days		Months
	Weeks	/	PRN
	Discharged with permanent limitations above		
/	Next Appointment: Waiting for auth for MRI L-Spine and AVD ESI		

Copy of office note to follow.

14 Medical Park • Suite 200 • Columbia, South Carolina 29203 • (803) 227-8000
7033 St. Andrews Road • Suite 104 • Columbia, South Carolina 29212 • (803) 227-8003
4721A Sunset Blvd • Lexington, South Carolina 29072 • (803) 227-8007

Moore Orthopaedics
104 Saluda Pointe Drive
Lexington, South Carolina 29072
(803) 227-8000 Phone / (803) 227-8015 Fax

April 20, 2009 **Joanne Brockington 192522** **Lexington Office**

PRESENT CONDITION: Ms. Brockington returns for her lumbar MRI. She is still having back pain radiating down her right leg.

REVIEW OF SYSTEMS: Refer to sheet.

PHYSICAL EXAMINATION: Physical exam shows straight leg raise is positive on the right, negative on the left. Her gait is slightly antalgic. She has lumbosacral tenderness to palpation. She is able to flex and extend her toes bilaterally with no apparent neurologic deficit.

RADIOGRAPHS: MRI scan shows multilevel congenital spinal stenosis, but it is most pronounced at L4-L5.

IMPRESSION: SPINAL STENOSIS L4-L5 WITH RIGHT LOWER EXTREMITY SYMPTOMS

PLAN: She has already had physical therapy and is at light duty with no lifting. She has significant back pain with leg pain. I am going to recommend she see Dr. Van Dam to see if an epidural steroid injection would help her. We will see her back in about six weeks. Until that time I am going to keep her on light duty with no lifting and predominantly sedentary type duties. I spoke with her case manager today, Ms. Sandy Gettys.

Frank K. Noojin, M.D.

FKN: ats32
cc: Tad Venn, MD
Palmetto Health Richland, 6 Richland Park Columbia SC 29203

DD: 04/20/09, DT: 04/21/09

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W. Alaric Van Dam, M.D.
Musculoskeletal Medicine & Electrodiagnostics

REPORT OF MEDICAL EXAMINATION

JOANNE BROCKINGTON
Employee's Name

XXX-XX
Social Security Number

~~BCBS TN BCBS OF TENNESSEE (PPO)~~ Corvel
Employer/Carrier

04/20/2009
Date of Office Visit

FRANK NOOJIN III MD
Physician/Provider

Signature of Physician

RETURN TO WORK STATUS:

Regular Duties ____
Light Duties ____/
Remain Out of Work ____

Date to Return: ____
Date to Return: ____
Duration: ____

MD 1.16

PHYSICAL LIMITATIONS:

____ None
____ No Walking or climbing
____ No standing
____ No prolonged standing
____ No sitting
____ No bending or stooping
____ No twisting or stretching
____ No change from previous status

____ Pushing and pulling limit ____ lbs.
____ Lifting and carrying limit ____ lbs.
____ Sedentary duties only
____ No kneeling, squatting, crawling
____ No work involving ____ arm/hand
____ No overhead work
____ No work at heights
____ Other: ____

FOLLOW UP:

____ Days
____ Weeks
____ Discharged with permanent limitations above
____ Next Appointment: Pending auth for EST

____ Months
____ PRN

Copy of office note to follow. Next - Monday June 1st @ 4:20

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4721A Sunset Blvd • Lexington, South Carolina 29072 • (803) 227-8007

June 17, 2009

CORVEL
Suite 410
Fredericksburg, VA 22401

RE: Joanne Brockington
EMPLOYER:

DATE OF INJURY: 07/07/2007

Dear Sir,

Regarding Joanne Brockingtons's injury to the low back, I believe Maximum Medical Improvement has been attained. The final diagnosis for Joanne Brockington remains lumbar radiculitis. According to the 5th Edition of the American Medical Association's Guidelines to the Evaluation of Permanent Impairment, I believe the patient is entitled to a 4% impairment rating to the lumbar spine for lumbar radiculitis.

Joanne Brockington is discharged from my care at this time. I would be happy to be of assistance in the future should this be necessary. Please do not hesitate to contact me should you have any further questions or require any additional information.

Sincerely,

Frank K. Noojin, III, MD
FKN: ats28
DD: 06/18/09 DT: 06/19/09

Moore Orthopaedics
14 Medical Park, Suite 200
Columbia, South Carolina 29203
(803) 227-8000 Phone / (803) 227-8015 Fax

June 17, 2009 **Joanne Brockington 192522** **Richland Office**

PRESENT CONDITION: Ms. Brockington returns for her right hip and leg. She is still having pain. The epidural steroid injection really gave her temporary relief at most. She is not really interested in further injections or surgery.

REVIEW OF SYSTEMS: The patient's medical history form is reviewed with the patient, signed and included in the chart.

PHYSICAL EXAMINATION: Physical exam shows straight-leg-raise is mildly positive on the right compared to the left. Hip range of motion is 30 degrees of internal rotation bilaterally. Gait is slightly antalgic. Generally she is alert and appropriate.

IMPRESSION: LUMBAR RADICULITIS RIGHT LEG

PLAN: We have tried all treatments at this time. She is not significantly better. It has been about a year. She has had multiple imaging studies that did not reveal any other cause of her pain. I think it is mostly her radiculopathy from the spine going down the right leg. However, she is neurologically intact. So we are going to go ahead and release her. I would like to keep her at light duty restrictions and make these permanent, which would be 20 pound lifting and pushing limit and no bending or stooping. She can work in the laundry if this is permanently available because I think she has done well with her current light duty but I don't think she can go back to her regular job with her leg condition. I don't think there is any further treatment we can do. I will see her back as needed.

Frank K. Noojin, M.D.

FKN:ats28
DD: 06/18/09 DT: 06/18/09

Moore Orthopaedics
104 Saluda Pointe Drive
Lexington, South Carolina 29072
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11/02/2010 **JOANNE BROCKINGTON 192522** **Lexington Office**

ADDENDUM: I reviewed Ms. Brockington's note as far as the work status. If she were to be working, it would be a 20 pound lifting restriction as previously delineated and a 20 pound carrying limit. I think these restrictions should be permanent. There probably should be no bending or stooping. There should also be no repetitive twisting or torsion to the spine area. She did voluntarily decide not to work, but technically she is at light duty with these restrictions.

Frank K. Noojin, III, M.D.

CC List:

FKN:ats32
DD: 11/08/2010 DT: 11/09/2010 10:57:01
73747

CORVEL

Questions to be asked by nurse case manager on 11/2/10 MD appointment with Dr. Noojin and Ms. Joanne Brockington.

1. Has there been any change in the IW's diagnosis? ND
2. What is the recommended treatment plan? Rehab, medications
3. Does the IW have any work restrictions? If so, what are they? ND CHANGE
4. Has the IW achieved MMI? If not, when do you expect MMI? Yes
5. Do you anticipate the IW to have and permanent work restrictions? If so, what are they? NA ACE
6. Do you anticipate the IW to have an impairment rating? If so, what do you anticipate it to be?
   solo spine
7. Do you anticipate the IW to need long term care for the work injury on 8/8/07? If so, what is the expected long term treatment plan?
   medications
   does not work injection, surgery
   pain management referral

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800-642-5137

Patient Name **BROCKINGTON, JOANN** Medical Record No. **M001523343**

Account Number **H00030081988** Date **8/8/2007**

ID H00030081988

Lexington Medical Center

Emergency Department Record

History of Present Illness

MN

56 Year Old Female Patient Presents with Neck Pain. The Onset is Fall (mild) S/P. Additional Symptoms or Pertinent History also involve fell from standing position; right hip pain. Furthermore, the Patient/Family Denies loc, syncope before fall, cp, abd pain.

Review of Systems

(Symptoms and Signs not covered in the HPI)

GU **Neg**	Neuro	ENT	Resp **Neg**	Musculoskeletal	Hematologic/Lymphatic
Skin	Psych	Heart **Neg**	GI **Neg**	Endocrine	Allergic/Immunologic
☒ All other ROS negative				Constitutional Sxs	Eyes

☑ Vital Signs/Triage/Nursing Notes Reviewed and Agree ☒ Hx unobtainable due to Tx urgency or poor historian(s) ☒ Additional Information from Police, Ambulance, Nursing Home or Relatives ☒ Old Medical Records Reviewed

Past Medical History ☐ No Relevant PMH ☒ Asthma ☒ COPD ☒ CAD ☒ Cancer ☒ CHF ☒ CVA

Other PMHx ☑ Diabetes ☑ HTN ☒ Psychiatric ☒ Renal ☒ Seizures

Social History ☑ No Relevant SoHx ☒ ETOH ☒ Drugs ☒ Smoking Additional Sx

Family History None

Physical Exam

Exam Time 16:45

MN

General Appearance	
HEENT	small hematoma occipital scalp, perl, eomi, op clear
Chest	RRR No MRG Lungs CTA No Tachypnea Chest Wall NT
Abdomen	Abd Wall-No Hernias or Abn Findings NI BS No Bruits Soft NT No HSM or Masses
GU	
Extremities	Hip R Decreased AROM (Mod) Point Tenderness
Neuro	CN2-12intact, Motor (=) 5/5 Gross Sensory Intact Gait NI No Ataxia
Skin	No pallor/rashes/bruising/petechiae/edema Warm & Dry
Back	paravertebral tender upper thoracic spine, no stepoff/deform
Neck	Paraspinal Tendrness L, from
Lymphatics	

Repeat or Additional Clinical Notes

MD	Notes	Time
MN	No Sx(s) or Objective findings that are life or limb threatening. Medically Screened and Stable for disposition(Transfer) from the ED.	8/8/2007 8:06:27 PM

Patient Name **BROCKINGTON, JOANN** Medical Record No. **M001523343**

Account Number **H00030081988** Date **8/8/2007**

Diagnostics

Specimen Collected / ECG .Rad Ordered

MD Initials	Time	Diagnostic Ordered	Result Interpretation	Result Reviewed By	RN Initials	Time
MN	16:47	Cervical Spine X-Ray	diffuse degen changes, no fx-per radiology	MN	MLK	17:21
MN	16:47	Hip R X-Ray	neg	MN	MLK	17:21

Medical Orders

MD Initials	Time	Order	RN Initials	Time	Location-Response-Quantity	RN Remarks
MN	18:35	Vicodin 1 Tab PO	MLK	18:45		
MN	18:35	Flexeril 10mg PO	MLK	18:45		
MN	19:59	walk pt	MLH	20:08		
MLH	20:22	RN LOS 3	MLH	20:22		

Recommended LOS/CPT/ICD-9 Codes

Physician's LOS = 3 99283 CPT

Nurse's LOS = 3 611 APC

Diagnoses

Neck Pain	847.0 ICD-9
Neck Contusion	920 ICD-9
Hip Contusion	924.01 ICD-9

Secondary Diagnoses

Hypertension	401.9 ICD-9
Diabetes Mellitus	250.00 ICD-9

	MD	MD Time		RN	RN Date/ Time	Admit to
Disposition	MN	20:06	Discharge Home	MLH	8/8/2007	20:08
Condition	MN	20:06	Good	MLH	20:08	

Physician (Print) Nowell, Mac MD (MN)

Physician Signature

Primary RN (Print) Koucky, Michelle Lynn (MLK)

Other Physicians
Nowell, Mac MD (MN)~

Other Nurses
Koucky, Michelle Lynn (MLK)~Caughman, Nancy Reasonover (NRC)~Mahan,Doug (RAD)~simmons, jennifer~Veronee, Jo Ann (JAV)~Martin, Suzette M (S_M)~Ballance, Shane E (SEB)~Hardison, Margaret L. (MLH)~

This chart has been electronically signed via the EmpowER software.

Patient Name **BROCKINGTON, JOANN**

Account Number **H00030081988**

Medical Record No. **M001523343**

Date **8/8/2007**

Patient Name **BROCKINGTON, JOANN**

Medical Record Number **M001523343**

Account Number **H00030081988**

Date **8/8/2007**

Lexington Medical Center
Emergency Department

Discharge Instructions

Discharge Date/Time **8/8/2007 8:22:23 PM**

Diagnoses

Neck Pain

Neck Contusion

Hip Contusion

You have been evaluated today by an independent healthcare provider practicing Emergency Medicine. In most cases follow-up care is recommended with your regular Doctor, HMO or Clinic.

Within **2** days ☒ Doctor ☒ HMO ☒ Clinic

Call for appointment as soon as possible. IDENTIFY Yourself as an ER Patient. If you don't have a doctor or need a specialist follow up with:

Physician/Specialist

Address

Phone

Additional instructions were given on the following conditions:

- ☒ Abdominal Pain
- ☒ Allergic Reaction/ Rash
- ☒ Asthma/ Wheezing/COPD
- ☒ Back Pain
- ☒ Chest Pain
- ☒ Conjunctivitis
- ☒ Corneal Abrasion/Eye Injury
- ☒ Fever
- ☒ Fracture/Sprain/Contusion
- ☒ Gastritis/Ulcer
- ☒ Head Injury
- ☒ Headache
- ☒ High Blood Pressure
- ☒ Kidney Stone
- ☒ Neck Strain
- ☒ Nose Bleed
- ☒ Middle Ear Infection
- ☒ PID/STD
- ☒ Sore Throat/Pharyngitis
- ☒ Threatened Abortion
- ☒ Toothache
- ☒ Upper Respiratory Infection
- ☒ UTI/Kidney Infection
- ☒ Vaginal Bleeding
- ☒ Vomiting/Diarrhea
- ☒ Wound Care/Sutures

Other

Additional Instructions:

If the symptoms worsen or new symptoms develop return to the Emergency Department (ED) immediately. Call your doctor for additional questions.

ED phone number: 803-936-8128

Work/School Restriction:

☒ You may return to work/school today.

You may not return to work/school until:

This information may be released to my school or employer

☒ If you had x-rays or blood tests, please note that these don't always show what's wrong. Sometimes x-rays don't show broken bones. After review by a specialist you will be notified if there is an abnormality.

☒ You may not drive or operate heavy machinery because the medicines you have may make you sleepy.

Physician (Print)
Nowell, Mac MD (MN)

Nurse Signature: X

Patient Signature X

Lexington Medical Center
Emergency Department
Phone: 803-936-8128

Date Printed **8/8/2007**

Patient Name **BROCKINGTON, JOANN**

DOB **07/04/1951**

Prescriptions

Rx: **flexeril 10mg p.o. TID prn muscle stiffness #20** Refills **Zero**

VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOI

Rx: **no work through 8/15/07** Refills **Zero**

VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOI

Rx: **Vicodin 5/500 1-2 p.o. q4-6h prn pain #20 (twenty)** Refills **Zero**

VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOID VOI

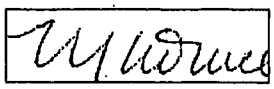
Patient Name **BROCKINGTON, JOANN** Medical Record Number **M001523343**

Account Number **H00030081988** Date **8/8/2007**

This Prescription is VOID if submitted to a Pharmacy 72 hours after the Date and Time listed above.

Physician (Print)

Nowell, Mac MD (MN)



DEA# **BN7492553**

SUBSTITUTION PERMISSIBLE-IN ORDER FOR BRAND NAME TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE "BRAND MEDICALLY NECESSARY" ON PRESCRIPTION

Patient Name **BROCKINGTON, JOANN** Medical Record No. **M001523343**

Account Number **H00030081988** Date **8/8/2007**

Lexington Medical Center

Emergency Department Nursing Notes and Vital Signs

TimeEntered: 8/8/2007 18:09 Vitals Taken By: MLK

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O	Right	98	R 132/86	20		Moderate 5 - 6
T	Left		L			
R						

TimeEntered: 8/8/2007 18:45 Vitals Taken By: MLK

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O	Right	93	R 150/86	20		Moderate 5 - 6
T	Left		L			
R						

TimeEntered: 8/8/2007 20:21 Vitals Taken By: MLH

Temperature	Pulse		Blood Pressure	Respirations	Pulse Ox	Pain Scale
O 98.8	Right	90	R 166/100	18		Moderate 5 - 6
T	Left		L			
R						

Nursing Notes

Time Note Entered		RN Initials	Note
8/8/2007	16:35	MLK	pt to rm in +FSP, pt c/o pain to back of head and R hip after slipped and fell at work. Pt denies LOC.;Awake A&Ox3;No pallor/ rashes warm & dry;PERRL EOMI Moist Mucous Membranes No Icterus; No JVD, lungs clear bilat, abd soft, nontender, all pulses intact, unable to assess ROM d/t FS. Pt denies blurred vision. hand grips equal bilat, R foot press weaker than L otherwise neuro intact.
8/8/2007	17:45	MLK	PT RETURNED TO RM FROM X-RAY. FILMS NOT CLEARED, PT STILL IN C-SPINE PRECAUTIONS
8/8/2007	18:22	MLK	PT TAKEN OFF BACK BOARD, C-COLLAR STILL IN PLACE.AWAITING RADIOLOGIST TO CLEAR FILMS.
8/8/2007	19:17	MLK	REPORT GIVEN TO LEIGHANN, RN
8/8/2007	20:15	MLH	PT UP AND AMBULATORY AROUND ROOM UNASSISTED. COLOR GOOD, RESP EVEN NONLABORED, FAMILY REMAINS AT BEDSIDE.
8/8/2007	20:21	MLH	; D/C INSTR GIVEN PT VERB UND PT D/C HOME WITH FAMILY

Primary Nurse Diagnosis	Primary Nurse Outcome	Achieved
Pain R/T FALL	Relates Relief after relief measure	Yes

Primary RN (Print) Koucky, Michelle Lynn (MLK)

Lexington Medical Center Triage

Category: 3 Potentially Un

Arrival Date/Time	Triage Time	Waiting Rm Time	Exam Rm Time
8/8/2007 16:34	16:34		16:34

PCP Staff Status: Staff
Family Physician: LFP
Transported by: Ambulance
Mode: Ambulance
Historian: Self
Police Dept: Custody | Notification | Beat #

Patient Name: BROCKINGTON,JOANN
Medical Record Number: M001523343
Account Number: H00030081988
DOB: 07/04/1951
Age: 56 Years
Gender: Female

Chief Complaint: Head Trauma
Onset Time: 45 Minute(s)
Location:

Associated Sxs / Pertinent History:
pt at work, slipped and fell, c/o of pain to back of head and R hip. -LOC

Past Medical History: Additional: Tubal Ligation; Hysterectomy; Gallstones; rotator cuff repair

☐ No Significant PMHx
☐ Asthma ☐ COPD ☐ CAD ☐ Cancer ☐ CHF ☐ CVA
☑ DM ☑ HTN ☐ Psych ☐ Renal ☐ Seizures ☐ Substance Abuse

Medications:
☐ No Meds ☐ Unknown
METFORMIN HYDROCHLORIDE 1GM BID (Twice a Day) GLYBURIDE 5MG BID (Twice a Day) LIPITOR HCTZ BENAZEPRIL HYDROCHLORIDE 40MG QD (Q-Daily) PROCARDIA ASA Baby

Allergies:
Penicillin

Immunizations UTD? UTD
TB Hx, PPD Pos or Exposures? No
If yes to TB or Infectious question take precautions

Vitals
Tem
Oral 100.4
Rectal
Tympanic
Pulse
Right 114
Left
Respirations 20
Blood Pressure
Right 171/108
Left
Pulse Ox
Weight (Kg 101 Kg
Height
Head Circumference
Pain Scale Moderate 5 - 6

Mental Status / Psychological Eval:

Lung Sounds:

	R	L
Clear	☐	☐
Diminished	☐	☐
Wheezes	☐	☐
Rales	☐	☐
Rhonchi	☐	☐
Retractions	☐	☐

Eyes:

	R	L
Equal	☐	☐
Reactive	☐	☐
Fixed	☐	☐
Constricted	☐	☐
Dilated	☐	☐
Cataract	☐	☐

Glascow Coma Scale:
Eye
Verbal
Motor
Total

OB/Gyn:
Hysterectomy
G P Ab Miscarriages

Skin:
Color
Temp
Moist

Extremities:
Pulses
ROM

Nutrition:

Fall Risk Assessment:
Recent History Of Fall

Domestic Violence Assessment:
Are you being hurt by someone you live with or who takes care of you?
Yes/No No
* Mandatory completion of Domestic Violence Referral.

Assessing Patient's, Child's or Parent's readiness to learn:
Primary Language: English
Assessed Disability: No Disability
Communication Barrier ☐
Language Translator ☐
Motivation Level: Med
Knowledge Level: Med
Comprehension Ability: Med

Plan:
1-13 Time: 16:50
Triage Nurse: Koucky, Michelle Lynn (ML
Triage II:
Triage III: MLK

Functional D/C Planning:
Daily Living: Independent
Living Conditions: Family
Going Home with: Family

☐ LWBS ☐ LW Completed Tx/ Eloped ☐ AMA ☐ AMA Refused ☑ Patient Rights and Responsibilities and Guide to Pain Management given to Patient, Family, and/or Caretaker

Patient Name **BROCKINGTON, JOANN** Medical Record No. **M001523343**

Account Number **H00030081988** **8/8/2007**

Emergency Department Pharmacy and Supply Charges

Interventions

Intervention Name	Comments	Charge Code
Vicodin 1 Tab PO		0
Flexeril 10mg PO		0
walk pt		
RN LOS 3		

Nurse LOS 3 611 APC **Charge Code** 0

VCNW

THE SOUTH CAROLINA NEUROLOGICAL CLINIC, P.A.
PO BOX 1488
COLUMBIA, SOUTH CAROLINA 29202

TELEPHONE: (803) 254-6391 FAX: (803) 799-0682

JULIAN C. ADAMS, M.D. J. E. CARNES, M.D. LAWRENCE B. MAULDIN, M.D. THEODORE T. FABER, M.D.
MARK K. LENCKE, M.D. CHARLES G. SHISSIAS, M.D. ALAN R. MORGAN, M.D.

Alan R. Morgan, M.D.
Patient ID: 223137
Patient Name: Joann Brockington
DOB: 07/04/51
Date of Service: 09/04/07

CONSULTATION

Christian Steen, MD
3209 Colonial Drive
Columbia, South Carolina 29203

Dear Dr. Steen:

Thank you for the opportunity to see Ms. Joann Brockington for neurological consultation. As you recall, this is a 56-year-old female who presents with headaches following a fall with head trauma in early August. The patient reports she may have experienced a loss of consciousness with this head trauma. She describes the headaches as global type headaches with no nausea but mild photophobia. There is no positional component to these headaches, and they do not change with coughing or straining. A CT scan of her neck after this fall just showed degenerative changes. A CT scan of her head showed parafalcine subdural hematomas. An MRI of her brain was obtained approximately two weeks after that which confirmed these subdural hematomas but showed no interval growth. Ms. Brockington's neurological examination is normal in the clinic today except for mild difficulty with tandem gait.

IMPRESSION:
1. Postconcussive headaches.
2. Subdural hematomas.

I have prescribed amitriptyline 25 mg every evening to help Ms. Brockington with her headaches. I have also asked Ms. Brockington to return to our clinic in six weeks' time, at which time we will repeat a CT of her head to follow these subdural hematomas. I will reevaluate her headaches at that time and see if we need to make any further additions to her medications for headache control.

Thank you for this kind referral. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Alan R. Morgan, MD

ARM/dmc

A full report is available upon request.

MIDLANDS NEUROLOGY & PAIN ASSOCIATES, P.A.

ELEANYA OGBURU-OGBONNAYA, M.D.

4801 North Main Street
Columbia, SC 29203

Phone (803)788-0038 FAX (803)788-0655

INDEPENDENT MEDICAL EVALUATION

PATIENT: Joann Brockington CHART No.: 877 DATE OF VISIT: 10/25/2008

Claim No.: C34502007017075

HISTORY: Patient is a 57-year-old African-American female with history of blurred vision, headaches, and low back pain since August of 2007. She noted that at that time she slipped and fell at work and did pass out. She noted that when she slipped and fell, she fell backwards and landed on a concrete floor and this occurred about August 08, 2007. She noted at that time she had pain radiating into her legs. She also complained of problem with the memory and also complained of pain extending to the stomach area. She noted her headache symptoms are variable in frequency, but on average it is about three times per week. The headache is mostly localized to the posterior occipital area. She denies any aura prior to the onset of headache. She notes some nausea and vomiting with headache. She denies any photophobia or phonophobia and no significant family history of headache. She also denies any other associated neurological abnormality with her headache. She reported that she sleeps fairly okay in initiating sleep, but has difficulty maintaining the sleep with episodic hypersomnolence and occasional snoring. She denies any burning, numbness, or paresthesia. No bladder or bowel dysfunction. She is currently being followed by Dr. Bennett. Her pain level is about 7/10.

PAST MEDICAL HISTORY: Hypertension, diabetes, hypercholesterolemia, post-concussion syndrome, and chronic headache.

PAST SURGICAL HISTORY: Cholecystectomy.

PREVIOUS HOSPITALIZATION: Hospitalization on 08/08/2007 due to fall.

CURRENT MEDICATIONS: Metoprolol 50 mg q.d., gabapentin 300 mg p.o. t.i.d., and benazepril 40 mg two tablets q.d., glimepiride 4 mg q.d., Lortab q.6h, metformin 1000 mg p.o. b.i.d., hydrochlorothiazide 25 mg q.d., and Reglan 10 mg p.o. b.i.d.

ALLERGIES: Penicillin.

FAMILY MEDICAL HISTORY: History of high blood pressure.

REVIEW OF SYSTEMS:

- **Head and Neck:** History of.
  - Headache and tinnitus.
  - Eye pain.

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INDEPENDENT MEDICAL EVALUATION

PATIENT: Joann Brockington CHART No.: 877 DATE OF VISIT: 10/25/2008

- Decreased vision.
- Double vision.

- **CV:** History of.
  - High blood pressure.
  - Night sweats.
- **Pulmonary/Lungs:** Unremarkable.
- **GI:** History of nausea and appetite loss.
- **GU:** Unremarkable.
- **Gynecological History:** Unremarkable.
- **MS:** History of:
  - Shoulder pain.
  - Muscle problem.
- **Neuropsychological:** Unremarkable.

SOCIAL HISTORY:

- Denies history of cigarette, alcohol, or illicit drug use.
- She is a widow and has five children.
- She worked as a cook. Last work was in August of 2007.

FUNCTIONAL CAPACITY:

- She ambulates without any assistive device.
- She is independent on all ADLs.
- She is continent to bowel and bladder.
- She is alert, oriented, and awake.

PHYSICAL EXAMINATION:

- **Vitals:** BP 231/138. P 83. R 18. T 99.0. W 220.
- **Appearance:** She is well-nourished African-American female in no acute respiratory distress. She is right-handed.
- **HEENT:** Atraumatic and normocephalic. Pharynx and tonsils are normal.
- **Chest:** Clear.
- **CV:** Regular rate and rhythm.
- **Abdomen:** Benign.

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INDEPENDENT MEDICAL EVALUATION

PATIENT: Joann Brockington CHART No.: 877 DATE OF VISIT: 10/25/2008

- **Peripheral Pulses:** Present and equal in all extremities.
- **Carotid pulsations:** Normal.
- **Skin:** Warm and dry.
- **MS:** Shows a localized tenderness over lumbosacral region without any pain in the suboccipital areas with normal straight leg raise and crossed leg sign.
- **Neuropsychological:**
  - **Consciousness:** She is awake, alert, and oriented x3.
  - **Speech**: Clear and appropriate.
  - **CN II-XII:** Pupils are equal and reactive to light. Ocular movement is intact.
  - **Facial**: Nasolabial fold symmetrical. Tongue and uvula in is midline. Fundi and disc are normal. No evidence of nystagmus noted. Facial shows no significant symmetry.
  - **Sensory**: To light touch, pinprick and joint position were relatively preserved.
  - **Motor:** Shows no pronation drift. Rapid alternating movement is symmetrical. Gross strength is 5/5 x4 with normal tone. No atrophy.
  - **Cerebellar**: Shows no dysmetria, ataxia, or pass pointing.
  - **Reflexes**: Reflex is symmetrical with bilateral downgoing plantars.
  - **Gait:** Normal. Also, initial micro-psychological screen was slightly abnormal.

PREVIOUS WORKUP: Review of available data indicates that patient had a C-spine series that shows diffuse degenerative changes with large anterior bulging osteophytic changes noted. X-ray of the hip shows also mild degenerative changes affecting the hips bilaterally. CT scan of the cervical spine showed chronic degenerative changes, extensive multilevel degenerative changes throughout the cervical spine with large bulk anterior osteophytic formation, facet arthropathy at C7-T1, and a small posterior osteophyte at C3-C4. CT of the head showed a small amount of blood along the falx. Very few images _____ seen with thickening present. No evidence of subarachnoid bleed that was on 06/16/2007. MRI of the brain on August 23, 2007 did show a small and tiny parafalcine subdural hematoma on the left seen both on anterior and posterior view without any evidence of subarachnoid bleed. Any significant finding such as infarct, intraparenchymal hemorrhage, mass lesion in brain denote a mass effect and the ventricles were symmetrical. There is no convexity subdural. Spinal sinuses were also normal. CT scan of the brain without contrast on 10/22/2007 shows no acute intracranial pathology. There is a small bilateral basal ganglia calcification. In previous note, a minor extra-axial hemorrhage along the falx on the left is no longer visualized. The calvarium is intact. Next study is 01/18/2006. X-ray of the left hand shows mild degenerative changes. X-ray of the left hand shows mild degenerative changes, date of study is 01/18/2008.

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INDEPENDENT MEDICAL EVALUATION

PATIENT: Joann Brockington CHART No.: 877 DATE OF VISIT: 10/25/2008

IMPRESSION:

- Postconcussion syndrome resulted head injury and sequelae.
- Malignant hypertension.
- Obesity.
- Diabetes mellitus.
- Hypercholesterolemia.
- Lumbar radiculitis with cervical radiculitis with myofascial pain syndrome.
- Significant finding of depression with anxiety _____ testing during these visits.
- In my opinion, proceeding the time of onset of these symptoms to present, it appears that the patient has reached MMI. Order of formal CAT scan may be necessary to evaluate if there is any definite evidence of intraparenchymal metabolic changes. EEG will also be in order to evaluate the other sequelae such as fissures.

SUGGEST:

- Recommend a neuropsychological testing with functional capacity evaluation and to determine patient's current status with reference to her memory in view of previous diagnosis of post-concussion syndrome.
- If patient continues to experience back and neck pain, suggest epidural steroid injections and physical therapy.
- We will also recommend aggressive management with patient's high blood pressure requiring echocardiogram to deal immediate further complications of this particular problem.
- Suggest referral to a psychiatrist.
- Management of underlying mood disorder, which may also play a significant role in patient's current medical condition.
- Based on these findings and these recommendations that are available on available record, it is also necessary to suggest that may need further workup prior to reaching an MMI.
- Some of the underlying pathology has not been adequately addressed or that the full impact of the injury has not been fully evaluated.
- Thus in reference to the list of questions required by Melissa Ellis with well cooperation.
- 1. I believe further testing such as neuropsychological testing, PET scan, management of high blood pressure, underlying mood disorder makes it difficult to suggest that patient has reached MMI. Some of this condition may be adequately managed and corrected. Especially, the mood disorder, which may also be a sequelae of patient not being able to function if baseline stays the date of injury.
- Question to #1. Yes, patient will require further medical and diagnostic testing such as

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INDEPENDENT MEDICAL EVALUATION

PATIENT: Joann Brockington CHART No.: 877 DATE OF VISIT: 10/25/2008

- 1. PET scan
- 2. Neurological testing.
- 3. Aggressive management of blood pressure with echocardiogram.
- 4. Physical therapy.
- 5. Add analgesia for neck and back pain.
- 6. Serial occipital nerve block for her headache. Blood test also for headache.
- Question #2. Patient has now reached MMI.
- Questions #3. The patient will also require functional capacity evaluation once issues are addressed or indicated in item #1, as properly addressed and adequately taken care of.

I do not believe permanent impairment rating is necessary at this point, as the patient has reached MMI.

Eleanya Ogburu-Ogbonnaya, M.D.

EOO:Vinfonet

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PSYCHOLOGICAL EVALUATION

Marc Harari, Ph.D.
1816 Bull Street
Columbia, SC 29201
(803) 422-0017

Testing Dates: 3/12/09 & 4/14/09
Date of Report: 4/15/09
Claim # - C34502007017075

Client: Joanne Brockington

DOB – 7/4/51

REASON FOR REFERRAL

Joanne Brockington was referred for this Independent Medical Evaluation (IME) by the CorVel Corporation. This report provides an examination of Joanne's neuropsychological and mental health functioning, and concludes with recommendations to address her treatment needs, Maximum Medical Improvement (MMI), pre-existing conditions, and the necessity of her treatment to date.

NOTICE

This report is confidential and meant for use by those who have received a written authorization from the CorVel Corporation. No unauthorized disclosure of this report or data contained in this report is allowed. Any person who, without proper authorization, discloses information contained in this report assumes all liability associated therewith.

DATA SOURCES

Clinical Interview with Joanne Brockington
Medical Records Provided by CorVel Corporation
Behavioral Observations
Psychological Testing:
- Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI)
- Conners' Continuous Performance Inventory II (CPT-II)
- Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III)
- Symptom Assessment Questionnaire – 45 (SA-45)
- Test of Memory Malingering (TOMM)
- Wechsler Abbreviated Scale of Intelligence (WASI)
- Wechsler Intellectual Achievement Test 2nd Edition (WIAT-II) Selected Subtests
- Wechsler Memory Scales - 3rd Edition (WMS-III)

BACKGROUND

Joanne reported that she was raised by her parents in Florence, South Carolina. She stated that her parents separated when she was 11 years old. Joanne mentioned that she continued to reside with her mother, but maintained frequent contact with her father. She described a positive childhood and denied any instances of abuse or traumatic experiences in her home. Joanne stated that she related well with both of her parents during the course of her childhood and adolescence.

Academically, Joanne stopped attending school in the 11th grade. She reported that she was always enrolled in mainstream classes and never received special education services. Joanne married and had four children with her husband, but has been widowed

for the past 12 years. Joanne stated that her four children range in age from 30 to 40 years old. She indicated a steady history of employment as a cook.

Joanne denied problems during her employment history until she suffered a work-related injury on August 8, 2007. She reportedly fell and hit her head on a concrete floor causing a concussion and bleeding in her brain. The results of the CT scan and MRI from the medical documentation provided by CorVel confirmed a small amount of bleeding in her brain. However, the medical evidence suggested a very small and thin subdural hematoma, without a significant mass effect. Please refer to the medical documentation provided by CorVel for a detailed account of her head injury.

Joanne reported that effects of her head injury prevented her from returning to work from August 2007 until January of 2009. She has been performing light-duty work such as folding towels. However, Joanne mentioned that she has missed many days from work because of various physical ailments she relates to her head injury. She endorsed frequent headaches, blurred vision, limited mobility, and chronic pain in her neck, back, hips, and legs. Joanne also reported experiencing short-term memory lapses since her work-related injury. She expressed frustration regarding her reduced physical and cognitive capacity. Joanne continues to receive medical treatment and physical therapy to address her varied concerns. Additionally, she has been cooperating with Worker's Compensation. While she has worked to maintain good attendance at work, she has missed numerous days because of her physical difficulties.

MEDICAL HISTORY/ADAPTIVE FUNCTIONING

Joanne indicated that she was physically healthy as a child and adolescent. She denied any serious health concerns during her early adulthood. However, she was diagnosed with diabetes, hypertension, and high cholesterol as an adult. Joanne receives medical treatment for these conditions and denied any history of absenteeism related to these illnesses. She began missing work for medical concerns following her head injury in August 2007.

Joanne denied any history of mental health treatment. She has never participated in psychotherapy or been prescribed psychotropic medication. Joanne did not indicate significant psychological symptoms such as psychosis, major mood disorder symptoms, or chronic anxiety. There is also no reported history of illicit substance abuse or interactions with the criminal justice system. However, Joanne did endorse situational symptoms of distress based on her reduced physical capacity and inability to maintain consistent attendance at work.

Regarding Joanne's adaptive functioning, she demonstrated moderate limitations related to her reduced physical capacity and apparent short-term memory problems. She stated that she is unable to drive because of chronic pain. Joanne is able to manage her funds, perform basic daily living tasks and live independently. There were no apparent deficits in her social skills and she receives social support from family members. She stated that the chronic pain she experiences prevents her from functioning adequately.

BEHAVIORAL OBSERVATIONS/MENTAL STATUS

Joanne is a 57-year-old African American female of heavy-set stature who appeared consistent with her chronological age. She dressed casually for the examination wearing

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appropriate attire. Her mood was calm, however she exhibited pain motor movement and complained of feeling ill, describing flu-like symptoms. Therefore, Joanne was encouraged to take her time and complete what she could. An appointment for her to complete the testing process was scheduled her for 4/14/09. Her speech quantity was normal and she spoke in a logical and coherent manner. Joanne was oriented to all spheres and was in full contact with reality. She appeared to provide her best effort on the psychological inventories and cognitive tasks. Therefore, this appeared to be a valid testing administration.

PSYCHOLOGICAL TEST RESULTS AND INTERPRETATION

Note to the Reader about the Interpretation of Psychological Tests

The interpretations of psychological tests presented in this report are hypotheses and should not be used in isolation from other information in this matter. The interpretative statements are primarily computer-generated, actuarial, and expert predictions based on the test patterns. The interpretations reflect characteristics of persons who have provided test response patterns that are similar to those of the current individual. Test results are probabilistic in nature and should be interpreted cautiously incorporating other data. Therefore, the reader should examine the test interpretations for general trends and not put too much weight on one specific statement. In the integration and presentation of the test data, when the results were unclear or in conflict, this examiner selected the most likely hypotheses for presentation here.

Mental Health Inventories

Joanne was first administered the Symptom Assessment-45 Questionnaire (SA-45). This is an exercise designed to provide a screen for various psychological conditions including depression, anxiety, symptom distress, interpersonal relations, and psychotic symptoms experienced during the past week. The SA-45 is a multidimensional instrument that provides both a global scale (GSI) and nine symptom subscales. Joanne's overall response pattern suggested that she moderate levels of psychological distress (GSI, T = 55). Examining the individual subscales, her profile resulted in significant elevations on the Somatization scale (T = 72). She endorsed problems with muscle soreness, heaviness in her arms and legs, numbness, and muscle weakness.

Joanne was next administered the MCMI-III. This is a self-report inventory designed to provide an assessment of an individual's clinical syndromes and underlying personality tendencies. Joanne's profile was suggestive of an individual with an established need for social approval and commendation, evidenced by tendencies to present herself in a favorable light. Such individuals demonstrate limited self-knowledge of psychological matters. Therefore, some caution is recommended regarding the validity of her MCMI-III profile based on the possibility that she minimized the true extent of her psychological difficulties. Despite Joanne's response pattern, she endorsed somatic complaints and dysthymic symptoms. These results were consistent with her presentation during the clinical interview.

Cognitive/Neuropsychological Tests

Joanne was first administered the TOMM an inventory disguised as a cognitive ability test that is really designed to assess an individual's overall effort. The results of this

inventory suggested that Joanne made an appropriate effort (First Trial – 41/50; Second Trial 47/50). Therefore, it is likely that she performed to the best of her abilities on the subsequent cognitive and neurological exercises.

Joanne also was administered the CPT-II. This is a computerized inventory that assesses an individual's attention span, impulsivity, and vigilance. This was a valid administration of this measure. Her response pattern on the CPT-II resulted in a 50% probability that she falls within the range of a clinical population. Joanne's response pattern was indicative of inattentiveness, based on her numerous errors. She also responded in an atypically quick manner indicative of impulsive tendencies. Finally, her performance declined during the course of this administration suggesting problems related to vigilance.

Wechsler Memory Scale – III (WMS-III)

Primary Subtest	Scaled Score
Logical Memory I – Recall	1
Faces I - Recognition	7
Verbal Paired Associates I – Recall	3
Family Pictures I – Recall	7
Letter-Number Sequencing	3
Spatial Span	3
Logical Memory II – Recall	4
Faces II – Recognition	5
Verbal Paired Associates II – Recall	6
Family Pictures II – Recall	5
Auditory Recognition – Delayed	7

Index	Score	%ile
Auditory Immediate	53	.1
Visual Immediate	81	10
Immediate Memory	59	.3
Auditory Delayed	71	3
Visual Delayed	68	2
Auditory Recognition Delayed	85	16
General Memory	69	2
Working Memory	63	1

The WMS-III is a measure of an individual's ability to hold information temporarily in memory for the purpose of using that information to perform a specific task. This measure assesses various forms of memory including immediate, working, and delayed memory. Joanne's performance suggested Extremely Low overall memory skills. She demonstrated a relative strength in her Visual Immediate Memory and Auditory Recognition skills, although she performed in the Low-Average range on these exercises. On the remaining tasks, Joanne functioned in the Extremely Low range. She demonstrated particular weaknesses on tasks requiring Auditory Immediate Memory. It is likely that these results represent a reduction compared to her prior functioning capacity prior to her head injury.

Wechsler Abbreviated Scale of Intelligence (WASI)

	T-Scores		IQ Scores	%ile
Vocabulary	40	Verbal IQ	85	16
Similarities	39	Performance IQ	79	8
Block Design	36	Full-4	79	8
Matrix Reasoning	36			

The WASI is an abbreviated version of the WAIS-III and is designed to provide a broad screen of intellectual functioning. On this administration, Joanne obtained a Full-4 IQ of 79, placing her within the Borderline to Low-Average range of overall cognitive ability. This score is a composite of Verbal and Performance skill measures of 85 and 79 respectively, placing her verbal abilities in the Low-Average range and her non-verbal abilities in the Borderline/Low-Average range. Examining the individual subscales, Joanne exhibited relative consistency across the skill domains. Based on these results, there is a 90% chance that her "true" IQ score would fall between 69 and 91.

Wechsler Individual Achievement Test (WIAT-II) – Selected Subtests

Subtest	Standard Score	Grade Level	Percentile
Word Reading	58	4:0	.3
Numerical Operations	60	1:8	.4
Spelling	56	2:5	.2

The WIAT-II is a series of subtests designed to measure reading, spelling, and mathematics. Joanne performed in the Extremely Low range on each of the academic exercises. These findings were significantly lower than expected given her intellectual abilities and suggestive of deficits in her basic academic skills. Finally, the VMI was administered to assess Joanne's visual and motor integration abilities. On this measure, she obtained a standard score of 45 that was in the Extremely Low range. This result was significantly lower than expected given her intellectual abilities and suggested fine-motor deficits.

SUMMARY

Joanne Brockington is a 57-year-old African American female who was referred for IME by the CorVel Corporation. On August 8, 2007, Joanne reportedly suffered a head injury at work. She experienced various somatic and cognitive problems following this injury. Regarding the validity of this testing administration, Joanne appeared to present in a candid and credible manner during the clinical interview and on the validity indices examining her response pattern and effort. She did not appear to engage in malinerging behaviors such as symptom exaggeration or a suspect effort. In contrast, Joanne appeared to minimize the true extent of her psychological difficulties, according to the MCMI-III data. Therefore, the accumulation of data suggests that this was a valid testing administration. It is noted that Joanne felt ill on the initial test date of March 12, 2009 and returned to complete the evaluation on April 14, 2009.

Joanne has worked primarily as a cook for many years prior to experiencing a head injury in August 2007. Despite the pre-existing medical conditions of diabetes, hypertension, and high cholesterol, she was able to sustain regular employment until her

accident in August 2007. Joanne reports frequent headaches, blurred vision, chronic pain in her body, and limited mobility. Additionally, she described problems related to her short-term memory since her head injury. Joanne receives medical treatment and physical therapy to address these concerns. While she recently returned to work for light-duty employment, she expressed frustration regarding excessive absenteeism due to her varied physical concerns.

Joanne did not endorse a history of mental health treatment services. She has never been prescribed psychotropic medication. She did not endorse prominent mental health symptoms aside for situational depression related to her reduced functioning capacity. On the mental health inventories including the SA-45 and MCMI-III, Joanne primarily endorsed somatic complaints and moderate depressive symptoms. These results were commensurate with the clinical interview data.

Joanne indicated moderate overall adaptive problems with significant difficulties related to chronic physical pain and short-term memory lapses. She stated that she is no longer able to drive a vehicle. However, Joanne manages her finances, lives independently, and is able to perform basic tasks of daily living in her home. She demonstrated adequate social skills and receives support from family members.

Joanne completed several instruments to provide a screen of her neurological functioning. Her performance on the WASI was suggestive of an individual with Borderline/Low-Average intellectual abilities. She exhibited relatively consistent verbal and perceptual abilities. On the CPT-II, Joanne's responded in an impulsive manner. While she demonstrated a fast reaction time, she made numerous errors and her performance deteriorated as the administration progressed. Joanne next completed the WMS-III. Her overall performance was suggestive of Extremely Low overall Auditory and Visual memory skills. She demonstrated particular deficits in her Immediate Memory abilities suggesting a reduction from prior functioning levels. On the academic achievement exercises, Joanne performed in the Extremely Low range on the basic verbal and non-verbal exercises. These results were significantly lower than expected based on her intellectual abilities. Finally, Joanne scored in the Extremely Low range on the VMI suggesting fine-motor deficits.

CONCLUSIONS

- DSM-IV-TR Preliminary Diagnoses

AXIS I	294.9	Cognitive Disorder, NOS (Report of Reduced Short-Term Memory Capacity)
	309	Adjustment Disorder with Depressed Mood
AXIS II	V71.09	No Diagnosis
AXIS III		Diabetes II, Hypertension, High Cholesterol, Head Injury in August 2007
AXIS IV	Stressors:	Complaints of a short-term memory problems, various physical conditions that impact her level of functioning
AXIS V	GAF – 60	

- Pre-existing Conditions

  Joanne endorsed pre-existing physical conditions to include Diabetes, Hypertension, and High Cholesterol. However, she denied that these illnesses impacted her work attendance. There are no reports of head injuries or memory problems prior to her work-related injury in August 2007. She stated that she first experienced cognitive and physical limitations following this work-related injury. Therefore, Joanne did not endorse pre-existing conditions that have significantly affected her cognitive and physical abilities.

- Necessity of Treatment to Date

  The acquired treatment data obtained from the CorVel Corporation suggest that Joanne has undergone MRI and CT scans that provide medical evidence of a head injury. She receives neurological treatment and physical therapy to address her headaches, chronic pain, and limited mobility. Joanne did not work from August 2007 through December 2008. She recently returned for light duty employment in January 2009. However, Joanne reported numerous absences related to medical problems experienced since her head injury.

- Issues Related to MMI

  Regarding Joanne's cognitive functioning levels, she demonstrated a significant difference between her intellectual abilities that were in the Borderline to Low-Average range compared to her performance on the remaining exercises that were in the Extremely Low range. She exhibited particular problems related to memory capacity, fine-motor abilities, and basic academic achievement skills. Her CPT results were indicative of poor vigilance and behavioral impulsivity. The findings suggest that Joanne has reached MMI as related to her cognitive capabilities. Regarding Joanne's medical condition, she is scheduled for further physical therapy to address her somatization and chronic headaches. Since Joanne has not completed the physical therapy process, this examiner cannot conclude with a reasonable degree of medical certainty, whether she has reached MMI.

- Need for Future Treatment

  Joanne reports that she is scheduled to undergo further neurological examinations and physical therapy to address her problems with blurry vision, memory, headaches, reduced mobility, and chronic pain in her neck, hips, and legs. She denied a history of mental health treatment and did not indicate a need for psychiatric or psychological services. Finally, Joanne should continue to receive medical treatment for her pre-existing medical conditions that include Diabetes, High Cholesterol, and Hypertension.

Marc Harari Ph.D.

Marc Harari, Ph.D. 4/15/09
Licensed Counseling Psychologist (875)

UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS®

Neurology Faculty

William L. Brannon, M.D.
General Neurology
(Emeritus)

Miroslav Cuturic, M.D.
Neurophysiology
Neuromuscular Diseases

David H. Hammett, M.D.
General Neurology
Memory Disorders
Vascular Neurology

Te-long Hwang, M.D.
General Neurology
Vascular Neurology

James Selph, M.D.
Neurophysiology
Neuromuscular Diseases
Epilepsy
General Neurology

Davit Mrelashvili, M.D.
General Neurology
Neuroimmunology
Multiple Sclerosis

JOANN BROCKINGTON
Date of Service: 3/27/09
Requesting Physician: Jeffrey Hall, MD

NEUROLOGY CONSULTATION

CHIEF COMPLAINT: Ms. Brockington is a 57-year-old African-American female who was evaluated for multiple complaints.

HISTORY OF PRESENT ILLNESS: She suffered from a falling accident on August 8, 2008. She fell backwards with a closed head injury and she blacked out for one minute. She was subsequently sent to Richland Memorial Hospital and she was found to have mild subdural hematoma. No surgical intervention was done. Ever since the accident, she has had the following complaints: 1) Pain of neck, back and hips. 2) Dizziness. 3) Sleeplessness. 4) Nausea and vomiting. 5) Headache. She described the headache as a hitting pain or dull pain lasting from one day to one week. The headache is usually associated with blurred vision, seeing spots and photophobia. The nausea and vomiting may or may not be associated with the headache. Currently, she is taking oxycodone/APAP 5/500 mg, one tablet every night.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Diabetes mellitus.
3. Hyperlipidemia.
4. Arthritis.
5. Subdural hematoma.

PAST SURGICAL HISTORY: Surgery for right rotator cap rupture, hysterectomy and tubal ligation.

SOCIAL HISTORY: She was a former smoker, but not currently. Denied drinking or drug use.

FAMILY HISTORY: Mother suffered from high blood pressure and diabetes. Mother also suffered from high blood pressure, diabetes and died of a stroke. Both brothers and sisters are alive and well.

REVIEW OF SYSTEMS: Patient has had multiple complaints, as mentioned in the present illness. The complete review of systems is as mentioned in the separate page as provided by the patient.

NEUROPSYCHIATRY
AND BEHAVIORAL SCIENCE
Division of Neurology
8 Medical Park, Suite 420, Columbia, SC 29203
803-545-6050, FAX 803-545-6051

JOANN BROCKINGTON
Date of Service: 3/27/09

PHYSICAL EXAMINATION: Vital signs: Blood pressure 196/133 in the left arm and 189/118 mmHg in the right arm (patient did not take medication today), pulse rate 72/min., respiratory rate 20/min. General appearance: Patient is a well-developed and overweight African-American female. She is cooperative for the examination. Head and ENT: Normal. Neck: No carotid bruit, no cervical lymphadenopathy. Chest: Lungs were clear to auscultation. Heart: Regular heartbeat without murmur or gallop. Abdomen: Bowel sounds were normally present. Extremities: Normal.

NEUROLOGIC EXAMINATION: Patient was oriented with intact memory and cognitive function. She was able to communicate very well. No speech disturbance. Both pupils were equal and reactive to light normally. Funduscopic examination shows no evidence of papilledema or retinal hemorrhage. Extraocular muscle movement was intact. No facial weakness or facial sensory impairment. Soft palate contraction was symmetrical and gag reflex was normally present. Tongue protrusion was in the midline. No hearing loss. Cranial nerve XI was normal. There was no focal weakness on extremities. No sensory impairment. No evidence of cerebellar ataxia. Her gait was normal. She was able to walk on tiptoes and heels, and able to do tandem walk. Deep tendon reflexes 2+ and symmetrical. No Babinski sign.

NEUROLOGICAL ASSESSMENT:
1. Most likely patient has suffered from postconcussion syndrome.
2. Headache, caused by posttraumatic vascular headache and/or migraine.
3. Hypertension.
4. Diabetes mellitus.
5. Hyperlipidemia.
6. Arthritis.

RECOMMENDATIONS:
1. MRI of lumbar spine to assess the etiology of low back pain ever since the accident.
2. Try Lamictal 25 mg every day for two weeks, then 50 mg every day for two weeks, then 75 mg every day.
3. Overnight sleep study to assess the possibility of obstructive sleep apnea (patient has severe snoring while sleeping).
4. Neurology Clinic follow-up in six weeks.

Thank you for the consultation.

Te-Long Hwang, M.D.

TLH/dmc-m5327 D&T: 3/27/09

cc: Tad A. Venn, M.D.

Division of Neurology
8 Medical Park, Suite 420, Columbia, SC 29203
Phone: 803-545-6050 Fax: 803-545-6051

PALMETTO IMAGING
WEST COLUMBIA

2997 Sunset Boulevard
West Columbia, South Carolina 29169
(803) 936-0223 p
(803) 936-0229 f

PATIENT:	**Brockington, Joann**
MRN:	**626132**
DATE OF BIRTH:	**7/4/1951**
REF PHYSICIAN:	**Frank Noojin, MD**
DATE OF EXAM:	**4/13/2009**
PATIENT PH#:	**803-740-4497**

EXAM: MRI LUMBAR SPINE WITHOUT CONTRAST

HISTORY: Low back pain and bilateral leg pain for several months.

TECHNIQUE: High-field MRI of the lumbar spine was performed utilizing standard institution technique, which does not include the intravenous administration of contrast.

COMPARISON: None available.

FINDINGS: Vertebral body heights and alignment are preserved. No fracture or listhesis are seen. Marrow signal is normal. Congenitally short pedicles are seen from L2 through L5 with narrowing of the thecal sac on sagittal imaging. Small anterior extradural defects are seen at L4-L5 and L5-S1. The conus medullaris terminates normally at the T12-L1 level and demonstrates normal signal. Other incidentally imaged surrounding soft tissue structures are without apparent abnormality.

Axial segmental analysis follows:
L2-L3: Congenitally short pedicles and epidural lipomatosis narrow the thecal sac to an AP dimension of 9 mm. No disc herniation is seen. There is posterior facet arthrosis and ligamentum flavum hypertrophy. No significant foraminal or lateral recess stenosis noted.

L3-L4: Congenitally short pedicles and epidural lipomatosis narrow the thecal sac to an AP dimension of 9 mm. No focal disc herniation is seen. There is prominent posterior facet arthrosis with some ligamentum flavum hypertrophy. Osteophytes from the facet disease partially impinge on the right neural foramen resulting in mild right foraminal stenosis. No significant lateral recess stenosis noted.

L4-L5: A circumferential disc bulge combines with congenitally short pedicles and ligamentum flavum hypertrophy to narrow the thecal sac to an AP dimension of 4 mm consistent with severe central canal stenosis. There is bilateral lateral recess stenosis. Abundant facet hypertrophy is present with osteophytes. Mild bilateral degenerative foraminal stenosis noted.

L5-S1: There is a circumferential disc bulge and ligamentum flavum hypertrophy without significant central canal stenosis. No significant lateral recess stenosis noted. There is significant facet hypertrophy with osteophyte formation. No significant foraminal stenosis noted.

IMPRESSION:
1. Multilevel congenitally short pedicles narrow the thecal sac throughout the majority of the lumbar spine, as

acr ACCREDITED FACILITY

SOUTHEASTERN SPINE INSTITUTE

BROCKINGTON, JOANN
Patient # 258070
November 25, 2009

This patient is a 57-year old from Columbia, SC. She is referred for an independent medical evaluation. She has complaints of low back pain with radiation into the right leg. She also has complaints of neck pain. She states that she was injured in 2007 around August. Since that time she has had neck and back pain. Her pain is aggravated by almost all activity. She takes Oxycodone 5mg 1 every 6 hours. She has not had any bowel or bladder issues.

Past back history is negative.

SOCIAL HISTORY: She does not smoke nor drink. She does have diabetes. She is employed working environmental services. She was a cook for 8-years, now is working in housekeeping on light duty, folding clothes. She relates that this would not be made for her into a permanent type job however.

She states that she has difficulty walking over 1 block. She must move from sitting to standing in on a continuous basis. She moves every 15-30 minutes. She finds by constantly moving that her pain is decreased somewhat.

She is accompanied by a lumbar MRI from 4/13/09. I reviewed it and the radiologist's report. The patient has severe spinal stenosis at L4-L5. She has narrowing of the thecal sac to approximately 4mm a critical level.

She has a pre-existing situation with congenital shortening of the pedicles.

She has had a CT scan done of the cervical spine 8/16/07. I have reviewed this from Richland Hospital; there is no evidence of herniation or fracture. There is evidence of chronic pre-existing degenerative changes.

The patient is accompanied by past medical records including the records of Dr. Van Dam. These include his L5-S1 transforaminal injection.

Medical records from the Moore Orthopedic Clinic from 6/19/09 from Dr. Noojin are reviewed. Impression is lumbar radiculitis right leg. He felt that the patient should be kept on light duty restrictions permanently with a 20-pound lifting, pushing limit, with no bending or stooping.

Past medical records from Dr. Alan Morgan at the SC Neurologic Clinic are reviewed. These include his 9/4/07 note. I note that his diagnosis include post concussive headaches with subdural hematoma. She is accompanied by past medical records from physical therapy that I have reviewed.

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Charleston, SC 29414
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Fax: (843) 769-6022

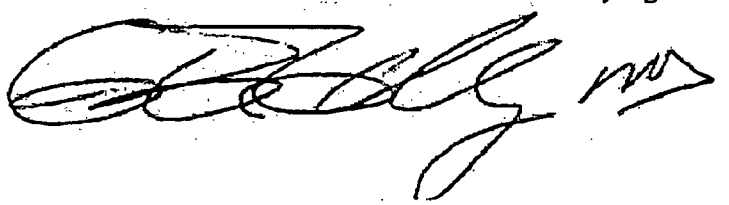
Patient: Brockington, Joann
MRN: 626132
Exam: MRI LUMBAR SPINE WITHOUT CONTRAST

above.
2. Severe central canal stenosis at L4-L5 due to a circumferential disc bulge and abundant ligamentum flavum hypertrophy.
3. Lateral recess and degenerative foraminal narrowing, as above.

Eric Morgan, M.D.
GM / dg

DD: 4/13/2009
DT: 4/14/2009
Job: 7990466

This document has been reviewed and electronically signed.



SOUTHEASTERN SPINE INSTITUTE

BROCKINGTON, JOANN
Patient # 258070
November 25, 2009

PHYSICAL EXAMINATION: She is 5'4" 231 pounds. Her range of motion is limited. She is tender in the right sciatic notch. Straight leg raising is provocative. She has pain which is in a fifth root distribution. She has no gross nor neurologic deficit. Her gait is antalgic however. Standing she is listed to the contralateral left side and she ambulates flexed forward 30 degrees typical with stenosis. She has no gross swelling or dysvascular changes.

IMPRESSION:

1. Severe spinal stenosis L4-L5 proven by MRI of 4/13/09.
2. Right leg pain with right neurogenic claudication.

RECOMMENDATIONS: This patient's inability to walk "more than a block" is secondary to her spinal stenosis which again is proven on her MRI scan. I would suggest that she try an L-5 selective nerve root block to see if this would give her temporary relief of her leg pain. Additionally she would probably be a candidate for minimally invasive interspinous distraction procedure for her spinal stenosis at the 4-5 level.

If she feels that she can live with the situation as it is I would place her at maximum medical improvement. Per the Fifth Edition AMA Guides, I would assign an eight percent (8%) impairment to the whole person. I would agree with her previous recommendations in regards to work, this should be light duty work only. I would agree to the previously stated 20-pound lifting restriction with no repetitive bending or lifting. She obviously cannot return to the previous type of work she was doing. She could return and do permanent light duty work. At this point she is not interested in any surgical consideration, however I do think in all likelihood she would be a candidate for a minimally invasive interspinous procedure such as an X-stop.

Donald R. Johnson, M.D.
DRJ/dam
T- 12/9/09

Cc: McWhirter Bellinger & Associates, P.A.

1106 Chuck Dawley Blvd., Ste. 200 Mt. Pleasant, SC 29464 (843) 849-1551 Fax: (843) 884-0629
1941 Savage Rd., Ste. 100-E Charleston, SC 29414 (843) 763-2720 Fax: (843) 769-6022

Southeastern Spine 3:34AM Dec. 10. 2009

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Joanne Brockington, Claimant, vs. NHC Lexington, Employer and Premier Group Insurance Co., Inc., Carrier Defendants.	WCC File No. 0712583 Carrier File No: Carrier Code No: Employer FEIN: **STATEMENT OF** **FRANK K. NOOJIN, III, M.D.**

1. Did Joanne Brockington have arthritis and/or an arthritic condition in her lower back prior to August 8, 2007?

Yes ✓ No _____
Comment:

2. Was this condition permanent and serious enough to constitute a hindrance or obstacle to her in obtaining employment or to obtaining reemployment if she should become unemployed?

Yes ✓ No _____
Comment:

3. Did the injury Ms. Brockington sustained on August 8, 2007 aggravate or combine with this pre-existing condition?

Yes ✓ No _____
Comment:

4. Did the fact that Ms. Brockington had this pre-existing condition cause her to lose substantially more time from work than she would have lost from the August 8, 2007 injury alone?

Yes ✓ No _____
Comment:

5. Did the fact that Ms. Brockington had this pre-existing condition cause her to have a substantially higher percentage of permanent disability than she would have had from the August 8, 2007 injury alone?

Yes ✓ No _____
Comment:

6. Have the medical costs in this case been substantially increased due to the existence of this pre-existing condition?

Yes ✓ No _____
Comment:

Frank K. Noojin, III, M.D.

Dated: 6/27/14

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Joanne Brockington, Claimant, vs. NHC Lexington, Employer and Premier Group Insurance Co., Inc., Carrier Defendants.	WCC File No. 0712583 Carrier File No: Carrier Code No: Employer FEIN: **STATEMENT OF IRIS CRUM**

COMES NOW, Iris Crum, being duly sworn and states as follows:

1. I am employed as Dietary Manager at NHC Lexington located in West Columbia, South Carolina.

2. Joanne Brockington was hired to work as a cook at NHC Lexington in August 2001. I supervised her between that time and August 2007 when she slipped and fell at work. After August 2007 she was transferred to the laundry at NHC Lexington and because of her inability to work as a cook in my department.

3. I am aware that Ms. Brockington fell at an Eckerd's drugstore in February 2004 and also fell again in August 2006. She lost time from her work at NHC Lexington as a result of both of these falls.

4. Ms. Brockington complained of lower back pain following these falls and continued to mention that lower back pain off and on until the time she fell at work in August of 2007. She also stated that she experienced difficulty in performing her duties as a cook due to the lower back pain she experienced as a result of the falls she experienced before August 2007.

5. Despite Ms. Brockington's complaints of lower back pain before August 2007, and her statements that this pain limited her ability to work as a cook, I made the decision to retain her as an employee of NHC Lexington.

Iris Crum

SWORN TO AND SUBSCRIBED BEFORE
ME THIS THE 15th DAY OF JUNE 2011

Notary Public - State of South Carolina
My Commission Expires 2/16/12

FILE

SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Joanne Brockington, Claimant,	) WCC File No:	0712583
	) Carrier File No:	WC34502007017075
	) Carrier Code No:	1100
vs.	) Employer FEIN:	
NHC Lexington, Employer,	)	
and	)	**AGREEMENT AND FINAL RELEASE**
Premier Group Insurance Company, Inc. Carrier, Defendants.	)	

RECEIVED
SETTLEMENT
NOV 02 2011
Division of Claims
SC Workers Comp. Comm.

Check #20157
175100

THIS AGREEMENT AND FINAL RELEASE, entered into as of the 21st day of July, 2011 by and between Joanne Brockington, referred to as the "Claimant", NHC Lexington, hereinafter referred to as the "Employer", and Premier Group Insurance Company, Inc., hereinafter referred to as the "Carrier", and referred to collectively as the "Parties",

WITNESSETH:

WHEREAS, the Claimant sustained an injury to her lower back and allegedly sustained a permanent physical brain injury on or about August 8, 2007 as a result of an accident arising out of and in the course of her employment, and at the time of said incident the Claimant was employed by the Employer and earning an average weekly wage of $377.55, for a compensation rate of $ 251.71; and

WHEREAS, at the time of said incident, the Claimant and Employer were subject to the Workers' Compensation Law of South Carolina, hereinafter referred to as the "Act", and the Carrier was the Employer's insurer under the Act; and

WHEREAS, the Employer and Carrier have paid $18,971.38 to the Claimant as temporary total compensation and $13,285.31 for medical treatment rendered to the Claimant as a result of the incident in question; and

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Division of Claims
S.C. Workers' Comp. Comm.

WHEREAS, bona fide disputes exist between the Parties as to the nature and extent of any permanent partial or total disability suffered by the Claimant as a result of said accident, and whether or not the Claimant is entitled to further medical treatment under the Act, and the Parties desire hereby to settle and finally conclude all differences between them through the payment by the Employer and Carrier to the Claimant of the sum hereinafter provided for, in exchange for a complete, final and conclusive agreement and release from all further liability under the Act or otherwise, the same to be approved by the South Carolina Workers' Compensation Commission,

hereinafter referred to as the "Commission".

NOW, THEREFORE, it has been agreed by and between the Parties that the Employer shall pay to the Claimant the sum of $110,000.00 in a lump sum, and in consideration of the mutual covenants herein contained, the Claimant hereby binds the Claimant, the Claimant's heirs, successors, assigns, dependents, next of kin and personal representatives under the Act and at common law, to release, discharge, defend and indemnify the Employer and its respective agents, servants, insurers, physicians, privies and its successors, from and against any action and liabilities whatsoever, including but not limited to, any consequences whatsoever of any injury sustained by the Claimant while employed by the Employer, whether known or unknown, or for benefits for disability, disfigurement, bodily or physical impairment, medical treatment, medicine or drugs, lost time from employment or death, under the Act or at common law, and specifically including any right which the Claimant might otherwise have to demand further benefits, in any form, under the Act because of a change in the Claimant's condition hereafter (which right is hereby expressly waived, released and renounced) whether or not arising out of directly or indirectly and in any way conceivably attributable to said accident and each and every consequence thereof, whether known or unknown.

THE CLAIMANT HEREBY represents and stipulates that the afore-mentioned lump sum payment shall be and is ample and adequate to compensate the Claimant in full for all claims which the Claimant or any persons claiming under or through the Claimant could assert against the Employer, the Carrier and any person privy to either on account of said incident and all consequences thereof. The Claimant further represents and stipulates that it is understood that the payment herein made is inclusive of all claims or liabilities which could be asserted against the Carrier or the Employer, including any claims to entitlement to any medical benefits.

IT IS UNDERSTOOD BY and between the Parties that the purpose of this settlement is to provide the Claimant with funds that will compensate her for future benefits. It is not the purpose of this agreement to shift to Medicare the responsibility for payment of medical expenses for the treatment of work-related conditions. Currently the Claimant is not receiving medical care for work-related conditions. Title 42 of the Code of Federal Regulations, Section 411.46, states Medicare will not pay for services related to work-related injuries until settlement funds have been exhausted. The claimant acknowledges that because the settlement does not designate an amount for future medical, Medicare may consider the entire amount for future medical expenses meaning they may not pay medical expenses that are otherwise reimbursable under Medicare and are related to the workers compensation case, until the entire settlement is exhausted. Pursuant to the July 11, 2001 "All Associate Regional Administrators" memo by the Center for Medicare and Medicaid Services ("CMS") and CMS guidance memos subsequent thereto, this case does not meet the threshold criteria for CMS review.

This Commission hereby approves the allocation of the aforementioned proposed settlement sum as follows: $43,794.24 as attorneys fees and costs; and $66,205.76 in compromised settlement of disputed future disability compensation benefits at the rate of $52.88 per week, commencing on the date of this agreement for a period of 1252 weeks thereafter, pursuant to Section 42-9-10 of the 1976 Code of Laws of South Carolina, as amended, as interpreted by the South Carolina Supreme Court in the case of James v. Anne's Inc., 390 S.C. 188, 701 S.E.2d 730 (2010); *Utica Mohawk.*"

THE CLAIMANT HEREBY further represents and stipulates that the Claimant has been fully advised of the Claimant's rights and entitlements under the Act and that the Claimant is of the opinion that the terms and provisions of this Agreement and Final Release are reasonable and fair; the undersigned Legal Counsel for the Claimant also hereby represents and stipulates that the terms and provisions of this Agreement and Final Release are reasonable and fair.

IT IS UNDERSTOOD BY and between the Parties that this Agreement and Final Release shall not be subject to review, modification or amendment by the Commission or by any court of law.

IN WITNESS WHEREOF, the Parties hereto have caused this instrument to be executed as of the Day and Year first hereinabove mentioned.

JoAnne Brockington

Joanne Brockington,
Claimant

WITNESSED AND APPROVED
AS TO THE CLAIMANT:

Tommy Bellinger, Esquire
Counsel for Claimant

TylerLee

NHC Lexington,
Employer

Premier Group Insurance Company, Inc.
Carrier.

NANCE, McCANTS & MASSEY

BY: _____
Clarke W. McCants, III, Esquire
Counsel for the Employer/Carrier

South Carolina Workers' Compensation Commission
P.O. Box 1715 · 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0712583
Carrier File # WC34502007017075
Carrier Code # 1100
Employer FEIN

Joann Brockington
Claimant's Name SSN

1208 Bush River Rd. Columbia, SC 29210
Address City State Zip

( ) Home Phone # ( ) Work Phone #

NHC Lexington
Employer's Name

2993 Suset Blvd. W. Columbia, SC 29169
Address City State Zip

Premier Group Insurance Company, Inc.
Insurance Carrier

Clarke W. McCants, III (803) 649-6200
Preparer's Name Phone #

Compensation Paid:	Number of Weeks	From	To	Amount
1. Number of weeks T.T.	74	08/08/07	01/06/09	$ 18,971.38
2. Number of weeks T.P.				$
3. Number of weeks P.P.				$
4. Disfigurement				$
5. Agreement and Final Release				$ 110,000.00
Total Compensation Paid				$
6. Total Medical Benefits* Paid				$ 11,285.51
7. Funeral Benefits				$

☐ Case Denied

Date of Injury: 08/08/07
month day year

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: Joann Brockington
Claimant

By:
Employer's Representative

Date: 2/19/11

Print or type the name of the person, other than the claimant, receiving benefits and sign below

By:

Report of additional Fees and Recoupment

A. Carrier Reimbursement by Third Party $

B. Attorney's Fee Paid by Employer $

C. Attorney's Fee Paid by Claimant $
(Non contingent fees, only)

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. *Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy birth and death certificates and impartial examination. Form 19 must be filed within sixteen days of final payment of compensation. Form 19 must be filed when a claim is denied.

WCC # 19 REV. DATE 3/96

19

STATUS REPORT AND COMPENSATION RECEIPT

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
The South Carolina Workers' Compensation Commission

Appellate Case No.: 2013-001474

Joann Brockington, ...

v.

NHC Lexington, and
Premier Group Insurance Co., Inc., Carrier, ... Respondents,

v.

The South Carolina Second Injury Fund,.....Appellant.

CERTIFICATE OF COUNSEL

The undersigned certified that this Record on Appeal complies with Rule 210(c), SCACR.

March 3, 2014

Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
S.C. Bar #: 14593
(803) 750-2214 (telephone)
(803) 750-2377 (facsimile)
ATTORNEY FOR APPELLANT

RECEIVED
MAR 03 2014
SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM
The South Carolina Workers' Compensation Commission

Appellate Case No.: 2013-001474

Joann Brockington, ...

v.

NHC Lexington, and
Premier Group Insurance Co., Inc., Carrier, ... Respondents,

v.

The South Carolina Second Injury Fund,.....Appellant.

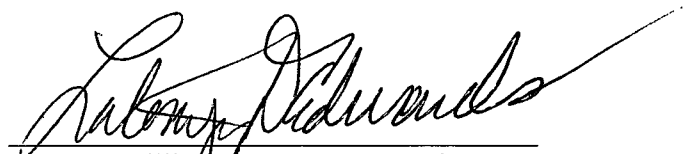
PROOF OF SERVICE

The undersigned employee of Dilligard Edwards, LLC, Attorney for the Appellant, does hereby certify that service of the **FINAL BRIEF OF THE APPELLANT, RECORD ON APPEAL** and **CERTIFICATES OF COUNSEL** to the South Carolina Court of Appeals in the above-captioned matter was made upon counsel of record for Respondents NHC Lexington, Employer, and Premier Group Insurance Co., Inc., Carrier, and the South Carolina Workers' Compensation Commission by placing same in the United States Mail, first class postage prepaid, at the below listed address clearly indicated on said envelope on this 3rd day of March 2014, addressed as follows:

RECEIVED
MAR 03 2014
SC Court of Appeals

Clarke W. McCants, III, Esquire
Nance, McCants & Massey
Post Office Box 2881
Aiken, South Carolina 29802-2881

The Honorable Virginia Crocker, Judicial Director
South Carolina Workers' Compensation Commission
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