**Brian D. Solberg, M.D.**
*Qualified Medical Evaluator*
*Orthopaedic Traumatology*
*Pelvic and Acetabular Reconstruction*
*Joint Replacement*
790 Leeward Way • Costa Mesa, California 92627
Phone (949) 333-1586 Fax (888) 838-3749

August 9, 2023

Workers Defenders Anaheim
Natalia Foley, Esq.
751 South Weir Canyon Road, Suite 157
Anaheim, California 92808

SCIF insured Fresno
Mark Blanco
P.O Box 65005
Fresno, California 93650

Employee: HANNA, Adel
Employer: California Institution for Men
Occupation: Chief Psychiatrist
DOI: 07/19/2022
Claim No: 06853258
WCAB No: ADJ17173512
DOB: 11/11/1972
DOE: 08/09/2023

## COMPREHENSIVE ORTHOPEDIC PANEL QUALIFIED MEDICAL EVALUATION

**ML-201-95– This is a Comprehensive Medical-Legal Evaluation.**
Number of pages of records reviewed in preparation of this report = 4661
**Subtract 200 pages for MLPRR units = 4461**

Dear Parties:

Mr. Adel Hanna is a 77-year-old male who was evaluated at 9555 Foothill Boulevard, Suite B, Rancho Cucamonga 91730, for the purposes of this Qualified Medical Examination on August 9, 2023. No interpreter was required for the evaluation. The face-to-face component of the examination commenced at 9:47 a.m. and concluded at 10:32 a.m. All history and physical examinations were conducted by me personally.

## TIME SPENT

1. Medical records reviewed per declaration: 4661 pages.
2. Face to face time with the applicant directly 0.80 hours

## HISTORY OF PRESENT INJURY

The applicant states that on July 19, 2022, during the course of his employment, he began having chest pain which he attributes to pressure and stress from work. He states he had chest pain with associated dizziness. He reported pain, to his employer and he was sent by an ambulance to hospital.

At hospital, a stent was placed in his heart. At hospital, an EKG and an angiogram were performed. A stent replacement surgery was then performed. He stayed hospitalized for about 4 days. He stayed home for unrecalled time and then he was released back to work. On unrecalled day, while working for the above noted employer, he began feeling chest pain again and he reported it to his employer. He was referred to hospital and he stayed hospitalized for unrecalled days. He was prescribed with medication. Another angiogram was performed. He was placed in disability by the doctor.

He continued attending to a cardiologist for follow-ups and examinations.

In December 2022, he retired.

To date, he is currently under care of unrecalled cardiologist doctor.

Medications are the two listed with the addition of Nitrostat on an as needed basis.

He had two reports of a fall while at work as Chief of Staff. He states that these were due to dizziness. He states that these were not reported.

## TREATMENT

The applicant is currently under care of a Cardiologist doctor and he is taking Lipitor and Amlodipine medications.

He states that he has had treatment in the form of physical therapy for his knee and for his shoulder twice a week for about three months. I do not have any records of that.

## CHIEF COMPLAINT

The applicant denies having orthopedic complaints, he reports shortness of breath and chest pain due to heart condition.

## EMPLOYMENT HISTORY

The applicant has been working for the above noted employer since June 2000. His job duties entailed seeing patients and writing reports. He had a problem with a psychologist, who used to be his boss, and for the past two years he was under too much stress. The physical requirements of the applicant's daily duties are prolonged sitting, walking, talking, and typing.

The applicant is not currently working for the above noted employer. He has retired in December 2022.

## PAST MEDICAL HISTORY

### Medical History

Reports heart problems and acid reflux.

### Surgical History

Colonoscopy- Unrecalled.
Heart surgery- 2022. Stent placement x4.

### Allergies

The applicant is allergic to Reglan.

## MEDICATIONS

Nitrostat, amlodipine, and atorvastatin.

## SOCIAL HISTORY

### Habits

**Alcohol: Denied**

**Tobacco: Denied**

**Recreational Drugs**

He denies illicit or recreational drug use.

**Marital Status**

He is married, with three children.

**Education**

Highest grade level completed doctor. He was trained as a Thoracic Surgeon in Cairo, Egypt, and then moved to the United States in roughly 1984 and then completed a residency in psychiatry and has been employed as a Psychiatrist since then.

**REVIEW OF SYSTEMS**

**Constitutional**

The applicant denies fever, weakness, fatigue, or appetite loss. There has been no significant weight loss or gain.

**Skin:**

The applicant has no skin disease or problems. There are no pigmentation changes or discoloration. There are no tumors/cancer or cysts.

**Head:**

The applicant denies frequent or severe headaches.

**Eyes/Vision**

The applicant denies eye injury, infection or pain. The applicant denies blurred, double or decreased vision, eye itching, burning or tearing and light sensitivity.

**Ears, Nose, Throat, Mouth**

The applicant denies ear pain, infection, discharge or decreased or loss of hearing. The applicant denies sinus problems, recurrent throat problems, voice change or dental disease.

**Cardiovascular**

The applicant reports chest pain.

**Respiratory**

The applicant denies chronic cough, asthma, emphysema or chronic bronchitis, pneumonia, tuberculosis or coughing of blood.

**Gastrointestinal**

The applicant reports frequent indigestion or reflux.

**Genitourinary**

The applicant denies painful or difficulty urination, blood in the urine, kidney infection/stones or venereal disease.

**Musculoskeletal**

The applicant denies musculoskeletal pain.

**Neurologic**

The applicant denies epilepsy or convulsions. The applicant denies other neurologic problems with the exception of those associated with this injury.

**Psychiatric**

The applicant reports depression. The applicant denies alcoholism or drug abuse treatment.

**Endocrine**

The applicant denies increased thirst, appetite or urination. The applicant denies diabetes or hair loss.

**Hematologic**

The applicant denies bleeding gums, easy bruising or spontaneous nose bleeding. The applicant denies easy bleeding or bleeding that is hard to stop.

**ACTIVITIES OF DAILY LIVING**

Answered by the applicant as part of the intake process

| | |
|---|---|
| Getting Dressed | No difficulty |
| Bathing and showering | No difficulty |
| Getting on and off toilet | No difficulty |
| Cutting your food | No difficulty |
| Lifting a cup to your mouth | No difficulty |
| Making a meal | No difficulty |
| Writing a note | No difficulty |
| Typing on a computer | No difficulty |
| Using a telephone | No difficulty |
| Working outdoors on flat ground | No difficulty |
| Climbing up one flight of stairs | Some difficulty* |
| Sitting | No difficulty |
| Standing | No difficulty |
| Reclining | No difficulty |
| Rising from a chair | No difficulty |
| Running errands | Some difficulty* |
| Light housework | No difficulty |
| Feeling what you touch | No difficulty |
| Opening a car door | No difficulty |
| Turning faucets on or off | No difficulty |
| Getting in and out of a car | No difficulty |
| Sleeping | Some difficulty* |
| Engaging in sexual activity | No difficulty |

*Because of shortness of breath

## REVIEW OF RECORDS

Total Pages of Records Received: 4661

**Please Note: The following records listed in the "Medical Providers List" were not available for review:**

- **Natalia Foley dated 12/17/21 & 01/31/22**
- **Return to Work dated 12/22/21, Nelson Flores, Ph.D. dated 05/02/22, Allan Morrison, MD dated 10/26/22.**

Signed by Diana Munoz
**07/28/23. Cover Letter.**

Signed by Diana Munoz
**07/28/23. Attestation.**
Attesting to 29 pages being sent to doctor for review.

07/28/23. Cover Letter. Signed by Diana Munoz.

07/28/23. Attestation. Signed by Diana Munoz.
Attesting to 176 pages of records being forwarded for review.

07/28/23. Cover Letter. Signed by Diana Munoz.

07/28/23. Attestation. Signed by Diana Munoz.
Attesting to 29 pages of records being forwarded for review.

Signed by Jeannie Gosiengfiao
**Undated. Attestation**
Attesting to 777 pages being sent to doctor for review.

Signed by Jeannie Gosiengfiao
**Undated. Attestation**
Attesting to 483 pages being sent to doctor for review.

Signed by Jeannie Gosiengfiao
**Undated. Attestation**
Attesting to 394 pages being sent to doctor for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 26 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 66 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 11 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 12 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 10 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 1297 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 257 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 67 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 180 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 675 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 17 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
**Undated. Attestation.**
Attesting to 11 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 10 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 64 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 25 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 13 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 7 pages of records being forwarded for review.

Signed by Jeannie Gosiengflao
Undated. Attestation.
Attesting to 54 pages of records being forwarded for review.

**DIAGNOSTIC REPORTS:**

Unknown Provider
04/14/05. EKG.
**Interpretation:** Normal sinus rhythm, rate 74.

Unknown Provider
04/15/05. EKG.
**Interpretation:** Normal sinus rhythm. Normal EKG.

Curtis Handler, MD/Steven Cobb, MD
04/15/05. X-ray of Chest 1 View.
**Findings:** A single portable AP view of the chest is received. No prior studies are currently available for comparison. The examination is notable for evidence of blunting of the right costophrenic angle with fibrotic streaking in the right lung base. Right pleural thickening is considered likely for the blunting in this case. There is minimal bibasilar discoid atelectasis. The heart size is at the upper limits of normal. The aorta is mildly ectatic. The upper lung zones are clear. The pulmonary vascularity is unremarkable.
**Impression:** 1) No acute abnormality is demonstrated. 2) Right base fibrosis and pleural thickening. 3) Bibasilar atelectasis.

Gary Harris, MD
11/19/08. X-ray of Chest 1 View.
**Findings:** 1) Nasogastric tube is in place with its tip near the region of the EG junction/gastric fundus; would recommend advancing the tube 6 to 8 cm. 2) Multiple air distended loops of central small bowel suggestive for distal small bowel obstruction. 3) No evident free air/mass or abnormal abdominal calcifications; the visualized osseous structures appear intact. 4) No other significant findings.
**Impression:** Nasogastric tube in place as described - recommend advancing tube 6 to 8 cm; findings suggestive for a distal small bowel obstruction.

Aaron Jun, MD
11/19/08. CT Abdomen and Pelvis Without IV Contrast.
**Findings:** Limited evaluation of lung bases shows bibasilar discoid atelectasis. Pleural calcifications are seen in the right base. In the abdomen, patient is status post cholecystectomy. Rest of the abdominal solid organs are normal in appearance. There is no free fluid collection identified. Small nonspecific mesenteric nodes are seen. There is moderate dilation of proximal small bowel seen. A transition point is identified in the right mid abdomen. The distal small bowel and colon are not dilated. These findings are consistent with small bowel obstruction. Normal appendix is identified. Degenerative spurring is seen in the lumbar spine. In the pelvis, the bladder is normal. Scattered diverticula are seen in the sigmoid colon. No adenopathy is seen. A tiny free fluid is seen in the pelvis. Bone structures of pelvis are within normal limits.
**Impression:** 1) Findings consistent with small bowel obstruction with a transition point in the right mid abdomen. 2) Status post cholecystectomy. 3) Normal appendix is identified. 4) Tiny nonspecific free pelvic fluid. 5) Scattered diverticula are seen in the sigmoid colon without CT evidence for acute diverticulitis.

Unknown Provider
11/19/08. EKG.
**Interpretation:** Normal sinus rhythm. Normal EKG.

Peter Phan, MD/Gary Harris, MD
11/19/08. X-ray of Abdomen Flatplt (Kub)
**Findings:** Nasogastric tube is in place with its tip near the region of the EG function/gastric fundus; would recommend advancing the tube 6 to 8 cm. Multiple air-distended loops of central small bowel suggestive for distal small bowel obstruction. No evident free air/mass or abnormal abdominal calcifications; the visualized osseous structures appear intact. No other significant findings.
**Impression:** Nasogastric tube in place as described, recommend advancing tube 6 to 8 cm; findings suggestive for a distal small bowel obstruction.

Peter Phan, MD/Aaron Jun, MD
11/19/08. X-ray of Chest 1 View (AP/PA)
**Findings:** Single view of chest shows bibasilar discoid atelectasis. There is no other focal infiltrate seen. Heart size and mediastinal width are within normal limits. No pleural effusion is seen.
**Conclusion:** Bibasilar discoid atelectasis.

Atul Patel, MD

11/20/08. Diagnostic Study of Abdomen.
**Comparison:** Compared with 11/19/08.
**Findings:** There is slight decrease in dilatation of numerous dilated small bowel loops. Feeding tube tip is in distal stomach/duodenum. Cholecystectomy clips are noted. No free air is seen. **Impression:** 1) Slight improvement in distal small bowel obstruction. Feeding tube tip is in distal stomach/duodenum.

Peter Phan, MD/Atul Patel, MD
11/20/08. X-ray of Abdomen FLATPLT (KUB)
**Comparison:** Compared with 11/19/08.
**Findings:** There is a slight decrease in dilatation of numerous dilated small bowel loops. Feeding tube tip is in the distal stomach/duodenum. Cholecystectomy clips are noted. No free air is seen.
**Impression:** Slight improvement in distal small bowel obstruction. Feeding tube tip is in the distal stomach/duodenum.

Jeanine McNeill, MD
11/21/08. X-ray of Abdomen KUB.
**Findings:** Supine abdomen. An NG tube appears to terminate in the region of the second/third portion of the duodenum. Air is scattered throughout both large and small bowel loops. Several of the jejunal bowel loops demonstrate a slight increase gaseous distention from normal. This, however, appears improved when compared to 11/20/08. No abnormal calcifications can be seen.
**Impression:** Slight decrease in small bowel ileus pattern.

Monika Kief-Garcia, MD
11/21/08. CT of Abdomen and Pelvis With and Without Contrast.
**Findings:** There is minimal patchy right basilar atelectasis. The cardiac silhouette does not appear enlarged. The nasogastric tube terminates in the descending duodenum. No peri-pancreatic changes are noted. The Kidneys show no abnormal calcifications. The liver and spleen show no abnormal calcifications and no areas of abnormal enhancement or attenuation. The gallbladder is surgically absent. No adrenal masses are noted. The kidneys show no areas of abnormal enhancement. The distal common bile duct appears minimally prominent measuring 1 om in the head of the pancreas. Multiple loops of fluid and contrast filled small bowel are present. No focally dilated small bowel loops are noted. There is no wall thickening. There is no inflammatory change. A normal appendix is visualized. The colon shows lack of distention versus edema to the sigmoid colon. There is no marked inflammatory change. No free intraperitoneal gas or fluid is appreciated. The prostate appears somewhat prominent.
**Impression:** The nasogastric tube terminates in the descending duodenum. There is no pattern of small bowel obstruction. There is lack of distention versus thickening to the wall of the sigmoid colon without marked adjacent inflammatory change.

Monika Kief-Garcia, MD
11/21/08. CT of Pelvis.
See accompanying CT of the abdomen which includes findings within the pelvis.

Johnson Lightfoote, MD

05/21/12. X-ray of Chest PA and Lateral.
**Findings:** The heart is not enlarged. The aorta is slightly tortuous. Right basal atelectasis, volume loss is demonstrated. There may be right apical pulmonary nodule and apical lordotic radiography and/or CT may be helpful. The osseous thorax and soft tissue are unremarkable. Right upper quadrant surgical clips are demonstrated.
**Impression:** 1) Possible right apical pulmonary nodule, e.g., scarring. 2) Right lateral basal pleural parenchymal scarring. 3) Degenerative cardiovascular and musculoskeletal changes as described. 4) If clinically indicated, CT may be helpful for further evaluation.

Christina Benedict, MD
05/21/12. Diagnostic Study of Upper GI.
**Findings:** Preliminary radiography of the abdomen demonstrates no significant abnormality. Deglutition was normal. Upper thoracic esophagus demonstrates mild mucosal irregularity, suggestive of esophagitis. There are occasional tertiary contractions. There is severe gastroesophageal reflux. There is a small hiatal hernia. Thoracic esophagus demonstrate mild mucosal irregularity, suggestive of esophagitis, s s for this is someo mass or mucosal lesions. The stomach demonstrates no mass or mucosal lesions. The duodenal bulb demonstrates no ulcerations or deformity. The duodenal loop is not widened. The proximal small bowel appears normal.
**Impression:** 1) Small hiatal hernia. 2) Esophageal mucosal irregularity, suggestive of esophagitis. 3) Severe gastroesophageal reflux.

David Berry, MD
06/12/12. X-ray of the Chest One View Portable.
**Findings:** Heart size is upper normal. The mediastinum appears to be satisfactory with the trachea midline. There is accentuation of the aortic arch and elongation of the descending aorta. There is evidence of mild atelectasis and/or infiltrate or fibrosis at the right base. Minimal atelectasis at the left base. There also appear to be fibrotic changes at the right lung apex. No evidence of pneumothorax.
**Impression:** Fibrosis at the right apex, along with atelectasis and/or fibrosis at the right base and minimal atelectasis at the left base. No evidence of an area of consolidation.

David Berry, MD
06/12/12. CT scan of the Chest with Contrast.
**Findings:** There are diffuse rib deformities on the right that could be related to previous surgery or trauma, or a combination of surgery and trauma. There are emphysematous changes in the lung apices. Old granulomatous changes with calcification are present. There is also evidence of mild atelectasis, fibrosis, or infiltration, particularly at the right lung base. This most likely represents chronic change. The examiner does not see evidence of pulmonary embolus and no evidence of an aortic dissection, and the examiner is unable to detect any significant coronary artery calcification. There appears to be a small hiatus hernia, and there also appear to be small metallic clips indicating previous surgery in the region of the EG junction, there may be some very mild thickening of the distal gastric esophageal mucosa, but the examiner does not see evidence of obstruction. The gallbladder is surgically absent.
**Impression:** The examiner does not see evidence of pulmonary embolus or aortic dissection. There has been previous surgery at the GE junction with small metallic densities and a small hiatus hernia, possibly very mild esophageal mucosal edema of the distal esophagus. Extensive deformities of the ribs are consistent with trauma, surgery, or a combination of both, along with pleural calcification,

granulomatous changes, and emphysematous changes. Evidence of fibrosis and/or atelectasis, possibly mild infiltrate at the right base. This is difficult to determine because the examiner does not have any previous images for comparison in a patient who has had the chronic changes noted above.

C. Agarwal, MD
06/12/12. ECG.
**Impression:** Normal Sinus rhythm. Minimal voltage criteria for LVH may be a normal variant. Abnormal ECG. When Compared with the ECG of 06/12/12, premature ventricular complexes are no longer present.

Unknown Provider
06/12/12. ECG.
**Impression:** Sinus rhythm with occasional premature ventricular complexes. Otherwise normal ECG.

Unknown Provider
06/12/12. ECG.
**Impression:** Normal sinus rhythm. Minimal voltage criteria for LVH may be a normal variant. Cannot rule out inferior infarct, age undetermined. Abnormal ECG. Premature ventricular complexes are no longer present.

R. Duber, DO
06/12/12. ECG.
**Impression:** Sinus rhythm with occasional premature ventricular complexes. Otherwise, normal ECG. When compared with the ECG of 03/10/06. Premature ventricular complexes are now present.

Unknown Provider
06/13/12. ECG.
**Impression:** Sinus rhythm with 1st degree A-V block. Minimal voltage criteria for LVH may be a normal variant. Borderline ECG. When compared with the ECG of 06/12/12. PR interval has increased. Minimal criteria for inferior infarct are no longer present.

C. Agarwal, MD
06/13/12. ECG.
**Impression:** Sinus rhythm with 1st degree A-V block. Minimal voltage criteria for LVH may be a normal variant. Borderline ECG. When compared with the ECG of 06/12/12. PR interval has increased. Minimal criteria for inferior infarct are no longer present.

Unknown Provider
08/06/12. BRAVO Esophageal pH Monitoring.
**Result:** First 24 hours: 1) Summary of Distal Esophageal pH exposure: Within normal limits. 2) Post/Pre-Prandral Ratio (Challenge Meal): 1. Second 24 Hours: Summary of Distal Esophageal pH exposure: Increased in supine position. 2) Post/Pre-Prandral Ratio (Challenge Meal): 1.

Christina Greene, MD
08/06/12. High-Resolution Esophageal Motility Study.

**Procedure**: Esophageal manometry.
**Interpretation / Findings:** Structurally defective LES due to short total length and no intra-abdominal length. Elevated resting pressure and residual pressure. Hiatal hernia seen throughout with classic double hump. Normal intra-bolus pressure. LES relaxes in all swallows. Esophageal body is peristaltic in 10 of 10 swallows. Normal wave amplitude and DCI. Common cavity seen in all swallows. UES is hypotensive.

Parakrama Chandrasoma, MD
08/06/12. Surgical Pathology Consultation Report
**Diagnosis:** A) Antrum/Body, Biopsy: Reactive gastropathy. B) SQC Junction, Biopsy: Reflux esophagitis; Reflux carditis. C) Esophagus @ 34 CM., biopsy: Reflux esophagitis.

Alison Wilcox, MD
08/14/12. X-ray of Upper GI with Air Contrast with KUB.
Refer to previously signed radiology report.

George Lacy, MD
08/14/12. X-ray of Esophagram.
**Findings:** 1) Scout AP abdominal radiograph demonstrates: nonspecific post gastric bowel gas pattern with no high-grade large nor small bowel obstruction appreciated; multiple right upper quadrant surgical clips consistent with previous cholecystectomy. 2) Scout chest radiographs (2) demonstrate: A) Calcified aortic arch without significant cardiomegaly; bilateral lung zones with no overt pulmonary edema and no frank pleural-based pneumonic consolidations appreciated. B) Chronic-appearing right-sided lower lung zones pulmonary fibrosis and costophrenic angle pleuroparenchymal adhesive scarring S/P Nissen fundoplication via laparoscopic approach circa 1998, with subsequent perforation and intrathoracic empyema historically. C) Suggested right superolateral chest ill-circumscribed parenchymal lesion overlying the first anterior rib on frontal projection view, potentially a focal cicatrix precautionary comment: The examiner recommend 3-month follow-up for continued surveillance and exclusion of scar carcinoma. 3) Videoesophagram with air-contrast upper gastrointestinal tract series was performed following oral ingestion of thin barium, thick barium with effervescent granules, solid food bolus consisting of barium coated hamburger. Multiple video images and digital spot films were obtained, with imaging in upright, supine, and prone positions. Esophageal motility was examined utilizing five 10-cc boluses of thin liquid barium as well as with two solid food boluses consisting of barium coated hamburger. 4) Within normal limits bolus formation and swallowing mechanism with no stigmata of oropharyngeal dysphagia appreciated ..no pooling within valleculae or piriform sinuses, no laryngeal penetration or frank aspiration, and no cervical esophageal cricopharyngeal bar, segmental stricture, or pulsion diverticulum identified. 5) Abnormal appearing esophageal motility on 5-out-of-5 swallows of thin liquid barium, as manifested by multiple episodes of contrast stasis and prolonged retention admixed with episodes of upper esophagus cephalic escape and retrograde movement. 6) Within normal limits esophageal motility on 2-out-of-2 swallows of solid food bolus, with no appreciable stasis and prolonged retention of orally ingested particulate matter. 7) EG juncture: moderate-sized epiphrenic wide-mouthed pulsion diverticulum, associated with an apparent smoothly marginated narrowing of the gastric cardial region, consistent with prior fundoplication status as discussed above, and with some gastric rugae cephalad to left hemi-diaphragmatic hiatus. 8) Within normal limits sub-fundal stomach.

**Impression:** 1) Within normal limits bolus formation and swallowing mechanism with no stigmata of oropharyngeal dysphagia appreciated. 2) Abnormal appearing esophageal motility on S-out-of-5 swallows of thin liquid barium, as manifested by multiple episodes of contrast stasis and prolonged retention admixed with episodes of upper esophagus cephalic escape and retrograde movement. 3) Within normal limits esophageal motility on 2-out-of-2 swallows of solid food bolus, with no appreciable stasis and prolonged retention of orally ingested particulate matter. 4) EG juncture: moderate-sized epiphrenic wide-mouthed pulsion diverticulum, associated with an apparent smoothly marginated narrowing of the gastric cardial region, consistent with prior fundoplication status as discussed above, and with some gastric rugae cephalad to left hemi-diaphragmatic hiatus. 5) Scout chest radiographs reveal: A) Chronic-appearing right-sided lower lung zones pulmonary fibrosis and costophrenic angle pleuroparenchymal adhesive scarring S/P Nissen fundoplication via laparoscopic approach circa 1998, with subsequent perforation and intrathoracic empyema historically. B) Suggested right superolateral chest ill-circumscribed parenchymal lesion overlying the first anterior rib on frontal projection view, potentially a focal cicatrix precautionary comment: Th examiner recommend 3-month follow-up for continued surveillance and exclusion of scar carcinoma.
C) Discussed with Dr. Oh on the early afternoon of 08/14/12.

John Vallone, MD
**02/10/14. Surgical Pathology Report.**
**Diagnosis:** Esophagogastroduodenoscopy: A) Gastric Antrum And Body, Biopsy: 1) Features of reactive gastropathy including foveolar expansion and intramucosal fibromuscular hyperplasia; and mild chronic gastritis, free of activity. 2) Minimal chronic oxyntic gastritis, free of activity. 3) Excess "G" cells and parietal cell hyperplasia consistent with proton pump inhibitor effect. 4) No Helicobacter organisms, intestinal metaplasia, dysplasia, or malignancy identified. B) Antegrade Gastroesophageal Junction, Biopsy: 1) Moderate chronic reflux carditis including mild excess eosinophils and foveolar expansion with mild activity; and focal pancreatic acinar metaplasia. 2) Mild chronic reflux oxyntocarditis including mild excess eosinophils and foveolar expansion, free of activity; with focal pancreatic acinar metaplasia. 3) Squamous mucosa with reactive changes consistent with reflux. 4) No Helicobacter organisms, intestinal metaplasia, dysplasia, or malignancy identified.

Steven Cobb, MD/Curtis Handler, MD
**12/23/14. CT of Head W/O IV Contrast.**
**Comparison:** There are no prior exams for comparison.
**Findings:** There is evidence of moderate to severe mucoperiosteal thickening involving the ethmoid air cells and left frontal sinus. Moderate mucoperiosteal thickening is noted involving the right maxillary sinus. The cranial vault is intact. Intracranially, the basal cisterns are preserved. The ventricular system is nondilated. There is no shift of midline structures. There is no evidence of edema, hemorrhage, or mass. There are no abnormal fluid collections over the convexities.
**Impression:** 1) No acute intracranial abnormality. There is evidence of pansinusitis as discussed above. 2) Radiation dose: The CTDI is 59.79 mGy. DLP is 988.11 mGy-cm.

Surtis Handler, MD/Sherman Rhee, MD
**12/23/14. MR Cerebral Angiogram Without Contrast.**
**Comparison Study**: None.

**Findings:** No aneurysm is appreciated. The bilateral proximal anterior, middle, and posterior cerebral arteries appear widely patent. There are bilateral posterior communicating arteries, right greater than left. The visualized bilateral distal internal carotid arteries appear widely patent. The visualized basilar artery appears widely patent. Please note that the intracranial vertebral arteries and lower half of the basilar artery are not captured in the field-of-view on this exam.
**Impression:** The visualized major intracranial arterial structures show no aneurysm or hemodynamically significant stenosis. Please note that the intracranial vertebral arteries and lower half of the basilar artery are not captured in the field-of-view on this exam.

Surtis Handler, MD/Sherman Rhee, MD
**12/23/14. MRI of Brain Study With and Without Contrast.**
**Comparison Study**: CT head 12/23/14.
**Findings:** The ventricular system is normal in size and configuration for the patient's age. Intracranially, no mass effect, midline shift, extra axial fluid collection, or hemorrhage is identified. There is a small amount of T2 FLAIR hyperintensity involving the periventricular white matter adjacent to the frontal horns and bodies of the lateral ventricles, favoring mild chronic small vessel ischemic change. No restricted diffusion is identified to suggest acute infarct. The post-contrast sequences show no abnormal areas of enhancement intracranially. No chiari malformation is identified. There is no abnormal enlargement of the pituitary gland. The major central vascular flow voids are maintained. There is complete opacification of the left frontal sinus. There is near-complete opacification of the bilateral ethmoid air cells. There is mucosal thickening of the bilateral maxillary sinuses with superimposed mucous retention cysts, right greater than left. A small air-fluid level within the right maxillary sinus is suspected. The bilateral mastoid air cells appear clear.
**Impression:** 1) Intracranially, no acute process or suspicious space-occupying mass lesion is seen. A small amount of T2 FLAIR hyperintensity of the periventricular white matter favors mild chronic small vessel ischemic change. 2) Extensive paranasal sinus disease as described above. This includes an air-fluid level within the right maxillary sinus, a finding which can be seen with acute sinusitis.

Dvora Cyrlak, MD
**03/18/15. X-ray of the Chest 2 Views.**
**Findings/Impression:** There is an elevation of the right hemidiaphragm, mild blunting of the right costophrenic angle, and right inferior lateral pleural thickening. No pneumonia edema or left effusion is identified. The cardiac silhouette appears mildly enlarged and the aorta is tortuous and ecstatic. There are questioned osteopenia and degenerative changes in the thoracic spine. Surgical clips and gaseous distention in the upper abdomen on lateral view.

Fargol Booya, MD
**03/18/15. CT of the Sinus Study Complete.**
**Findings:** There is moderate mucosal thickening of the left frontal sinus and left frontoethmoidal junctions. Mild mucosal thickening of the inferior aspect of the right frontal sinus and right frontoethmoidal junction. Moderate to severe mucosal thickening of ethmoidal air cells. Sphenoid sinus and frontoethmoidal recesses are clear. Moderate mucosa! thickening of bilateral maxillary sinuses. There is an additional drainage passway of the maxillary sinuses to the inferior aspect of the bilateral nasal cavity. If there has not been prior sinus surgery the findings are likely anatomical variation. Ostiomeatal units are moderately narrowed by mucosal thickening however they are patent The right

carotid canal is dehiscent into the sphenoid sinus. The lamina pappy race is intact. The roofs of the ethmoid air cells are symmetric. The optic canals are well-covered. by bone. The nasal septum is in the midline. The visualized mastoid air cells are clear. Visualized parts of the brain and orbit and globe are unremarkable. The visualized overlying soft tissues are unremarkable.
**Impression:** Severe mucosal thickening of ethmoid air cells and left frontal sinus and frontoethmoidal junction and moderate mucosal thickening of bilateral maxillary sinuses. The remainder of the paranasal sinuses are relatively clear. Accessory drainage passways of the inferomedial walls of the bilateral maxillary sinus into the nasal cavity. Findings are likely related to prior surgery otherwise they may be developmental.

Unknown Provider
03/18/15. ECG.
**Impression:** Sinus rhythm. Normal ECG.

Beverly Wang, MD
03/30/15. Surgical Pathology Report.
**Final Diagnoses:** Sinus Contents, Bilateral, Excision: Fragments of polypoid sinonasal mucosa with edema, fibrosis, and chronic inflammation. Fragment of bone.

Unknown Provider
07/19/15. EKG.
**Interpretation:** Normal sinus rhythm. Normal EKG.

Daniel Heitz, MD
07/19/15. X-ray of Left Rib Including Chest radiograph 3 Views.
**Comparison:** 07/19/15.
**Findings:** No rib fracture, pulmonary contusion, pleural effusion, or pneumothorax is demonstrated. No lytic or blastic lesions are demonstrated. Aorta is tortuous and mildly calcified. Heart size upper limits normal with clear visible lung fields. There has been prior cholecystectomy.
**Impression:** No acute abnormality is demonstrated.

Daniel Heitz, MD
07/19/15. X-ray of Port Chest 1 View.
**Findings:** Heart size is borderline prominent with mild scarring or atelectasis both lung bases. Mild blunting of the right lateral sulcus suggest pleural thickening and post inflammatory changes along with evidence of prior cholecystectomy. Tortuousaorta is seen with normal mediastinal width.
**Impression:** No acute cardiopulmonary disease is demonstrated. Minimal bibasilar scar versus atelectasis. Post inflammatory pleural thickening right base with volume loss. Borderline cardiomegaly. Status post cholecystectomy.

Jonathan Park, MD
08/13/15. X-ray of Right Shoulder 3 Views.
**Comparison:** None.
**Findings:** The bones and soft tissues about the right shoulder appear normal. No acute osseous injury nor lytic nor blastic lesions are demonstrated.

**Impression:** No acute nor specific abnormality is demonstrated.

Jonathan Park, MD
08/13/15. X-ray of Right Knee 3 Views.
**Comparison:** None.
**Findings/Impression:** 1) Mild tricompartmental joint space narrowing involving the right knee. No fractures or subluxations. 2) No significant knee effusion. 3) Otherwise, unremarkable soft tissues.

Hamidreza Torshiz, MD
09/15/15. MRI of Right Shoulder WO Contrast.
**Comparison:** Right shoulder radiographs 08/13/15.
**Findings:** No masses or lesions are identified within the suprascapular notch, spinal glenoid notch, or quadrilateral space. Rotator cuff: Low-grade intrasubstance partial tearing of the supraspinatus and infraspinatus tendons at the footprint, within a background of tendinosis. The tendons of the subscapularis, deltoid, teres minor muscles are grossly intact. A small reactive subacromial subdeltoid bursitis is appreciated. Muscle: No evidence of muscle atrophy or edema. Glenoid: The labrum is grossly intact. Articular cartilage: Mild cartilage loss is appreciated. Long head of the biceps tendon (intra-articular and extra-articular portions): Grossly intact. Osseous structures: No acute fracture or dislocation. Acromioclavicular joint: The acromion is type 2, as characterized on the sagittal plane. There is mild osteoarthrosis. Joint: A paucity of fluid is appreciated in the glenohumeral joint.
**Impression:** No acute osseous abnormalities. Low-grade intrasubstance partial tearing of the supraspinatus and infraspinatus tendons at the footprint, within a background of tendinosis.

Hamidreza Torshiz, MD
09/15/15. MRI of Right Knee WO Contrast.
**Comparison:** Right knee radiographs 08/13/15.
**Findings:** Ligaments: The anterior and posterior cruciate ligaments are grossly intact. The medial and lateral supporting structures are grossly intact. The iliotibial band is unremarkable. Menisci: Medial meniscus: Multidirectional tearing of the body and posterior horn of the medial meniscus. Lateral meniscus: Grossly intact. Cartilage: Mild cartilage loss in the medial and lateral femorotibial compartments is noted. Area of high-grade cartilage loss is seen within the central weight-bearing aspect of the lateral tibial plateau with underlying subchondral cystic change and reactive marrow edema. The patellar and trochlear cartilage are grossly intact. Extensor mechanism: Nonspecific mild prepatellar soft tissue edema is noted. Edema seen in the suprapatellar fat pad suggesting an element of abnormal patellar tracking. The prefemoral infrapatellar fat pads are grossly unremarkable. The quadriceps and patellar tendons are grossly intact. Posterior soft tissues: Unremarkable. No popliteal cyst is identified. Osseous structures: No evidence of acute fracture or dislocation. Muscles: No evidence of muscle atrophy or edema.
**Impression:** Multidirectional tearing of the body and posterior horn of the medial meniscus. Evidence of abnormal patellar tracking. Degenerative changes, most pronounce the lateral femorotibial compartment. No acute osseous abnormality.

Yanle Zhao, MD
10/30/15. X-ray of Cervical Spine 2 or 3 Views.

**Findings:** The vertebral bodies are normal in alignment. The vertebral body heights are maintained. Anterior osteophyte is seen at C4, C5, C6, C7 vertebral body with disc space narrowing at C5-C6, C6-C7 levels. No acute osseous injury is demonstrated. No lytic or blastic lesions are demonstrated. No paravertebral masses are demonstrated.
**Impression:** Degenerative disc disease at C5-C6, C6-C7 levels.

Paul Reisch, MD
**10/30/15. X-ray of Chest 2 Views.**
**Comparison:** 07/19/15.
**Findings:** The heart size is borderline enlarged. The aorta is tortuous. There is right apical parenchymal scarring and right basilar parenchymal scar versus atelectasis. There is mild right costophrenic angle blunting. The left lung is clear.
**Impression:** Mild right apical and right basilar parenchymal scarring. Mild right costophrenic angle blunting, possibly pleural thickening, or small right pleural effusion.

Sergei Tatishchev, MD
**11/06/15. Surgical Pathology Report.**
**Diagnosis:** Esophagogastroduodenoscopy with biopsy. Squamocolumnar Junction: 1) Cardia-type gastric mucosa with mild chronic inflammation, no activity. 2) No squamous epithelium. 3) No intestinal metaplasia.

Unknown Provider
**06/01/16. EKG.**
**Interpretation:** 1) Normal sinus rhythm. 2) Possible inferior infarct age undetermined. 3) Abnormal EKG.

Christina Benedict, MD
**06/01/16. X-ray of Port Chest 1 View.**
**Comparison:** 10/30/15.
**Findings:** Heart is normal in size. There is scarring in the right lung apex. There is bibasilar atelectasis/infiltrate, slightly progress since prior examination. There is no pleural effusion or pneumothorax.
**Impression:** Basilar atelectasis/infiltrate.

Arnold Rotter, MD
**09/13/18. X-ray of the Chest Posterior Anterior Lateral.**
**Findings:** PA and lateral chest x-ray without any prior films for comparison. The right hemidiaphragm and right lateral costophrenic angle are elevated. Mild pleural thickening in the right lower lung laterally is noted. Reticular opacities were noted in the right apex. No pulmonary nodules, infiltrates or congestion are seen. The heart is normal in size with moderate to marked tortuosity of the descending aorta. No lytic or blastic bone lesions and no fractures were identified.
**Impression:** 1) Elevated right hemidiaphragm lateral minimal pleural thickening. Probable scarring. 2) No acute inflammatory or metastatic disease was seen.

Huiqing Wu, MD

09/17/18. Surgical Pathology Report.
**Final Diagnoses:** Prostate, core biopsies: Right base (A): -Benign prostatic tissue. Right mid (B): - Benign prostatic tissue. Right apex (C): - Benign prostatic tissue. Left base (D): - Benign prostatic tissue. Left mid (E): - Benign prostatic tissue - see microscopic description. Left apex (F): - Benign prostatic tissue.

Unknown Provider
12/13/19. EKG Rhythm Strip.
Interpretation not available.

Johnson Lightfoote, MD
12/13/19. CT of Abdomen and Pelvis with Contrast.
**Findings:** The lung bases and pleural spaces demonstrate no nodules, consolidation, or pleural effusions. The liver and spleen are normal in position size and shape. Surgical clips are demonstrated in the gallbladder fossa. The pancreas is not enlarged. The kidneys demonstrate no masses or hydronephrosis. No free intraabdominal fluid or lymphadenopathy is demonstrated. The mid abdominal large and small bowel appear normal. The visualized bones of the lumbar spine are unremarkable for the patient's age. The ureters demonstrate no masses or hydronephrosis. No free intraabdominal fluid or lymphadenopathy is demonstrated. A few distal colonic diverticula are demonstrated, associated with mural thickening, but without pericolonic mass or free fluid. Neoplastic disease should be considered as well, however. The prostate gland is enlarged, and there is a mild to moderate infravesical prostatic impression. Otherwise, the bladder and rectum are unremarkable. Anterolisthesis of L4 upon L5 is demonstrated.
**Impression:** 1) Sigmoid colonic mural thickening and diverticula, without pericolonic abscess formation or pneumoperitoneum. Neoplasm should be considered as: well. 2) Previous cholecystectomy. 3) No other acute nor specific abnormality is demonstrated in the abdomen or pelvis. CT radiation dose reduction techniques used include automatic exposure control, and adjustment of kVp and/or mA according to patient size. DICOM images are available to non-affiliated providers, secure, media free, reciprocally searchable, upon patient authorization, using RadConnect.

Jeffrey Nakashioya, MD
12/13/19. EKG.
**Interpretation:** 1) Sinus bradycardia. 2) HR: 54. 3) Normal axis. 4) Otherwise, Normal EKG.

Philip Strassle, MD
12/14/19. Surgical Pathology Report.
**Final Diagnoses:** A) Cecum valve biopsy: Colonic mucosa with focal underlying adipose tissue, could fit with submucosal lipoma, clinical correlation is recommended. B) Transverse colon polyp: tubular adenoma.

Unknown Provider
05/31/20. EKG.
**Interpretation:** Normal tachycardia. Normal EKG except for rate.

Dr. Frank Ornelas

06/01/20. EKG.
**Interpretation:** Sinus rhythm. Normal P axis, V-rate 50-99. Normal EKG.

William Paik, MD#.
06/01/20. X-ray of Chest 1 View~
**Comparison:** X-ray chest on 11/19/08, 1 image.
**Findings:** Bibasilar atelectasis. Trace right pleural effusion is not excluded. Probable right upper lobe scarring. No focal consolidation. No pneumothorax. The heart size is within normal limits. Tortuous aorta. No evidence of acute osseous pathology. Stable elevation of the right hemidiaphragm.
**Impression:** 1) Bibasilar atelectasis. 2) Trace right pleural effusion is not excluded. 3) Probable right upper lobe scarring. 4) Stable elevation of the right hemidiaphragm.

Stanley Chou, MD
06/01/20. Comprehensive 2D, Doppler, and Color-Flow Echocardiogram.
**Conclusion:** 1) The left ventricle is normal in size and systolic function. 2) Estimated left ventricular ejection fraction of 60-65%. 3) Grade 1 diastolic dysfunction.

Dr. Stanley Chou
06/02/20. EKG.
**Interpretation:** 1) Sinus rhythm. 2) Borderline prolonged PR interval. 3) Baseline wander in lead(s) V1.

Kevin Bui, MD
06/20/20. NM Rest Stress W Motion + EFR.
**Comparison:** None.
**Findings:** Normal left ventricular volume. No left ventricular wall defect on rest or stress imaging. No gross wall motion abnormality. The left ventricular ejection fraction is 71%.
**Impression:** 1) No evidence of myocardium at ischemic risk. 2) The left ventricular ejection fraction is 71%.

Jeffrey Karst, MD
07/09/21. X-ray of the Hip Complete Right.
**Findings:** The proximal femurs are smooth and intact and normally articulated with the glenoid. The right superior and inferior pubic rami are intact. The right iliac bone and right sacroiliac joint appear normal.
**Impression:** Normal 2-view x-ray of the right hip.

Choon Koo, MD
08/12/21. Surgical Final Report.
**Final Diagnoses:** 1) Right inguinal hernia sac: Consistent with hernia sac. 2) Right cord lipoma: Consistent with being lipoma.

Reza Pakdaman, MD
08/12/21. X-ray of the Chest Portable 1 View.

**Findings:** A single view of the chest is provided. Mild elevation of right hemidiaphragm. Linear opacities at lung bases, indicating mild chronic scarring. No large pleural effusion. No pneumothorax. Heart size is normal. The mediastinal contour is normal.
**Impression:** No radiographic evidence of acute pulmonary process.

John Abed, MD
**11/14/21. ECG.**
**Impression:** Normal sinus rhythm. Possible lateral infarct, age undetermined. Cannot rule out inferior infarct, age undetermined. Abnormal ECG. When compared with the ECG of 06/13/22. PR interval has decreased. Minimal criteria for inferior infarct are now present.

Peter Kim, MD
**11/14/21. ECG.**
**Impression:** Normal sinus rhythm. Minimal voltage criteria for LVH may be a normal variant statement not found. Cannot rule out infarct. Abnormal ECG. When compared with the ECG of 11/14/21. Questionable change in initial forces of interior leads.

John Abed, MD
**11/14/21. ECG.**
**Impression:** Abnormal EKG.

Peter Yoo, MD
**11/14/21. X-ray of the Chest Portable in ER.**
**Comparison:** 08/12/21.
**Findings:** The cardio mediastinal silhouette is within normal limits. Mild bibasilar linear opacities. There is no pleural abnormality.
**Impression:** Mild bibasilar linear opacities, probably atelectasis. Please clinically correlate to exclude pneumonia.

Unknown Provider
**11/15/21. ECG.**
**Impression:** Normal ECG sinus rhythm. Nonspecific T wave abnormality. Prolonged QT. Abnormal ECG.

Larry Chan, DO
**11/15/21. Echocardiogram Report.**
**Findings:** 1) Left ventricle: Left ventricular chamber size is within normal limits, measured at 4.98 cm. There is borderline concentric left ventricular hypertrophy with a septal diameter measured at 1.05 cm and a posterior wall measured at 1.03 cm. Left ventricular ejection fraction is estimated at 65-70%. There is grade 1 diastolic dysfunction. 2) Right ventricle: Normal size and function. 3) Left atrium: Mildly dilated with normal function with left atrial dimension measured at 4.3 cm. 4) Right atrium: Normal size and function. 5) Interatrial septum: Cannot rule out ASD/PFO without bubble study, but no obvious interatrial septal defect seen by color flow Doppler. 6) The aortic root is mildly dilated with the widest measurement of 4.2 cm. 7) Mitral valve: Normal structure and function. No mitral regurgitation was seen. 8) Aortic valve: Normal structure and function. No significant aortic stenosis

was seen. There is trace aortic insufficiency seen. 9) Tricuspid valve: Normal structure and function. Mild tricuspid regurgitation with right ventricular systolic pressure estimated at 24 mmHg. 10) Pulmonic valve: Normal structure and function, trivial pulmonary insufficiency seen. 11) Pericardium: No significant pericardial effusion seen.
**Impression:** 1) Left ventricular ejection fraction estimated at 65-70%. 2) Grade 1 diastolic dysfunction. 3) Aortic root is mildly dilated with the widest measurement of 4.2 cm. 4) There is trace aortic insufficiency seen, 5) Right ventricular systolic pressure is estimated to be at 24 mmHg.

Froilan Tuozo, FNP
**11/15/21. Lexiscan (Regadenoson) Nuclear Stress Test.**
**Impression:** Interpretation is not available.

Jeffrey Karst, MD
**11/15/21. NM Myocardial Perf Multi Rest/Stress.**
**Findings:** Ejection fraction: 90% (Normal: Greater than 50% (females); greater than 45% (males). End-diastolic volume: 54 ml (Normal: Less than 100 ml (females); less than 142 ml (males). End-systolic volume: 5 ml (Normal: less than 42 ml (females); less than 65 ml (males). Perfusion imaging: Left ventricular stress images demonstrate the distribution of activity in left ventricular walls appearing within normal limits. rest images demonstrate no significant change in the distribution of activity. wall motion left ventricular stress wall motion appears within normal limits.
**Impression:** Left ventricular perfusion activity appears within normal limits. Left ventricular stress ejection fraction calculated at greater than 70% with left ventricular stress wall motion normal in appearance.

Froilan Tuozo, NP
**11/15/21. ECG Portion of Lexiscan Stress Test.**
**Summary of Findings:** 1) Baseline ECG demonstrated normal sinus rhythm at 76 beats per minute. PR 190 MS, ORS 90 MS, QTc 470ms, normal axis, ST/T waves were normal. 2) There were no arrhythmias seen. 3) The starting heart rate was 76 beats per minute and blood pressure was 149/89 mmHg. Peak heart rate was 86 beats per minute and blood pressure was 135/80 mmHg. The ending heart rate was 75 beats per minute and blood pressure was 148/84 mmHg. 4) $O_2$ sat ranged from 98% at rest and, in recovery, ranged from 898% to 99% on room air. 5) The patient did not have any chest pain or shortness of breath throughout the test.
**Impression:** 1) T wave inversion in V4 and V5 was noted during the stress phase and returned baseline in recovery. 2) Appropriate hemodynamic response. 3) No arrhythmias or conduction abnormalities were seen. 4) The patient did not have any chest pain, shortness of breath, or other associated symptoms during the stress test. 5) Correlation with Sestamibi scans to follow nuclear images will be interpreted/reported separately by radiologists.

Berry Stuart, MD
**12/23/21. X-ray of the Chest 2 Views.**
**Comparison:** Chest x-ray 11/14/21.
**Findings:** Heart size is normal. Tortuous thoracic aorta. Stable elevation of the right hemidiaphragm. Mild right basilar scarring/atelectasis. Lungs are otherwise clear. No pleural effusion or pneumothorax. Soft tissues and bones are unremarkable.

**Impression:** No acute cardiopulmonary process.

Unknown Provider
12/28/21. Cardiac Cath Lab Posting.
**Procedure**: Left heart cath.
**Diagnosis:** Chest pain.

Larry Chan, DO
12/28/21. ECG.
**Impression:** Normal Sinus rhythm. Possible inferior infarct. Abnormal ECG. When compared with the ECG of 11/14/21. Questionable change initial forces of inferior leads.

Unknown Provider
07/19/22. ECG.
**Impression:** Normal sinus rhythm. Normal ECG. When compared with the ECG of 12/28/21, borderline criteria for inferior infarct are no longer present.

Unknown Provider
07/19/22. ECG.
**Impression:** Normal sinus rhythm. Possible inferior infarct. Abnormal ECG. When compared with the ECG of 07/19/22, non-specific T wave abnormality is now evident in anterior leads.

Unknown Provider
07/19/22. ECG.
**Impression:** Normal sinus rhythm. Possible inferior infarct, age undetermined. Abnormal ECG. When compared with the ECG of 07/19/22, borderline criteria for inferior infarct are now present.

Megin Bannes, Scribe
07/19/22. ECG.
**Impression:** Normal ECG.

Reza Pakdaman, MD
07/19/22. X-ray of the Chest Portable in ER.
**Findings:** A single view of the chest is provided. Low lung inflation. Linear opacities at lung bases may represent atelectasis or chronic scarring, unchanged. No large pleural effusion. No pneumothorax. Heart size is normal. The mediastinal contour is normal.
**Impression:** 1) No radiographic evidence of acute pulmonary process. 2) Mild bibasilar atelectasis or chronic scarring.

Larry Chan, MD
07/20/22. ECG.
**Impression:** Sinus bradycardia. Possible inferior infarct. Abnormal ECG. When compared with the ECG of 07/19/22. Nonspecific T wave abnormality improved anterolateral leads.

Catherine Suen, DO

09/10/22. Surgical Pathology Report.
**Diagnoses:** Ascending colon biopsy polyp: Tubular adenoma.

Mohamed Ali, MD
Undated. EKG.
**Interpretation:** 1) Sinus bradycardia. 2) Normal axis. 3) ST abnormality, possible transmural injury (inferior). 4) Abnormal EKG.

**SURGERY/PROCEDURES:**

Umesh Shah, MD
06/15/07. Operative Report.
**Procedures Performed**: Upper GI endoscopy with biopsy. Colonoscopy with polypectomy.
**Impression:** Status post fundal plication. Some erosion at the GE junction on the retroflex view. This is probably traumatic.

Chandrahas Agarwal, MD
06/13/12. Procedure Note.
**Procedure**: 1) Left heart catheterization. 2) Selective left and right coronary angiography. 3) Left ventriculography. 4) Right femoral artery angiography.
**Findings:** The left ventricular pressure is 169/3 with an end-diastolic of 21. Aortic root pressure was 161/81 with a mean of 110. No gradient across the aortic valve on pull-back. Left Ventriculography: Left ventriculography reveals normal left ventricular wall motion. The ejection fraction is 60% on visual assessment. There is no mitral regurgitation. Coronary Angiography: Coronary angiography reveals the left main coronary artery to be normal. The left anterior descending coronary artery only has mil luminal irregularities. It reaches up to the apex and wraps around the apex. The 1st diagonal branch is a medium-caliber vessel with no significant disease. The circumflex coronary artery is normal. The 1st obtuse marginal is small. The 2nd obtuse marginal is a larger vessel and is also normal. The circumflex coronary artery itself is normal. The right coronary artery is a large caliber vessel with mild luminal irregularities up to 10% to 20% in the midpart. It is a 4.0-mm vessel. It is a dominant vessel and otherwise has no significant disease. The right femoral artery is normal. The insertion site is above the bifurcation.
**Impression:** Normal left ventricular function, ejection fraction 60 %, no mitral regurgitation. 2) Mild coronary artery disease involving the mid left anterior descending in the form of luminal irregularities and mid-right coronary artery as noted above with a right dominant system.

Daniel Oh, MD
08/06/12. Operative Report.
**Procedure Performed**: Esophagogastroduodenoscopy with biopsies and insertion of motility catheter.
**Preoperative Diagnosis:** Esophageal dysmotility.
**Postoperative Diagnosis:** Esophageal dysmotility.

Daniel Oh, MD
08/24/12. Operative Report.

**Procedure**: Esophagogastroduodenoscopy with balloon dilatation of the lower esophageal high-pressure zone to 20 mm.
**Preoperative Diagnosis:** Hypertensive lower esophageal high-pressure zone.
**Postoperative Diagnosis:** Hypertensive lower esophageal high-pressure zone.

Daniel Oh, MD
02/10/14. Operative Report.
**Procedures Performed**: 1) Esophagogastroduodenoscopy with biopsy. 2) Endoscopic CRE balloon dilatation, 18, 19 and 20 mm.
**Preoperative Diagnosis:** Nissen fundoplication with episodic chest pain.
**Postoperative Diagnosis:** Same as preoperative diagnosis.

Christian Barnes, MD
03/30/15. Operative Report.
**Operation**: Bilateral imagine-guided endoscopic sinus surgery.
**Pre-op Diagnosis:** Chronic sinusitis with polyps.
**Post-op Diagnosis:** Same as pre-op diagnosis.

Naveen Bhandarkar, MD
03/30/15. Operative Report.
**Operations**: 1) Bilateral endoscopy frontal sinusotomy. 2) Bilateral endoscopic total ethmoidectomy. 3) Bilateral endoscopic maxillary sinusotomy with tissue removal. 4) Bilateral endoscopic sphenoidotomy with tissue removal. 5) Bilateral insertion, steroid eluting implant, left frontal ethmoidal, right middle meatal region. 6) Stereotactic computer-assisted extradural navigation.
**Pre-op Diagnoses:** 1) Chronic frontal sinusitis. 2) Chronic ethmoid sinusitis. 3) Chronic maxillary sinusitis. 4) Chronic sphenoid sinusitis. 5) Nasal and sinus polyposis. 6) History of prior sinus surgery.
**Post-Op Diagnoses:** Same as pre-op diagnoses.

Daniel Oh, MD
11/06/15. Operative Report.
**Operative Procedure**: Esophagogastroduodenoscopy with biopsy and balloon dilatation of gastroesophageal junction.
**Preoperative Diagnosis:** Dysphagia status post Nissen fundoplication.
**Postoperative Diagnosis:** Dysphagia status post Nissen fundoplication.

Nischita Merla, MD
06/02/16. Operative Report.
**Procedure Performed**: Colonoscopy, diagnostic.
**Preoperative Diagnosis:** Rectal bleeding of unclear etiology without hemodynamic instability.
**Postoperative Diagnoses:** 1) Bleeding identified in the left colon. 2)Moderate diverticulosis in the left colon. 3) Scattered diverticulosis in the right colon. 4) Single inflamed diverticulum in the ascending colon. 5) Submucosal bulge versus edema identified at 25 cm from the anal verge. 6) Previously placed mucosal tattoo identified at 23 cm from the anal verge. 7) Internal hemorrhoids. 8) Normal ileum.

09/17/18. Operative Note.

**Operation**: Transrectal ultrasound-guided prostate biopsy
**Pre-op Diagnosis:** Elevated prostate-specific antigen.
**Post-op Diagnosis:** Same as pre-op diagnosis.

Kenneth Lee, MD
12/14/19. Operative Report.
**Procedure**: Colonoscopy with snare polypectomy and biopsy.
**Preoperative Diagnosis:** Melena and diverticulosis.
**Post-Operative Diagnoses:** 1) A 12-minute withdrawal time. 2) No blood or bleeding lesions seen in the colon. 3) Pan diverticulosis. 4) A 6 mm transverse colon polyp removed as described with no bleeding. 5) Lipomatous appearance to the ileocecal valve, status post biopsies.

Dr. Stanley Chou,
06/02/20. Procedure Note.
**Procedure:** Lexi scan SPECT.
**Findings:** 1) Resting EKG showed normal sinus rhythm. 2) Stress EKG without ischemic ST segment changes or arrhythmia.
**Conclusions:** Normal Lexi scan stress EKG results. Imaging results to be reported separately.

Bryce Beseth, MD
08/12/21. Operative Report.
**Operation**: 1) Right inguinal hernia repair with mesh. 2) Excision of right cord lipoma.
**Pre-op Diagnosis:** Right inguinal hernia.
**Post-op Diagnoses:** 1) Right direct and indirect inguinal hernias. 2) right cord lipoma.

Larry Chan, DO
12/28/21. Cardiac Cath Procedure Note.
**Procedure**: 1) Left heart catheterization. 2) Selective left coronary angiography. 3) Selective right coronary angiography. 4) Successful 3.0 x 28 mm Boston Scientific Synergy Drug Eluting Stent to proximal to mid LAD. 5) Successful 2.75 x 24 mm Boston Scientific Synergy Drug Eluting Stent to mid LAD. 6) Successful 3.0 x 12 mm Boston Scientific Synergy Drug Eluting Stent to mid to distal RCA. 7) Successful TR band placement over the right radial artery. 8) Interpretation of data. 9) Ultrasound guidance of right radial access. 10) Conscious sedation time: 50 minutes. 11) Modifier 22 for multiple vessel CAD and very difficult engagement and delivery of RCA stent with very little support from guide
**Findings:** The left ventricular end-diastolic pressure is noted to be at 15 mmHg. There is no significant gradient upon pullback across the aortic valve. The left main is a large caliber vessel that bifurcates into left anterior descending, and left circumflex vessels and is angiographically free of significant disease. The left anterior descending artery is a large caliber vessel with 2 moderate caliber diagonal branches. Just after a large septum! perforator, there is a 70% tandem lesions in the proximal to mid LAD. There is a 70-80% mid-LAD lesion seen. The left circumflex is a large caliber vessel with 2 moderate caliber OM branches, which is angiographically free of significant disease. The right coronary artery is a large caliber vessel that bifurcates into the posterior LV branch and posterior descending artery. It is a right-dominant system. There is a 70% mid to distal RCA lesion seen.

**Assessment:** 1) Unstable angina. 2) 70% tandem lesions in the proximal to mid LAD status post successful 3.0 x 28 mm Boston Scientific Synergy Drug Eluting Stent implantation. 3) 70% mid LAD stenosis status-post successful 2.75 x 24 mm Boston Scientific Synergy Drug Eluting Stent to mid LAD. 4) 70% mid to distal RCA stenosis status post successful 3.0 x 12 mm Boston Scientific Synergy Drug Eluting Stent implantation.

Chandrahas Agarwal, MD
**06/13/22. Procedure Report.**
**Procedure**: Left heart Cath/ coronary Angio with LV gram.

Larry Chan, DO
**07/20/22. Procedure Report.**
**Procedures Performed**: 1) Left heart catheterization. 2) Selective left coronary angiography. 3) Selective right coronary angiography. 4) Successful 2.75 x 28 mm Boston Scientific Synergy Drug Eluting Stent to mid LAD.
5) Successful TR band placement over the right radial artery. 6) Interpretation of data. 7) Ultrasound guidance of right radial access. 8) Conscious sedation time: 39 minutes.
**Findings:** 1) The left ventricular end-diastolic pressure is noted to be at 9 mmHg. There is no significant gradient upon pullback across the aortic valve. 2) The left main is a large caliber vessel that bifurcates into left anterior descending, and left circumflex vessels, and is angiographically free of significant disease. 3) The left anterior descending artery is a large caliber vessel with 2 moderate caliber diagonal branches. There is a widely patent stent in the proximal and
mid to distal area with a hazy 70% lesion just before the distal stent. 4) The left circumflex is a large caliber vessel with 2 moderate caliber OM branches, which is angiographically free of significant disease. 5) The right coronary artery is a large caliber vessel that bifurcates into the posterior LV branch and posterior descending artery. It is a right
dominant system. It is angiographically free of significant disease.
**Assessment:** 1) Abnormal stress test. 2) 70% hazy mid LAD stenosis status-post successful 2.75 x 28 mm Boston Scientific Synergy Drug Eluting Stent implantation.

Basim Abdelkarim, MD
**09/10/22. Procedure Report.**
**Procedure**: 1) Colonoscopy with moderate sedation. 2) Colonoscopy with biopsy.
**Pre-op Diagnoses:** 1) Colon cancer screening. 2) Personal history of colonic polys.
**Post-op Diagnoses:** 1) Colon polyp x 1. 2) Mild pan diverticulosis. 3) Grade II internal hemorrhoids.
**Impression:** Colon polyp x1. Mild pandiverticulosis. Grade II internal hemorrhoids.

**MEDICAL RECORDS:**

02/15/05. Physician Progress Note.
The patient shows evidence of dehydration. He was given 75 cc/hr NS. Partially Illegible)

Ashok Madahar, MD
**04/14/05. Disposition and Admission Note.**
**Subjective:** The patient is feeling better.

**Diagnostic Impression:** 1) Chest pain, rule out unstable angina. 2) Hypertension, controlled. 3) Past tobacco abuse.
**Imaging Studies**: 1) Pulse Oximetry **Interpretation:** The pulse oximetry was 97% on room air, which is normal. Rhythm Strip **Interpretation:** The patient is in sinus rhythm with no ectopy, a normal rhythm. EKG **Interpretation:** EKG done at 0050 hours revealed a heart rate of 69. The patient is in sinus rhythm with no ectopy. Intervals are normal. Axis is normal. No QRS configuration abnormality. The patient has Q waves in leads II, III and aVF and a subtle upward curving of the ST segment, which is nonspecific but comparable to the EKG done about three hours ago, a borderline EKG.

Unknown Provider
**04/15/05. Admission Note.**
**Chief Complaint/HPI:** The patient here with CP x1 day. The patient states pain 7/10 at iots worst and become progressively worse.
**Diagnostic Impression:** 1) CP. 2) R/O ACS. 3) Hiatal hernia. 4) Hypertension. 5) Dehydration.
**Plan:** Instructed to patient to admit.

Raj Yande, REX, DO/James Lally, DO
**04/15/05. Discharge Summary Report.**
**Admitting Diagnoses:** 1) Chest pain. 2) Hiatal hernia. 3) Hypertension. 4) Dehydration.
**Summary of Hospital Course**: The patient was admitted to the direct observation unit, on telemetry, and started with chest pain protocol. His pain decreased once on the floor with 2-3/10. Cardiac enzymes were negative x2 sets and as previously described, EKG remained in normal sinus with no acute changes. The patient was reevaluated and found to be stable for discharge.

Ashok Madahar, MD
**04/15/05. Office Visit.**
**Chief Complaint**: The patient presents with chest pressure.
**History of Present Illness:** The patient who while attending a meeting this morning, he had a substernal pressure type sensation radiating to his jaw and the right arm. He looked pale and sick to the staff members. They told him to go home. He went home and rested, then tried to fall asleep, but the pain continued rating from 4-7/10 scale. He thought it is his hiatal hernia and took Mylanta without any relief. Then the pain continued, eventually he decided to get an EKG done. He had an EKG done, which was read by machine as normal, but the symptoms continued, thus he came to this hospital for an evaluation.
**Past Medical History:** Hypertension, migraine headaches, and hiatal hernia.
**Allergies:** Reglan.
**Interim Diagnostic Impression:** Chest pain.
**Medical Decision Making**: The patient's history is classic for angina. EKG done at the facility where he was working showed possibly an old inferior wall MI, otherwise unremarkable. EKG done here has similar changes, but nothing acute. Cardiac workup has been initiated. He will be treated with sublingual nitro, nitro paste, and aspirin. Supplemental O2 has been placed.
**Final Disposition:** He will require admission for ongoing evaluation of his symptoms.

Christianson Warren, RES, DO/James Lally, DO
**04/15/05. History and Physical Report.**

**Chief Complaint**: The patient presents with chest pain x1 day.
**History of Present Illness:** The patient has chest pain, started on 04/14/05. The patient's chest pain was intermittent but continued to become progressively worse. The patient states that his chest pain was 7/10 and was sharp in nature. The patient has a strong family history of myocardial infarction.
**Past Medical History:** Positive for cholecystectomy in 1987, hiatal hernia in 1994 with Nissen fundoplication in 1994, and hypertension.
**Social History:** The patient drinks alcohol approximately once per month and two caffeinated beverages per day.
**Family History:** The patient has three brothers who all died of myocardial infarction in their early 50s. Family history is positive for diabetes mellitus type 2.
**Assessment:** 1) Chest pain. 2) Rule out acute coronary syndrome. 3) Hiatal hernia. 4) History of Nissen fundoplication repair. 5) Hypertension. 6) Dehydration.
**Plan:** The patient will also be given Diovan 80 mg. The patient is also to be supplied with p.r.n. medications for the patient's comfort and IV fluid hydration for the patient's dehydration. The patient will be discharged home upon satisfactory clinical resolution of symptoms.
**Prognosis**: Fair.

Unknown Provider
**04/15/05. Progress Note**

(Handwritten report is partially illegible).

Unknown Provider
**06/15/07. Progress Note.**
**Chief Complaint**: H-H.
**Present Illness**: S/P H-H repair screening colonoscopy part history of colon polyps.
**Diagnoses:** 1) GERD. 2) Chest pain. 3) Colon polyps.

Unknown Provider
**06/15/07. Pre-Procedure Note.**
**Indication for Procedure**: Chest pain, GERD, colon.
(Handwritten report is partially illegible).

Dr. Robert Bearman
**06/15/07. Pathology Consultation Report.**
**Diagnosis:** Large intestine right, colonoscopy- Tubular adenoma.

Unknown Provider
**06/15/07. Preprocedure Note.**
Indications for Procedure: Atypical chest pain, GERD. (Partially Illegible)

Unknown Provider
**06/15/07. Post Procedure Note.**
**Operative Procedure:** Status post mission plication. No active inflammation, colon polyp. Hemorrhoids.

**Post Procedure Diagnosis:** Colonoscopy with polypectomy.
**Type of Anesthesia:** Sedation analgesia. Partially Illegible)

James Lally, DO/Yoonjung Jang, RES, DO
**11/19/08. History And Physical Report.**
**Chief Complaint**: The patient presents with abdominal pain with nausea x2 days.
**History Of Present Illness:** The patient here with two days' history of abdominal pain. The patient states that his abdominal pain is 5/10, which is also accompanied with chills, fever, dizziness, diarrhea, and generalized body ache. The patient states that he was unable to tolerate the food or drink for two days due to nausea, vomiting, and diarrhea. The patient has no urinary output for two days either. The patient describes the abdominal pain as continuous cramping and generalized everywhere. The patient has a history of depression and migraine.
**Past Medical History:** Migraine and depression.
**Diagnoses:** 1) Acute abdominal pain. 2) SBO. 3) Acute nausea. 4) Diarrhea. 5) Dehydration. 6) Migraines. 7) Depression. 8) Possible a/c s/d HF.
**Plan:** Protonic IV ordered. Surgical consult recommended.
**Prognosis**: Guarded.
**Disposition:** The patient is to be discharged upon medical treatment.
(Handwritten report is partially illegible).

Unknown Provider
**11/19/08. Physician Note.**
**Diagnoses:** Intractable acute abdominal pain, dehydration, depression.
**Plan:** The patient was recommended liquid diet. He was advised to follow up with the primary care physician. Partially Illegible)

Mukesh Amin, MD
**11/20/08. Consultation Report.**
**Reason For Consultation**: The patient presents with multiple problems, which includes abdominal pain, SBO, azotemia, and dehydration.
**History of Present Illness:** The patient with multiple past medical histories, which includes migraine and depression who was essentially admitted with abdominal pain, nausea x2 days, chills, fever, dizziness, and some generalized body ache. The abdominal pain was continuous. The patient was admitted and found to have SBO.
**Past Medical History:** Migraine, depression.
**Past Surgical History:** Cholecystectomy, Hiatal hernia repair, also, complication from surgery as well.
**Assessment:** 1) Abdominal pain, small bowel obstruction. 2) Dehydration, azotemia. 3) Depression. 4) Migraine.
Plan/**Recommendations:** IV fluids ordered. Follow up chem-7. Add 40 mEg of KCl in IV, UA C&S recommended. Agree with other care plan rendered and will closely monitor and follow the patient for further evaluation pending the results.

James Lally, DO
**11/20/08. Progress Note**
**Assessment:** 1) Abdominal pain. 2) Dehydration, azotemia. 3) Depression. 4) Migraine.

(Handwritten report is partially illegible).

James Lally, DO
11/20/08. Progress Note
(Handwritten report is partially illegible).

James Lally, DO
11/20/08. Progress Note
**Subjective:** The patient complaints of slight throat and epigastric discomfort starting PNG tube placement.
**Assessment:** 1) Distal SBO. 2) Acute abdominal pain. 3) Acute nausea. Improved with Zofran and NG tube.
(Handwritten report is partially illegible).

James Lally, DO
11/20/08. Progress Note
**Subjective:** The patient complaints of overnight drainage NG tube.
**Assessment:** 1) Distal SBO. 2) Acute abdominal pain. 3) Acute nausea. 4) Electrolyte imbalance.
(Handwritten report is partially illegible).

James Lally, DO
11/21/08. Progress Note
(Handwritten report is partially illegible).
James Lally, DO
11/21/08. Progress Note
(Handwritten report is partially illegible).

James Lally, DO
11/21/08. Progress Note
(Handwritten report is partially illegible).

James Lally, DO
11/21/08. Progress Note
**Discussion:** The patient got better with hospital course & SBO. Patient on full liquid diet.
(Handwritten report is partially illegible).

Yoonjung Jang, RES DO/Daljinder Takhar, DO
11/21/08. Discharge Summary Report.
**Discharge Diagnoses:** 1) Intractable acute abdominal pain. 2) Acute small bowel obstruction. 3) Intractable acute nausea, vomiting, and diarrhea. 4) Dehydration. 5) Migraine. 6) Depression. 7) Possible acute/chronic systolic/diastolic heart failure.
**Hospital Course**: The patient presents with migraine, depression, and cholecystectomy who came in complaining of diffuse and cramping abdominal pain x2 days with chills, fever, dizziness, and diarrhea. The patient was admitted to medical/surgical with NG tube placement in the ER with intermittent loss of low suction. The patient was put on NPO and IV fluid 100 ml/hour of normal saline with Zofran 4 mg

IV q.4h. prn nausea and vomiting, morphine 2 mg IV q.4h. prn pain, Ativan 1 mg IV q.4h. prn anxiety, Protonix 40 mg IV daily for GERD, Ambien 5 mg p.o, at bedtime, Toradol 30 mg IV q.6h. prn pain, ampicillin 1 g q.8h. for possible sepsis, atenolol 50 mg p.o. at bedtime for migraine prophylaxis was continued, and Benadryl. Dr. Oh was consulted for small bowel obstruction and he recommended NPO, NG tube suction out-of- bed, and DVT prophylaxis. The patient tolerated full liquid diet starting on the discharge date and per Dr. Oh, the patient was okay to be discharged. The patient also increased Ativan 2 mg IV q4h. prn agitation, K-Phos 2 mEq in two liter of normal saline was given for low phosphate, Gaviscon 15 mL p.o. q.i.d. was given prn for digestion, and Cepacol was given p.o. q.4h. prn for sore throat. The patient was given incentive spirometer for bibasilar discoid atelectasis, out-of-bed, and decreased IV fluid to 90 ml/hour of normal saline because the patient's BUN and creatinine was improving with less dehydration. Also, sodium phosphate rider was given 40 mEq in 250 ml per normal saline due to the patient's low phosphate. NG tube was removed on 11/21/08 at 1000 hours, which the patient tolerated well. A repeat CT showed no apparent small bowel obstruction. Upon discharge, the patient's vitals were temperature 98.6 degrees, heart rate 62, respirations 20, blood pressure 137/91, and saturation 96% on room air with no pain. At this point, the patient has no nausea, vomiting, and tolerating full liquid diet without any complication. The patient was agreeable to be discharged. The patient got better with hospital course. There was no chest pain, abdominal pain, or headache upon discharge and the patient's hydration resolved too.

Paul Razo, MD
**06/12/12. Emergency Department Provider Note.**
**Chief Complaint:** Chest pain, ongoing.
**History of Present Illness:** The patient presents to the Emergency Department with complaints of chest pain. He states that pain is mostly located in his left side. He states that pain has been off and on for 2 weeks. He reports that pain became constant 1 hour ago today. He also complains of numbness/tingling in left shoulder and difficulty swallowing. He states that he never had chest pain like this before. He tried taking ASA last night but was given no relief. He has history of hiatal hernias. He denies any cause for stress but family states that his job has been very stressful as of late. Symptoms are localized, left side. No associated diaphoresis. Associated with nausea. No associated vomiting.
**Past Medical History:** Neurological disease, migraine headaches.
**Diagnoses:** 1) Chest pain, unspecified. 2) Hiatal hernia, rule out gastric volvulus.
**ED Summary: Re-Evaluation:** Psychiatrist presents with chest pain since yesterday. Anxious on exam; 2 sets cardiac markers negative. CT Angio chest official result pending, her primary medical doctor cardio Dr. Agarwal made aware; he will follow the result and accepts him to tele with likely cath tomorrow, as he has ongoing chest pain. He will come see him in ED with orders to follow; stable for admit. He had transient relief with Ativan. CT angio suggestive of intermittent hiatal hernia volvulus with edema of the distal esophagus; Dr. Agarwal in ED now and apprised of this finding. He will obtain appropriate consults; of note, he was scoped by his GI with in the past few weeks with negative findings. Administered; IV fluids, ASA, Ativan. He has improved since arrival to Emergency Department. Discussed this case with Dr. Choudhary.
**Plan:** CT of the chest without and x-ray of the chest were ordered. EKG was ordered. He was advised to take Aspirin 162 mg, Ativan 1 mg, Sodium Chloride 0.9%.
**Condition:** Stable.
**Disposition:** Admit to Telemetry.

Chandrahas Agarwal, MD
06/12/12. Consultation Note.
**Reason for Consultation:** Chest pain.
**History of Present Illness:** The patient stating that he was having chest pain and wants to go to the Emergency Room and was directed to come to San Antonio Community Hospital Emergency Room. He came here by private auto. He is currently in the Emergency Room, comfortable and in no distress. He was evaluated by Dr. Khan and a CT angiogram was ordered. His cardiac enzymes are normal. He states that he has been having this pain in the epigastric area which radiates to the right side of the neck, and then he feels a swelling and cannot swallow for the past 3 months. He had an EGD done by Dr. Unesh Shah at the Four Seasons Surgery Center about 2 weeks ago and was told that his esophagus was normal. He had a colonoscopy done and 2 polyps removed. the patient is concerned because of he was told a few years ago that his esophagus looks like liver and had a Barrett esophagus secondary to hiatal hernia and reflux. He cannot understand why it is normal now. He was given Nexium 40 mg b.i.d. He was also treated for H. pylori with triple antibiotics including Clarithromycin, Amoxicillin and Flagyl. He was today sitting and working at this desk when he developed severe epigastric pain, radiating to the substernal area in the right side of the neck again and felt like there was swelling and he could not swallow anything. He cannot even drink tea. The pain does not happen with walking, exertion or climbing stairs only happens when he is sitting.
**Past Medical History:** Significant for cholecystectomy. He had laparoscopic surgery for hiatal hernia which was complicated by perforation of the esophagus leading to bilateral empyema. He was in a San Francisco hospital for 61 days and now has since recovered. He has a hiatal hernia with gastroesophageal reflux which causes him pain. He also has a history of asymptomatic PVCs. He has mild hypercholesterolemia and mild hypertension.
**Assessment:** 1) He has chest pain who appears most likely of gastric or esophageal origin. 2) Hypertension. 3) Premature ventricular complexes. 4) CT scan finding suggestive of mucosal edema of the distal esophagus which may be causing his pain.
**Recommendations:** He is scheduled for cardiac catheterization tomorrow because he is very anxious and requests angiogram be done. Examiner have explained to him the risks and complications of cardiac catheterization including but not limited to bleeding, stroke, myocardial infarction and death which he understands and wishes to proceed. They will discuss with him the CT angiogram findings, especially the mucosal edema of the distal esophagus.

Unknown Provider
06/13/12. Progress Note.
**Subjective Complaints:** The patient presents for cardiac follow up.
**Assessment/Plan:** Chest pain. Partially illegible)

Chandrahas Agarwal, MD
06/14/12. Discharge Summary.
**Final Diagnoses:** 1) Chest pain. 2) Gastroesophageal reflux disease. 3) Hypertension. 4) Premature ventricular contractions.
**Brief History and Course in the Hospital:** The patient complains of chest pain for the past several weeks, getting worse, and he was very concerned because he had an EGD done about 3 weeks ago by Dr. Umesh Shah at Four Seasons Urgent Care and was told his esophagus was normal. However, a CT scan done here upon his arrival into the Emergency Room by the ER MD revealed no evidence of

embolism. However, there is mild esophageal mucosal edema of the distal esophagus and a small hiatus hernia, which is from his prior fundoplication with metal clips. Extensive deformity rib considered trauma of surgery or a combination of both, atelectasis, infiltrate at the right base. It was read by Dr. David L. Berry. He ruled out for myocardial infarction, underwent cardiac catheterization on 06/13/12, revealed no significant pericardial or coronary artery disease with ejection fraction of 60%, and normal left ventricular wall motion. He developed epigastric discomfort or pain after eating, and he had a barium swallow done a few weeks ago and was told that he has severe gastroesophageal reflux disease, but the EGD as noted above by Dr. J. Shah, was unremarkable. He is now being discharged home. He will continue is home medication, which includes Atenolol 50 mg daily, Aspirin 81 mg daily, Nexium 40 mg b.i.d., Mylanta, Flonase inhaler. He will follow with examiner in 10 days. He is otherwise not to do any heavy lifting or bending for 3 days. His right groin is healing well. There is no bruise or hematoma. His vital signs at the time of discharge, blood pressure 193/56, heart rate 61, respirations 20, temperature 97, pulse oximetry 95% on room air. He was to resume his home medications. He has been given the name of Dr. Nguyen, GI surgeon at UCI, to consider surgery for his GE-junction disease. He wants also the name of a surgeon at other facility. Examiner will try to obtain one at UCLA or Cedars-Sinai and give it to him. He was advised to follow up in 10 days.

Unknown Provider
06/14/12. Progress Note.
**Subjective Complaints:** The patient right groin is healing well. He complains of epigastric discomfort after eating.
**Assessment/Plan:** GERD. Resume home medications. He was discharged home. He was advised to follow up in 10 days. He was given restrictions of no heavy lifting or bending for 2 days. Partially illegible)

Unknown Provider
08/06/12. Short History and Physical Examination Report.
**Chief Complaint/History of present Illness:** The patient with retrosternal CP x3 hours worse at night. GER resolved by PPI/anti acids.
**Impression:** The patient with fundoplication and paraoesophageal hernia repair here with symptoms suggestive and persistent GERD.
**Treatment Plan:** EGD with manometry and PH monitoring ordered.

Unknown Provider
08/06/12. Short History and Physical Examination Report.
**Chief Complaint/History of present Illness:** The patient with retrosternal CP x3 hours worse at night. GER resolved by PPI/anti acids.
**Impression:** The patient with fundoplication and paraoesophageal hernia repair here with symptoms suggestive and persistent GERD.
**Treatment Plan:** EGD with manometry and Ph monitoring ordered.

Unknown Provider
08/24/12. History and Physical Report.
**Chief Complaint & History of Present Illness:** The patient states s/p Nissen (complaints of esophageal protraction) with recurrent dysphagia, heartburn, and atypical chest pain.

**Impression:** GERD following Nissen fundoplication.
**Treatment Plan:** EGD with dilatation ordered.
(Handwritten report is partially illegible).

Daniel Oh, MD
**06/04/13. Consultation Note.**
**Subjective:** The patient return for follow-up. He will occasionally get some heartburn if he eats spicy food or if he eats too quickly and too much. He is able to control these symptoms with his diet and he is just taking Zantac. He is overall doing very well.
**Discussion:** In summary, the patient had a previous Nissen fundoplication at an outside hospital in 1998, complicated by perforation of his esophagus. He had debilitating chest pain in the setting of an elevated resting pressure at the gastroesophageal junction. He is now 10 months out from balloon dilatation of the area with complete resolution of his chest pain. He is pleased with his outcome. The examiner will follow him expectantly with his next visit in 6 months.

Daniel Oh, MD
**11/19/13. Consultation Note.**
**Subjective:** The patient return for follow-up. The patient states that his chest pain, which he used to get just under the sternal area associated with eating, has increased in frequency. It used to be every day and even several times a day prior to the dilatation. After the dilatation it completely went away. He feels it is starting to get worse. Interestingly, it is exacerbated by emotional stress.
**Discussion:** The examiner discussed the indication for redoing an EGD and balloon dilatation to 20 mm. The examiner do not think this will have significant effect on the Nissen fundoplication but should help with the episodic chest pain that he was getting in the past. He prefers to schedule this in early 2014.

Albert Mansour, DC/Jon Christensen, DC
**06/12/14-10/13/14. Chiropractic Therapy Note.**
**Number of Sessions**: 37.
**Modalities:** Pelvic tilt therapeutic exercise. Spinal adjustments. Electrical stimulation. Cryotherapy
**Diagnoses:** 1) Neuritis/Radiculitis thoracic or lumbosacral 2) Lumbosacral sprain/strain.

Jorge Perez, MD
**10/23/14. Emergency Room Report.**
**Chief Complaint**: The patient presents with headache.
**History of Present Illness:** The patient here with headache on and off for three weeks; but worse in the last three days. It is frontal. The patient feels nauseous. He states the pain decreased with Tylenol and then returned. The patient used to have a history of migraine headaches for 40 years. When initially started having the migraines, he used to have them every week, then it became every month, then every six months, and then discontinued approximately three years ago. He does take atenolol prophylactically for the migraine headaches.
**Emergency Department Course**: The patient states that he was feeling more comfortable. He received IV antibiotics for sinusitis given that he has had progressive symptoms. He still has a mild headache. Therefore, IV of normal saline was established. He was hydrated with normal saline 100 ml per hour. The patient was given Unasyn 3 g IV and fentanyl 25 mcg IV. Repeat neurological

examination at approximately 1140 hours revealed he is neurovascularly intact with a non-focal examination.
**Diagnoses:** 1) Intractable headache. 2) Sinusitis. 3) Neutropenia. 4) Hypertension,
**Medical Decision Making**: The patient will be admitted for IV antibiotic therapy, serial neurological examinations, evaluation of his neutropenia, and better blood pressure control. The examiner will discuss the case with the admitting physician, so they can arrange for ongoing care and evaluation and consultations on this patient.
**Morbidity/Mortality**: For this patient otherwise is low.
**Discharge Plan:** Final disposition is to be arranged by the admitting physician.

Unknown Provider
**12/23/14. Emergency Department Physician Record.**
**History of Present Illness:** The patient here with headache.
**Diagnostic Impression:** 1) Headache. 2) Sinusitis.
(Handwritten report is partially illegible).

James Lally, DO/William Dalrymple, RES DO
**12/23/14. History and Physical Report.**
**Chief Complaint**: The patient presents with severe headache, on and off, for the past three weeks.
**History of Present Illness:** The patient here for severe headache for the past three days, located bilaterally and diffusely throughout the head, 9/10 on the pain scale. Headaches have been on and off. Most recent headache occurred at work and was severe for 15 minutes and the pain became more tolerable. The last previous migraine headache was three years ago.
**Past Medical History:** Allergic rhinitis, exercise-induced asthma, GERD, migraines, chronic sinusitis, and a history of right lower lobe atelectasis, which occurred during a Nissen fundoplication surgery. He is currently up to date on all of his immunizations.
**Past Surgical History:** Cholecystectomy in 1986 and a Nissen fundoplication in 1998.
**Assessment:** 1) Intractable headaches, rule out mass, vasculitis, and aneurysm. Possible migraine exacerbation versus sinusitis. 2) History of migraines. 3) Gastroesophageal reflux disease. 4) Sinusitis. 5) Allergic rhinitis. 6) Asthma.
**Plan:** Admit to telemetry on 2 south. Neurology consult ordered. MRI with and without contrast of the brain, magnetic resonance angiography ordered. Pain control and restart home medications. Care plan was discussed with the patient. Due to the patient's comorbidities, the patient will be monitored for any potential complications.
**Prognosis**: Guarded.
**Disposition:** To be determined over the course of hospital stay.

James Lally, DO
**12/23/14. Progress Note.**
(Handwritten report is partially illegible).

Jeffrey Ries, DO
**12/24/14. Consultation Report.**
**Reason For Neurologic Evaluation**: The patient here with headache.

**History of Present Illness:** The patient has had severe headache for the past three days, which seems to be located bilaterally and diffusely throughout the head. The headaches have been daily. The patient states that he may have had them longer than this time. The patient states that most of these headaches have occurred while he is at work. He does have a history of migraine headache. The patient presented because the headache would not dissipate. He does have a history of chronic sinus infection.
**Impression:** 1) Suspect chronic sinusitis as the cause of current headache. Other possibility would be a muscular based headache. 2) Essential hypertension with fluctuation of blood pressure may have been related to pain. 3) History of migraine. 4) Gastroesophageal reflux disease.
**Recommendations:** Treat for chronic sinus. Observe for future blood pressure elevations. Reassess for future direction of headache control. He is feeling better.

William Dalrymple, RES, DO/James Lally, DO
**12/24/14. Discharge Summary Note.**
**Discharge Diagnoses:** 1) Intractable headache likely secondary to acute on chronic sinusitis. 2) History of migraines. 3) GERD. 4) Chronic sinusitis. 5) History of exercise-induced asthma.
**Hospital Course**: Patient presented to the FD with headache off and on for 3 weeks recently worsening. Patient has a history of migraine headaches but stated this headache was different than his migraines. Patient had a CT scan of the head that showed evidence of moderate to severe mucoperiosteal thickening involving the ethmoid air cells and left frontal sinus. Moderate mucoperiosteal thickening involving the right maxillary sinus. An MRI brain showed complete opacification of the left frontal sinus. Near-complete opacification of the bilateral ethmoid air cells. Mucosal thickening of the bilateral maxillary sinuses with superimposed mucous retention cysts, right greater than left. Dr. Ries (neurology) was consulted and suggested the etiology of headaches was from his acute on chronic sinusitis. Patient's vitals remained stable, and he stable for discharge home. He will be given prescriptions for Augmentin, prednisone, and intranasal glucocorticoid.

James Lally, DO
**12/24/14. Progress Note.**
**Assessment:** Acute hypertension improved.
(Handwritten report is partially illegible).

Naveen Bhandarkar, MD
**02/25/15. Ambulatory Consult Note.**
**Chief Complaint:** Headache.
**History of Present Illness:** The patient presents for evaluation of chronic sinusitis. He reports a several year history of sinus symptoms, previous sinus surgery, turbinate reduction, septoplasty 20 years ago. Symptoms of headache started 2 months ago, quite severe and prompted visit to Chino Valley Emergency Room where CT and MRI done negative for intracranial hemorrhage or tumor, positive for sinusitis. He was then given a course of antibiotics and also had courses of oral steroids. He was currently placed on another course of Zpak. Medication had resulted in temporary improvement with current severity decreased but severe pressure still occurring at random last yesterday, taking frequent Excedrin. Sinus symptoms had been overall manageable prior to that, taking periodic steroid injections, history of allergic rhinitis. Last allergy test was negative.
**Past Medical History:** Pre-diabetes, Right lung collapse from complicated hospital course post EGD, hypertension, GERD, CRS.

**Past Surgical History:** Cholecystectomy 1986, Nissen fundaptication 1996.
**Procedure:** Diagnostic nasal endoscopy.
**Diagnoses:** 1) Chronic sinusitis with polyps., with persistent disease despite maximal medical therapy. 2) Frontal headaches likely in part due to sinusitis, may have concurrent neurologic origin.
**Plan:** The risks, benefits, and alternatives of treatment options, including further medical therapy and/or surgery were discussed. He has elected to proceed with surgery based on failure of optimal medical therapy to result in sufficient improvement thus far. This will consist of bilateral image guided endoscopic sinus surgery with polypectomy. Examiner discussed that surgery is not a cure for chronic sinusitis and continued medical management is likely to be necessary and further surgery is occasionally necessary. He should continue medical therapy in the meantime. Obtain prior CT scan on CD, may need repeat for use with image guidance. He understands that headaches may be multifactorial in origin and that sinus optimization alone may not result in complete improvement. Examiner also discussed that surgery is not a cure for chronic sinusitis.

Israel Alba, MD
**03/18/15. Consultation Note.**
**History of Present Illness:** The patient is referred for hypertension. He has a history of prediabetes, GERD, right lung collapse post EGD.
**Assessment/Plan:** He has a past medical history of hypertension, GERD, prediabetes scheduled for endoscopic sinus surgery after refractory sinusitis to medical therapy. 1) Cardiac preoperative evaluation. He denies chest pain, shortness of breath with excellent physical capacity. No cardiac contra indications to elective surgery. He was at low risk for adverse cardiac events. 2) Hypertension: Blood pressure elevated, he has a compliant with medication regimen. He just started Prednisone, that may be a contributing factor. Continue with Atenolol at 50 mg daily. Start Amlodipine 5 mg. Labs were ordered.

Naveen Bhandarkar, MD
**03/18/15. Progress Note.**
**Chief Complaint:** Sinus problems.
**Subjective Complaints:** The patient presents for follow up of chronic sinusitis with polyposis with significant frontal headaches. His symptoms and disease have failed to sufficiently improve with extensive medical therapy including oral steroids and antibiotics, nasal sprays. He is currently on a repeat course of oral steroids and antibiotics for exacerbation with meant worsening headaches. During this time he was also experiencing disequilibrium and imbalance and got into a car accident damaging a wheel from swerving. Previously, they had discussed the option for bilateral image guided endoscopic sinus surgery to address persistent disease.
**Diagnoses:** 1) Chronic sinusitis with polyps with persistent disease despite maximal medical therapy. 2) Frontal headaches likely in part due to sinusitis, may have concurrent neurologic origin consider vestibular migraine.
**Plan:** He has elected to proceed with surgery based on failure of optimal medical therapy to result in sufficient improvement thus far. This will consist of bilateral image guided endoscopic sinus surgery with polypectomy. Repeat CT scan ordered with image guided protocol. Hospitalist evaluation pending today for optimization prior to surgery, will follow recommendations. He understands that headaches may be multifactorial in origin and that nasal airway/sinus optimization alone may not result in complete improvement. Consult with Neuro-Otology for evaluation of possible vestibular origin of symptoms.

Naveen Bhandarkar, MD
04/07/15. Progress Note.
**Chief Complaint:** Sinus follow up.
**Subjective Complaints:** The patient presents for follow up of chronic sinusitis with polyposis status post bilateral endoscopic sinus surgery. Current medical therapy for treatment includes saline irrigations, post op steroid and antibiotics. Symptoms have been overall reasonably well controlled following surgery. He reports some bloody clots persisting up until today but decreasing. Frontal headaches have been overall improved, nearly gone on the right side, persistent but not as severe overall on the left. He did not had as much disequilibrium. He denies fever, shortness of breath, severe epistaxis, vision change or chest pain.
**Diagnoses:** 1) Chronic sinusitis with polyps with persistent disease significantly improved status post endoscopic sinus surgery. 2) Frontal headaches likely in part due to sinusitis, may have concurrent neurologic origin consider vestibular migraine.
**Plan:** He was advised to continue saline irrigations multiple times daily, increases to atleast 5 times daily to minimize crusting. Restart nasal steroid spray for anti inflammatory management. Finish perioperative steroids/antibiotics to completion. Proceed with consultation with Dr. Lim for possible vestibular migraine contributing to the headaches. He understands that headaches may be multifactorial in origin and sinus optimization alone may not result in complete improvement, decrease in severity at this time examine encouraging, will carefully follow, still healing from surgery.

Jennifer Hatzkilson, MD
04/13/15. Audiological Evaluation.
**Result:** Bilateral SNHL. Poor word recognition.

Harrison Lin, MD
04/13/15. Consult Note.
**Chief Complaint:** Hearing loss.
**Subjective Complaints:** The patient presents with a long history of AU hearing loss. He reports that he had tremendous difficulty understanding speech and difficulty listening environments especially in conference rooms with large degree of echo. His wife reports that he turns on the TV very loudly and that when she calls him from behind he does not even acknowledge that he is being called. No otalgia, otorrhea, vertigo, mild tinnitus, aural fullness, no facial nerve symptoms. He reports that he has some degree of dizziness at one point to Dr. Bhandarkar, however he feels that his migraine headaches are not of inner ear origin or relation. The dizziness episode was only one time and he believes to be and orthostatics hypertension episode after an additional antihypertensive medication was started.
**Assessment/Plan:** He has mild severe SNHL AU and poor speech discrimination. They spoke about the utility and limitations of hearing aids and about cochlear implants. He is interested in trying at least 1 may be 2 hearing aids at this time. If it provides him benefit, he will continue to use them. If he feels like they are of no benefit, he will contact them for a cochlear implant evaluation.

Naveen Bhandarkar, MD
04/22/15. Progress Note.
**Chief Complaint:** Sinus follow up.

**Subjective Complaints:** The patient presents for follow up of chronic sinusitis with polyposis status post bilateral endoscopic sinus surgery. Current medical therapy for treatment includes nasal steroid spray. He stopped Saline irrigations due to significant discomfort and increased headaches but states was performing hypertonic (2 salt packets). Frontal headaches have been overall substantially improved only 3-4 major episodes following surgery and much milder and less frequent with morning headaches located across upper forehead, temple but not present during the majority of the day. He saw Dr. Lin for possible migraine vestibular involvement and hearing loss with recommendations provided. He denies fever, shortness of breath, severe epistaxis, vision change, or chest pain.
**Diagnoses:** 1) Chronic sinusitis with polyps, disease significantly improved status post endoscopic sinus surgery, no recurrent polyps. 2) Residual frontal headaches unrelated to sinusitis.
**Plan:** He was advised to continue nasal steroid spray for anti inflammatory management. Consider neurology evaluation for residual headaches - he will assess further occurrences and decide. He was advised to return to the clinic in 2-3 months for surveillance of chronic sinusitis with polyps.

Unknown Provider
**07/19/15. Emergency Department Chart**

(Handwritten report is partially illegible).

Christine Yoon, MD
**07/19/15. Office Visit.**
**Chief Complaint**: The patient presents with left rib pain.
**History of Present Illness:** The patient here with history of hypertension, who comes in with focal left-sided rib pain, worse with movement and coughing. It has been there for about a week, gradually worsening. It feels like there is a lump there. It is very focal.
**Emergency Department Course and Medical Decision Making**: The patient received Tylenol and aspirin with improvement in his pain. The examiner's suspicion for ACS is extremely low, given the reproducibly of his pain located along focal area of his left lateral rib negative EKG and cardiac markers that were drawn more than 6 hours after onset of his pain. The examiner suspect musculoskeletal pain, will go ahead and discharge with follow-up with PCP in several days.
**Impression:** Musculoskeletal pain and atypical chest pain.
**Plan:** Discharge home.

Pro-Body Orthopaedic And Sports Physical Therapy
**08/19/15-09/01/15. Physical Therapy Daily Note.**
**Date of Onset**: 05/19/15.
**Number of Sessions**: 4.
**Modalities:** 1) Therapeutic Exercise. 2) Manual therapy.
**Diagnoses:** 1) Sprain and strain of unspecified site of shoulder and upper arm. 2) Sprains and strains of unspecified site of knee and leg.

Pro-Body Orthopaedic And Sports Physical Therapy
**11/09/15-11/20/15. Physical Therapy Daily Note.**
**DOI:** 11/09/15.
**Number of Sessions**: 3

**Modalities:** 1) Therapeutic Exercise. 2) Manual therapy.
**Diagnosis:** 1) Cervical disc disorder with radiculopathy, mid-cervical region.

Pro-Body Orthopaedic And Sports Physical Therapy
05/23/16-07/08/16. Physical Therapy Daily Note.
**DOI:** 12/27/15.
**Number of Sessions**: 13.
**Modalities:** 1) Therapeutic Exercise. 2) Manual therapy.
**Diagnoses:** 1) Encounter for other orthopedic aftercare. 2) Impingement syndrome of left shoulder

Naveen Dhiman, MD
06/02/16. History and Physical Report.
**Reason For Consultation**: The patient present for lower gastrointestinal bleed.
**History of Present Illness:** The patient came to the ER with a chief complaint of lower GI bleed. The bleed started today when he had 2 episodes of bright red blood at home. The patient got anxious. The patient had 2 more episodes of pure red bright blood defecation 2 times, now the patient is anxious, but his vitals are stable.
**Clinical Impression:** 1) Lower gastrointestinal bleed. 2) Hypertension.
**Plan:** The patient will be started with IV hydration gently, GI and DVT prophylaxis will be given. The patient will be continued with Protonix for now and pain medication will be given if needed. Dr. Merla has been consulted for GI and her recommendation will be followed.

Nischita Merla, MD
06/02/16. Consult Initial Patient Evaluation.
**Reason For Consultation**: The patient present for rectal bleeding.
**History of Present Illness:** The patient admitted to the hospital with several episodes of bright red blood per rectum. He reports undergoing colonoscopy 5 years ago with evidence of diverticulosis.
**Problem List**: 1) Rectal bleeding, painless in nature. 2) History of diverticulosis. 3) Obesity.
**Recommendations:** Plan on colonoscopy to be performed today to evaluate the source of bleeding.

Geoffrey Pableo, MD
06/02/16. Emergency Department Stat Admit.
**Reason For Consultation**: The patient present for severe rectal bleeding.
**History of Present Illness:** The patient complains of severe rectal bleeding that started earlier today that consists of gross bright red blood. He has had recent diarrhea. He describes having GERD symptoms and requested a GI cocktail during his ED course. He has some dizziness. He described having a recent EGD that showed a hiatal hernia.
**Emergency Department Course**: The examiner wrote for IV Protonix and Zofran for him. He was also written for a liter bolus of normal saline given his recent diarrhea and possible dehydration. On reassessment prior to this dictation, the patient feels better. He requested gastroenterologist, Dr. Merla, be notified about this case. She is going to provide GI consultation on him.
**Emergency Department Impression:** 1) Gastrointestinal bleed. 2) Diarrhea. 3) Gastroesophageal reflux disease.
**Disposition:** The patient is going to be admitted to the hospital for further workup and care.

Dr. Hla Hwang
**06/02/16. Inpatient SOAP Note.**
**Subjective:** The patient states still bloody watery stool, waiting for the GI lab procedure.
**Assessment:** 1) Lower GI bleeding. 2) Benign essential hypertension.
**Plan:** Recommended follow up with GI procedure today, keep with Protonix and follow-up blood pressure. Thromboprophylaxis recommended.

Unknown Provider
**06/02/16. Pre-Sedation Evaluation.**
**Pre-Operative Diagnosis:** Rectal bleeding.
**Plan:** Remove IV prior to discharge. Planned moderate sedation. Discharge when criteria met for outpatients only.

Hla Hwang, MD
**06/03/16. Discharge Summary Report.**
**Discharge Diagnosis:** Lower gastrointestinal bleeding secondary to diverticulosis bleeding. No evidence of diverticulitis as per Dr. Merla.
**Hospital Course**: After being admitted to the hospital, was seen by Dr. Merla, and the patient had colonoscopy preparation. Hemoglobin was pretty stable during hospitalization. By the time the patient was brought to the hospital, hemoglobin level was 15.1, and later with IV hydration, looked like it went down to 12.1 and 11.4/11.3 and stayed there. Colonoscopy was found him to have diverticulosis bleeding and Dr. Merla clear, the patient to be discharged home. The patient was no longer having blood in the rectum.

Hla Hwang, MD
**06/03/16. Physician Progress Note.**
**Subjective:** The patient feels well.
**Assessment:** 1) Rectal bleeding. 2) Diverticulosis left sided. 3) Obesity.
**Plan:** Follow-up with the examiner & PCP in 2-3 weeks. Hold ASA x7 days. High fiber diet recommended.
(Handwritten report is partially illegible).

Jason Hamilton MD
**04/16/18. Office Visit.**
**History of Present Illness:** The patient complains of nasal trauma about 1 month ago. It happened while in the shower. He developed a bump on the bridge of his nose. It has not subsided. He denies pain. This is the first time he has sought medical treatment for this problem.
**Diagnosis:** Fracture of nasal bones, initial encounter for closed fracture.
**Assessment:** Nasal fracture with dorsal supratip swelling with cystic mass with fluctuant mobility of the supratip region, nontender. No nasal septal ulceration or laceration.
**Plan:** Recommended MRI or CT scan of the nose follow-up after exam.

Clayton Lau, MD
**09/13/18. History & Physical.**

**History of Present Illness:** The patient has Obstructive Lower Urinary Tract Symptom. On Testerone Supplementation. PSA 2.9-3.5. DRE normal with 35 gram prostate. His brother who is 10 years his Sr. Has a history of prostate cancer and is doing well after treatment. His father died at the age of 65 and had no known prostate cancer. There is no family history of breast cancer. ExoDx 31.57 indicating higher chance of high grade cancer. Could not tolerate office TRUS Prostate Biopsy. He is self-referred to the city of Hope and would like to undergo a prostate biopsy under general anesthesia.
**Assessment:** Elevated PSA. Obstructive LUTS. ExoDX was high.
**Plan:** Transrectal ultrasound-guided prostate biopsy in the operating room at a mutually convenient time. He will be consented today for the procedure and given biopsy instructions. He will perform a Fleet enema the night before in the morning of surgery and IV antibiotics will be given intraoperatively.

Cecilio Cay, NP
09/25/18. Progress Note.
**Chief Complaint:** Post operative follow up.
**Subjective Complaints:** The patient has BPH, Elevated PSA, Status post transrectal ultrasound-guided prostate biopsy last 09/17/18.
**History of Present Illness:** He was a retired physician with a history of elevated PSA within the range of 2.9-3.5. He was being followed by his local urologist in Chino Hills-Dr. Michael Loui. His last digital rectal exam in September 2018 showed benign findings. It was a 35 g prostate as per note. In addition he was seen as a consult for the first time by Dr. Lau last 09/13/18 for elevated PSA and obstructive lower urinary tract symptoms. He was previously on testosterone supplementation and was given 200 mg intramuscular supplement every 2 weeks and he stopped taking the supplements 4 months ago. Moreover, he has a family history of prostate cancer. His father died at the age of 65 years old. There is no family history of breast cancer. Today, he is here for discussion of his pathology results. A copy of his pathology report was given to him. His lower urinary tract symptoms have remained to be stable and not bothersome for him. During the night he wakes up twice or 3 times and has remained to be stable. During the day he voids every 3-4 hours. He has the habit of drinking plenty fluids and water at night and for him this is his normal lifestyle. He has good bowel movement regimen daily as well. Denied hematuria, fever, chills, dysuria, abdominal pain or flank pain. He is able to empty his bladder subjectively to completion. On 09/17/18 he underwent for a transrectal ultrasound-guided prostate biopsy done by Dr. Lau which revealed benign prostatic tissue.
**Assessment:** Elevated PSA. That is post transrectal ultrasound-guided prostate biopsy done last 09/17/20 which showed benign prostatic tissue in all 6 cores. Lower urinary tract symptom.
**Plan:** Copy of the pathology report regarding the prostate biopsy completed on 09/17/18 was given to her. Due to the fact that he has strong family history of prostate cancer they can see him back in 6 months time with a PSA level. Thereafter if he remains to be stable then they can space out his follow-up visits possibly on an annual basis with PSA and DRE.

Jeffrey Nakashioya, MD/Dr. Peter Duong
12/13/19. ED Physician Note.
**Chief Complaint**: The patient presents for rectal bleed.
**History of Present Illness:** The patient brought in by ambulance presents to the emergency department for evaluation of bloody stools for 1 day. Patient reports 4 recent episodes of bright red stools with the 3rd episode causing nausea and dizziness. Patient reports 2 cups of bright red blood.
**Assessment:** Rectal bleed.

**Medical Decision Making**: Will admit to the unassigned hospitalist service for GI consult for possible colonoscopy while inpatient. Hemoglobin trend in the emergency Hartman's stable x2.

Alan Wong, MD/Jaison Fraizer, PA-C
**12/13/19. ED Physician Note.**
**Note**: Upon assessment of the patient his blood diagnostic studies are stable with a hemoglobin of the examiner's concern is patient has had past abdominal surgeries and states he has had 7 episodes of approximately 1 cup of bright red blood. When this happened 2 years ago he ended up having a syncopal episode here in the ER and he had a ruptured diverticula that they diagnosed on a colonoscopy and had to be rushed to surgery. He also has a history of a Niesen fundoplication and states that he needs to be admitted for colonoscopy.

Ronald Chang, MD
**12/13/19. History and Physical Report.**
**Chief Complaint**: The patient presents for rectal bleed.
**History of Present Illness:** The patient with PMH hiatal hernia, fundoplication surgery, cholecystectomy 'over 30 years prior, 2016 admission for lower GI bleed post colonoscopy, that presents for concern of GI bleed. Patient states that his last episode of this occurred 3 years prior. Patient this morning had 2 episodes of bright red blood per rectum, however decided to go into work. Patient today while at work with continued episode, to the point where he was dizzy and surrounded by his coworkers. Patient reportedly total had about 6-7 episodes, last about 1 hour prior to evaluation, patient hemodynamically stable but lightheaded upon arising.
**Assessment:** 1) Rectal bleed. 2) History of 2016 bleed from left colon. 3) Hypertension. 4) Migraine. 5) Suspect orthostatic hypotension.
**Plan:** GI consult, serial Hb, Bolus 1L recommended. Clear liquid diet, suprep recommended. Blood consented.

Kenneth Lee, MD
**12/14/19. Gastroenterology Consultation Note.**
**Reason For Consultation**: The patient presents for Melena and diverticulosis.
**History of Present Illness:** The patient did have prior history of lower gastrointestinal bleeding, for which he was admitted. According to the patient, there was severe bleeding requiring blood transfusion at that time. He did undergo colonoscopy which showed diverticulosis and some submucosal bulges in the sigmoid colon with a tattoo in the area. He went to the hospital yesterday morning for work, and then developed gross hematochezia. He had multiple more episodes of gross hematochezia yesterday and overnight, which then became more maroon in color. He has been afebrile and hemodynamically stable here in the hospital. There are surgical clips in the gallbladder fossa.
**Assessment:** The patient with prior history of severe lower gastrointestinal bleeding in 2016, with colonoscopy that only showed diverticulosis and some sort of submucosal bulging area in the sigmoid colon. He now presents with recurrent bleeding, although he is hemodynamically stable with normal hemoglobin. Most likely diagnosis would be recurrent diverticular bleeding.
**Recommendations:** Colonoscopy requested. The patient needs to get more fiber in the diet. Further management will be determined based on results of colonoscopy. Continue to monitor. Follow up blood counts.

Ronald Chang, MD
12/14/19. Progress Note.
**Subjective:** The patient presents with concern of GI bleed. States that he walked to the restroom slightly lightheaded.
**Assessment:** Remains unchanged.
**Plan:** GI consult, serial Hb recommended. Hold blood pressure medications. Blood consented.

Ronald Chang, MD
12/15/19. Discharge Summary Note.
**Assessment:** 1) Rectal bleed. 2) History of 2016 bleed from left colon. 3) Hypertension. 4) Migraine. 5) Suspect orthostatic hypotension.
**Hospital Course**: The patient while hospitalized Hb remains in normal limits. Post colonoscopy, no overt bleed but noted lipomatous appearing ileocecal valve post biopsy and polyp removed. Increasing diet, at this point stable for discharged. Follow-up with PMD and GI 1-2 weeks. Stop BP and ASA meds for now in setting of GI bleed.

Gary Lai, MD
05/19/20. Progress Note.
**Subjective Complaints:** The patient has hypertension, migraine or the last 4-5 days. He has a history of migraine headaches but it has never been this bad. On the right side has mild temporary visual problems. No nausea, no vomiting. He has mild photophobia. He works as a psychiatrist, unable to work secondary to headache. Rectal Bleeding: Ruptured polyp. He was admitted to Pomona Valley Hospital Medical Center for work up and evaluation.
**Diagnoses:** 1) Hypertension. 2) Migraine.
**Plan:** He was advised to take Imitrex 50 mg. He was advised to follow up in 2-3 months or as needed. He was placed off work until 05/24/20.

Zarina Khabibulina
06/01/20. History and Physical.
**Chief Complaint:** Chest pain for one day.
**History of Present Illness:** The patient has a past medical history of hypertension, migraines ad GERD came to Emergency Department with complaints of substernal chest tightness and pressure with radiation to the left shoulder left arm and jaw for 1 hour at rest associated with nausea but no vomiting or diaphoresis. He stated that he had a cardiac catheterization about 5 or 6 years ago and he showed mild disease but no stents were placed. He was given 2 nitro and one tab of ASA at home. He denies fever, chills, cough, shortness of breath, vomiting, diarrhea, or body aches. No risk factors or symptoms suspicious for COVID at the moment. He had 1 brother die at almost 50 years old and a second brother die at 65 years old from heart attack.
**Diagnoses:** 1) Chest pain, rule out ACS versus GERD. 2) Hypokalemia. 3) Mild dehydration BUN 19, Cr 1. 0. 4) Hypertension, controlled BP 105/69. 5) History of migranes. 6) DVT prophylaxis.
**Plan:** Labs, x-ray of the chest and EKG were ordered. He was advised to take Omeprazole 20 mg, Amlodipine 5 mg, Atenolol 100 mg. Encourage PO intake.

Dr. Stanley Chou
06/01/20. Consultation Report.

**Reason For Consultation**: The patient presents for chest pain.
**History of Present Illness:** The patient presented with chest pain amongst a constellation of other symptoms including shortness of breath, inability to sleep, and loss of appetite. He reports having a coronary angiogram 4-5 years ago in the setting of chest pain and was found (6 have mild nonobstructive coronary artery disease with a 30% lesion in the left anterior descending artery.
**Assessment:** 1) Chest pain. 2) Mild nonobstructive coronary artery disease. 3) Hypertension. 4) Migraine headaches.
**Plan:** Follow up transthoracic echocardiogram. Lexiscan SPECT ordered. Continue Aspirin 81mg, lisinopril 5mg, metoprolol 12.5mg. Atorvastatin 10mg daily prescribed. Adjust anti-hypertensive medications as needed. Follow-up psychiatry evaluation.

Dr. Frank Ornelas
**06/01/20. ED Physician Documentation.**
**Reason For Consultation**: The patient presents for chest pain.
**History of Present Illness:** The patient with substernal chest tightness and pressure with radiation to the left shoulder left arm and jaw for 1 hour at rest associated with nausea. He does have a history of hypertension. There is significant family history for heart disease. Patient states he had a cardiac catheterization about 5 or 6 years ago and he showed mild disease. Currently he rates his pain as a 5/10.
**Diagnoses:** 1) Chest pain. 2) Hypokalemia.
**Medical Decision Making**: Patient required serial treatments as well. Currently patient is resting comfortably, however having chest pressure and tightness at rest for 1 hour he will require further work-up and is unstable for transfer at this time. Patient admitted to telemetry by Dr. Crudo.

Dr. Zarina Khabibulina RES/Dr. Jeffrey Crudo
**06/01/20. History and Physical Report.**
**Reason For Consultation**: The patient presents for chest pain.
**History of Present Illness:** The patient with PMH of hypertension, migraine and GERD came to ED with complaints of substernal chest tightness and pressure with radiation to the left shoulder left arm and jaw for 1 hour at rest associated with nausea. Patient stated he had a cardiac catheterization about 5 or 6 years ago and he showed mild disease.
**Assessment:** 1) Chest pain, r/o ACS VS GERD. 2) Hypokalemia 2.8. 3) Mild dehydration BUN 19, Cr 1.0. 4) Hypertension, controlled blood pressure105/69. 5) H/o migraines. 6) DVT prophylaxis.
**Plan:** Magnesium, Potassium, Metoprolol 12.5BID, Nitro PRN, ASA 81 mg, Lisinopril S mg, Atorvastatin 10 mg, Omeprozole 20 mg and Tums ordered. ECHO pending. Consult cardiology ordered. Hypokalemia: Repleated in ED with 60 Meq. Monitor blood pressure, hypokalemia, dehydration. Prescribed Prophylactic Atenolol 100 mg at home, currently on hold. BLE SCD ordered.
**Discussion:** If he stops breathing, he is OK with intubation and placed on a ventilatory machine. The patient is OK tube feedings.

Unknown Provider
**06/01/20. Mobile Intensive Care Record.**
**Chief Complaint**: The patient presents with chest pain, heavy right shoulder pain rates as 8-10/10, moderated distress. Pain woke him up from sleep.
(Handwritten report is partially illegible).

Dr. Sushma Thiruvoipati RES/Dr. Jeffrey Crudo
**06/01/20. Progress Note.**
**Subjective:** The patient reports chest pain is alleviated. The patient reported that he has had a lot of work stress.
**Assessment:** 1) Chest pain, r/o ACS VS GERD. 2) Hypokalemia 2.8> > 4.2, repleted. 3) Mild dehydration BUN 19, Cr 1.0. 4) Hypertension, controlled blood pressure 105/69. 5) H/o migraines. 6) DVT prophylaxis.
**Plan:** Cardiology and Psychiatry consult pending. ECHO pending. Metoprolol 12.5BID, Nitro PRN, ASA 81 mg, Lisinopril 5 mg, Atorvastatin 10 mg, Omeprazole 20 mg and Tums ordered. Monitor blood pressure, hypokalemia, dehydration. Prescribed Prophylactic Atenolol 100 mg at home, currently on hold. BLE SCD ordered.

Dr. Zaheib Idrees
**06/02/20. Consultation Report.**
**Plan:** Patient is in Lexiscan will follow-up 06/03/20.

Dr. Stanley Chou
**06/02/20. Consultation Report.**
**Subjective:** Lexiscan SPECT today.
**Assessment:** 1) Chest pain. 2) Mild nonobstructive coronary artery disease. 3) Hypertension. 4) Migraine headaches.
**Plan:** Follow up transthoracic echocardiogram. Follow up Lexiscan SPECT results. Continue aspirin 81mg daily, atorvastatin 10mg daily, lisinopril 5mg daily. Combine metoprolol to succinate form at 25mg daily. Follow up psychiatry evaluation.

Dr. Stanley Chou
**06/03/20. Consultation Report.**
**Assessment:** 1) Chest pain. 2) Mild nonobstructive coronary artery disease - patient reports 30% lesion in left anterior descending artery seen on coronary angiogram 4-5 years ago. 3) Hypertension. 4) Migraine headaches.
**Plan:** 1) Continue aspirin & daily. 2) Continue atorvastatin 10mg. 3) Continue metoprolol succinate 25mg.

Unknown Provider
**06/03/20. Discharge Summary Note.**
**Discharge Diagnosis:** 1) Chest pain. 2) Hypokalemia 2.8 resolved. 3) Mild dehydration, BUN 19, Cr 1.0. 4) Hypertension, controlled BP 105/69. 5) History of migraines. 6) DVT prophylaxis.
**Hospital Course**: The patient was admitted for chest pain and hypokalemia. The patient received a cardiology consultation with Dr. Chou. Potassium was replaced and hypokalemia resolved.

Zaheib Idrees, MD
**06/05/20. Consultation Report.**
**Reason for Consultation**: The patient presents for anxiety.
**History of Present Illness:** The patient was visited at bedside by this provider due to increasing anxiety and stress. The patient reports that he has been having a significant amount of stress at his work at the

Chino prison. He reports that he has been doing well there and that he enjoys his job until recent change of supervisors. He reports that the CEO has been very critical of him. He feels that the CEO has been very unfair in his criticisms, has not had an open discussion with him and this has been worsening and has been causing a lot of stress. He also reports that he overheard the CEO talking among others about wanting to remove the patient as the psychiatrist in the prison and his role as chief psychiatrist. The patient reports that ever since hearing this his anxiety has been increasing. He has been feeling restless. He has been feeling anxious and worried and has not been able to sleep. He has reached out to multiple people for a consolation and how to proceed going forward. However, this has been causing an immense amount of stress for the patient. He reports that prior to this, was doing well, tolerating stress well. He reports that if his reporting person changes to a different person other than the C&O, he feels that his anxiety will relieve.

**Assessment:** The patient admitted under the diagnosis of chest pain. His cardiac workup has been unremarkable. Psychiatry was consulted for anxiety and stress. The patient has been at the same employment at the Chino prison for over 20 years, doing well and has been serving as a chief psychiatrist for many years as well. He reports that this change has caused an immense amount of distress due to being treated unfairly. He reports he also has overheard conversations of him being removed. He also reports that his feedback has been unfair and his attempts to remedy any issues have not been successful with this individual. Since then, the patient has been endorsing high anxiety, high distress, difficulties with sleep, changes in his appetite causing physical issues, including the chest pain.

**Provisional Diagnoses:** Adjustment disorder with depressed mood and anxious distress, rule out major depression with anxious distress.

**Treatment Plan:** The patient's symptoms seem very consistent with an adjustment disorder given that if the examiner were to remove the stressor, the patient's symptoms appear will most likely resolve. Therefore, advised the patient remain off work for the next 2 months. Also, advised the patient follow up with outpatient mental health. Also, prescribed Ambien CR 6.25 mg at bedtime as needed.

Zaheib Idrees, DO
06/08/20. SOAP Note.

**History of Present Illness:** The patient was working as a Psychiatrist at the Chino State Prison. He developed chest pain and other physical signs after significant stress at work due to supervisor mistreatment of patient. He was diagnosed with adjustment disorder and asked to follow up. He reports that he feels tearful, emotional, cannot sleep, anxious. He reports that new supervisor is causing significant amount of stress and if supervisor was gone then he would be feeling back to normal. He reports no SI/HI. He reports significant lack of sleep.

**Diagnosis:** Adjustment disorder with mixed anxiety and depressed mood.

**Plan:** He was advised to continue Ambien. He had therapy referral. He was advised to follow up in one month.

Zaheib Idrees, DO
07/06/20. SOAP Note.

**History of Present Illness:** The patient was seen via telepsychiatry. He continues with similar symptoms. He reports chest discomfort, flare up of stomach ulcer, poor appetite and poor sleep, planning to see PCP. No new signs and symptoms since hospitalization but also no improvement. Ambien was ineffective. Remeron was started between appointments to which he reports minimal benefit and has no side effects.

**Assessment:** Poor response to Ambien and Remeron.
**Plan:** He can continue Remeron which can help with appetite and sleep. Start Temazepam 15 mg. He had therapy referral. He was advised to follow up in one month.

Mohamed Ali, MD
07/09/21. General Progress Note.
**History of Present Illness:** The patient The patient presents for well adult exam. His general health status is described as good. His diet is described as balanced. Exercise: occasional. Additional pertinent history: Occasional caffeine use, tobacco use none and alcohol use socially.
**Diagnoses:** 1) Prediabetes. 2) Inguinal hernia. 3) HTN (hypertension), benign.
**Plan:** ECG was ordered. He was advised General Surgery consultation. A1c 5.7, new, Will try LSM, diet/weight loss and recheck labs in 3 months. Heart rate is 58, will hold Amlodipine and recheck in 4 weeks. Refer to Surgery for hernia repair. He was doing well, up-to-date with vaccines and screening tests. Continue current treatment and return to the clinic in 3 months for routine.

Bryce Beseth
08/04/21. Surgical Consultation Report.
**Chief Complaint:** Hernia.
**History of Present Illness:** The patient has right inguinal hernia increasing in size. Bothering him especially at night.
**Diagnosis:** Robotic right inguinal hernia repair with mesh.
**Plan:** He was advised Robot assisted lap versus open right inguinal hernia repair with mesh at SARH, Right inguinal hernia. Examiner had a long discussion with him regarding the risks and benefits of Robotic surgery.

Mohamed Ali, MD
08/06/21. Progress Note.
**History of Present Illness:** The patient presents for one month follow up.
**Diagnoses:** 1) Hypertension. 2) Inguinal hernia.
**Plan:** BP/HR are much improved with taking Amlodipine off.

Bryce Beseth, MD
08/12/21. Progress Note.
**Chief Complaint:** Right inguinal hernia.
**History of Present Illness:** The patient has a right inguinal hernia. The hernia is gradually increasing in size and has been bothering him increasingly. Hernia is interfering with many of his activities. He strongly wished to proceed with surgical management.
**Assessment/Plan:** He has an enlarging right inguinal hernia. The hernia has become increasingly symptomatic. Examiner discussed the options of laparoscopic versus open repair and he wished to proceed with an open right inguinal hernia repair. Examiner spoke to him length regarding the risks and benefits of surgery. Examiner explained the risks including bleeding requiring transfusion, infection, reoperation, and damage to adjacent structures including arteries nerves, veins, intestines, spermatic cord, testicle and other structures including structures contained in the hernia sac such as large or small intestine. He understands that damage to the blood supply to the testicle can result in loss of function of the testicle and testicular loss. He understands that in some cases, chronic groin pain can develop after

surgery. He also understands that they will use mesh for the repair and that there is a chance that the mesh may become infected. He understands that if mesh infection were to occur, then reoperation for removal of mesh may be required. He agrees to proceed with open right inguinal hernia repair with mesh.

Adam Yuan, DO
08/12/21. Preoperative Note.
**Anesthesia Type:** General.

Bryce Beseth
08/19/21. Surgical Progress Note.
**Subjective:** The patient is feeling well after surgery but having back pain with radiation down the left leg. He has had this before and has gotten physical therapy but now the pain is worse. His pain in the groin is manageable. He is eating well and having normal bowel movements. He has not had any fevers, chills, nausea or vomiting.
**Assessment:** The patient is doing well. Incision well per patient. The examiner reviewed the pathology results with the patient.
**Plan:** The patient will follow-up in the office in 2 weeks for the reveal and to discuss an MRI.

Mohamed Ali, MD
11/08/21. General Progress Note.
**History of Present Illness:** The patient complaints of HA, SBP was 190, that came down to 170 with rest. Blood pressure went up while at work. He was off work x4 days, feels better.
**Associated Diagnoses:** 1) Hypertension, benign. 2) Headache.
**Plan:** Atenolol 100 mg oral tablet prescribed. Atenolol 50 mg oral tablet discontinue.

Larry Chan, DO
11/14/21. Consultation Report.
**Reason for Visit**: The patient here for chest pain.
**History of Present Illness:** The patient presents with 5 days of chest pain. He describes a 6/10 chest pressure substernally located with radiation to his neck with associated SOB. The episode is ongoing, it started when he was at rest.
**Assessment:** 1) Chest pain. 2) Hypertension. 3) Shortness of breath. 4) Palpitations. 5) Family history of CAD.
**Plan:** Recommend 2D Echocardiogram, outpatient Holter monitor and Lexiscan stress test. Further recommendations based on cardiac workup. Suboptimal control on atenolol and amlodipine. Will increase amlodipine dose and add losartan to regimen.

Abed John, MD/Kamryn Infantino, Scribe
11/14/21. ED Note.
**Chief Complaint**: The patient here for chest pain.
**History of Present Illness:** The patient presents to the ED complaints of chest pain. The patient reports with increased pain from his regular chest pain, which comes and goes. The patient reports the pain started earlier today and has progressed. The patient reports that he is under severe stress due to the family history and is very nervous about his chest pain.

**Assessment:** 1) Chest pain. 2) Hypertension.
**ED Medical Decision Making**: The patient presents with significant substernal chest pain going on for much of the day. The examiner was quite concerned about possible ACS, patient was given aspirin on arrival, nitroglycerin ordered. Discussed with the cardiologist who was evaluating the patient.
**Plan:** Continue Amlodipine 5mg and Atenolol 50mg.

Paul Razo, MD/Harshil Shukla, Scribe
**11/14/21. ED Note.**
**Chief Complaint**: The patient here for chest pain.
**History of Present Illness:** The patient presents to the ED complaints of chest pain. The patient reports experiencing non-radiating substernal CP with associated SOB for the past couple hours, intermittently radiating to the left chest, that he states feels like someone standing on his chest. The patient states his pain worsens with exertion.
**Assessment:** Same as previous visit.
**Plan:** Continue Atenolol 50mg tablet.

Rishi Talwar, MD
**11/14/21. History and Physical Note.**
**Chief Complaint**: The patient here for chest pain.
**History of Present Illness:** The patient present with hypertension presents emergency room complaining of 1 week of worsening episodes of chest pain. Sometimes associated with shortness of breath. He had similar issues 10 years ago and underwent angiogram was found to have mildly obstructive LAD and was diagnosed with stress-induced coronary spasms by cardiologist at that time. He has noticed recurrence of the symptoms over the past week, described as substernal, pressure-like, with radiation to the left and right chest.
**Assessment:** Remains the same.
**Plan:** 12 lead EKG, laboratory studies, troponins, and possible stress test in am ordered. Follow-up cardiology consultation recommended. Start labetalol resume patient's home medications.

Mansurur Khan, MD
**11/15/21. Discharge Summary Report.**
**Discharge Diagnoses:** 1) Chest pain. 2) Hypertension.
**Hospital Course**: The patient with hypertension presented with chest pain x5 days. He was admitted cardiac markers were all negative. He was seen for cardiology consultation. Lexiscan form and is negative for any reversible perfusion defects. He has been cleared for discharge. cardiology follow-up with his PCP.

Suraj Rasania, MD
**11/15/21. Physician Progress Note.**
**Assessment:** 1) Chest pain. 2) Hypertension. 3) Dyspnea. 4) Palpitations. 5) Family history of CAD.
**Plan:** Continue to trend troponin. Pending 2D echocardiogram. Full echo report is also pending. Further recommendations based on cardiac work up. Will increase amlodipine dose and add losartan to regimen. Awaiting stress findings/ final read. Recommend outpatient Holter monitor.

Sanford Weimer, MD

12/02/21. Progress Note.
**Subjective:** The patient has chest pain again, feels attacked by system unappreciated. Blood pressure elevated. The patient states mood depressed and some hesitation.
**Assessment:** 1) Depression, major. 2) Acute stress. 3) Hypertension.
**Plan:** Trazodone 50 mg prescribed. Prozack20 start up 3 days after trazodone.

Sanford Weimer, MD
12/02/21. Progress Note.
**Subjective:** Advised by lawyer to return to work. Trazodone +/- anx improved with inc certainty.
**Assessment:** Work stress anxiety.
**Plan:** Return on 01/17/22.

Larry Chan, DO
12/13/21. Progress Note.
**Chief Complaint**: The patient here to establish cardiac care as a hospital follow-up.
**Subjective:** The patient presents with 5 days of chest pain. He describes a 6/10 chest pressure substernally located with radiation to his neck with associated SOB. The episode is ongoing, episode started when he was at rest. On 12/2/21 he was sitting down and watching TV and stood up and felt dizzy. He had a syncope episode. He hit his head and required stitches at the urgent care for SARH. He checked his own blood pressure and was found to have SBP in the 170's.
**Assessment:** 1) Chest pain. 2) Essential (primary) hypertension. 3) Shortness of breath. 4) Family history of ischemic cardiac disease. 5) Syncope.
**Plan:** Recommend definitive evaluation with LHC to rule out CAD as etiology of his symptoms. Will obtain event monitor to rule out arrhythmia as etiology.
Will increase amlodipine dose and add losartan to regimen. Recommend event Holter monitor.

Dr. Larry Chan
12/13/21. Work Status Report.
**Work Status:** The patient has been under the examiner's care and was totally incapacitated from 12/13/21 to 01/03/22, as of date he is still unable to return to work.

Sanford Weimer, MD
01/17/22. Progress Note.
**Subjective:** The patient feels oppressed by newly appointed boss. Just had 3 stents placed in coronaries stressed.
**Assessment:** Work stressed.
**Plan:** Suggest demand rights from HR.

Larry Chan, DO
01/18/22. Progress Note.
**Chief Complaint**: The patient here to follow-up on LHC and event results.
**Subjective:** The patient still feels stressed at work.
**Diagnoses:** Remains unchanged.
**Plan:** Continue ASA, Brilinta, Amlodipine and Atorvastatin. Will increase amlodipine dose and add losartan to regimen.

Larry Chan, DO
03/09/22. Progress Note.
**Chief Complaint**: The patient presents for chest pain.
**Subjective:** The patient still feels stressed at work. He is having chest discomfort that he believes is due to GERD and stress. He went back to work earlier and feels even more stress at this time. He is feeling like he is going to choke in his throat. The chest pain he describes is different compared to prior to his PCI.
**Diagnoses:** Remains unchanged.
**Plan:** Will start Protonix. Continue ASA, Brilinta, Amlodipine and Atorvastatin.

Nelson Flores, Ph.D.
03/09/22. Evaluation and Management of New Patient Report.
**DOI:** 11/05/16-11/12/21; 12/01/16-12/05/21.
**Chief Complaints**: The patient has anxious and depressive symptomatology. Sleeping difficulties.
**Comprehensive History of Occupational Injury**: The patient reports that he began working for the California Institution for Men on 05/26/00 as a staff psychiatrist. He was subsequently promoted to chief psychiatrist. His regular work functions included interviewing clients, writing prescriptions, writing reports, admitting clients to the hospital, treating clients, and supervising staff members.

He remained on his feet, standing, and sitting for prolonged periods throughout his shift. He performed his regular work functions for California Institution for Men without difficulty until approximately 2016 or 2017. Around that time, he fell at work, injuring his back. He does not recall the events surrounding his fall. He reported the incident to his employer. He was referred to his employer's industrial clinic. He does not recall if he was placed on TTD or was provided with work restrictions. He continued working despite his pain. He reports that as he continued to work, with time, he experienced worsening pain in his back and legs, which he related to his prolonged standing and walking during his work shift.

He explains that he worked in four branches of the prison and would have to walk between the branches. He sought treatment at his employer's industrial clinic two or three times for his orthopedic condition. He underwent evaluations and x-rays. His pain persisted and progressively worsened. In approximately 2020, the patient began to be supervised by chief executive officer, Louie Escobell. He reports that he had worked without any problems or difficulties under psychologist, Dr. Victor Jordan, for 19 years previously. On approximately 02/20, he overheard Mr. Escobell telling the chief medical executive, Dr. Mohammad Farooq, the chief of internal medicine, Dr. Le, and others, Dr. Jordan told him, if he wants to get rid OF The patient, he need to start writing him up now. He told Dr. Jordan not now.

The patient says he felt shocked. He could not believe that Dr. Jordan would say such a thing, as he had never had any issues with Dr. Jordan previously had received only excellent performance evaluations from Dr. Jordan and considered him to be his friend. He says Mr. Escobell began asking him when he was going to retire so that he could enjoy his lovely house. He felt that he was being discriminated against based on his age. Shortly after the aforementioned incident, on 11/12/21, Mr. Escobell called the patient to his office and gave his performance evaluation and asked him to sign it. He read the evaluation in Mr. Escobell's office. He was shocked to see that Mr. Escobell and Dr. Jordan had written the evaluation. He says Dr. Jordan should not have been involved in the matter because he was

no longer his supervisor. He says he received scores of improvements needed in all categories. He felt angry, devastated, and emotionally overwhelmed he signed the evaluation and write that he did not agree with it. When he arrived home after work, he continued to feel emotionally overwhelmed. He experienced chest pain and shortness of breath. His emotional condition did not improve, and his chest pain and shortness of breath worsened to the point that two days later, he was taken by his wife to a San Antonio hospital. He underwent an angioplasty and remained in the hospital for one day.

He was prescribed medication. He was placed on TTD. On approximately later 11/21, he began psychiatric treatment on his own Dr. Weimner. He was prescribed psychotropic medication. His temporary total disability was extended. On approximately 01/10/22, he was released to return to work without restrictions. As soon as he returned to work, he continued to be exposed to a stressful and hostile work environment and incidents of harassment. In approximately late 01/22, he was again placed on TTD by his treating psychiatrist. At approximately 02/22, he began treatment with Dr. Haronia. He was referred for physical therapy. His temporary TTD was extended until approximately 03/15/22. By then, he was experiencing persisting pain, anxious and depressive symptomatology, and sleeping difficulties. Due to his mental condition, he was subsequently referred to the examiner's office for psychological evaluation and treatment.

**Current Complaints:** The patient reports feeling sad, afraid, angry, and irritable. He tends to socially withdraw from others. He has lost confidence in himself and interest in his appearance. He has a decreased motivation to do things. He has lost interest in his usual activities; he no longer enjoys these activities as he once did. At times, he feels pushed to complete tasks. He experiences crying episodes. He feels much more emotional than he once was. He has a decreased appetite and estimates that he has lost approximately ten pounds. He reports sleep difficulties due to his excessive worries and pain. He awakens throughout the night and early in the morning. He maintains a low energy level and feels easily tired throughout the day. He experiences nightmares, distressing dreams, and intrusive recollections of the events surrounding his work incidents. He reports angry outbursts. He feels nervous and tense. He has difficulty making decisions, concentrating, and remembering things. He is fearful without cause and worries excessively. He is bothered by shortness of breath, muscle tension, and chest pain and discomfort. He experiences trembling in his hands and shakiness. He feels unable to relax. He fears the worst happening, losing control, and dying. He feels pessimistic and self-critical. He has a decreased sexual desire. He reports gastrointestinal disturbances, headaches, hypertension, ringing in his ears, and chronic pain. His headaches and cardiovascular condition are exacerbated and or triggered when he feels under stress.

**Mental Health and Relevant Medical History:** The patient underwent an evaluation with the examiner on 08/12/20 related to a worker's compensation claim he filed while working for his current employer. This worker's compensation claim was related to the same type of work incidents associated with his current claim. He was diagnosed with high blood pressure when he saw Dr. Chan at the Hospital on 11/21. His high blood pressure is stable with medication. He underwent gallbladder removal surgery in approximately 1996 or earlier. He reports he fully recovered following this procedure. He underwent a heart stent placement surgery on 12/21.

**Diagnoses:** Axis I: 1). Major depression disorder, recurrent, moderate. 2). Generalized anxiety disorder. 3). Insomnia related to generalized anxiety disorder and chronic pain. 4). Stress-related physiological response affecting headaches and cardiovascular condition. Axis II: No diagnosis. Axis III: Status post orthopedic injury. Headaches, Gastrointestinal disturbances: Heartburn, stomach

discomfort and pain, and constipation. Hypertension. Cardiovascular problem. Axis IV: Health problems, occupational problems. Axis V: Current GAF Score: 51.
**Causation:** Based on the patient's history and clinical presentation, mental status examination, as well as psychological testing, and the results of the examiner's clinical evaluation of the patient, it is the examiner's opinion that more than 51% of all combined factors contributing to his current psychiatric injury are directly related to his exposure to work stress and incidents of harassment and the orthopedic injuries he sustained while at work for California Institution for Men (CT 11/05/16-11/12/21; 12/01/16-12/05/21). The examiner will address the issue of causation in detail when the patient's mental condition reaches MMI status.
**Disability:** From a psychological perspective, the patient is TTD. The examiners defer the issue of disability as it relates to the patient's orthopedic and cardiovascular conditions to the orthopedic and internal medicine fronts.
**Treatment Recommendations:** The examiner recommended cognitive behavioral group psychotherapy 1x/week for 8 weeks, and hypnotherapy/relaxation training 1x/week for 8 weeks. The examiner recommended continued treatment of the patient's orthopedic and heart conditions as indicated by Dr. Harnian and Dr. Chan. He is advised to continue treatment with his current treating psychiatrist. He is referred for internal medicine evaluation to assess the causation of his cardiovascular condition, including his hypertension. He will follow-up in 45 days.

Anshul Varshney, MD
**03/23/22. Office Visit.**
**Impression:** DES.
**Plan:** A.T 1 gtt OU QID recommendations. Return to clinic in 6 months.
(Handwritten report is partially illegible).

Samir Samarany, MD
**07/19/22. Consultation Report.**
**Reason for Consultation**: The patient complaints of chest pressure.
**History of Present Illness:** The patient presented with new episode of chest pressure in the middle of the chest at rest recurrent with associated difficulty to breathe. He recently seen his primary cardiologist in March with intermittent chest pain deemed to be related to acid reflux with initiation of Protonix. Patient is compliant with his dual antiplatelet therapy as he stated.
**Assessment:** 1) CAD status post PCI in 12/2021. 2) Hypertension. 3) GERD status post hiatal hernia surgery. 4) Typical chest pain.
**Plan:** Schedule coronary angiogram for better risk stratification and diagnosis. Continue dual antiplatelet therapy with atorvastatin for secondary prevention. Afterload reduction below 130/90 as per Sprint trial recommends. Repeat troponin x2.

Mitchell Tyler, DO
**07/19/22. ED Note.**
**Reason for Consultation/History of Present Illness:** The patient complaints of chest pressure. The patient reports that he experiences pressure over his mid- chest. He describes as someone sitting on his chest. The patient had 3 stents placed a couple months ago: 2 of them in the LAD. As of recently, the patient reports that he has been experiencing a lot of work-related stress as well as intermittent shortness of breath while sleeping at night.

**Assessment:** Chest pain.
**Plan:** Prescribed Ticagrelor (Brilinta Ticagrelor) 90mg oral tablet prescribed. Continue Amlodipine 10mg, Atorvastatin 40mg, Losartan 50mg. Stop taking Aspirin.

Mansurur Khan, MD
**07/19/22. History and Physical Report.**
**Chief Complaint**: The patient complaints of chest pain.
**History of Present Illness:** The patient presents with a history of CAD, stents x3, hypertension who presents with chest pain. He developed substernal patient. He states pain was 10/10, non-radiating and lasted 15 minutes.
**Assessment:** 1) CAD. 2) Chest pain. 3) Stented coronary artery. 4) Hypertension.
**Plan:** 12 lead EKG ordered. Cardiac diet recommended. The patient is admitted for further evaluation and treatment. Will check serial cardiac markers. The patient will be placed in a telemetry bed. Cardiology consultation is pending.

Larry Chan, MD
**07/20/22. Consultation Report.**
**Chief Complaint**: The patient states unstable angina.
**History of Present Illness:** The patient presents with 1 day of chest pain. He describes a 9/10 chest pressure substernally located with radiation to right shoulder and right arm witty associated SOB and nausea. The episode lasted for 20 minutes. The episode started when he was at rest.
**Diagnoses:** Remains unchanged.
**Plan:** Checked patient prior to conscious sedation given and agrees to proceed with conscious sedation. Continue ASA, Brilinta, amlodipine, losartan, and atorvastatin.
**Work Status:** The patient may return to work on 08/20/22 with no restrictions.

Mansurur Khan, MD
**07/20/22. Consultation Report.**
**Discharged Diagnoses:** 1) CAD. 2) Chest pain. 3) Stented coronary artery. 4) Hypertension.
**Hospital Course**: The patient with a history of CAD status post PCI in 12/2021, hypertension and GERD pain. He was admitted. Post Cath he did well and he has been cleared for discharge. He will follow-up with his cardiologist next week.

Dr. Larry Chan
**07/20/22. Work Status Report**

**Work Status:** The patient may return to work on 08/20/22 with no restrictions.

Dr. Larry Chan
07/20/22. Work Status Report.
**Work Status:** The patient may return to work on 08/20/22 with no restrictions.

Sean To, MD
**07/26/22. SOAP Note.**
**Subjective:** The patient here for checked blood pressure and labs. The patient Shas been stressed x 2

1/2 years due to work problems. The patient complaints of high blood pressure due to stress at work. Patient has 4 shots for covid.
**Assessment:** 1) Elevated blood pressure reading without diagnosis of hypertension. 2) History of appendectomy.
**Plan:** Recommended blood pressure monitoring at home. If consistent or worsens will consider blood pressure meds, monitor.

Larry Chan, DO
08/16/22. **Progress Note.**
**Chief Complaint**: The patient is here for hospital follow-up.
**Subjective:** The patient had a total of 3 episodes of chest discomfort since the PCI. This occurred when he was asleep. He states he gets SOB as well and he has to stand up to get the SOB to be resolved.
**Diagnoses:** Diagnoses are remains unchanged.
**Plan:** Will change Brilinta to Effient. Colchicine prescribed. Continue ASA, amlodipine, Losartan, and atorvastatin.

Sean To, MD
08/19/22. **SOAP Note.**
**Subjective:** The patient complaints of chest pain that wakes him up during the night. Per patient, cardio reported chest pain may be stress or anxiety related. Admits to increased stress from work. Still on disability until 09/23.
**Assessment:** 1) Hypertension. 2) Chest pain. 3) Stented coronary artery.
**Plan:** Recommends low salt diet. Continue Brilinta 90mg. Recommends follow-up with cardio. Return to clinic for physical exam 1 month. PE labs, PSA ordered. Referral to GI Dr. Abdelkarim ordered.

Basim Abdelkarim, MD
09/06/22. **Gastroenterology Consultation.**
**Chief Complaint**: CRCS.
**History of Present Illness:** The patient complaints of hypertension.
**Assessment:** 1) Colon polyps. 2) Hypertension.
**Plan:** Colonoscopy will be scheduled.

Sean To, MD
09/19/22. **SOAP Note.**
**Subjective:** The patient here for physical exam. The patient complaints of intermittent dizzy episodes. Was trying to sleep more as he had severe nausea as well. Reports nausea is exacerbated when in the car. Also reports elevated blood pressure at 165/100 and severe headaches.
**Assessment:** 1) Positional vertigo. 2) Hypertension. 3) Polyp of colon. 4) BPH. 5) Encounter for general adult medical examination without abnormal findings.
**Plan:** Recommends OTC Dramamine. Consider referral to ENT if worsens. Start Flomax 0.4mg qhs and Tamsulosin Hcl 0.4mg oral capsule. Labs ordered.

Larry Chan, DO
09/23/22. **Progress Note.**

**Chief Complaint**: The patient is here for 1 month follow-up.
**Subjective:** 2 weeks ago, the patient was getting a covid screening for his colonoscopy. Afterwards he started throwing up and his SBP was in the 160's. He still feels fatigued very easily. He feels he does not have energy to exercise. He has SOB with exertion.
**Diagnoses:** Remains unchanged.
**Plan:** Will change Brilinta to Effient. Will enroll to cardiac rehab. Continue ASA, amlodipine, losartan, and atorvastatin.

Jon Chaffee, MD/Sasha Watts, Ph.D.
10/11/22. Panel Qualified Medical Evaluation in Psychiatry.
**DOI:** CT 11/05/16- 11/12/21.
**Description of Patient/Mental Status Examination**: The patient's speech patterns were somewhat pressured. He became highly agitated when describing his work stress, and he would speak in a rapid and pressured manner. However, he was a very poor historian, and his thought processes tended to be nonlinear and ruminative. He perseverated on the same difficulties he experienced in the workplace over and over again, and he had to be redirected to the topic at hand on numerous occasions. He had significant difficulty maintaining a linear narrative due to his rumination. The patient's overall mood was anxious. He became highly agitated and anxious when describing the difficulties he experienced in the workplace.
**Current Condition**: Physical Complaints: The patient reports that he has had cardiac issues for the past two years, which he attributes to stress at work. He reports that he has been in and out of the hospital because of all the stress in the past couple of years. He first went to the hospital for chest pain on 05/20, as he recalls, shortly after 2 negative performance evaluations. He further reports that he has had four stents inserted in his heart. As he recalls, shortly after he received a negative performance evaluation. He further reports that he has had four stents inserted for blockages in his heart. As he recalls, the first three stents were inserted on 12/21. He had a fourth stent inserted approximately three months ago, and he remains off work at present secondary to his most recent surgery. He reports that he is eager to return to work, and he plans to ask his doctor to clear him to return to work at his next appointment in late October. He feels up to returning to work, and notes, "he doesn't like to stay home." Secondary to his cardiac issues. He reports that he experiences reduced energy levels. He cannot walk far before he begins to experience shortness of breath. He reports he used to walk all over the place, but now it is very hard to walk." He notes that any physical exertion at this point generally results in shortness of breath and fatigue. He reports that many years ago (approximately 50 years ago by his estimate).., he experienced migraine headaches. He states that at present, he gets headaches about three times a week, which last for about an hour or less. They occasionally interfere with his sleep. He also reports that he sometimes experiences constipation or colon irritability. He also states that he experiences, hyperacidity about four to five times a week. He takes Mylanta for the condition, which he finds effective.
**Emotional Complaints**: The patient reports that he feels more discouraged about his future than he used to. He does not derive as much enjoyment from previously enjoyed activities, and he is less interested in social contact at present. He also finds that he is more irritable, and states, he has not noticed it, but his wife does. Whenever she is talking to a patient or discussing something, he guesses he gets frustrated easily. He has more difficulty making decisions than he did in the past. He also reports that he has significant difficulty focusing and concentrating at present. He attributes his difficulties with attention and concentration to his constant rumination about work, which distracts him from the tasks at

hand. For instance, when he is watching TV, his mind will wander and he will ruminate about work, and he cannot track the program. He feels much more apathetic than he did before experiencing work stress. He states that he lacks motivation and enthusiasm for most things. Concerning social activities, he has no desire to socialize with people at present. He states that he very seldom joins his wife on social outings, such as visiting family or social get-togethers.

**Family History:** The patient reports that he was much younger than his siblings. When he was only 9 months old, one of his siblings, who was in high school and approximately 16 or 17- years old at the time, died after being hit by a bus driver at school.

**Military History**: After the applicant completed his medical internship, he worked as a physician in the military for one and one-half years.

**Medical and Mental Health History**: The patient reports he underwent a surgical procedure for an inguinal right-sided hernia. He also underwent a cholecystectomy. He states that he had some chest pain many years ago. He states that because of his hyperacidity, he sometimes experiences chest pain. He reports that shortly after he came to the United States in 1982, while working as a security guard, two individuals stabbed him as he was leaving his shift at 2.00 am and demanded money. He was transported by ambulance to California Hospital. He reports that his wounds turned out to be superficial. As he was hospitalized for three to four days.

**Discussion:** Based on the clinical interview, psychological testing, and our review of the medical records, the patient meets DSM-IV-TR criteria for an adjustment disorder with mixed anxiety and depressed mood. Regarding AOE/COE causation, based on the information available at present, the predominant cause (greater than 50%).., of the patient's psychiatric injury is his perception of a hostile work environment. A substantial portion of that (greater than 35%-40%). is personnel actions. The remaining 30% of his psychiatric injury is caused by his cardiac issues and concern about his physical health. The patient's psychiatric condition has not yet reached permanent & stationary status for rating purposes. Consequently, all issues of apportionment are deferred until his condition reaches maximum medical improvement. Concerning mental health treatment, the patient has been prescribed psychotropics on various occasions but he has only taken them for several months, per his report. He underwent once-per-month psychotherapy with Dr. Nelson Flores. However, the patient's psychiatric condition remains significant, and the examiner is recommending that he receive six months of additional and consistent mental health treatment, including a psychiatric consultation, monthly psychotropic medication sessions, and weekly psychotherapy sessions. His psychiatric condition is likely to reach permanent and stationary status in six months. The examiner recommends a re-evaluation of his psychiatric condition after he has completed the aforementioned round of treatment.

**Diagnoses:** The patient meets DSM-IV-TR criteria for an adjustment disorder with mixed anxiety and depressed mood. The patient reports feeling discouraged about the future. He does not derive as much pleasure from previously enjoyed activities. He experienced increased irritability. He has more difficulty making decisions than he did in the past. He also reports that he has significant difficulty focusing and concentrating at present. He attributes his difficulties with attention and concentration to his constant rumination about work, which distracts him from the tasks at hand. For instance, when he is watching TV, his mind will wander and he will ruminate about work, and he cannot track the program. In addition, he is often forgetful. He reports that he is so distracted by work-related issues much of the time, that he does not remember appointments and events. He further reports that he feels much more apathetic than he did before experiencing work stress. He states that he lacks motivation and enthusiasm for most things. Regarding social activities, he states that he has no desire to socialize with people at present. He very seldom joins his wife on social outings. The patient further reports that due

to his apathy, he does not engage in activities that he once did, including playing tennis and ping pong, fishing, and cooking. Concerning anxiety, as noted above, he experiences persistent rumination and perseveration around his work situation. He is anxious about the future of his work, and how things will be when he returns to the workplace. He reports that he is nervous, agitated, and tense, and he has difficulty relaxing.

**Pre-Existing Impairment:** The records from Chino Valley Medical Center indicate that the patient was prescribed Ativan and Ambien dating back to at least 02/05. Then in records from the same facility on 11/08, it was noted that the patient had a history of depression and had been prescribed Lexapro for the past three years. From that time and continuing, there is no mention of any mental health-related issues, or psychotropic medication, for over 10 years, until 01/20, he was evaluated by Dr. Nelson Flores in connection with his current claim. There is no evidence, based on the medical records, the patient has had an ongoing depressive disorder in the 10 years or so predating his current claim. The examiner does not find pre-existing impairment in this case. Should additional evidence become available, the examiner will review it and amend the examiner's opinion, if appropriate.

**Periods of Temporary Disability:** The patient has experienced no periods of temporary total or temporary partial disability on a purely psychiatric basis. It appears that he has experienced several periods of temporary disability secondary to his cardiac condition, but the examiner defer to the patient's medical specialists in that regard. At no time did the patient's psychiatric symptoms, in and of themselves, prevent him from performing his duties as a psychiatrist.

**Current Disability Status**: The patient's psychiatric condition has not yet reached permanent and Stationary status for rating purposes. He continues to experience significant psychiatric symptoms, and he has received limited mental health treatment to date. With a course of mental health treatment, including six months of individual weekly psychotherapy and psychotropic medication management, his psychiatric condition is likely to become permanent and stationary in approximately six months, or after the recommended mental health treatment is completed.

**Medical Causation:** Concerning to AOE/COE of causation, based on the information available at present, the predominant cause of 70 % of the patient's psychiatric injury is his perception of a hostile work environment while he was employed by California Institute for Men, beginning in approximately 01/20, when he came under the supervision of Dr. Louise Escobell. In remaining 30 % of the patient's psychiatric injury was caused by his cardiac issues.

**Apportionment:** The patient's psychiatric condition has not yet reached permanent and stationary status for rating purposes. Consequently, all issues of apportionment are deferred until his condition reaches maximum medical improvement.

**Comment**: Based on the medical records, it does not appear that the patient took psychotropic medication or underwent psychotherapy consistently. He continues to experience significant psychiatric symptoms at present, and he reports that he is not under the care mental health professional.

**Recommendations:** The examiner recommends an additional six months of consistent mental health treatment, including a psychiatric consultation, monthly psychotropic medication sessions, and weekly, individual psychotherapy sessions. His psychiatric condition is likely to reach permanent and stationary status in six months. The examiner recommends a re-evaluation of his psychiatric condition after he has completed the aforementioned round of treatment.

**Discussion/Final Opinion and Summary**: The patient meets DMS-TR criteria for an adjustment disorder with mixed anxiety and depressed mood. He does not meet the diagnostic criteria for a personality disorder. Concerning AOE/COE causation, based on the information available at present, the predominant cause of the patient's psychiatric injury is his perception of a hostile work environment.

A substantial portion of that (greater than 35 %-40 %). is due to personnel actions. The remaining 30 % of the patient's psychiatric injury is caused by his cardiac issues and concerns about his physical health. The patient's psychiatric condition has not yet reached permanent and stationary status for rating purposes. Consequently, all issues of apportionment are deferred until his condition reaches MMI. Concerning mental health treatment, the examiner recommends that he receive six months of additional and consistent mental health treatment including psychiatric consultation, monthly psychotropic medication sessions, and weekly, individual psychotherapy sessions. His psychiatric condition is likely to reach permanent and stationary status in six months. The examiner recommends a re-evaluation of his psychiatric condition after the has completed the aforementioned round of treatment.

Syed Tirmizi, MD
10/26/22. Panel Qualified Medical Evaluation.
**DOI:** CT: 12/01/16-12/05/21.
**Past Medical History:** The patient has a history of hypertension, diagnosed formally in the last several years, although there is a history that he was on Diovan in 2005. Records indicate that he was no longer on antihypertensive as of 2008, except for a beta-blocker for migraine prophylaxis.
**Past Surgical History:** 1). Coronary artery disease status-post PCI x4. 2). Inguinal hernia repair more than 40 years ago. 3). History of Nissen fundoplication and thoracic surgery for empyema more than 40 years ago.
**Impression:** 1). Coronary artery disease. 2). Hypertension cardiovascular disease. 3). Upper digestive tract disorder. 4). Hernia.
**Discussion:**
1). Coronary Artery Disease: The patient has been found to have coronary artery disease and has required cardiac stenting. The examiner requests these records to be sent to the examiner's attention, so the examiner may confirm the historical narrative provided by the patient to the examiner. In the absence of medical records confirming this history, this would be considered only a preliminary assessment regarding coronary artery disease. **Impairment Rating:** It is the examiner's opinion that the patient has class 2 impairment of the whole person, 20%, due to coronary heart disease. He has had coronary angioplasty; however, at this time, does not appear to have any significant use of medications to prevent angina or congestive heart failure. **Causation:** Causation is industrial. **Apportionment:** The examiner will apportion 25% to hyperlipidemia, however, the examiner will need to confirm if he was hyperlipidemic before undergoing PCI. Medical records requested. The examiner will apportion 75% to hypertension and cardiovascular disease. On this apportionment, the examiner will apportion 50 % to aggravation due to work factors and 50% to age-related factors. Therefore, 25% is non-industrial due to hyperlipidemia, 37.5 % nonindustrial due to age-related factors, and 37.5% due to aggravation of hypertension due to industrial factors.
2). Hypertensive Cardiovascular Disease: **Impairment Rating:** It is the examiner's opinion that the patient has 12 % WPI secondary to hypertensive cardiovascular disease. He has stage 1 hypertension on medications. The patient reports that he has had an echocardiogram, which does not show evidence of LVH. His echocardiogram, which the examiner reviewed, also did not show LVH. Therefore, there is no need for LVH assessment for impairment rating for hypertension. **Causation:** Causation is industrial. **Apportionment:** The examiner will apportion 50% to age-related factors due to age-related hardening of arteries, and apportion 50% to aggravation of hypertension due to industrial factors of stress at the place of his work. The patient reports that he noticed his blood pressure creeping up after the period of stress began in 2020. He was never on antihypertensive medication before; however, he is

now on Norvasc 10 mg daily. Therefore, 50% is industrial and 50% is nonindustrial. **Future Medical Care:** Future medical care for the treatment of hypertension is indicated on an industrial basis. He will require medical supervision of a doctor skilled in the treatment of hypertension semiannually and more frequently as indicated by control of blood pressure and the development of complications. He will require surveillance for the progression of disease in the form of apportion testing including, but not limited to, blood chemistries, electrocardiogram, echocardiogram, and ECG stress testing on an annual basis. He will require medication as appropriate.
3) Upper digestive tract disorder: At this time, he has no symptoms of an upper digestive tract disorder. It is the examiner's opinion at this time that without any symptoms or medication use for hiatal hernia/upper digestive tract disorder, the patient does not have a ratable upper digestive tract disorder. **Causation:** Causation is nonindustrial. **Apportionment:** The examiner finds no factors responsible for industrial apportionment. **Future Medical Care:** None required.
4) Inguinal hernia: It is the examiner's opinion that he has 0% WPI secondary to hernia. **Causation:** Causation is nonindustrial. **Apportionment:** The examiner finds no factors responsible for industrial apportionment. **Future Medical Care:** None required.

Unknow Provider
Undated. Work Status Report.
**Work Status:** The patient may return to work on 12/15/21.

James Lally, DO
**Undated. Neuro Consult Report.**
**Assessment:** 1) Suspect chronic sinusitis on cause of current HA; possible muscle contraction HA. 2) Essential Hypertension. 3) History of migraine. 4) GERD.
**Recommendations:** Treat for chronic sinusitis.
(Handwritten report is partially illegible).

James Lally, DO
**Undated. Progress Note.**
(Handwritten report is partially illegible).

Unknown Provider
**Undated. Progress Note.**
(Handwritten report is partially illegible).

Unknown Provider
**Undated. Progress Note.**
(Handwritten report is partially illegible).

Larry Chan, DO
**Undated. Work Status Report.**
**Work Status:** The patient may return to work on 12/15/21.

Unknown Provider
**Undated. Emergency Department Physician Record.**

**Chief Complaint**: The patient complaints of chest pain.
**Assessment:** 1) Chest pain. 2) Hypertension.
**Plan:** IV Heplock ordered. Cardiac monitoring ordered.
(Handwritten report is partially illegible).

**NON-MEDICAL RECORDS:**

California Correctional Health Care Services
12/01/16. Job Description
**Job Title**: Chief Psychiatrist.
**Essential Functions List**: Under the direction of the Supervisor/Manager/Designee, the Chief Psychiatrist, Correctional and Rehabilitative Services (Safety)., supervises and directs the provisions of services by Psychiatrists while providing extensive psychiatric evaluations and/or consultative services. While some functions may be performed infrequently or occasionally, the need to perform them may arise at any time with or without prior notice. Essential functions are the fundamental job duties that an employee must be able to perform, with or without reasonable accommodation. The Chief Psychiatrist, Correctional and Rehabilitative Services (Safety). must always be ready, willing, and able to perform all of the essential functions. The following skills are ones that the employee will be expected to perform as-a Chief Psychiatrist, Correctional and Rehabilitative Services (Safety). If after reviewing these essential functions Chief Psychiatrist becomes aware that he may need reasonable accommodations to successfully perform all of the essential functions of the position, he may contact either his manager/supervisor or the Return to Work Coordinator assigned to his institution/program. It is the Chief Psychiatrist's responsibility to provide necessary medical documentation to the Department as required.
**Administrative Functions**: Must be able to work several hours according to the time base at the time of hire, during any work shift as assigned, change work shift hours as assigned, respond to calls on short notice, work any post or assignment as directed, and work weekends and holidays as the needs of the institution/program dictate. Maintain regular and reliable attendance, be punctual, and complete the workday and workweek following the position requirements. Maintain certifications and licensure as required by job specification and licensing or certifying body. Perform all duties within the scope of licensure. Work in any correctional institution regardless of the level of security, acuity, or population gender including; but not limited to, inside housing units, and clinical environments. Be supervised or directed by an assigned manager or supervisor. Must be able to lead, supervise or manage staff. Maintain cooperative working relationships with members of staff, public officials, wardens, institutional and administrative staff, legal, public agencies, interested community/professional groups, inmates, and inmate families. Function professionally under highly stressful circumstances, get along well, and interact with co-workers, managers/supervisors, occasionally to frequently, in person and through electronic means of communication, professionally and courteously to accomplish common tasks. Interpret and apply appropriate laws, rules, regulations, policies, etc. to gather and provide information and respond to inquiries from within and outside the department to ensure compliance. Communicate effectively, intelligibly, and professionally, by way of verbal, written, or electronic communication, disseminate information, respond to inquiries, provide direction and training, and document appropriate information. Legibly and intelligibly document, prepare, report, and maintain clinical records of treatment of patients using word processor, spreadsheet, and database programs; write responses to client's complaints; provide medical care statistics. Inspect, observe, lock, and secure

clinical areas and medical materials. Observe and report contraband, such as weapons or Illegal drugs. Observe and report the conduct of inmates to prevent self-injurious behavior by inmates, or behavior by inmates which has or is likely to lead to injury to other inmates or staff members, when at the Institution. Work under pressure and tight deadlines. Represent the Department at formal and informal settings such as meetings, conferences, hearings, etc. Solve problems, reason, and make sound clinical judgments in patient assessment, diagnostic planning, and therapeutic planning. Comprehend, retain, integrate, synthesize, and apply information to meet departmental demands. Work independently and with minimal, or at times, no supervision. Follow verbal and written instructions. Accept appropriate suggestions and constructive criticism and if necessary, respond by modification of behavior. Manage the use of time effectively and prioritize actions to complete professional and technical tasks within expected time constraints. Exercise professional judgment and ethical behavior at all times. Possess reading and writing skills sufficient to meet departmental demands. Identify and communicate limits of one's knowledge and skills to others when appropriate. Multitask and deal with changing priorities.

**Physical Functions**: Ability to respond quickly and appropriately during an emergency. Ability to maneuver or respond quickly over varying surfaces including uneven grass, dirt areas, pavement, cement, etc., sometimes in inclement weather conditions. Responding/maneuvering can also include stairs or several flights of stairs. Maneuvering up or down. Access all floors of facilities with multiple levels separated by flights of stairs. Have and maintain sufficient strength, agility, and endurance to respond during stressful or emergency (physical, mental, and emotional). situations without compromising the health and well-being of self or others. Have the mental capacity to recall an incident to accurately document it in writing. Maintain and ensure confidentiality of all information, records, documents, concerns, issues, etc. Remain conscious, alert, and focused to effectively evaluate and respond to dangers or emergencies to maintain a safe and secure environment for self and others, and anticipate problems (e.g., harm to self or others, escapes, change in an inmate's mental functioning). Lift and carry occasionally to frequently, in the light (up to 20. pound maximum). to medium (up to a 50-pound maximum). range, from the ground to an overhead position. Push, pull, and grip occasionally too frequently to constantly. Sit and stand occasionally too frequently to continuously. Stoop, bend, kneel, reach, squat, climb, crawl, twist, and stretch, occasionally to frequently to continuously, to sufficiently inspect, observe, manipulate, and move objects 360 degrees horizontally, from the floor through overhead levels. Walk occasionally to frequently to continuously on a wide range of surfaces for varying distances, indoors or outdoors, in various weather conditions, which may become slippery due to the weather or spillage of liquids or which may be uneven or rough. Properly wear and/or all types of personal protective equipment or clothing including safety vests, eye protection, footwear, ear plugs, gloves and respirators, masks, or breathing apparatuses to prevent injury or exposure to blood and/or airborne pathogens. Work indoors or outside in direct sunlight while wearing full protective gear. Observe and react to hazards, warnings, alarms, sirens, flashing lights, voice commands, and hand signals. Be aware of safe working practices. Withstand periodic exposure to chemical agents, including cleaning agents and solvents, and excessive noise. Use fingers and hands steadily, occasionally to frequently. Use and operate common office machines/equipment including telephones, cellular telephones, photocopiers, fax machines, personal computers, laptops, keyboards, video display terminals, printers, mail machines/scales/meters. Use fingers and hands steadily, occasionally to frequently. Use and operate common office machines/equipment including telephones, cellular telephones, photocopiers, fax machines, personal computers, laptops, keyboards, video display terminals, printers, mail machines/scales/meters, calculators, and similar equipment to complete assigned duties. Attend and participate in various training courses to comply with departmental policies,

procedures, or supervisory directives, as needed or required. Safely manipulate patient-utilized equipment. Work under a variety of adverse weather conditions such as extreme heat, cold, rain, wind, and dust, possibly for extended periods. Perform required tasks in various lighting conditions, including dim or bright light. Tolerate exposure to extremely loud or chaotic environments.

12/15/21. Worker's Compensation Claim Form (DWC 1)..
**DOI:** CT: 12/01/16-12/05/21.
**Description of Injury**: The patient alleged that while working, he sustained cumulative trauma injury that began on 12/01/16 and ended on 12/05/21. He states that he sustained stress and strain due to repetitive work, and prolonged occupational exposure to industrial air pollution, causing injury.
**Claimed Injury**: Neck, shoulder, lower back, chest pain, eye, ear, other bodily system, stress and strain.

12/15/21. Application for Adjudication of Claim.
**DOI:** CT: 12/01/16-12/05/21.
**Description of Injury**: The patient alleged that while working for California Institution for Men as a Chief Psychiatrist, he sustained a cumulative trauma injury that began on 12/01/16 and ended on 12/05/21. He states stress is a strain due to repetitive work, prolonged occupational exposure to industrial air pollution, and repetitive physically traumatic activities extended over some time, the combined effect of which caused disability.
**Claimed Injury**: Neck, shoulder, lower back, chest pain, eye, ear, other bodily systems, unclassified-insufficiency, ear not specified, eye-including optic nerve, nervous system-not specified, and circulatory system heart other than a heart attack.

01/26/22. Amended Application for Adjudication of Claim.
**DOI:** CT: 12/01/16-12/05/21.
**Description of Injury**: The patient alleged that while working for California Institution for Men as a Chief Psychiatrist, he sustained a cumulative trauma injury that began on 12/01/16 and ended on 12/05/21.
**Claimed Injury**: Unclassified-insufficiency, ear not specified, eye-including optic nerve, nervous system-not specified, and circulatory system-heart-other than a heart attack.
**Amendment**: The application is amended to include the following body parts: Circulation system, digestive system, knee patella, lower extremities, hernia, and back.

01/06/23. Worker's Compensation Claim Form (DWC 1).
**DOI:** 07/19/22.
**Description of Injury**: The patient alleged that while working, he sustained a specific injury on 07/19/22. He states that he had chest pain, and he could not keep his balance, so he grabbed the desk and his secretary helped him but he twisted his knee and lower back, later he was referred to the hospital.
**Claimed Injury**: Chest, knee, and lower back.

01/12/23. Application for Adjudication of Claim
**DOI:** 07/19/22.
**Description of Injury**: The patient alleged that while working for California Institution for Men as a Chief Psychiatrist, he sustained a specific injury on 07/19/22. He states that he had chest pain, and he

could not keep his balance, so he grabbed the desk and his secretary helped him but he twisted his knee and lower back, later he was referred to the hospital.
**Claimed Injury**: Back, chest, neck, and knee patella.

01/06/23. Worker's Compensation Claim Form (DWC-1)
**DOI:** 07/19/22.
**Injury Description:** The patient had a chest pain and couldn't keep the balance, so the patient grubbed the desk and secretory helped but the patient twisted his knee and lower back, later the patient was delivered to the hospital.

01/12/23. Application for Adjudication of Claim

**DOI:** 07/19/22.
**Injury Description:** The patient alleges that while working for California Institution for men as a chief psychiatrist. The patient had a chest pain, and I couldn't keep the balance, so the patient grubbed the desk and secretory helped but the patient twisted his knee and lower back, later the patient was delivered to the hospital.
**Claimed Injury**: Back, chest, neck, and knee patella.

**MISCELLANEOUS RECORDS:**

Prescriptions, rhythm strip and patient health summary, and shipping list were reviewed but not summarized. Prescriptions and letter were reviewed but not summarized. Respiratory therapy progress notes, physician order sheets, and prescription forms were reviewed but not summarized.

The medical providers list, a notice of application, EAMS, E-cover sheet, instructions, proof of service, application verification, venue authorization, fee disclosure statement, an addendum to disclosure, declaration according to labor code section 4906(G).., request for medical treatment in the MPN, mental health 10-day letter, labs, shipping list, and attestation, fax, physician's return to work and voucher report, workers' defenders' law group, health care services, were reviewed but not summarized.

**This is the end of records review.**

## PHYSICAL EXAMINATION:

### General Appearance

A pleasant, but anxious-appearing male. He appears his stated age of 77.

Height: 5'8"
Weight: 160 pounds
BP: 129/92
Respirations: 16

Pulse: 90

**CERVICAL SPINE EXAMINATION**

Visual Inspection:

Cervical posture and lordosis are well maintained without splinting. There is no obvious deformity, spasm or loss of curvature.

Skin:

No surgical or traumatic scars or burns visible. There are no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Palpation:

He has no tenderness in the cervical spine. No splinting or spasm.

Range of motion exams were performed as the average of three measurements using a dual inclinometer technique.

| RANGE OF MOTION | RIGHT | LEFT |
|---|---|---|
| Flexion | 38, 38, 40 (60) | 38, 38, 40 (60) |
| Extension | 30, 30, 32 (45) | 30, 30, 32 (45) |
| Lateral Bending | 28, 30, 30 (45) | 32, 30, 32 (45) |
| Lateral Rotation | 42, 46, 44 (90) | 48, 46, 46 (90) |
| Spurling's Test | Negative | Negative |
| Hoffman's Test | Negative | Negative |
| Romberg | Negative | Negative |

| MOTOR | RIGHT | LEFT |
|---|---|---|
| Trapezius | 5/5 (5/5) | 5/5 (5/5) |
| Shoulder External Rotation | 5/5 (5/5) | 5/5 (5/5) |
| Shoulder Internal Rotation | 5/5 (5/5) | 5/5 (5/5) |
| Shoulder Abduction | 5/5 (5/5) | 5/5 (5/5) |
| Supraspinatus | 5/5 (5/5) | 5/5 (5/5) |
| Deltoid | 4−/5* (5/5) | 5/5 (5/5) |

| | | |
|---|---|---|
| Biceps | 4−/5* (5/5) | 5/5 (5/5) |
| Triceps | 4−/5* (5/5) | 5/5 (5/5) |
| Wrist Extensor | 4−/5* (5/5) | 5/5 (5/5) |
| Wrist Flexors | 4−/5* (5/5) | 5/5 (5/5) |
| Brachioradialis | 4−/5* (5/5) | 5/5 (5/5) |

*with giveaway weakness

| SENSORY | RIGHT | LEFT |
|---|---|---|
| Anterior Shoulder | Intact | Intact |
| Lateral Shoulder | Intact | Intact |
| Anterior Arm | Intact | Intact |
| Lateral Arm | Intact | Intact |
| Volar forearm | Intact | Intact |
| Lateral Forearm | Intact | Intact |
| Posterior Forearm | Intact | Intact |
| Thumb and index finger | Intact | Intact |
| Dorsum of Hand | Intact | Intact |
| Ulnar border of hand | Intact | Intact |

| DEEP TENDON REFLEXES | RIGHT | LEFT |
|---|---|---|
| Biceps | 3+ (2+) | 3+ (2+) |
| Brachioradialis | 2+ (2+) | 2+ (2+) |

Upper Arm Circumference Measurement

| | |
|---|---|
| Right | 27.2 cm |
| Left | 28.0 cm |

Forearm Circumference Measurement

| | |
|---|---|
| Right | 26.6 cm |
| Left | 26.0 cm |

**SHOULDER EXAMINATION**

Examination of the upper extremity reveals.

Visual Inspection:

There are no obvious gross deformities. Anatomical alignment of the shoulder (s) are well preserved.

Skin:

No surgical or traumatic scars or burns visible. There are no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Palpation:

He has no tenderness to palpation in either shoulder.

| SHOULDER | RIGHT | LEFT |
|---|---|---|
| Forward Flexion | 160 (180) | 170 (180) |
| Glenohumeral Abduction | 120 (120) | 120 (120) |
| Extension | 50 (50) | 50 (50) |
| Internal Rotation | 80 (90) | 90 (90) |
| External Rotation | 90 (90) | 100 (90) |
| Abduction | 130 (165) | 170 (165) |
| Adduction | 50 (40) | 50 (40) |
| Hawkin's Test | Minimally Positive | Negative |
| Empty Can Test | Negative | Negative |
| O'Brien's Test | Negative | Negative |
| Impingement Test | Negative | Negative |
| Speed's Test | Negative | Negative |
| Yergason's Test | Negative | Negative |
| Crank Test | Negative | Negative |
| X-over test | Negative | Negative |
| Anterior Slide Test | Negative | Negative |
| Drop Test | Negative | Negative |
| Horn Blower's Test | Negative | Negative |
| Anterior Apprehension Test | Negative | Negative |
| Posterior Apprehension Test | Negative | Negative |

| | | |
|---|---|---|
| Relocation Test | Negative | Negative |
| Scapular Winging | Negative | Negative |

**Grip Strength Testing (Jamar Dynamometer)**

Setting 2 grip strength testing in three successive trials is:

| Right Hand | Left Hand |
|---|---|
| 20, 4, 16 pounds | 40, 40, 40 pounds |

**LUMBAR SPINE EXAMINATION**

Visual Inspection:

Lumbosacral posture is well maintained without splinting. There is no obvious deformity, loss of lordosis, scoliosis, spasm or loss of curvature.

Skin:

No surgical or traumatic scars or burns visible. There are no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Gait:

Gait pattern is normal without limp. Heel toe ambulation does not increase back pain and there is no evidence of stance widening.

Palpation:

He has no tenderness in the lumbar spine to palpation.

Range of motion exams were performed as the average of three measurements using a dual inclinometer technique.

| RANGE OF MOTION | RIGHT | LEFT |
|---|---|---|
| Flexion | 68, 70, 70 (60) | 68, 70, 70 (60) |
| Extension | 22, 22, 24 (25) | 22, 22, 24 (25) |
| Lateral Bending | 22, 24, 22 (25) | 22, 20, 22 (25) |
| Lateral Rotation | 36, 36, 38 (45) | 38, 40, 38 (45) |

| | | |
|---|---|---|
| Straight leg raise @60° | Negative | Negative |
| Cross straight leg raise | Negative | Negative |
| FABER test | Negative | Negative |
| Ober test | Negative | Negative |
| SI joint | Non-tender | Non-tender |

| MOTOR | RIGHT | LEFT |
|---|---|---|
| Iliopsoas | 4--3+/5* (5/5) | 5/5 (5/5) |
| Abductors | 4--3+/5* (5/5) | 5/5 (5/5) |
| Gluteus | 4--3+/5* (5/5) | 5/5 (5/5) |
| Quadriceps | 4--3+/5* (5/5) | 5/5 (5/5) |
| Hamstrings | 4--3+/5* (5/5) | 5/5 (5/5) |
| Tibialis Anterior | 4--3+/5* (5/5) | 5/5 (5/5) |
| Peroneal | 4--3+/5* (5/5) | 5/5 (5/5) |
| Tibialis Posterior | 4--3+/5* (5/5) | 5/5 (5/5) |
| Extensor hallucis longus | 4--3+/5* (5/5) | 5/5 (5/5) |
| Gastrocnemius | 4--3+/5* (5/5) | 5/5 (5/5) |

*with giveaway weakness.

| SENSORY | RIGHT | LEFT |
|---|---|---|
| Lateral Femoral Cutaneous | Intact | Intact |
| Medial Thigh | Intact | Intact |
| Posterior Thigh | Intact | Intact |
| Lateral Calf | Intact | Intact |
| Medial Calf | Intact | Intact |
| Dorsum of Foot | Intact | Intact |
| Lateral Border of Foot | Intact | Intact |
| Sole of Foot | Intact | Intact |

| DEEP TENDON REFLEXES | RIGHT | LEFT |
|---|---|---|
| Quadriceps | 3+ (2+) | 3+ (2+) |
| Achilles | 2+ (2+) | 2+ (2+) |

Thigh Circumference Measurement

(10 cm above the superior pole patella)

| | |
|---|---|
| Right | 38.2 cm |
| Left | 38.0 cm |

Calf Circumference Measurement

| | |
|---|---|
| Right | 34.7 cm |
| Left | 34.5 cm |

**KNEE EXAMINATION**

Visual Inspection:

There are no obvious gross deformities about the knee, thigh or calf area. There is no obvious loss of muscle mass or atrophy.

Gait:

Gait pattern is normal without limp. No evidence of shortened stance phase of gait or loss of knee motion

Skin:

No surgical or traumatic scars or burns visible. There are no lacerations, abrasions, puncture wounds or skin breakdown. There is no ecchymosis or erythema.

Palpation:

He has no focal tenderness in either knee.

| KNEE EXAM | RIGHT | LEFT |
|---|---|---|
| Flexion | 144 (135) | 146 (135) |
| Extension | 0 (0) | 0 (0) |
| Anatomic Alignment | 9° | 9° |
| Varus Stress | Negative | Negative |
| Valgus Stress | Negative | Negative |
| Anterior Drawer @ 30° | Negative | Negative |
| Lachman's | Negative | Negative |
| Medial Joint Line | Non-Tender | Non-Tender |

| | | |
|---|---|---|
| Lateral joint line | Non-Tender | Non-Tender |
| Patellofemoral Joint | Non-Tender | Non-Tender |
| Apley Grind Test | Negative | Negative |
| McMurray Test | Negative | Negative |
| Effusion | Negative | Negative |

| PULSES | RIGHT | LEFT |
|---|---|---|
| Dorsalis Pedis | 2+ (2+) | 2+ (2+) |
| Posterior Tibialis | 2+ (2+) | 2+ (2+) |

**IMPRESSION AND ASSESSMENT:**

The applicant is a 77-year-old right hand-dominant male, who presents for an Orthopedic Panel QME pursuant to a claimed injury, 07/19/2022, for chest, knee, and lower back. There is also an application for Adjudication of Claim for continuous trauma injurious exposure from 12/01/2016 to 12/05/2021 for neck, shoulder, low back, chest, eye, ear, nervous system, circulatory system, heart attack, digestive system, lower extremities, and hernia. In this case, the applicant was employed as a Staff Psychiatrist at CDCR where he functioned as Chief of Staff as well as Chief of Psychiatry. A 01/06/2023 DWC form indicates that he had an injury occurring 07/19/2022. This injury was in the form chest pain. He states he developed dizziness and could not keep his balance and twisted his knee and lower back. There is no evidence of any record of this injury being reported in the record as far as I can determine. The treatment notes from that hospital admission make no notation of any musculoskeletal complaints. The applicant's treatment has largely been psychiatric and also workup for coronary artery disease. Other treatment records over the years include upper and lower gastrointestinal complaints, sinusitis, headaches and multiple work ups for chest pain and shortness of breath. My understanding is that opinions regarding those aspects of his claim have been provided. Aside from the orthopedic claims, I will not be providing any other opinions regarding other parts of the claim.

On evaluation, the applicant did have some, what I would consider to be exaggerated pain behaviors. Specifically, he had non-physiologic global weakness in his right upper and lower extremities, which I would characterize as giveaway weakness. This is important because he had initial good effort followed by giveaway weakness, which is, in my opinion, non-physiologic and represents a substantial volitional component. I would, therefore, opine that any rating methods using strength measurement are not credible measures of impairment and therefore not admissable in this case. His cervical spine examination had no pain, but some limited motion consistent with degenerative disc and facet joint disease. This is within what I would expect as normal for a 77-year-old man. His shoulder exam on the right hand side showed some limitation in abduction and forward elevation consistent with mechanical impingement. There was no evidence of rotator cuff pathology or instability. His lumbar spine

examination showed fairly well preserved range of motion, and he had no objective evidence of radiculopathy. He did have giveaway weakness in his lower extremities without any evidence of associated sensory changes or atrophy in the musculature. His knee exam bilaterally was completely normal.

There is no evidence that has been provided in this case to support the applicant's assertion of an injury on a continuous trauma or specific injury basis. There is no evidence of a fall documented in any of the paperwork that I have seen. Furthermore, his examination of his back and his knees are largely within normal limits, and I see no evidence of restricted motion, instability, or crepitance. His neck exam is consistent with degenerative disc disease. I believe that this is idiopathic given his age of 77 years. The only entry for musculoskeletal issues of any kind are X-rays of right shoulder, neck and knee and MRI of the right shoulder and knee from the 2015 time period. The office visit notes associated with these imaging studies. The results showed degenerative disc disease of the cervical spine, impingement in the right shoulder and a medial meniscus tear of the right knee. There is no documentation of treatment for these conditions.

There is no reasonable mechanism of injury which has been put forth, which I would consider to be reasonable to explain any other mechanism for his cervical spine degenerative disc disease aside from age-related degenerative changes. His shoulder examination and previous imaging studies are consistent with impingement, and there is no evidence that he had any mechanism of injury, which, in my opinion, could have caused this type of condition or pattern. His knee examination was normal and his previous imaging studies from 2015 demonstrated a degenerative medial meniscus tear. This condition is also an age-related degenerative condition that is very common in the 70+ age group. Therefore, based on the substantial medical evidence, which has been provided, the applicant's history, and his presentation, I would opine there is no evidence of any industrial injury on an orthopedic basis, which occurred throughout his employment.

**DIAGNOSES:**

1) CERVICAL SPINE DEGENERATIVE DISC DISEASE (M50.36).

2) IMPINGEMENT, RIGHT SHOULDER (M75.41).

3) MEDIAL MENISCUS TEAR RIGHT KNEE (S83.231)

**SUBJECTIVE FACTORS OF DISABILITY:**

He really has no orthopedic complaints as far as I can parse out.

**OBJECTIVE FACTORS OF DISABILITY:**

He has mildly diminished range of motion in the right shoulder, and he also has diminished range of motion in the neck. He has a medial meniscus tear on an MRI from 2015

**DISABILITY STATUS:**

MMI.

**IMPAIRMENT RATING:**

For the cervical spine, based on the limited range of motion in his cervical spine without objective evidence of radiculopathy, I would opine the applicant has a DRE category 2 impairment using table 15-5. Since his he has no pain associated with this, I would assign a 5% whole person impairment.

For the Shoulder:

Forward elevation: 160 degrees, 1% upper extremity impairment using figure 1640.
Abduction: 130 degrees, 2% upper extremity, figure 1643.
Combining yields 3% upper extremity impairment.
Converting yields 2% whole person impairment.

Right Knee:
By analogy he has the equivalent of a partial medial menisectomy using table 17-33 with an associated 1% whole person impairment

**CAUSATION/APPORTIONMENT:**

I am familiar with labor code section 4664, which indicates that "the employer shall only be liable for the percentage of permanent disability directly caused by the injury arising of and occurring in the course of his employment." In addition, "if the applicant has received prior award for permanent disability, this should be conclusively presumed that the prior permanent disability existed at the time of any subsequent industrial injury".

**Causation of Injury** – Within reasonable medical probability and based on the principles outlined in *Escobedo v. WCAB, 70 CC 604* regarding what constitutes medical causation as well as my background, training and experience as an orthopedic surgeon I would opine as follows:

There is no evidence of industrial causation for any body parts with ratable impairments. I have identified no mechanism of injury. There is no evidence to support the applicant's assertion of a specific injury on 07/19/2022. No Injury involving the musculoskeletal system was reported. Furthermore, his ongoing job duties do not require him to be doing any repetitive lifting, pushing, pulling, or overhead reaching. Therefore, based on my evaluation of his job duties in conjunction with his condition, I find no reasonable basis within reasonable medical probability to explain how his job could have contributed to these conditions. Absent any additional evidence, which is to be put forth, I would opine that these conditions are non-industrial.

**Causation of Disability** – Within reasonable medical probability and based on the principles outlined in *Escobedo v. WCAB, 70 CC 604* regarding what constitutes medical causation as well as my background, training and experience as an orthopedic surgeon I would opine as follows:

In my estimation, he has impairment without any associated disability in the neck and the shoulder. I found no evidence of disability in the lower back or either knee. Based on the evidence provided and mechanism of causation for these conditions it is my opinion that they are age-related degenerative conditions and therefore not work related.

**Apportionment** – Within reasonable medical probability and based on the principles outlined in *Escobedo v. WCAB, 70 CC 604* regarding what constitutes medical causation as well as my background, training and experience as an orthopedic surgeon.

A 100% of the applicant's impairment associated with the neck, right knee and right shoulder is non-industrial, and the basis is lack of any substantial medical evidence to support causation.

**PERIODS OF TEMPORARY TOTAL DISABILITY:**

None.

**PERIODS OF PARTIAL TEMPORARY DISABILITY:**

None.

**Functional Capacity Assessment:**

Limited, but retains MAXIMUM capacities to lift and or carry.

| | |
|---|---|
| | 10 pounds |
| | 20 pounds |
| | 30 pounds |
| | 40 pounds |

| | |
|---|---|
| | 50 or more pounds |
| X | Unlimited |

FREQUENTLY LIFT or CARRY

| | |
|---|---|
| | 10 pounds |
| | 20 pounds |
| | 30 pounds |
| | 40 pounds |
| | 50 or more pounds |
| X | Unlimited |

OCCASIONALLY LIFT or CARRY

| | |
|---|---|
| | 10 pounds |
| | 20 pounds |
| | 30 pounds |
| | 40 pounds |
| | 50 or more pounds |
| X | Unlimited |

STAND AND/OR WALK a total of:

| | |
|---|---|
| | Less than 2 hours of an 8 hour day |
| | Less than 4 hours of an 8 hour day |
| | Less than 6 hours of an 8 hour day |
| | Less than 8 hours of an 8 hour day |
| X | No restriction |

SIT a total of:

| | |
|---|---|
| | Less than 2 hours of an 8 hour day |
| | Less than 4 hours of an 8 hour day |
| | Less than 6 hours of an 8 hour day |
| | Less than 8 hours of an 8 hour |

| | |
|---|---|
| | day |
| X | No restriction |

PUSH and PULL:

| | |
|---|---|
| X | Unlimited |
| | 50 pounds maximum |

| **Activities Allowed** | Frequently | Occasionally | Never |
|---|---|---|---|
| Climbing | X | | |
| Balancing | X | | |
| Stooping | X | | |
| Kneeling | X | | |
| Crouching | X | | |
| Crawling | X | | |
| Twisting | X | | |
| Reaching | X | | |
| Handling | X | | |
| Fingering | X | | |
| Feeling | X | | |
| Seeing | X | | |
| Hearing | X | | |
| Speaking | X | | |

Environmental Restrictions:

None.

Can the applicant return to his usual and customary duties? Yes.

Work Restrictions:

None.

**QUALIFIED INJURED WORKER STATUS:**

He is not eligible for a supplemental job displacement benefit based off his Orthopedic presentation.

**ALMARAZ-GUZMAN:**

I am familiar with the Almaraz-Guzman decisions and the decision issued by the WCAB in *Almaraz v. SCIF* and *Guzman v. Milpitas Unified School District* regarding how permanent disability is to be assessed. Specifically, Labor Code 4660 (b) (1) specifically states that "the nature of the physical injury or disfigurement shall incorporate the descriptions and measurements of physical impairments and the corresponding percentages of impairments published in the AMA Guides to the Evaluation of Permanent Impairment 5th Ed".

I do not believe alternative rating methods for the neck, knees, back, or shoulders are indicated.

**TESTS REQUESTED:**

None.

**FUTURE MEDICAL CARE:**

None is indicated for any of the body parts on an industrial basis.

**SUMMARY:**

In summary, the applicant presents for a number of orthopedic conditions, which have been asserted on an application for Adjudication of Claim. I find no evidence to support the applicant's assertion of injury to any body part. His impairment in his neck and shoulder are consistent with age-related degenerative conditions, which are idiopathic.

**DISCLOSURE**

The conclusions and opinions expressed in this report were dictated by me and are mine, based on my personal evaluation of the patient and any records available to me.

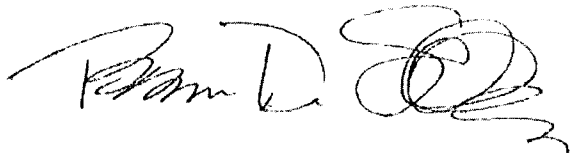
In compliance with Labor Code §4628(b), §4628G), §5703(a)(2) and Regulations 9795, I declare under penalty of perjury that the information in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, I believe it to be true.

I further declare under penalty of perjury that I personally performed the evaluation on the date and at the location stated on the face sheet of this report and that, except as stated herein, the

evaluation was performed under, and the time spent performing the evaluation was in compliance with, the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to §5307.6 of the California Labor Code.

I further declare under penalty of perjury that I have not violated the provisions of California Labor Code §139.3 with regard to the evaluation of this patient or the preparation of this report.

DATED THIS 31st DAY OF AUGUST 2023, IN LOS ANGELES COUNTY, CALIFORNIA.



**BRIAN D. SOLBERG, M.D.; Q.M.E.; F.A.A.O.S**
*Diplomate, American Board of Orthopedic Surgery*

BS/SS

State of California
DIVISION OF WORKERS' COMPENSATION – MEDICAL UNIT

AME or QME Declaration of Service of Medical - Legal Report (Lab. Code § 4062.3(i))

Case Name: ADEL HANNA v SCIF
*(employee name)* *(claims administrator name, or if none employer)*

Claim No.: 06853258 EAMS or WCAB Case No. (if any): ADJ17173512

I, ODETTE SISSI declare:
*(Print Name)*

1. I am over the age of 18 and not a party to this action.

2. My business address is: 790 Leeward Way, Costa Mesa, CA 92627

3. On the date shown below, I served the attached original, or a true and correct copy of the original, comprehensive medical-legal report on each person or firm named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

Addressee and Address Shown on Envelope:

Workers Defenders Anaheim
Natalia Foley, Esq.
751 South Weir Canyon Road, Suite 157
Anaheim, California 92808

SCIF insured Fresno
Mark Blanco
P.O Box 65005
Fresno, California 93650

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date: 08/31/2023

*(signature of declarant)* ODETTE SISSI *( print name)*

QME Form 122
Rev. February 2009