Stewart Lonky, M.D., Q.M.E.
QUALIFIED MEDICAL EXAMINER

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PANEL QUALIFIED MEDICAL EVALUATOR'S SUPPLEMENTAL REPORT IN THE SPECIALTY OF INTERNAL MEDICINE AND PULMONOLOGY

March 3, 2022

Gabrielle Akierman
SCIF
P.O. Box 65005
Fresno, CA 93650

George SooHoo
2506 Lighthouse Lane
Corona Del Mar, CA 92625

Re:	George SooHoo
Employer:	State of California Institution for Men
WCAB No.:	ADJ11815610
Panel No.:	2303154
Applicant DOB:	11/28/1953
Date of Injury:	07/06/2018
Claim No.:	06380832

My discussion begins on page 75.

Dear Parties:

I evaluated George SooHoo for a Panel Qualified Medical Evaluation, in the specialty of Internal Medicine and Pulmonology on November 14, 2018.

I have now received a request from Gabrielle Akierman, requesting I provide a supplemental report.

Therefore, I am issuing this report within 60 days required by the QME Regulations.

The entire medical file available to this physician was fully reviewed. All of the records reviewed were instrumental in this evaluator arriving at the opinions as expressed in this report. The new medical legal fee schedule, which went into effect on April 1, 2021, requires that all medical records submitted to the QME be accompanied by a declaration.

"Any documents sent to the physician for record review must be accompanied by a declaration under penalty of perjury that the provider of the documents has complied with the provisions of Labor Code section 4062.3 before providing the documents to the physician. The declaration must also contain an attestation as to the total page count of the documents provided. A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider. Any documents or records that are sent to the physician without the required declaration and attestation shall not be considered available to the physician or received by the physician for purposes of any regulatory or statutory duty of the physician regarding records and report writing."

Accordingly, if no declaration was received from a submitting party then the accompanying documents or records were not considered available and therefore were not reviewed. If the parties wish for this QME to review any records or documents which were not previously submitted with the required declaration then please visit calmedeval.com/upload, complete a declaration form there, and upload the records along with a letter requesting a supplemental report.

BILLING

This report qualifies for Procedure Code **ML-203-95** as this is a supplemental medical-legal evaluation in my capacity as the Panel Qualified Medical Evaluator.

Time spent includes:

1. Sub-rosa video review time **0.00 hours**

The number of pages reviewed are **3,334** pages.

Pages reviewed from AA: 0
Pages reviewed from ADJ: 3, 334

As you will recall, I have been serving as a Panel Qualified Medical Evaluator in internal medicine on the case of Mr. George SooHoo versus the California Institute for Men. I did initially see this gentleman in 2018 and issued a report at that time as well as a report dated June 10, 2019. I am now in receipt of medical records. The following is a review of those records and my comments.

REVIEW OF RECORDS PROVIDED BY APPLICANT

Medical records from the defense were not available to this physician. The new medical legal fee schedule, which went into effect on April 1, 2021, requires that all medical records submitted to the QME be accompanied by a declaration.

If the defense would like this QME to review any records or documents which have not been submitted with the required declaration then please visit calmedeval.com/upload, complete a declaration form there, and upload the records along with a letter requesting a supplemental report.

REVIEW OF RECORDS PROVIDED BY ADJUSTER

Approximately 3334 pages of records have been received and reviewed by the undersigned. Documents within the records that are not considered of medical importance to this practitioner may not be included in the summary though they have been reviewed in their entirety.

NON-MEDICAL RECORDS:

MEDICAL RECORDS:

Office Visit/Progress Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated July 3, 2007.

The applicant was seen for discharge and possible scratched cornea. He was seeing floaters in the left eye.

He is allergic to Atorvastatin, Calcium, and Aspirin.

On examination, his blood pressure was 119/63 mmHg and pulse rate was 73 bpm.

Assessment/Plan: Floaters, left eye, with no "RD" [retinal detachment] or "RT" [retinitis pigmentosa]. No instructions were given.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated September 7, 2007.

The applicant was requesting blood work as well as immunization. He had a history of metabolic syndrome. He was attempting diet; exercise had fallen off.

On examination, his blood pressure was 119/65 mmHg and pulse rate was 65 bpm. He weighed 198 pounds.

Assessment: 1) Essential hypertension stable. 2) Hyperlipidemia. 3) Obesity with BMI 30-39.9. 4) Elevated transaminase measurement. 5) Adult health checkup.

Laboratory studies including diabetes panel, serum creatinine, liver function panel, HIV antibody, iron and total iron binding capacity, and hepatitis chronic profile were ordered. Meningococcal vaccine was administered.

Office Visit/Progress Report, signed by Pauline Chang, O.D., Kaiser Permanente, dated October 23, 2007.

The applicant presented for an eye examination. On examination, his blood pressure was 126/81 mmHg. Assessment: 1) Myopia. 2) Astigmatism. 3) Presbyopia. 4) Nuclear cataract. Plan: Prescription as per refraction was given. Adaptation was discussed. Referral to Dr. Ghiasi, ophthalmologist, was made.

Office Visit/Progress Report, signed by Zahra Ghiasi, M.D., Kaiser Permanente, dated October 25, 2007.

The applicant was seen for glaucoma evaluation. He was using Artificial Tears on an as-needed basis. Assessment: Glaucoma suspect, per high C/D, low suspicious. IOP and CCT were normal bilaterally. As OCT machine was down, he would be scheduled for OCT/3DX and HVF. He had a history of sleep apnea, for which he was utilizing CPAP.

Progress Report, signed by Cara Abesia, R.N., Kaiser Permanente, dated November 27, 2007.

The applicant was seen for disc photography of both eyes.

Laboratory Report, Kaiser Permanente, dated January 4, 2008.

Diabetes panel showed decreased HDL at 38 with increased levels of microalbumin/creatinine at 179.5 and triglyceride at 310. Liver function panel was unremarkable, except for increased ALT at 48. Serum creatinine, glomerular filtration rate, iron, total iron binding capacity, and iron saturation were within normal limits. Hepatitis B surface antigen and hepatitis C virus antibody were negative.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated January 10, 2008.

The applicant presented for discussion of laboratory results. He had recent worsening in weight as well as cholesterol. He admitted to falling off of diet and exercise program. He also complained of bilateral hand pain with intermittent trigger in left 4th digit.

Physical Exam: He had a blood pressure of 117/68 mmHg and a pulse rate of 67 bpm. He weighed 196 pounds.

Assessment: 1) Essential hypertension. 2) Hyperlipidemia. 3) Obesity with BMI 30-39.9. 4) Elevated transaminase measurement. 5) Prediabetes. 6) Trigger finger, acquired.

Comments: He needed to get aggressive with weight loss and diet. He was to repeat fasting labs in 3 months.

Plan: Laboratory studies including diabetes panel, creatinine, ALT, fasting glucose, and serum electrolytes were ordered. Vytorin 10-20 mg, K-Tab 10 mEq, Amlodipine 10 mg, Hydrochlorothiazide 25 mg, Triamcinolone 0.025% ointment, and Triamcinolone 0.1% cream were prescribed.

Office Visit/Progress Report, signed by Pauline Chang, O.D., Kaiser Permanente, dated January 16, 2008.

The applicant was seen for an eye examination. He did not bring his old glasses. On examination, his blood pressure was 145/87 mmHg.

Assessment: 1) Myopia. 2) Astigmatism. 3) Presbyopia. 4) Nuclear cataract. 5) Fitting or adjustment of glasses or contact lenses.

Plan: There was no change in spectacle prescription. Axis for the right eye lens seemed to be off by a little bit. It was recommended that a third party check it.

On two of the lensometers, the right eye axis was off by 35 degrees. He was counseled about cataract and adaptation to new lenses. He was to follow up with ophthalmologist for glaucoma suspect.

Office Visit/Progress Report, signed by Zahra Ghiasi, M.D., Kaiser Permanente, dated January 22, 2008.

The applicant was seen in follow-up regarding glaucoma suspect with high CCT. Assessment: Glaucoma suspect, per high C/D, low suspicious. "FDT" [Frequency doubling technology] was ordered.

Office Visit/Progress Report, signed by Khang Nguyen, M.D., Kaiser Permanente, dated February 28, 2008.

The applicant had a history of obstructive sleep apnea, hyperlipidemia, obesity, hypertension, and prediabetes. He complained of bilateral hand/finger clicking with locking of left 4th ring finger. He had had trigger finger injection in the past with good results.

Physical Exam: He had a blood pressure of 126/75 mmHg and a pulse rate of 77 bpm. He weighed 196 pounds.

Assessment: 1) Essential hypertension. 2) Prediabetes. 3) Hyperlipidemia. 4) Sleep disorder/sleep apnea. 5) Dermatitis chronically to body.

Plan: Lisinopril-Hydrochlorothiazide 10-12.5 mg was prescribed. Laboratory studies including BUN, electrolytes, and fasting glucose were ordered. Weight loss was advised. Use of BiPAP was recommended. Triamcinolone cream was refilled.

Laboratory Report, Kaiser Permanente, dated March 5, 2008.

Fasting glucose was elevated at 114. BUN, creatinine, and glomerular filtration rate were normal. Electrolyte panel was unremarkable.

Office Visit/Progress Report, signed by Khang Nguyen, M.D., Kaiser Permanente, dated March 27, 2008.

The applicant presented for left middle trigger finger injection. On examination, his blood pressure was 126/68 mmHg and his pulse rate was 82 bpm. He weighed 196 pounds.

Assessment: 1) Trigger finger, acquired. 2) Essential hypertension controlled. 3) Hyperlipidemia.

Plan: An injection was administered into the left middle finger, on palmar side, at A-1 pulley. Laboratory studies including creatinine, BUN, electrolytes, fasting glucose, CBC with no differential, and urine microalbumin were ordered.

Office Visit/Progress Report, signed by Sajjadian Rofagha, M.D., Kaiser Permanente, dated August 26, 2008.

The applicant presented with rash on the face. He had a history of eczema as a child and had had dry itchy skin. He had worsened the past 2 weeks as he had used new facial cream. He noted skin burns. He was using Triamcinolone 0.1% cream.

Review of Systems: This was positive for dry skin on the legs and arms. He reported no improvement with emollients.

On examination, his blood pressure was 129/72 mmHg and pulse rate was 69 bpm. There was red, dry, and edematous skin at the face and eyelids.

Assessment: 1) Contact dermatitis. 2) Allergic dermatitis.

Plan: Desonide 0.05% topical cream, Elidel 1% topical cream, and Derma-Smoothe/FS scalp oil 0.01% topical oil were prescribed.

Office Visit/Progress Report, signed by Sajjadian Rofagha, M.D., Kaiser Permanente, dated October 21, 2008.

The applicant was seen for removal of 2 irritated lesions at scalp and left forearm. Shave biopsy was performed. Antibiotic ointment was applied to biopsy site, which was then covered with dressing. Wound care instructions were discussed. On examination, his blood pressure was 130/78 mmHg and pulse rate was 74 bpm.

Surgical Pathology Report, Kaiser Permanente, dated October 21, 2008.

Final Pathologic Diagnosis: Shave biopsy of skin from scalp and left forearm revealed seborrheic keratosis.

Laboratory Report, Kaiser Permanente, dated November 4, 2008.

Electrolyte panel was unremarkable. Creatinine and glomerular filtration rate were normal.

Office Visit/Progress Report, signed by Khang Nguyen, M.D., Kaiser Permanente, dated December 11, 2008.

Electrolyte panel was unremarkable. Creatinine and glomerular filtration rate were normal.

ECG Report, Kaiser Permanente, dated December 11, 2008.

This normal ECG revealed normal sinus rhythm. Ventricular rate was 71 bpm. PR interval was 178 ms, QRS duration 98 ms, and QT/QTc 372/404 ms. P-R-T axes were 35-17-1.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated March 24, 2009.

The applicant had a history of hyperlipidemia, high triglycerides, hypertension, and obesity. He noted gradual increase in weight. He also had ingrown nail on right big toe with recent infection in right foot. He complained of bilateral hand pain that had been present for 1 year. He had received 2 trigger injections previously, with brief benefit. He had stiffness in the bilateral 3rd proximal interphalangeal joints without significant trigger.

His medications included Cozaar 100 mg 1 tablet daily, Amlodipine 5 mg 1 tablet daily, Gemfibrozil 600 mg 1 tablet twice daily, K-Tab 10 mEq 1 tablet daily, and Hydrochlorothiazide 25 mg 1 tablet daily.

Physical Exam: His blood pressure was 121/77 mmHg and pulse rate was 65 bpm. He weighed 199 pounds.

Assessment: 1) Hyperlipidemia. 2) Essential hypertension. 3) Prediabetes. 4) Obesity with BMI of 30-39.9. 5) Elevated transaminase measurement. 6) Osteoarthritis of hand.

X-ray of the hand was requested. Laboratory studies including rheumatoid factor, ESR, uric acid, lipid panel, fasting glucose, and ALT were ordered. Simvastatin 20 mg was prescribed. Metabolic syndrome, weight loss, and exercise were discussed. He was advised to soak toe followed by antibiotic ointment to soften nail. He was to trim his nail straight.

X-rays of the Bilateral Hand, signed by Alfonso Pham, M.D., Kaiser Permanente, dated March 24, 2009.

Impression: Unremarkable study of the hands.

Laboratory Report, Kaiser Permanente, dated May 15, 2009.

Impression: Unremarkable study of the hands.

Office Visit/Progress Report, signed by Saeed Torabzadeh, M.D., Kaiser Permanente, dated July 28, 2009.

The applicant had 2 episodes of cold sweats and nausea. He denied chest pain or dizziness. He had a history of hypertension and hyperlipidemia.

Physical Exam: Cardiovascular exam revealed normal rate and regular rhythm. Heart sounds were normal. Distal pulses were intact. He had a blood pressure of 120/73 mmHg and a pulse rate of 65 bpm. He weighed 190 pounds.

Assessment: 1) Diabetes mellitus type 2, uncontrolled. 2) Essential hypertension. 3) Hyperlipidemia. 4) Obesity with BMI of 30-39.9. 5) Sleep disorder/sleep apnea.

Plan: He was willing to try diet to control the blood sugar. Laboratory studies including troponin I, CK-MB, and CBC with differential were requested. ECG was ordered.

Laboratory Report, Kaiser Permanente, dated July 28, 2009.

A CBC with differential showed high WBC at 12 and low lymphocytes % at 17.6. Troponin I and CK-MB were normal.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated July 30, 2009.

The applicant complained of excessive sweating and nausea that had been present for 1 week. He was eating okay, but felt bloated and gassy. He started Lutein approximately the same time.

Physical Exam: Abdominal exam revealed normal bowel sounds with no distention, mass, or tenderness. There was also no rebound and no guarding. His blood pressure was 131/75 mmHg and pulse rate was 64 bpm. He weighed 195 pounds.

Diagnosis: Dyspepsia.

Laboratory studies including liver function panel, CBC with differential, H. pylori IgG, urinalysis, and urine culture were ordered. Famotidine 40 mg was prescribed.

Laboratory Report, Kaiser Permanente, dated July 30, 2009.

Liver function panel was significant for elevated ALT at 45. Automated urinalysis without microscopy showed trace glucose at 50. A CBC with differential was unremarkable. H. pylori IgG was negative. Urine culture revealed no growth.

Emergency Department Provider Report, signed by Bradley Marquette, M.D., Kaiser Permanente, dated August 26, 2009.

The applicant noted sudden onset of vertigo associated with nausea and vomiting. He had some tinnitus last evening, but denied any this morning. He had a history of vertigo, but much more mild than today's experience. His symptoms were worse when moving his head or opening his eyes.

Medications: These included K-Tab 10 mEq 1 tablet daily, Hydrochlorothiazide 25 mg 1 tablet daily, Simvastatin 20 mg 1 tablet daily at bedtime, Cozaar 100 mg 1 tablet daily, Amlodipine 5 mg 1 tablet daily, Gemfibrozil 600 mg 1 tablet 2 times daily 30 minutes before breakfast and dinner, Desonide 0.05% topical cream, Elidel 1% topical cream, Derma-Smoothe/FS Scalp Oil 0.01% topical oil, and Triamcinolone 0.025% topical ointment.

Physical Exam: His blood pressure was 148/83 mmHg and pulse rate was 65 bpm. He weighed 192 pounds.

On reevaluation, he still had mild vertigo. Ativan 1 mg was given. Other orders placed included laboratory studies, IV line, Ondansetron 4 mg/2 ml injection, Lorazepam 2 mg/ml injection, and Meclizine 25 mg.

Assessment: Peripheral vertigo.

Plan: Meclizine 25 mg was prescribed.

Laboratory Report, Kaiser Permanente, dated August 26, 2009.

Random glucose was high at 177. Creatinine, glomerular filtration rate, and BUN were within normal limits. Electrolyte panel and CBC with differential were unremarkable.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated August 27, 2009.

The applicant was seen in ER yesterday for vertigo. The symptoms were consistent with benign positional vertigo. Off work order was given. He was to follow up early next week if symptoms continued.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated September 4, 2009.

The applicant complained of decreased hearing. He had benign positional vertigo symptoms, which were improving, especially in morning. He still had disequilibrium, but also improving. He noted tinnitus with whooshing sound. He underwent an audiogram with military 2 weeks ago, revealing mild hearing loss.

Physical Exam: His blood pressure was 125/73 mmHg and his pulse rate was 58 bpm. He weighed 194 pounds.

Assessment: 1) Otitis media. 2) Benign paroxysmal positional vertigo. 3) Cerumen impaction.

Amoxicillin 500 mg was prescribed.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated September 14, 2009.

The applicant continued to complain of fullness and muffled hearing in the left ear. His vertigo was slight better. He completed a course of antibiotics.

Physical Exam: Examination of the left ear revealed small amount of cerumen in the mid canal. His blood pressure was 120/73 mmHg and pulse rate was 67 bpm. He weighed 199 pounds.

Assessment: 1) Benign paroxysmal positional vertigo. 2) Hearing loss.

Referral for head and neck surgery consultation was made. Use of Sudafed as needed was recommended.

Audiology Report, signed by Debra Motz, AUD., Kaiser Permanente, dated October 1, 2009.

The applicant was seen for audiologic evaluation. He reported a sudden decrease in hearing for the left ear accompanied with vertigo and tinnitus 1 month ago.

Results: On pure tone hearing evaluation, there was mild "HF" [high-frequency] sensorineural hearing loss in the right ear and mild to severe sensorineural hearing

loss in the left ear. On speech discrimination performance, right ear was 100% at 55 dB and left ear 40% at 100 dB. On immitance measurements, type A tympanogram was suggestive of normal middle ear pressure and compliance, bilaterally.

Recommendations: Audiologic reevaluation was advised. Ear protection when exposed to loud noise levels was recommended.

Office Visit/Progress Report, signed by Annette Luetzow, M.D., Kaiser Permanente, dated October 1, 2009.

The applicant was seen for evaluation of sudden hearing loss and sudden onset of vertigo about 4 weeks ago. He went to ER on August 26, 2009, at which time he was diagnosed as having vertigo and discharged home on meclizine and exercises. He reported that meclizine made him worse and that exercises were not helpful. His vertigo was gradually improving. He was able to work and drive, but he still felt off balance. He noted no change in hearing. He had had tinnitus in the left ear since onset. He was a brigade commander in the Army. He was leaving on delayed honeymoon to Europe. He was borderline diabetic.

Physical Exam: He had a blood pressure of 117/68 mmHg and a pulse rate of 72 bpm. He weighed 192 pounds.

Assessment: Sudden hearing loss, left, with vertigo.

Plan: MRI of the brain and internal auditory canal was ordered. Intratympanic Dexamethasone injection was provided. He was to taper Prednisone as this might raise blood sugar.

Office Visit/Progress Report, signed by Annette Luetzow, M.D., Kaiser Permanente, dated October 21, 2009.

The applicant was seen for second Dexamethasone injection after sudden hearing loss and sudden onset of vertigo about 6 weeks ago. First injection was on October 1, 2009. He stopped oral steroids on his own as he did not like the way they made him feel. He was able to work and drive, but still felt off balance.

Physical Exam: His blood pressure was 121/66 mmHg and pulse rate was 91 bpm. He weighed 197 pounds.

Assessment: Sudden hearing loss, left, with vertigo.

Plan: Second Dexamethasone injection was done.

Office Visit/Progress Report, signed by Annette Luetzow, M.D., Kaiser Permanente, dated October 28, 2009.

The applicant was seen for second Dexamethasone injection after sudden hearing loss and sudden onset of vertigo about 6 weeks ago. First injection was on October 1, 2009. He stopped oral steroids on his own as he did not like the way they made him feel. He was able to work and drive, but still felt off balance.

Physical Exam: His blood pressure was 121/66 mmHg and pulse rate was 91 bpm. He weighed 197 pounds.

Assessment: Sudden hearing loss, left, with vertigo.

Plan: Second Dexamethasone injection was done.

Audiology Report, signed by Mehrnaz Karimi, AuD., Kaiser Permanente, dated November 18, 2009.

The applicant presented for repeat hearing evaluation regarding monitoring of sudden sensorineural hearing loss in the left ear. He complained of tinnitus in the left ear as well as vertigo or dizziness. He felt his left ear hearing was fluctuating.

Results: Almost same hearing thresholds on the ears since October 1, 2009. Word discrimination score had improved from 40% to 80% in the left ear since October 1, 2009. On the right ear, he primarily had normal hearing up to 3 KHz with moderate to mild sensorineural hearing loss from 4 KHz and over. "SRT" [Speech recognition threshold] was 10 dB hearing loss and "WRS" [word recognition score] was 100% at 55 dB hearing loss. On the left ear, he primarily had normal hearing up to 750 KHz with essentially severe sensorineural hearing loss from 1 KHz and over. SRT was 50 dB hearing loss and WRS was 80% at 85 dB hearing loss.

Recommendation: Hearing aid consultation after completion of treatment plan and medical clearance by Dr. Luetzow was recommended. Hearing protection when exposed to loud noises and loud music was discussed.

Office Visit/Progress Report, signed by Mehrnaz Karimi, AuD., Kaiser Permanente, dated November 18, 2009.

The applicant thought his tinnitus was less, but still present. Discrimination ability in the left ear was better. He still had occasional brief vertigo. He likely would be laid off by State.

Physical Exam: His blood pressure was 96/54 mmHg and pulse rate was 90 bpm. He weighed 200 pounds.

Assessment: 1) Sudden hearing loss. 2) High-frequency sensorineural hearing loss.

Plan: Audiogram was recommended in 4-6 weeks. Vestibular exercises were advised. He was medically cleared for hearing aid in the left ear, if desired.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated December 1, 2009.

The applicant wanted to see an "8th nerve specialist" for second opinion, preferably at USC. He was upset with delay in care. He still had vertigo, which was worse with movement. He also complained of constant tinnitus.

Physical Exam: His blood pressure was 117/70 mmHg and pulse rate was 70 bpm. He weighed 196 pounds.

Diagnosis: Sudden hearing loss.

Referral to Dr. Cueva, head and neck surgeon, was made.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated December 4, 2009.

The applicant complained of right shoulder pain that had been present for 3-4 months. There was no specific trauma. He was a dentist and had to use his upper extremity a lot.

He also reported increased vertigo and tinnitus. He was exposed to loud, high speed drill and hand piece. He had difficulty preparing for work as well as driving. He was pending second opinion with head and neck surgery department.

Physical Exam: His blood pressure was 112/67 mmHg and pulse rate was 63 bpm. He weighed 198 pounds.

Assessment: 1) Impingement syndrome of shoulder. 2) Hearing loss. 3) Tinnitus. 4) Dizziness. 5) Essential hypertension.

X-rays of the right shoulder were ordered. Losartan 25 mg was prescribed. He was to follow up with head and neck surgery department. He declined "patient disability." He was provided with shoulder handout.

X-rays of the Right Shoulder, signed by Yung Cho, M.D., Kaiser Permanente, dated December 7, 2009.

Findings: Mild inferior glenohumeral joint arthropathy with associated osteophyte formation. There was no fracture or dislocation. There was mild AC joint arthropathy with associated osteophyte formation. There was no evidence for a calcific tendinitis.

Office Visit/Progress Report, signed by Roberto Cueva, M.D., Kaiser Permanente, dated December 11, 2009.

The applicant was seen for evaluation and/or management of left-sided sudden sensorineural hearing loss. His problems began in mid to late August with onset of vertigo symptoms and left-sided tinnitus. The vertigo was thought to be benign paroxysmal positional vertigo. He was a dentist who had practiced for many years and had existing high-frequency sensorineural hearing loss with previous tinnitus. However, this tinnitus was much worse. As the dizziness persisted, he was seen in HNS on October 1, 2009. Audiogram at that time showed an asymmetric left mid to high-frequency sensorineural hearing loss with 40% "SDS" [speech discrimination score]. The right ear had a mild to moderate high-frequency sensorineural hearing loss with 100% SDS. He was scheduled to go on a trip that following Saturday and he was started on high dose Prednisone and given a Dexamethasone injection in the left middle ear. On his return about 3 weeks later, 2 more Dexamethasone injections were given 1 week apart. Follow-up audiogram had shown no significant improvement in his pure tone hearing, but a marked improvement in his SDS from 40% to 80%. MRI was done and reported as normal. He presented for a second opinion regarding his hearing loss and if there was anything more that could be done to try and restore hearing.

Review of Systems: He reported mild ongoing disequilibrium as well as left worse than right tinnitus.

Allergies: He is allergic to Lisinopril (dry cough and headaches), Atorvastatin (skin rash and/or hives), and Aspirin (wheezing).

Medications: These included Cozaar 25 mg 2 tablets daily, Gemfibrozil 600 mg 1 tablet 2 times daily 30 minutes before breakfast and dinner, K-Tab 10 mEq 1 tablet daily, Hydrochlorothiazide 25 mg 1 tablet daily, Simvastatin 20 mg 1 tablet daily at bedtime, and Amlodipine 5 mg 1 tablet daily.

Physical Exam: He was moderately obese. His blood pressure was 145/80 mmHg and pulse rate was 68 bpm.

Impression: A 56-year-old male with left sudden sensorineural hearing loss who had completed high dose Prednisone and Dexamethasone treatment. He had had a significant improvement in SDS, but not pure tone hearing. The left ear was now aidable. The disequilibrium should improve with time and rehab exercises. Tinnitus might get better on its own, but it was recommended that he get a hearing aid for the left to and likely tinnitus suppression. There was no further treatment that would hold hope for restoring hearing in his left ear.

Plan: Hearing aid was recommended. Better management of his hypertension, type II diabetes, and hyperlipidemia was discussed.

Laboratory Report, Kaiser Permanente, dated December 11, 2009.

HGB A1c was elevated at 6.7%.

Physical Therapy Initial Evaluation Report, signed by Ruth Millan, P.T., Kaiser Permanente, dated December 18, 2009.

The applicant developed right shoulder pain 3 to 4 months ago. Overall, the symptoms remained unchanged. He is right-hand dominant.

Assessment: Impaired functional mobility due to pain, limited range of motion, decreased strength, unfamiliarity with proper exercise program, and poor posture.

Treatment Plan: He was to attend therapy every other week for 12 weeks with treatment consisting of home exercise program, postural education, therapeutic exercises, and modalities. Of note, he might be deployed overseas as was in Reserve.

Office Visit/Progress Report, signed by Annette Luetzow, M.D., Kaiser Permanente, dated January 13, 2010.

The applicant had been monitored for sudden hearing loss in the left ear. He had tinnitus. He admitted to noise exposure.

Results: Audiogram revealed moderate sensorineural hearing loss in the right ear, confined mainly to highest tones. On the left, there was severe sensorineural hearing loss. Speech reception threshold was 15 dB in the right ear and 45 dB in the left ear. Word recognition was 100% at 60 dB in the right ear. On the left, word recognition was 88% at 95 dB unmasked and 76% at 95 dB with effective masking. Type A tympanogram of right ear showed acoustic reflex thresholds present; on the left, acoustic reflex thresholds were absent.

Impression: 1) Moderate sensorineural hearing loss of highest tones in the right ear. 2) Severe high-frequency sensorineural hearing loss in the left ear.

Recommendations: Audiologic reevaluation and hearing aid evaluation were recommended.

Laboratory Report, Kaiser Permanente, dated February 11, 2010.

Fasting glucose and hgbA1c were elevated at 118 and 6.7, respectively. ALT was also increased at 58. Lipid panel showed decreased HDL at 39 and increased triglyceride at 218. There were increased levels of urine microalbumin at 44.4 and microalbumin/creatinine at 47.7. PSA was normal.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated September 7, 2010.

The applicant continued with left-sided hearing loss and tinnitus. He was planning on seeing outside specialist for this. He had diabetes, which was well controlled. He had no regular exercise due to increase in work. He would travel to Texas for training exercises.

His medications included Amlodipine 5 mg 1 tablet daily, Cozaar 25 mg 2 tablets daily, Gemfibrozil 600 mg 1 tablet 2 times daily 30 minutes before breakfast an dinner, Losartan 100 mg 1 tablet daily, Potassium Chloride 10 mEq 1 tablet daily, Hydrochlorothiazide 25 mg 1 tablet daily, Simvastatin 20 mg 1 tablet daily at bedtime, and Triamcinolone 0.025% topical ointment.

Physical Exam: Examination of the skin revealed normal diabetic foot exam with normal appearance, warmth, and sensation. Pulses were present. His blood pressure was 126/73 mmHg and pulse rate was 78 bpm. He weighed 200 pounds.

Diagnoses: 1) Diabetes mellitus type 2, controlled. 2) Diabetic foot exam. 3) Sensorineural hearing loss. 4) Essential hypertension. 5) Hyperlipidemia. 6) Sleep disorder/sleep apnea. 7) Diabetes mellitus type 2 with diabetic microalbuminuria.

Diabetic foot exam was performed. Pneumococcal and Tdap vaccines were administered. Use of Amlodipine 5 mg, Hydrochlorothiazide 25 mg, Simvastatin 20 mg, and Losartan 100 mg would be continued. Daily exercise was encouraged, 5 days per week, for at least 30 minutes of walking, gardening, or cycling.

Audiology Report, signed by Rosalia Aiello, AuD., Kaiser Permanente, dated November 12, 2010.

Impression: 1) AD: Moderate sensorineural hearing loss of highest tones. 2) AS: Severe high-frequency sensorineural hearing loss.

Laboratory Report, Kaiser Permanente, dated January 11, 2011.

HgbA1c was increased at 6.7. Lipid panel revealed increased triglyceride at 189 and decreased HDL at 31. ALT and fasting glucose were elevated at 60 and 107, respectively. There were also increased levels of urine microalbumin at 72.6 and microalbumin/creatinine at 54.6. Creatinine and glomerular filtration rate were normal. Electrolyte panel was unremarkable.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated January 13, 2011.

The applicant complained of productive cough for 3 weeks. He was seen for follow-up regarding his diabetes for follow-up laboratory test studies and results. He was frustrated by inability to lose weight. He wanted to know how to get blood sugar <100 in the morning.

He complained of cough in 3 weeks, mostly in the morning, slowly improving. He has a history of asthma as a kid. He had pneumonia for 1 day and he was a non-smoker. He had some sweats.

Medications: He was currently on Norvasc 5 mg, Hydrochlorothiazide 25 mg, Zocor 20 mg, Cozaar 100 mg, Lopid 600 mg, and K-tab 10 mEq.

Vital Signs: He weighed 200 pounds and his blood pressure was 132/75 mmHg. Pulse rate was 89 bpm.

Assessment: 1) Diabetic retinopathy screening. 2) Diabetes mellitus type 2, controlled. 3) Essential hypertension. 4) Hyperlipidemia. 5) Diabetes mellitus type 2 with diabetic microalbuminuria. 6) Hearing loss, sensorineural.

Plan: Diabetic eye examination was requested. He was prescribed Metformin 500 mg. He was provided One Touch diabetic test kit.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated February 14, 2011.

The applicant was seen for follow-up regarding his laboratory test studies results.

Medications: He was currently on Norvasc 5 mg, Hydrochlorothiazide 25 mg, Zocor 20 mg, Cozaar 100 mg, Lopid 600 mg K-tab 10 mEq.

Vital Signs: He weighed 200 pounds and his blood pressure was 109/67 mmHg. Pulse rate was 82 bpm.

Assessment: 1) Diabetes mellitus type 2, controlled. 2) Essential hypertension. 3) Hyperlipidemia. 4) Diabetes mellitus type 2 with diabetic microalbuminuria. 5) Obesity. 7) Elevated Transminase measurement.

Plan: The results of the laboratory test studies were reviewed with the applicant **Office Visit/Progress Report, signed by Philip Quirk, M.D., Kaiser Permanente, dated February 21, 2011.**

The applicant was seen for a glaucoma evaluation and eye examination.

Vital Signs: His blood pressure was 128/72 mmHg and pulse rate was 79 bpm.

Impression: 1) No retinopathy. 2) No glaucoma.

Plan: He was instructed to return or follow-up in 1 year.

Laboratory Report, Kaiser Permanente, dated July 30, 2011.

The lipid panel showed decreased levels of HDL at 35 and triglyceride at 206.

The ALT was elevated at 50.

The Hgb A1C was elevated at 6.4.

The fasting blood glucose was high at 103.

The creatinine, PSA, and electrolyte panel were otherwise within normal limits.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated October 17, 2011.

The applicant was seen for medication review and flu immunization. He was seen for his routine month check. He basically admitted to decrease in diet and exercise due to increased demands of job. He was requesting medication review regarding supplements and vitamins.

Medications: He was currently on Glucophage XR 500 mg, Norvasc 5 mg, Hydrochlorothiazide 25 mg, Zocor 20 mg, Cozaar 100 mg, Lopid 600 mg, and K-tab 10 mEq.

Vital Signs: He weighed 195 pounds and his blood pressure was 134/76 mmHg. Pulse rate was 82 bpm.

Physical Examination: Normal diabetic foot examination with normal appearance, warmth, pulses present, and normal sensation with nylon fiber.

Assessment: 1) Diabetes mellitus type 2, controlled. 2) Essential hypertension. 3) Hyperlipidemia. 4) Diabetes mellitus type 2 with diabetic microalbuminuria. 5) Diabetic foot examination. 6) Prophylactic vaccine for influenza.

Plan: Diabetic foot examination was requested. He was prescribed Lofibra 160 mg and Metformin 500 mg.

Office Visit/Progress Report, signed by Hege Grande Sarpa, M.D., Kaiser Permanente, dated May 25, 2012.

The applicant was seen for his complaints of rash. He had eczema in the face and back. He was using Tac with some improvement. He had a very sensitive skin and did not use moisturizing cream.

Review of Systems: He had essential hypertension, obesity, elevated transaminase measurement, sleep disorder, sleep apnea, hyperlipidemia, and controlled diabetes mellitus type 2.

Vital Signs: His blood pressure was 109/58 mmHg and pulse rate was 89 bpm.

Assessment: 1) Eczema. 2) Dermatitis. 3) Epidermal cyst, epidermal infusion cyst.

Plan: He was prescribed Desonide 0.05% topical cream and Triamcinolone acetonide 0.1% topical cream.

Office Visit/Progress Report, signed by Diane Kim, M.D., Kaiser Permanente, dated January 22, 2013.

The applicant was seen for his complaints of cough and sinus problems. He complained of intermittent cough with clear or yellow sputum for 6 weeks. He had rhinorrhea with clear or yellow rhinorrhea. He had occasional sneezing. He had post nasal gtt. He had tried Antihistamine with partial relief and Nyquil without relief. He had subjective fevers/chills yesterday but he felt better today.

Medications: He was currently on Glucophage XR 500 mg, HCTZ 25 mg, Lofibra 160 mg, Norvasc 5 mg, Zocor 20 mg, Cozaar 100 mg, and K-tab 10 mEq.

Vital Signs: He weighed 193 pounds and his blood pressure was 116/77 mmHg. Pulse rate was 93 bpm.

Assessment: 1) Upper respiratory tract infection. 2) Examination of the foot diabetic. 3) Essential hypertension.

Plan: Diabetic foot examination was requested. Laboratory test studies were requested. He was prescribed Guaifenesin AC 10-100 mg/5 ml. Increased fluids//rest/Robitussin AC was recommended as needed.

Laboratory Report, Kaiser Permanente, dated February 10, 2013.

The lipid panel showed increased levels of triglycerides at 164 and decreased values of HDL at 38.

The fasting glucose was elevated at 104.

The Hgb A1C was 6.3.

The urine microalbumin was 27.9.

The creatinine, ALT, and electrolyte panel were otherwise within normal limits.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated February 26, 2013.

The applicant was seen for his routine follow-up. He complained of non-productive cough for 6 to 7 weeks. He complained of retiring from the military at the end of this year. He was working full time and caring for 98-year-old mother with recent hip fracture. He complained of decrease in exercise.

He started with upper respiratory infection about 6 to 7 weeks ago with persistent cough. His symptoms were mostly dry, occasionally productive, slight postnasal drip, without fever, chills, shortness of breath, and tightness.

Medications: He was currently on Glucophage XR 500 mg, HCTZ 25 mg, Lofibra 160 mg, Norvasc 5 mg, Zocor 20 mg, Cozaar 100 mg, K-Tab 10 mEq.

Vital Signs: He weighed 193 pounds and his blood pressure was 115/66 mmHg. Pulse rate was 81 bpm.

Assessment: 1) Essential hypertension. 2) Hyperlipidemia. 3) Diabetes mellitus type 2 with diabetic microalbuminuria. 4) Cough.

Plan: He was prescribed Vibra-Tabs 100 mg. He was instructed to continue with his current medications. He was cleared to decrease the HCTZ/Hydrochlorothiazide to 1/2 tablet, along with the Cozaar/Losartan to 1/2 tablet.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated June 27, 2013.

The applicant was seen for diabetes mellitus care management. He reported that since his last visit he had decrease in both Cozaar/Losartan from 100 to 50 mg and HCTZ/Hydrochlorothiazide 25 to 12.5 mg daily. He had also decreased Metformin to 500 2 times per day from 1000 mg 2 times per day. His home blood pressures was 130-135/70's. He was asymptomatic, but he was questionable regarding medications, diet program, CPAP supplies, pharmacy issues, and even complaining of injection to wrist given years ago.

Medications: He was currently on Metformin 500 mg, Cozaar 50 mg, HCTZ 25 mg, Zocor 20 mg, K-Tab 10 mEq, Norvasc 5 mg, and Lofibra 160 mg.

Vital Signs: He weighed 195 pounds and his blood pressure was 130/68 mmHg. Pulse rate was 83 bpm.

Assessment: 1) Diabetes mellitus type 2, controlled. 2) Hyperlipidemia. 3) Essential hypertension. 4) Obstructive sleep apnea.

Plan: Laboratory test studies were requested. He was prescribed Hyzaar 50-12.5 mg. he was instructed to follow-up with ophthalmology.

Laboratory Report, Kaiser Permanente, dated June 27, 2013.

The Hgb A1C was 6.2.

The lipid panel showed decreased levels of HDL at 39 and triglyceride at 231.

The ALT was otherwise within normal limits.

Progress Report, Kaiser Permanente, dated August 16, 2013.

The applicant was seen due to sleep apnea.

Impression: No diagnosis found.

Plan: He complained of machine noise and pressure not being as strong as it first was. Machine was checked and it was delivering 12/9 cm H2O as set. He was using the device every night and did not complained of EDS. HE was shown how to separate the device from the humidifier so he could travel easier with the smaller unit. He needed the back port to be able to use the device without the humidifier which would be ordered. He was given a disposable filter. He would continue CPAP use at 12/9 cm H2O, sleep hygiene and weight loss.

Laboratory Report, Kaiser Permanente, dated December 19, 2013.

The BUN was elevated at 20.

The electrolyte panel and creatinine were otherwise within normal limits.

Laboratory Report, Kaiser Permanente, dated December 19, 2013.

The Hgb A1C was 6.6.

The lipid panel showed increased levels of triglyceride at 229 and decreased levels of HDL at 39.

The ALT was otherwise within normal limits.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated December 20, 2013.

The applicant was seen for his annual physical examination. He complained of cough, postnasal drip, and productive cough for 3 weeks.

He was seen for his routine checkup. He was just retiring from military at end of this month. He continued with lower dosages of medications, and laboratory test studies were stable. He was intending to get serious with diet and exercise. He was also planning on diabetes classes.

He complained of cough for 3 weeks, with upper respiratory infection then. He has a history of allergic rhinitis. He had postnasal drip and dry cough.

He complained of hearing loss, questionably worse with increase in tinnitus.

Medications: He was currently on Hyzaar 50-12.5 mg, Glucophage XR 500 mg, Zocor 20 mg, and Norvasc 5 mg.

Vital Signs: He weighed 197 pounds and his blood pressure was 123/77 mmHg. Pulse rate was 98 bpm.

Physical Examination: Normal diabetic foot examination with normal appearance, warmth, pulses present, and normal sensation with nylon fiber.

Assessment: 1) Diabetes mellitus type 2 with diabetic microalbuminuria. 2) Essential hypertension. 3) Hyperlipidemia. 4) Bilateral hearing loss. 5) Obstructive sleep apnea. 6) Obesity, BMI 30-34.9, adult. 7) Routine adult health checkup examination. 8) Cough.

Plan: Diabetic foot examination was requested. He was prescribed Metformin 500 mg. he was overall stable.

Emergency Department Provider Report, signed by Ali Ghobadi, M.D., Kaiser Permanente, dated March 31, 2014.

The applicant was seen for his complaints of left rib pain. He had a sudden left rib pain after a severe cough attack about one hour ago. He had "post nasal drip" and cough with yellow sputum for about 5 days, getting worse tonight, getting frequent bursts of cough attacks, he had a sudden episode and coughed very hard and felt a sudden severe pain to left rib (located just lateral to left nipple near the axillary area), since then got a spasm every time he coughed or moved in certain way or if pushed on that area.

Vital Signs: He weighed 195 pounds and his blood pressure was 153/89 mmHg. Pulse rate was 73 bpm.

Physical Examination: Pulmonary examination showed wheezing.

Assessment: 1) Cough. 2) Rib contusion.

Plan: He was prescribed Albuterol inhaler, Z pack, and Hydromet. He was instructed to follow-up with his primary care physician in 1 to 2 days for recheck. X-rays of the left ribs was requested.

X-rays of the left Rib with Chest PA, signed by Alfonso Pham, M.D., Kaiser Permanente, dated March 31, 2014.

Impression: A single view of the chest and multiple views of the ribs were obtained. No fracture identified. Bony structures were within normal limits. Poor inspiration film noted, which might explained exaggeration of mild bihilar lung markings.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated April 24, 2014.

The applicant was seen for his complaints of abdominal pain. He had a chest wall contusion on March 31 with negative x-rays. He had left-sided chest wall pain, improving, without rash at the affected area. He complained of rash, itchy, left upper back, with rare use of Kenalog cream as needed.

Medications: He was currently on Glucophage XR 500 mg, Zocor 20 mg, Norvasc 5 mg, and Lofibra 160 mg.

Vital Signs: He weighed 198 pounds and his blood pressure was 114/69 mmHg. Pulse rate was 76 bpm.

Physical Examination: Pulmonary examination showed minimal left lower chest wall tenderness, but very slight.

Assessment: 1) Diabetes mellitus type 2 with diabetic microalbuminuria. 2) Chest wall muscle strain. 3) Atopic dermatitis.

Plan: He was prescribed Temovate 0.05% topical cream. He was provided refill prescriptions without changes.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated June 17, 2014.

The applicant complained of low back pain status post motor vehicle accident on June 12, 2014.

He complained of struck on passenger side of Tesla, by Ford Fusion, without air bags, but seat belts. He recalled right hip and right anterior chest pain at scene, with stiffness in the morning, slowly improving and treating with Jacuzzi. He had no work since due to limited range of motion, stiffness. He had no medical evaluation yet. He was currently on Tylenol for pain.

Medications: He was currently on Glucophage XR 500 mg, Hyzaar 50-12.5 mg, Zocor 20 mg, Norvasc 5 mg, and Lofibra 160 mg.

Vital Signs: He weighed 197 pounds and his blood pressure was 123/68 mmHg. Pulse rate was 69 bpm.

Assessment: 1) Left trapezius strain. 2) Diabetes mellitus type 2 with diabetic microalbuminuria. 3) Essential hypertension. 4) Hyperlipidemia. 5) Chest wall contusion. 6) Lumbosacral joint sprain. 7) Neck muscle strain.

Plan: He was referred to physical therapy/occupational therapy. He was instructed to return for follow-up in 7 days.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated June 24, 2014.

The applicant complained of muscle strain, left trapezius muscle strain for follow-up care.

He was seen for follow-up regarding his neck strain, motor vehicle accident on June 12. His symptoms were improving, and even back to work in administrative role. He continued with neck, left trap and low back pain, but without radiculopathy. He was unable to get in with physical therapy until mid-July.

Medications: He was currently on Glucophage XR 500 mg, Hyzaar 50-125 mg, Zocor 20 mg, Norvasc 5 mg, and Lofibra 160 mg.

Vital Signs: He weighed 197 pounds and his blood pressure was 121/70 mmHg. Pulse rate was 66 bpm.

Physical Examination: Pulmonary examination showed slightly tender over the left lower SCM.

Assessment: 1) Neck muscle strain. 2) Left trapezius strain. 3) Lumbosacral joint sprain.

Plan: He was placed on modified duties. He was instructed to continue with current treatment regimen and he was expected to full recovery.

Office Visit/Progress Report, signed by Sepideh Mirfakhraie, M.D., Kaiser Permanente, dated July 8, 2014.

The applicant complained of back pain for 1 day. He was in a car accident 2 weeks ago. His back pain was currently rated 7/10 and was very stiff. He was taking Ibuprofen for pain. He was refusing stronger pain medications. He was currently on modified duties but he was not able to do his job due to back pain.

Medications: He was currently on Temovate 0.05% topical cream, Glucophage XR 500 mg, Hyzaar 50-12.5 mg, Norvasc 5 mg, and Lofibra 160 mg.

Review of Systems: he had back pain.

Vital Signs: He weighed 196 pounds and his blood pressure was 132/68 mmHg. pulse rate was 76 bpm.

Assessment: 1) Cause of injury, motor vehicle accident, car driver injured in collision with car, nontraffic. 2) Accident. 3) Back pain.

Plan: He was placed off work.

Physical Therapy Initial Evaluation, signed by George Stablein, P.T., Kaiser Permanente, dated July 14, 2014.

The applicant had a good rehabilitation potential. He had showed improved pain level to 0/10. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated July 21, 2014.

The applicant complained of tightness in his hamstrings. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated July 28, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated August 11, 2014.

The applicant had 50% improvement. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated August 18, 2014.

The applicant complained of pain rated 2/10. He felt stronger less pain. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated August 26, 2014.

The applicant complained of pain rated 1/10. He felt stronger less pain. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated September 2, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Office Visit/Progress Report, signed by Robert Langer, M.D., Kaiser Permanente, dated September 8, 2014.

The applicant was seen for follow-up regarding his atopic dermatitis facial upper extremity. He noted that the Triamcinolone Acetonide did not help better with Clobetasol.

Review of Systems: He had cyst in the neck.

Vital Signs: He weighed 190 pounds and his blood pressure was 134/83 mmHg. Pulse rate was 70 bpm.

Assessment: 1) Atopic dermatitis. 2) Epidermal cyst.

Plan: He was referred to HNS. He was prescribed Temovate 0.05 % topical cream, Atarax 10 mg, and Desonide 0.05% topical ointment.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated September 22, 2014.

The applicant complained of pain rated 4/10 at worse. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated September 29, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated October 7, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated October 13, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated October 20, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated October 27, 2014.

The applicant complained of pain rated 6/10 at worse. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated November 3, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated November 17, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated December 1, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated December 15, 2014.

The applicant complained of pain rated 3/10 at worse. He indicated that his back was feeling fine. He had left upper trapezius pain. He had undergone therapeutic exercises.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated December 22, 2014.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Laboratory Report, Kaiser Permanente, dated January 3, 2015.

The lipid panel showed increased levels of triglycerides at 241.

The Hgb A1C was elevated at 6.9.

The urine microalbumin was elevated at 178.3 and the microalbumin/creatinine was high at 86.6.

The ALT and uric acid were otherwise within normal limits.

Physical Therapy Progress Report, signed by George Stablein, P.T., Kaiser Permanente, dated January 5, 2015.

The applicant was seen for therapy.

Diagnoses: 1) Left trapezius strain. 2) Lumbosacral joint sprain. 3) Neck muscle strain.

Interventions include modalities and therapeutic exercise.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated March 12, 2015.

The applicant was seen for follow-up regarding his diabetes mellitus and diabetic foot exam. He had a slightly worsening in A1C. He had a stable proteinuria and chronic kidney disease 2, and increase in weight.

He had intermittent low back pain, history of physical therapy in the past. He kne his exercises but he was not doing it.

Medications: He was currently on Triglide 160 mg, Hyzaar 50-12.5 mg, Glucophage XR 500 mg, Zocor 20 mg, and Norvasc 5 mg.

Vital Signs: He weighed 201 pounds and his blood pressure was 133/53 mmHg. Pulse rate was 83 bpm.

Physical Examination: Normal diabetic foot examination with normal appearance, warmth, pulses present, and normal sensation with nylon fiber.

Assessment: 1) Severe obesity equivalent, BMI 35-35.9, adult with co-morbidity. 2) Diabetes mellitus type 2 with diabetic microalbuminuria. 3) Essential hypertension. 4) Hyperlipidemia. 5) Diabetes mellitus type 2 with diabetic

chronic kidney disease stage 2 (GFR 60-89). 6) Family history of colon cancer <50 years. 7) Low back pain.

Plan: Diabetic foot examination was requested. He was provided refill prescriptions for his medications. He was instructed to restart his low back exercises.

Laboratory Report, Kaiser Permanente, dated May 23, 2015.

The Hgb A1C was 6.8.

The ferritin was elevated at 506.

The BUN was elevated at 20.

The TSH, CBC, iron and TIBC, creatinine, ALT, and electrolyte panel were otherwise within normal limits.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated May 29, 2015.

The applicant was seen for follow-up regarding his laboratory test studies results review. He had a slight decrease in blood pressure. He had increased exercise. He was asymptomatic.

Medications: He was currently on Hyzaar 50-12.5 mg, Glucophage XR 500 mg, Zocor 20 mg, Triglide 160 mg, and Norvasc 5 mg.

Vital Signs: He weighed 196 pounds and his blood pressure was 128/73 mmHg. Pulse rate was 76 bpm.

Assessment: 1) Diabetes mellitus type 2 with diabetic microalbuminuria. 2) Essential hypertension. 3) Hyperlipidemia. 4) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 (GFR 60-89).

Plan: He was instructed to continue with his current medications. He was instructed to return for follow-up in 6 months.

Laboratory Report, Kaiser Permanente, dated June 29, 2015.

The lipid panel showed increased levels of cholesterol at 209, triglyceride 378, and CHOL/HDL at 5.4 and decreased levels of HDL at 39.

The Alt was otherwise within normal limits.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated July 2, 2015.

The applicant was seen for follow-up regarding the lump over his left axillary area without obvious change but felt smaller now. He discontinued Simvastatin and Fenofibrate 4 to 5 weeks ago.

Medications: He was currently on Norvasc 5 mg, Hyzaar 50-12.5 mg, and Glucophage XR 500 mg.

Vital Signs: He weighed 196 pounds and his blood pressure was 138/72 mmHg. Pulse rate was 66 bpm.

Assessment: 1) Hyperlipidemia. 2) Myalgia. 3) Diabetes mellitus type 2 with diabetic microalbuminuria. 4) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 (GFR 60-89). 5) Seborrheic dermatitis.

Plan: He was provided refill prescriptions for his medications. He was instructed to continue with his other medications.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated October 5, 2015.

The applicant had flu like symptoms for 10 days. He had productive cough.

Medications: He was on Losartan-hydrochlorothiazide 50-12.5 mg, Metformin 500 mg, Amlodipine 5 mg, and Simvastatin 20 mg.

Vital Signs: He had a blood pressure of 124/53 mmHg with pulse rate of 75 bpm. He weighed 195 pounds.

On examination, he had diffuse rhonci and wheezing.

Assessment: 1) Bronchitis. 2) Atopic dermatitis. 3) Reactive airway disease. 4) Eczema. 5) Abnormal sputum.

Plan: He was prescribed Albuterol 90 mcg/act, Beclomethasone 80 mcg/act, Azithromycin 250 mg, and Desonide 0.05%.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated December 10, 2015.

The applicant complained of various pots. He also complained of a lump in his right armpit for 5 years or more that was progressively enlarging and with intermittent tenderness.

He also complained of bumps on his scalp with occasional itching.

He complained of itchy rash in his face for at least 6 months.

Ultrasound of the Left Axilla Non-vascular, signed by Alfonso Pham, M.D., Kaiser Permanente, dated December 16, 2015.

Impression: Lymph node visualized.

Laboratory Report, Kaiser Permanente, dated December 30, 2015.

The creatinine and BUN were within normal limits.

MRI of the Left Axilla with/without Contrast, signed by Michael Kabiri, M.D., Kaiser Permanente, dated January 11, 2016.

Impression: No significant abnormality.

Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated January 20, 2016.

The applicant was seen in follow-up regarding itchy rash.

Medications: These included Hydrocortisone 2.5% topical ointment, Clindamycin 1% topical gel, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg, Amlodipine 5 mg, and Simvastatin 20 mg.

Objective: His blood pressure was 138/80 mmHg and pulse rate was 78 bpm. He weighed 190 pounds.

Assessment: 1) Dermatitis possibly secondary to disperse blue dye 106, less favor gold. 2) Lipoma in right axilla.

Plan: Hydrocortisone 2.5% topical cream was prescribed. He was advised to change clothing color palette and discontinue gold chair. He might consider surgery for lipoma in the future.

Office Visit/Progress Report, signed by Jeff Tracy, M.D., Kaiser Permanente, dated March 1, 2016.

The applicant complained of numbness in the distal right hand with Flick's sign. He worked as a dentist. He also noted left 2nd digit swelling and pain with decreased range of motion. He had a history of trigger finger injections. He reported experiencing stress.

Physical Exam: His blood pressure was 127/63 mmHg and pulse rate was 76 bpm. He weighed 187 pounds.

Diagnoses: 1) Paresthesia. 2) Eye exam, fundus photography screening. 3) Hyperlipidemia. 4) Diabetes mellitus type 2 with diabetic microalbuminuria. 5) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 6) Essential hypertension. 7) Screening for diabetic foot disease, category 0 – normal diabetic foot. 8) Grief reaction. 9) Caregiver stress.

Diabetic foot exam was doe. Fundus photography was ordered. He declined injection. He was counseled regarding grief.

Office Visit/Progress Report, signed by Alan Evans, M.D., Kaiser Permanente, dated April 14, 2016.

The applicant wanted to change primary care physician. He declined digital retinal photos; he would see ophthalmologist soon. He was a dentist, working in military. His mother was sick recently and hospitalized after stroke and pneumonia. He stopped Simvastatin as a pharmacist told him it was dangerous. He wanted to stop all medicine.

His medications included Clindamycin 1% topical gel, Hydrocortisone 2.5% topical ointment, Hydrocortisone 2.5% topical cream, Albuterol 90 mcg/actuation inhaler, Beclomethasone 80 mcg/actuation aero, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg, Amlodipine 5 mg, and Clobetasol 0.05% topical cream.

On examination, his blood pressure was 130/69 mmHg and pulse rate was 72 bpm. He weighed 184 pounds.

Assessment: 1) Diabetes mellitus type 2 with diabetic microalbuminuria. 2) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 3) Obesity with BMI of 32-32.9, adult.

Plan: Diet and exercise were discussed. Laboratory studies including hgbA1c, lipid panel, urine microalbumin, creatinine, electrolyte panel, ALT, and TSH were ordered. Use of medications would be continued. Lovastatin 20 mg was prescribed.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated May 13, 2016.

The applicant presented to establish care. He was generally feeling well. He had no chest pain or shortness of breath. He was active and trying to lose weight.

His medications included Metformin 500 mg 1 tablet 2 times per day, Lovastatin 20 mg 1 tablet daily with evening meal, Losartan-Hydrochlorothiazide 50-12.5 mg 1 tablet daily, and Amlodipine 5 mg 1 tablet daily.

Objective: His blood pressure was 121/70 mmHg and pulse rate was 76 bpm. He weighed 182 pounds.

Assessment: 1) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 2) Obesity with BMI of 32-32.9, adult. 3) Hyperlipidemia. 4) Essential hypertension. 5) Severe obesity equivalent, BMI 35-35.9, adult, with co-morbidity. 6) Adult obstructive sleep apnea. 7) Screening exam for prostate cancer. 8) Diabetes mellitus type 2 with diabetic microalbuminuria.

Laboratory Report, Kaiser Permanente, dated May 15, 2016.

Lipid panel was significant for increased triglyceride at 265. Urine microalbumin and microalbumin/creatinine were elevated at 163.4 and 106.3, respectively. HgbA1c, creatinine, glomerular filtration rate, ALT, and TSH were normal. Electrolyte panel was unremarkable.

Laboratory Report, Kaiser Permanente, dated May 15, 2016.

A CBC with differential revealed decreased levels of RBC at 4.58 and hematocrit at 41.3. PSA was normal.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated June 20, 2016.

The applicant was seen for discussion of laboratory results. He tried Lovastatin 40 mg, but he developed muscle pain. He was tolerating the 20 mg well.

His medications included Clopidogrel 75 mg 1 tablet daily, Lovastatin 40 mg 1 tablet daily with evening meal, Metformin 500 mg 1 tablet 2 times daily, Losartan-Hydrochlorothiazide 50-12.5 mg 1 tablet daily, and Amlodipine 5 mg 1 tablet daily.

Objective: His blood pressure was 138/78 mmHg and pulse rate was 78 bpm. He weighed 184 pounds.

Assessment: 1) Hyperlipidemia. 2) Diabetes mellitus type 2 with diabetic microalbuminuria. 3) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 4) Obesity with BMI of 32-32.9, adult. 5) Essential hypertension. 6) Adult obstructive sleep apnea.

Plan: Lovastatin was decreased to 20 mg. Use of Clopidogrel and blood pressure medications would be continued. He was to follow up after fasting labs.

Office Visit/Progress Report, signed by Philip Quirk, M.D., Kaiser Permanente, dated July 18, 2016.

The applicant was seen for eye examination.

Impression: No retinopathy.

Plan: He would be rechecked in 1 year.

Laboratory Report, Kaiser Permanente, dated December 11, 2016.

Electrolyte panel was significant for increased anion gap at 17. Lipid panel showed increased triglyceride at 409 and decreased HDL at 38. Creatinine, glomerular filtration rate, ALT, and direct LDL were normal.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated December 16, 2016.

The applicant complained of sinus problems that had been present for 1 week. His lab results were reviewed. His medications included Losartan-Hydrochlorothiazide 50-12.5 mg, Amlodipine 5 mg, Lovastatin 20 mg, Metformin 500 mg, and Clopidogrel 75 mg.

Objective: He had a blood pressure of 135/73 mmHg and a pulse rate of 88 bpm. He weighed 198 pounds. Monofilament was intact bilaterally. There were no foot ulcers.

Assessment: 1) Diabetes mellitus type 2. 2) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 3) Obesity with BMI of 32-32.9, adult. 4) Screening for diabetic foot disease, category 0 – normal diabetic foot. 5) Hyperlipidemia. 6) Essential hypertension. 7) Adult obstructive sleep

apnea. 8) Screening exam for prostate cancer. 9) Left subjective tinnitus. 10) Screening for colon cancer.

Plan: Diabetic foot exam was performed. Laboratory studies including hgbA1c, lipid panel, urine microalbumin, electrolyte panel, creatinine, ALT, TSH, CBC with no differential, and PSA were ordered. Referrals to audiologist and GI specialist were made. PEG 3350-Electrolyte 240-22.72-6.72-5.84 gm was prescribed.

Office Visit/Progress Report, signed by Richard Kim, D.O., Kaiser Permanente, dated December 27, 2016.

The applicant complained of sinus pressure with phlegm that had been increasing over the last 3 weeks. He was coughing. He also had left-sided trapezius pain.

His medications included Losartan-Hydrochlorothiazide 50-12.5 mg, Amlodipine 5 mg, Lovastatin 20 mg, Metformin 500 mg, Clopidogrel 75 mg, Hydrocortisone 2.5% topical ointment, Hydrocortisone 2.5% topical cream, and Clobetasol 0.05% topical cream.

On examination, his blood pressure was 137/73 mmHg and pulse rate was 79 bpm. He weighed 193 pounds. Chest examination revealed very mild expiratory wheeze with coughing.

Assessment: 1) Sinusitis. 2) Cough.

Plan: Azithromycin 250 mg and Ventolin HFA 90 mcg/actuation inhaler were prescribed.

Colonoscopy Report, signed by Gavin Jonas, M.D., Kaiser Permanente, dated February 23, 2017.

Impression: Colon polyp/s.

Surgical Pathology Report, Kaiser Permanente, dated February 23, 2017.

Final Pathologic Diagnoses: 1) Polypectomy from colon cecum and ascending colon revealed tubular adenoma. 2) Polypectomy from colon at 25 cm revealed colonic mucosa with hyperplastic epithelial changes.

Office Visit/Progress Report, signed by Sandra Herman, M.D., Kaiser Permanente, dated July 10, 2017.

The applicant complained of right ankle pain that had been present for a few weeks. He used to wear tight cowboy shoes. He had since stopped wearing them, but he still had pain. He noted pain when putting pressure on the right ankle. He also had pain with running or when getting up to stand. He hit his ankle on a pole 2 years ago; he was unsure if he had fracture then. He had been taking turmeric to help with inflammation. He was unable to take NSAIDs due to allergy. He reported having bilateral 4th finger pain and shooting sensation for several months.

His medications included Losartan-Hydrochlorothiazide 50-12.5 mg, Amlodipine 5 mg, Lovastatin 20 mg, Metformin 500 mg, and Clopidogrel 75 mg.

On examination, his blood pressure was 130/69 mmHg. His pulse rate was 65 bpm. He weighed 196 pounds.

Assessment: 1) Tendinitis of right ankle. 2) Right ankle joint pain. 3) Bilateral finger pain.

Plan: Tylenol 1000 mg was prescribed. Use of turmeric might be continued. X-ray of the right ankle was ordered. Physical therapy was recommended.

X-rays of the Right Ankle, signed by Anthony Caldarone, M.D., Kaiser Permanente, dated July 11, 2017.

Findings/Impression: No acute fracture was identified. The alignment was normal. Mild arthritic changes were noted in the medial and lateral joint compartments. Mild posterior calcaneal spurring was noted. Minimal plantar calcaneal spurring was seen. No significant soft tissue abnormality was identified.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated August 1, 2017.

The applicant was exercising and following diet. His blood pressure at home was 120s. He had a history of decreased hearing.

His medications included Losartan-Hydrochlorothiazide 50-12.5 mg, Amlodipine 5 mg, Lovastatin 20 mg, Metformin 500 mg, and Clopidogrel 75 mg.

Objective: His blood pressure was 138/82 mmHg and pulse rate was 79 bpm. He weighed 194 pounds.

Assessment: 1) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 2) Obesity with BMI of 32-32.9, adult. 3) Hyperlipidemia.

4) Essential hypertension. 5) Adult obstructive sleep apnea. 6) Diabetes mellitus type 2. 7) Myalgia due to statin.

Plan: Laboratory studies including lipid panel, ALT, hgbA1c, urine microalbumin, electrolyte panel, and creatinine were ordered. Fenofibrate 54 mg was prescribed. Low cholesterol diet was advised. He was to limit carbohydrates.

Physical Therapy Initial Evaluation, signed by Brian Kim, P.T., Kaiser Permanente, dated August 10, 2017.

The applicant was seen for therapy.

Diagnosis: Right ankle joint pain.

Interventions include therapeutic activity/exercise.

Office Visit/Progress Report, signed by Dean Chan, M.D., Kaiser Permanente, dated October 11, 2017.

Subjective Complaints: The applicant complained of fever, sinus congestion, and cough for 2 weeks.

Vital Signs: He weighed 197 pounds. He had blood pressure of 134/63 mmHg. His pulse rate was 75 bpm.

Assessment: 1) Upper respiratory infection. 2) Left elbow joint pain.

Plan: He was off work on October 2-6. She was prescribed Diclofenac Sodium 1 % gel.

Office Visit/Progress Report, signed by Albert Tran, M.D., Kaiser Permanente, dated October 23, 2017.

Chief Complaint: The applicant complained chest cold and cough for 5 weeks.

Vital Signs: He weighed 191 pounds. He had blood pressure of 140/68 mmHg. His pulse rate was 75 bpm.

Assessment: Bacterial infection.

Plan: Azithromycin 250 mg, Albuterol 30 mcg, and Beclomethasone Dipropionate 80 mcg were prescribed. He was to follow up if was not feeling better in 1 week, or sooner if his symptoms worsened. He was to recheck blood pressure in 1 month.

Office Visit/Progress Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated November 13, 2017.

The applicant was seen for eye examination.

Assessment: 1) Diabetes mellitus without diabetic retinopathy bilaterally. 2) Intraocular pressure – ocular hypertension.

Plan: He needed glaucoma workup.

Office Visit/Progress Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated December 7, 2017.

The applicant was seen for eye examination.

Assessment/Plan: 1) Intraocular pressure 23 bilaterally. High eyelid squeezer. 2) OCT/FDT – within normal limits.

Office Visit/Progress Report, signed by Seema Goyal, M.D., Kaiser Permanente, dated December 23, 2017.

Chief Complaint: The applicant complained of cough and runny nose for 1 week. He had nasal drip, fever and chills, and coughing and congestion. He worked as dentist.

Vital Signs: He weighed 195 pounds. He had blood pressure of 122/66 mmHg. His pulse rate was 77 bpm.

Assessment: 1) Sinusitis. 2) ABNL sputum.

Plan: Sodium Bicarbonate-Sodium Chloride, Azithromycin 250 mg, Fluticasone, and Guaifenesin 600 mg were prescribed.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated January 24, 2018.

History of Present Illness: The applicant presented for Hydrocortisone 2.5% cream refill.

Medications: Losartan-hydrochlorothiazide 12.5-50 mg, Lovastatin 20 mg, Metformin 500 mg, Fenofibrate 54 mg, Amlodipine 5 mg, and Clopidogrel 75 mg.

Vital Signs: He weighed 195 pounds.

Assessment: 1) Dermatitis. 2) Rash/itch-body. 3) Rash/itch-face. 4) Xerosis cutis. 5) Pseudofolliculitis barbae. 6) Open wounds after shaving.

Plan: Clobetasol 0.05 % aero spray, Triamcinolone Acetonide 0.1 % cream, Hydrocortisone 2.5 % cream hydrocortisone 2.5 % ointment, Erythromycin-Benzoyl Peroxide gel, and Benzamycin gel were prescribed. He was advised to return to clinic earlier if symptoms worsen or fail to improve.

Telephone Appointment Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated March 14, 2018.

Subjective Complaints: The applicant was getting for Japan trip.

Assessment: 1) Essential hypertension. 2) Diabetes mellitus type 2. 3) Travel medicine.

Plan: "PHYS TAV, EST PAT, 5-10 minutes of medical discussion" was recommended. He was prescribed Azithromycin 250 mg and Ciprofloxacin 500 mg. He was to follow-up in a few days if was not feeling better.

Office Visit/Progress Report, signed by Daljeet Singh, M.D., Kaiser Permanente, dated April 11, 2018.

History of Present Illness: The applicant complained of back pain in past few weeks. He requested work note.

Vital Signs: He weighed 200 pounds. He had blood pressure of 147/69 mmHg. His pulse rate was 70 bpm.

Objective Findings: He had pain with flexion extension.

Plan: He was to undergo diabetic foot exam.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated June 29, 2018.

Subjective Complaints: The applicant complained of cough. He had dry throat. He had stopped Losartan-Hydrochlorothiazide. He experienced sneezing and postnasal drip.

Vital Signs: He weighed 202 pounds. He had blood pressure of 143/74 mmHg. His pulse rate was 66 bpm.

Assessment: 1) Postnasal drip. 2) Hyperlipidemia. 3) Essential hypertension. 4) Diabetes mellitus with chronic kidney disease stage 2. 5) Obesity. 6) Adult obstructive sleep apnea. 7) Diabetes mellitus type 2. 8) Post viral cough.

Plan: Sodium Bicarbonate-Sodium Chloride and Flunisolide 25 mcg were prescribed.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated July 18, 2018.

Subjective Complaints: The applicant complained of stress and high blood pressure.

Assessment: 1) Chronic stress reaction. 2) Essential hypertension.

Plan: "PHYS TAV, EST PAT, 5-10 minutes of medical discussion" was recommended.
Amlopidpine 7.5 mg was prescribed. He was to re-check high blood pressure in 3-4 weeks. He would attend Behavioral Health or Psychiatry appointment. He was to follow-up in a few days if was not feeling better.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated July 24, 2018.

Subjective Complaints: The applicant was informed regarding primary care policy and ROI recommendations. He would get another FMLA from Psychiatry if needed.

Assessment: 1) Chronic stress reaction. 2) Essential hypertension. 3) Diabetes mellitus type 2.

Plan: "PHYS TAV, EST PAT, 5-10 minutes of medical discussion" was recommended. He was to follow-up in a few days if was not feeling better.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated September 5, 2018.

History of Present Illness: The applicant requested a prescription for his dry itchy skin on the rest of his body. He used hydrocortisone 2.5% ointment with some improvement. He took long dry showers. He also requested clindamycin gel for pseudofolliculitis and HNS referral for progressively enlarging cyst on nape of neck, which intermittently inflamed from sweating, present for 4-5 years.

Medications: Hydrocortisone 2.5% cream, Hydrocortisone 2.5% ointment, Clindamycin Phosphate gel, Amlodipine 5 mg, Flunisolide 25 mcg, Fenofibrate 54 mg, Metformin 500 mg, Losartan-hydrochlorothiazide 12.5-50 mg, Clopidogrel 75 mg, Clobetasol 0.05% in aero spray, and Lovastatin 20 mg.

Vital Signs: He weighed 195 pounds.

Assessment: 1) Epidermal inclusion cyst. 2) Seborrheic keratosis. 3) Lentigo. 4) Dermatitis. 5) Folliculitis. 6) Vaccination for influenza.

Plan: He was referred for head and neck surgery. Hydrocortisone 2.5% cream and ointment were prescribed. Clindamycin phosphate 1% gel was recommended.

Office Visit/Progress Report, signed by Navyata Shah, D.O., Kaiser Permanente, dated September 25, 2018.

Chief Complaint: The applicant complained of sciatica for 3 weeks. He had right low back pain radiated to the buttock. His symptoms started 4 weeks ago. He experienced pain on and off over the years. He worked as dentist; moreover, she experienced worse pain when he was on his feet for prolonged periods of time. He had not found adequate relief with over-the-counter and prescription medication.

Social History: He was a non-smoker.

Vital Signs: He weighed 199 pounds. He had blood pressure of 133/76 mmHg. His pulse rate was 71 bpm.

Assessment: 1) Sciatica, right side. 2) Chronic back pain. 3) Essential hypertension.

Plan: He was advised to take over the counter non-steroidal anti-inflammatory medications food as directed. He was recommended to do stretching, apply heat to the area as needed and to do back exercises daily. He was to avoid heavy lifting and activities that aggravate the pain. He was to follow-up if pain did not improve or if neurological symptoms such as bladder or bowel dysfunction, numbness, weakness of lower extremities occurred. He was to undergo X-ray of the lumbosacral spine.

He was advised to control blood pressure. He was advised to take medications daily as directed. He was to recheck blood pressure if headaches, dizziness, blurred vision chest pain or sob occurred. He was to return to clinic if symptoms persisted or worsened, or if any new concerns.

X-rays of the Lumbosacral Spine, signed by David Alvarez, M.D., Kaiser Permanente, dated September 27, 2018.

Findings/Impression: Frontal and lateral views of the lumbar spine were obtained. Osseous mineralization was normal. There was preservation of lumbar vertebral body heights and alignment. Moderate lower lumbar disc and facet degenerative changes were seen. The prevertebral soft tissues appeared normal.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated October 3, 2018.

Subjective Complaints: The applicant complained of low back pain for a few weeks. He was seen on September 26 for an X-ray result, which revealed degenerative disc disease. He was doing home physical therapy, which did help.

Assessment: Sciatica, right side.

Plan: "PHYS TAV, EST PAT, 5-10 minutes of medical discussion" was recommended. Meloxicam 15 mg was prescribed. He was to follow-up in a few days if he was not feeling better.

Office Visit/Progress Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated October 29, 2018.

Chief Complaint: The applicant complained of glaucoma suspect.

Assessment: 1) Ocular hypertension bilaterally, stable. 2) Diabetes mellitus without diabetic retinopathy bilaterally.

Plan: He was to recheck in 6 months.

Office Visit/Progress Report, signed by Noubar Ouzounian, M.D., Kaiser Permanente, dated November 9, 2018.

History of Present Illness: The applicant had nape neck pain in 5 years, progressively enlarging, intermittently inflamed with sweating. He had progressively enlarging cyst on the posterior neck.

Vital Signs: He weighed 202 pounds. He had blood pressure of 154/90 mmHg. His pulse rate was 90 bpm.

Impression: Epidermal inclusion cyst.

Plan: He was to undergo lesion excision of the neck.

Surgical Pathology Report, Kaiser Permanente, dated November 9, 2018.

Final pathologic Diagnosis: Skin, posterior neck, mass excision: Epidermal inclusion cyst.

Office Visit/Progress Report, signed by Noubar Ouzounian, M.D., Kaiser Permanente, dated November 20, 2018.

History of Present Illness: The applicant had undergone excision of inclusion cyst from posterior neck in November 9, 2018. His skin closed in layers using Biosyn. He presented with erythema and consistent swelling with foreign body reaction along the suture line.

Impression: Aftercare for subcutaneous tissue surgery.

Plan: He was to return to clinic as needed.

Office Visit/Progress Report, signed by Noubar Ouzounian, M.D., Kaiser Permanente, dated November 20, 2018.

History of Present Illness: The applicant had undergone excision of inclusion cyst from posterior neck in November 9, 2018. He had a foreign body reaction to the Biosyn suture.

Vital Signs: He weighed 202 pounds. He had blood pressure of 153/91 mmHg.

Impression: Aftercare for subcutaneous tissue surgery.

Plan: He was to return to clinic as needed.

Office Visit/Progress Report, signed by Samuel Chung, M.D., Kaiser Permanente, dated January 7, 2019.

Chief Complaint: The applicant complained of right hip sciatica. He had pain in his right lower back radiated down to right anterior thigh area, which come and go for few months. He described pain as sharp/electric. Meloxicam did not help.

Social History: He was a non-smoker.

Vital Signs: He weighed 201 pounds. He had blood pressure of 138/71 mmHg. His pulse rate was 76 bpm.

Diagnosis: Sciatica, right side.

Plan: He was to check-in at the Kaiser pharmacy. He was prescribed Prednisone for 5 days. He was to monitor his blood sugar. He was referred for radiology for an X-ray.

X-rays of the Cervical Spine, signed by Anthony Caldarone, M.D., Kaiser Permanente, dated January 7, 2019.

Impression: Cervical vertebral bodies were normal in height. The alignment was normal. No fracture was identified. Osteophytes and multilevel disc space narrowing was noted from C4 through C7. No significant soft tissue abnormality. Oblique view demonstrated mild C4-C7 neural foraminal narrowing bilaterally.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated January 23, 2019.

Subjective Complaints: The applicant complained of itchy skin.

History of Present Illness: He got pimples around his mouth. Prior to this, he applied cream. He had dry skin. He also had bumps.

Family History: His mother had neuroleptic malignant syndrome.

Past Medical History: He had hyperlipidemia, essential hypertension, sleep disorder; sleep apnea, obesity, elevated transaminase, and diabetes mellitus type 2, controlled.

Surgical History: He had undergone colonoscopy.

Social History: He was a non-smoker.

Medications: He had taken Pimecrolimus, Fluocinolone, Hydrocortisone cream, Hydrocortisone ointment, Clindamycin Phosphate, Amlodipine 5 mg, Loratadine 10 mg, Fenofibrate 54 mg, Metformin 500 mg, Losartan-hydrochlorothiazide 12.5-50 mg, Clopidogrel 75 mg, Triamcinolone Acetonide cream, Lovastatin 20 mg, Albuterol 90m mcg, and QVAR 80 mcg.

Vital Signs: He weighed 200 pounds.

Assessment: Pruritus.

Plan: Liquid Nitrogen was recommended. He was advised to return to clinic earlier if symptoms worsen or fail to improve.

Laboratory Report, Kaiser Permanente, dated January 23, 2019.

Protein, urine was high at 34.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated February 4, 2019.

Subjective Complaints: The applicant presented for laboratory results and referral request. He was seeing dermatology for his allergies. He was already known to have chronic kidney disease from diabetes. He had pain in right low back radiated down to the right leg. He tried Prednisone with no relief. X-ray revealed that he had moderate degenerative disease.

Tobacco History: He was a non-smoker.

Vital Signs: He weighed 198 pounds. He had blood pressure of 131/76 mmHg. His pulse rate was 85 bpm.

Assessment: 1) Sciatica, right side. 2) Declines vaccination. 3) Hyperlipidemia. 4) Stage 2 of Chronic Kidney Disease. 5) Obesity. 6) Essential hypertension. 7) Microalbuminuria. 8) Screening exam for prostate cancer. 9) Vaccination for strep pneumonia with prevnar. 10) Screening for diabetic foot disease.

Plan: He was referred for physical medicine. Metformin 500 mg was prescribed.

Telephone Appointment Visit/Progress Report, Ashmi Doshi, M.D., Kaiser Permanente, dated February 12, 2019.

The applicant was seen for skin rash.

Medications: He was on Metformin 500 mg, Pimecrolimus 1%, Fluocinolone 0.01%, Hydrocortisone 2.5%, Clindamycin 1%, Amlodipine 5 mg, Loratadine 10 mg, Sodium bicarbonate-sodium chloride, Flunisolide 25 mcg, Fenofibrate 54 mg, Losartan-hydrochlorothiazide 20-12.5 mg, Clopidogrel 75 mg, Clobetasol 0.05%, Triamcinolone 0.1%, and Lovastatin 20 mg.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Assessment: Dermatitis.

Plan: He was recommended moisturizer. Patch test was recommended.

Phototherapy Treatment Record for NBUVB, Kaiser Permanente, dated February 13, 2019.

The applicant had his treatment.

Dose in MJ: 260.

Office Visit/Progress Report, signed by Esther Cohen, M.D., Kaiser Permanente, dated February 15, 2019.

The applicant had chronic low back pain for years with radiation down to right lower extremity lateral aspect to right knee with some numbness/tingling.

He was working with a personal trainer and also not working right now as a dentist (on hiatus) and had some improvement.

He was working with a chiropractor on his own.

Medications: He was currently on Tylenol as needed.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Medications: He was on Metformin 500 mg, Pimecrolimus 1%, Fluocinolone 0.01%, Hydrocortisone 2.5%, Clindamycin 1%, Amlodipine 5 mg, Loratadine 10 mg, Sodium bicarbonate-sodium chloride, Flunisolide 25 mcg, Fenofibrate 54 mg, Losartan-hydrochlorothiazide 20-12.5 mg, Clopidogrel 75 mg, Clobetasol 0.05%, Triamcinolone 0.1%, and Lovastatin 20 mg.

Vital Signs: He had a blood pressure of 134/67 mmHg with pulse rate of 71 bpm. He weighed 199 pounds.

Assessment: 1) Chronic low back pain >3 months. 2) Lumbar radiculopathy. 3) Lumbar spondylosis. 4) Obesity, BMI 35-39.9, adult. 5) Weight loss counseling.

Plan: Lumbar spine images were reviewed. He was recommended physical therapy. He was encouraged weight loss. He declined pain medications. He was to follow up with Dr. Cohen.

Phototherapy Treatment Record for NBUVB, Kaiser Permanente, dated February 15, 2019.

The applicant had his treatment.

Dose in MJ: 300.

Phototherapy Treatment Record for NBUVB, Kaiser Permanente, dated February 18, 2019.

The applicant had his treatment.

Dose in MJ: 340.

Phototherapy Treatment Record for NBUVB, Kaiser Permanente, dated February 22, 2019.

The applicant had his treatment.

Dose in MJ: 380.

MRI of the Lumbar Spine no Contrast, signed by Johnny Soong, M.D., Kaiser Permanente, dated March 5, 2019.

Impression: Disc bulges, spondylosis and facet degeneration. Annulus irregularities/fissures. Multilevel canal narrowing. Short pedicles and congenital narrowing of the spinal canal.

Laboratory Report, Kaiser Permanente, dated March 5, 2019.

Cardiolipin IGM, EIA was elevated at 17.7 MPL units.

Telephone Appointment Visit/Progress Report, signed by Esther Cohen, M.D., Kaiser Permanente, dated March 5, 2019.

The applicant continued to have low back pain with radiation to right lower extremity with some radiation to left side but had improved. He had been taking Tumeric.

He would be starting physical therapy.

Assessment: 1) Chronic low back pain > 3 months. 2) Lumbar spondylosis. 3) Lumbar radiculopathy. 4) Spinal stenosis of lumbar spine.

Plan: MRI of the spine was reviewed. He was to start physical therapy as scheduled. LESI was discussed.

Physical Therapy Initial Evaluation, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated March 5, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Telephone Appointment Visit/Progress Report, signed by Esther Cohen, M.D., Kaiser Permanente, dated March 8, 2019.

The applicant wanted more information about kidney cyst otherwise he wanted to just continue physical therapy for his low back pain.

Assessment: 1) Chronic low back pain > 3 months. 2) Lumbar spondylosis. 3) Lumbar radiculopathy. 4) Spinal stenosis of lumbar spine.

Plan: He was to follow up with PCP for further work up of his kidney cyst seen incidentally on MRI. He was to continue with physical therapy. He was to follow up with Dr. Cohen as needed.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated March 13, 2019.

The applicant's MRI showed some cysts. He wanted to know if he needed ultrasound. He would be seeing rheumatology soon to discuss cardiolipin antibody.

Assessment: Simple renal cyst.

Plan: Ultrasound of the kidney was requested.

Office Visit/Progress Report, signed by Ricardo Bardales Mendoza, M.D., Kaiser Permanente, dated March 14, 2019.

The applicant had history of hypertension, hyperlipidemia, type 2 diabetes mellitus, CKD, obesity, and OSA. He was referred to rheumatology for further evaluation.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Vital Signs: He had a blood pressure of 136/62 mmHg with pulse rate of 67 bpm. He weighed 202 pounds.

Assessment: He was referred for evaluation of +aCL indeterminate without any clinical indications of APS. He merits further evaluation.

Diagnoses: 1) Abnormal laboratory finding. 2) Dermatitis.

Plan: Laboratory work ups were ordered. He would repeat aCL in 3 months and LAC now and 3 months.

Laboratory Report, Kaiser Permanente, dated March 14, 2019.

The results were within normal limits.

Office Visit/Progress Report, signed by Ashmi Doshi, M.D., Kaiser Permanente, dated March 28, 2019.

The applicant was seen for 72 hour read of patch tests.

This was well tolerated.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Vital Signs: He weighed 203 pounds.

Assessment: Allergic contact dermatitis.

Plan: Each ingredient was discussed.

X-rays of the Left Hip, signed by Alfonso Pham, M.D., Kaiser Permanente, dated April 5, 2019.

Findings/Impression: No acute fracture was identified. The alignment was normal. Mild prominent osteoarthritis changes noted in the superior acetabuli, bilaterally. No significant soft tissue abnormality was identified.

Audiology Report, signed by Mehrnaz Karimi, AuD., Kaiser Permanente, dated April 11, 2019.

Results: Almost stable hearing thesholds on both ears since 2017. Word discrimination score had improved from 32% to 60% in the left.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated April 17, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Ultrasound of the Kidney, signed by Yung Cho, M.D., Kaiser Permanente, dated April 23, 2019.

Impression: Heterogeneous mass with cystic components visualized in the right kidney. Follow up CT kidneys without and with IV contrast was recommended.

Non-obstructing calculus visualized in the left kidney.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated April 24, 2019.

The applicant had itchy skin.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Vital Signs: He had a blood pressure of 130/79 mmHg with pulse rate of 67 bpm. He weighed 201 pounds.

Assessment: 1) Dermartitis. 2) Verruca vulgaris.

Plan: He was prescribed Fluocinolone 0.01%, Clindamycin 1%, and Hydrocortisone 2.5%. He was recommended liquid nitrogen.

Physical Therapy Discharge Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated May 1, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated May 3, 2019.

The applicant had been off diet and exercise.

Assessment: 1) Diabetes mellitus 2 microalbuminuria. 2) Diabetes mellitus 2 with CKD 2 (GFR 60-89). 3) Hyperlipidemia. 4) Diabetes mellitus 2.

Plan: Laboratory work ups were ordered. He was prescribed Metformin 500 mg and was advised to take twice a day.

CT Urogram Abdomen and Pelvis with/without IV Contrast, signed by Oneil Lee, M.D., Kaiser Permanente, dated May 6, 2019.

Impression: Large lobulated and partially exophytic enhancing right renal solid mass, suspicious for renal cell carcinoma. No definite extension into the right renal vein, although the assessment was limited by suboptimal venous opacification.

No pathologic lymphadenopathy or other convincing suspicious findings.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated May 9, 2019.

The applicant presented with incidentally found right renal mass.

Vital Signs: He had a blood pressure of 134/70 mmHg with pulse rate of 73 bpm. He weighed 200 pounds.

Impression: Large right renal mass.

Plan: Only option was right lap nephrectomy.

X-rays of the Chest, signed by Yung Cho, M.D., Kaiser Permanente, dated May 9, 2019.

Findings/Impression: The lungs were clear. No pleural effusion were seen. The cardiomediastinal silhouette was normal.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated May 30, 2019.

The applicant presented with incidentally found right renal mass.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Medications: He was on Metformin 500 mg, Amlodipine 5 mg, Fenofibrate 54 mg, Losartan-hydrochlorothiazide 50-12.5 mg, Clopidogrel 75 mg, and Lovastatin 20 mg.

Vital Signs: He had a blood pressure of 147/75 mmHg with pulse rate of 68 bpm. He weighed 200 pounds.

Assessment: Large right renal mass.

Plan: He was recommended right laparoscopic nephrectomy.

Laboratory Report, Kaiser Permanente, dated May 30, 2019.

The results were within normal limits.

Operative Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated June 6, 2019.

Pre and Postoperative Diagnosis: Right renal mass.

Procedure: Right laparoscopic nephrectomy

Surgical Pathology Report, Kaiser Permanente, dated June 6, 2019.

Final Diagnosis: Right kidney, nephrectomy: Renal cell carcinoma.

Urology Progress Report, signed by George Abdelsayed, M.D., Kaiser Permanente, dated June 7, 2019.

The applicant was doing well.

He did not take any pain medications last night. He complained of abdominal soreness.

He voided this morning.

Assessment: Right renal mass POD#1 status post right laparoscopic radical nephrectomy.

Plan: He would be discharged home.

Laboratory Report, Kaiser Permanente, dated June 7, 2019.

Electrolyte panel showed decreased potassium at 3.2 mEq/L.

Creatinine was elevated at 1.48 mg/dL.

CBC revealed low levels of auto RBC at 4.26 Mill/mcL, HGB at 13.2 g/dL, and auto HCT at 37.7%.

Urology Discharge Report, signed by George Abdelsayed, M.D., Kaiser Permanente, dated June 7, 2019.

Principal Diagnosis: Renal mass.

Secondary Diagnoses: 1) Hyperlipidemia. 2) Essential hypertension. 3) Adult obstructive sleep apnea. 4) Elevated transaminase. 5) Diabetes mellitus with CKD stage 2 (GFR 60-89). 6) Family history of colon cancer <50 years. 7) Obesity, BMI 32-32.9, adult. 8) Diabetes mellitus 2. 9) Screening colonoscopy. 10) Asymmetric bilateral sensorineural hearing loss. 11) Myalgia due to statin. 12) Colonoscopy. 13) Colon polyp. 14) Allergic contact dermatitis. 15) Renal mass.

Hospital Course: The applicant was admitted for operation. He tolerated the procedure well. He was watched overnight and discharged home on POD#1 after passing voiding trial.

Condition: Good.

Disposition: Home.

Discharge Medication: He was to start taking Hydrocodone-acetaminophen 5-325 mg and Sennosides 8.6 mg. He was to continue Metformin 500 mg, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Amlodipine 5 mg, Loratadine 10 mg, Sodium bicarbonate-sodium chloride, Flunisolide 25 mcg, Fenofibrate 54 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Clopidogrel 75 mg, Triamcinolone 0.1%, and Lovastatin 20 mg.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated June 18, 2019.

The applicant was seen and treated.

Vital Signs: He had a blood pressure of 148/75 mmHg with pulse rate of 62 bpm.

Assessment: Status post right lap nephrectomy for T1b renal cell carcinoma (RCC), clear cell.

Plan: CT would be repeated. Staples were removed. He held Plavix. He would resume Plavix once oozing stops. He was advised no heavy lifting for 6 weeks.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated June 28, 2019.

The applicant was seen and treated.

Vital Signs: He had a blood pressure of 121/64 mmHg with pulse rate of 83 bpm. He weighed 185 pounds.

Assessment: Status post right lap nephrectomy for T1b renal cell carcinoma (RCC), clear cell.

Plan: CT would be repeated. Ok to resume Plavix. CT would be repeated.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated July 17, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated July 22, 2019.

The applicant presented for refill for upper lip dermatitis.

He was recently diagnosed with renal cell carcinoma.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Vital Signs: He weighed 186 pounds.

Assessment: 1) Seborrheic keratosis. 2) Guttate hypomelanosis. 3) Dermatitis.

Plan: He was prescribed Fluocinolone 0.01%, Clindamycin 1%, and Hydrocotisone 2.5%. He was recommended trial of not shaving for 4 weeks.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated July 25, 2019.

The applicant had right low back pain.

He already did physical therapy but needed to be interrupted due to right nephrectomy.

Assessment: 1) Back pain. 2) Diabetes mellitus 2.

Plan: Laboratory work ups were ordered. He was recommended physical therapy.

Office Visit/Progress Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated August 1, 2019.

The applicant was seen for eye examination.

Assessment/Plan: 1) Ocular hypertension - OCT - within normal limits. No changes. 2) Diabetes mellitus without diabetic retinopathy bilaterally.

Both eyes were dilated with one drop each of Proparacaine 0.5%, Phenylephrine 2.5%. Tropicamide 1%.

Laboratory Report, Kaiser Permanente, dated August 20, 2019.

Creatinine was elevated at 1.38 mg/dL.

Microalbumin/creatinine was high at 70.3 mcg/mg.

Lipid panel revealed high levels of triglyceride at 286 mg/dL and cholesterol/high density lipoprotein at 4.5; and low HDL at 34 mg/dL.

HGB A1c was normal at 6.0%.

Office Visit/Progress Report, signed by Phi Vo, M.D., Kaiser Permanente, dated August 21, 2019.

The applicant had right low back pain.

His kidney removed on June 6, 2019 due to cancer.

Vital Signs: He had a blood pressure of 133/70 mmHg with pulse rate of 77 bpm. He weighed 188 pounds.

Assessment: 1) Right sacroiliitis. 2) Declines influenza vaccination.

Plan: He was prescribed Lidocaine-prilocaine 2.5-2.5%.

Telephone Appointment Visit/Progress Report, signed by Esther Cohen, M.D., Kaiser Permanente, dated September 6, 2019.

The applicant continued to have chronic low back pain and right hip pain.

He was doing physical therapy.

He was not taking medications.

He also had right thumb pain.

He was requesting x-rays of the low back, right hip, and right thumb.

He was worried his cancer may have spread to his bones.

Assessment: 1) Chronic low back pain > 3 months. 2) Lumbar spondylosis. 3) Spinal stenosis of lumbar spine. 4) Right hip joint pain. 5) Right thumb pain.

Plan: He declined MRI of the lumbar spine. He was offered bone scan but he also declined. He could follow up with urology. He was to continue physical therapy. He also declined LESI trial. He also declined acupuncture.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated September 11, 2019.

The applicant did not take blood pressure medication this morning.

He was exercising regularly.

He was having back pain on the right side.

He saw physical medicine and rehabilitation that recommended acupuncture which he was holding off doing.

MRI was planned.

He was better after stretching.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Vital Signs: He had a blood pressure of 147/72 mmHg with pulse rate of 75 bpm. He weighed 190 pounds.

Assessment: 1) Essential hypertension. 2) Vaccination for influenza. 3) Hyperlipidemia. 4) Diabetes mellitus with CKD stage 2 (GFR 60-89). 5) Adult obstructive sleep apnea. 6) Obesity, BMI 32-32.9, adult. 7) History of transitional cell carcinoma, right kidney. 8) Diabetes mellitus 2.

Plan: He was recommended influenza vaccination. Considered acupuncture. He was to continue stretching and exercises.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated September 11, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated September 25, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

X-rays of the Right Thumb, signed by Oneil Lee, M.D, , Kaiser Permanente, dated September 27, 2019.

Findings/Impression: No evidence of acute fracture or malalignment. Mild degenerative changes at the interphalangeal joint of the thumb and basillar joint. No suspicious osseous lesion. Soft tissue grossly unremarkable.

X-rays of the Lumbosacral Spine, signed by Oneil Lee, M.D, , Kaiser Permanente, dated September 27, 2019.

Impression: No compression deformity. Minimal retrolisthesis of L2 on L3 and L3 on L4, unchanged.

Mild disc space narrowing at L4-L5 and L5-S1, similar. Similar multilevel osteophytes and lower lumbar facer arthropathy.

Atherosclerosis of the aorta.

MRI of the Lumbar Spine no Contrast, signed by Michael Kabiri, M.D., Kaiser Permanente, dated September 30, 2019.

Impression: 1) L3-L4: There was posterior annular fissure. No disc protrusion. There was mild central canal stenosis due to hypertrophy of the ligamentum flavum and prominent epidural fat. AP dimension of the canal was 8 mm (image 24 series 6). No significant foramina narrowing. There was posterior annular fissure hypertrophic change.

2) L4-L5: There was posterior annular fissure and 4 mm circumferential posterior disc bulge. There was moderate to severe spinal stenosis due to posterior disc bulge, hypertrophy of the ligamentum flavum and prominent epidural fat. AP dimension of the canal was 6 mm (image 30 series 6). There was bilateral facet degenerative change.

3) L5-S1: There was posterior annular fissure and 4 mm circumferential posterior disc bulge. No significant canal stenosis. There was mild to moderate bilateral foramina narrowing. There were moderate bilateral facet hypertrophic change.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated October 16, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated October 30, 2019.

The applicant was seen for therapy.

Diagnoses: 1) Chronic low back pain > 3 months. 2) Chronic neck pain >3 months. 3) Bilateral scapulalgia.

Interventions include manual therapy, therapeutic exercise, and modalities.

Office Visit/Progress Report, signed by Esther Cohen, M.D., Kaiser Permanente, dated November 5, 2019.

The applicant was concerned about tumors due to recent renal cancer.

He follow up with urology.

His pain was improving with physical therapy.

He continued to have low back pain with intermittent radiation to right lower extremity.

He was not taking any meds.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Vital Signs: He had a blood pressure of 130/71 mmHg with pulse rate of 65 bpm. He weighed 190 pounds.

Assessment: 1) Chronic low back pain >3 months. 2) Spinal stenosis of lumbar spine. 3) Lumbar spondylosis. 4) Lumbar radiculopathy. 5) Right hip joint pain.

Plan: Repeat MRI of the lumbar spine and right hip images were reviewed. He was to continue with physical therapy. Acupuncture was recommended. He declined LESI trial. He was to follow up with Dr. Cohen as needed.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated November 14, 2019.

The applicant had pain with opening and closing hands. Right thumb was painful. X-rays showed mild osteoarthritis. He needed physical therapy. He had pain in joints.

Many years ago, he had vertigo attack.

He was seen in emergency department in 2009.

Assessment: 1) Right thumb pain. 2) Hearing problem. 3) Vertigo.

Plan: He was recommended physical therapy. He would be referred to HNS. He was prescribed Diclofenac 1%.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated November 18, 2019.

The applicant was going through workmans comp for job. He had very high blood pressure. He was exercising.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Vital Signs: He had a blood pressure of 135/80 mmHg with pulse rate of 78 bpm. He weighed 193 pounds.

Assessment: 1) Essential hypertension. 2) Hyperlipidemia. 3) Diabetes mellitus with CKD stage 2 (GFR 60-89). 4) Obesity, BMI 32-32.9, adult. 5) Adult obstructive sleep apnea. 6) Diabetes mellitus 2. 7) History of transitional cell carcinoma, right kidney. 8) Screening for diabetic foot disease, category 0 – normal diabetic foot. 9) Diabetes mellitus 2 with microalbuminuria.

Plan: He was recommended diabetic foot exam. He was prescribed Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, and Losartan-hydrochlorothiazide 50-12.5 mg. Stress echocardiogram was recommended.

ECG Report, Kaiser Permanente, dated November 18, 2019.

VR: 68. PR: 68. QRS: 180. QT: 112. QTc: 396. P-R-T: -3/-32/30.

Results: Normal sinus rhythm. Left axis deviation. Nonspecific T wave abnormality. Abnormal ECG.

Audiology Report, signed by Emily Vanides, AUD., Kaiser Permanente, dated November 20, 2019.

Impression: Right ear had mild sloping to moderate high frequency sensorineural hearing loss 3 to 8kHz with excellent work recognition score.

Left ear had mild sloping to severe sensorineural hearing loss 750 to 8kHz with poor word recognition score.

Office Visit/Progress Report, signed by Syed Ahsan, M.D., Kaiser Permanente, dated November 20, 2019.

The applicant was referred to rule out menieres disease. He had TAV with PCP with complaints of vertigo and sudden hearing loss. He was seen in ED in 2009 for vertigo. He had history of hearing loss and noise exposure. He used BICROS aids. He had obstructive sleep apnea. He got dizzy when lying down. He had last spinning sensation last week, which occurred when turning in bed. He had long standing left side tinnitus due to hearing loss. The spinning sensation lasted few seconds. He had nephrectomy earlier this year. He hydrates regularly. He worked as a dentist and had issues with load drills. He did not know the decibel level.

He was not starting to get energy back form the nephrectomy. He felt fatigue but getting better.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Vital Signs: He had a blood pressure of 159/81 mmHg with pulse rate of 70 bpm.

Assessment/Plan: No vertigo. He had no BPPV, possibly had that previously. No Menieres related symptoms. Considered cardiac evaluation.

History of left side vestibular dysfunction back about 10 years ago. He had recent imbalance could be due to decompensation from recent nephrectomy due to malignancy. If balance did not improve with increasing activity, may benefit from physical therapy.

Chronic sleep apnea. Should consider repeat sleep study if continued to have fatigue and dizziness even after increasing activity.

Occupational Therapy Initial Evaluation, signed by Kathleen Jefferies, O.T., Kaiser Permanente, dated November 27, 2019.

The applicant was seen for therapy.

Interventions include ice application, paraffin baths, ultrasound, ergonomic education, functional activities/training, home exercise program, postural education, and therapeutic exercise.

Physical Therapy Progress Report, signed by Linh Ngo-Reyes, P.T., Kaiser Permanente, dated November 27, 2019.

The applicant was seen for therapy.

He was discharged from therapy due to goals met.

CV Stress Test Treadmill, signed by Babak Kasravi, M.D., Kaiser Permanente, dated December 11, 2019.

Final Impression: 1) Good exercise tolerance. 2) Appropriate heart rate and blood pressure response to exercise. 3) No evidence of ischemia by EKG criteria at this workload. 4) No evidence of stress induces regional wall motion abnormalities at this workload.

Transthoracic Echo Rest and Stress/Exercise, signed by Babak Kasravi, M.D., Kaiser Permanente, dated December 11, 2019.

Conclusion/Summary: 1) Overall, this was a low risk stress echocardiogram with no evidence of stress induced regional wall motion abnormalities at this workload. 2) Good exercise tolerance. 3) Appropriate hear rate and blood pressure response to exercise. 4) No evidence of ischemia by EKG criteria at this workload.

Internal Medicine Telephone Appointment Visit, signed by Alexander Berdy, M.D., Kaiser Permanente, dated December 17, 2019.

The applicant was seen for lab review.

Assessment: 1) Diabetes mellitus 2. 2) Diabetes mellitus with CKD stage 2 (GFR 60-89).

Plan: Laboratory work ups were ordered.

Occupational Therapy Initial Evaluation, signed by Kathleen Jefferies, O.T., Kaiser Permanente, dated December 19, 2019.

The applicant was seen for therapy.

Interventions include ice application, paraffin baths, ultrasound, ergonomic education, functional activities/training, home exercise program, postural education, and therapeutic exercise.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated December 19, 2019.

The applicant had bump on his incision, non-tender.

Vital Signs: He weighed 193 pounds.

Assessment: Status post right lap nephrectomy for T1b renal cell carcinoma (RCC), clear cell. He would likely need repeat CR in six months.

Opthalmology Report, signed by Kevin Yuhan, M.D., Kaiser Permanente, dated December 19, 2019.

The applicant was seen for eye examination.

Assessment/Plan: 1) Diabetes mellitus without diabetic retinopathy bilaterally. 2) Glaucoma screening -- negative.

Both eyes were dilated with one drop each of Proparacaine 0.5%, Phenylephrine 2.5%. Tropicamide 1%.

Office Visit/Progress Report, signed by Aparche Yang, M.D., Kaiser Permanente, dated December 20, 2019.

The applicant had history of RCC right kidney status post nephrectomy.

He wanted refill for Triamcinolone, Dermasmooth, and Clindamycin gel.

He also wanted to know the result of CT of the abdomen and pelvis.

He saw urologist yesterday but results were not in yet.

Vital Signs: He had a blood pressure of 136/70 mmHg with pulse rate of 76 bpm. He weighed 191 pounds.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Vital Signs: He weighed 191 pounds.

Assessment: 1) Dermatitis. 2) Abnormal lung imaging.

Plan: He was prescribed Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, and Triamcinolone 0.1%. He was advised to follow up with Dr. Choi.

CT of the Abdomen and Pelvis no oral IV Contrast, signed by Sung Pak, M.D., Kaiser Permanente, dated December 20, 2019.

Impression: Status post right nephrectomy.

Left renal cyst.

Unchanged left adrenal adenoma measuring at 1 cm.

8 mm lobulated lung nodule in the posterior medial aspect of the right lower lung on image 28 series 3.

Broad-based 8 mm subpleural density/nodule in the right lower lung posteriorly on image 12 series 3.

Moderate diffuse fatty infiltration of the liver.

Scattered small sclerotic lesion throughout the pelvis vertebral body likely bone island.

Diffuse multilevel degenerative change of the spine.

Unchanged 4 mm sclerotic lesion in the right side of the vertebral body. The superior endplate of L3 unchanged.

CT Thorax no Contrast, signed by Pankaj Mowji, M.D., Kaiser Permanente, dated December 30, 2019.

Impression: Lungs showed an 8 mm nodule over the right lower lobe. With no prior comparison of the lower lungs a 3 month follow up may be considered with history.

Status post right nephrectomy.

Visualized abdomen showed fatty infiltration of the liver as well as a 11 mm left adrenal nodule.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated January 7, 2020.

The applicant was seen for health maintenance.

Vital Signs: He had a blood pressure of 150/80 mmHg with pulse rate of 79 bpm. He weighed 194 pounds.

Assessment: 1) Hyperlipidemia. 2) Essential hypertension. 3) Diabetes mellitus 2 with CKD stage 2 (GFR 60-89). 4) Obesity, BMI 32-32.9, adult. 5) Adult

obstructive sleep apnea. 6) Diabetes mellitus 2. 7) History of transitional cell carcinoma, right kidney.

Plan: He was prescribed Amlodipine 10 mg. He was to continue Losartan-hydrochlorothiazide.

Occupational Therapy Report, signed by Kathleen Jefferies, O.T., Kaiser Permanente, dated January 8, 2020.

The applicant was seen for therapy.

Interventions include ice application, paraffin baths, ultrasound, ergonomic education, functional activities/training, home exercise program, postural education, and therapeutic exercise.

Office Visit/Progress Report, signed by Wesley Choi, M.D., Kaiser Permanente, dated January 16, 2020.

The applicant had bump on his incision.

Vital Signs: He had a blood pressure of 140/67 mmHg with pulse rate of 74 bpm.

Assessment: Status post right lap nephrectomy for T1b renal cell carcinoma (RRC), clear cell.

Plan: He was recommended CT of the chest/abdomen/pelvis in 6 months.

Occupational Therapy Progress Report, signed by Kathleen Jefferies, O.T., Kaiser Permanente, dated January 17, 2020.

The applicant was seen for therapy.

Interventions include ice application, paraffin baths, ultrasound, ergonomic education, functional activities/training, home exercise program, postural education, and therapeutic exercise.

Office Visit/Progress Report, signed by Guillermo Sturich, M.D., Kaiser Permanente, dated February 4, 2020.

The applicant had tunny nose, cough, nasal drip, possible fever, and chills in the beginning for 4 weeks. He took over-the-counter Tylenol.

Medications: He was on Fluticasone 50 mcg/act, Azithromycin 250 mg, Amlodipine 10 mg, Clindamycin 1%, Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Losartan-hydrochlorothiazide 50-12.5 mg, and Metformin 500 mg.

Vital Signs: He had a blood pressure of 141/66 mmHg with pulse rate of 72 bpm. He weighed 193 pounds.

Assessment: Sinusitis.

Plan: He was prescribed Fluticasone 50 mcg/act and Azithromycin 250 mg.

Office Visit/Progress Report, signed by David Lou, M.D., Kaiser Permanente, dated February 5, 2020.

The applicant had history of diabetes mellitus 2, hypertension, hyperlipidemia, obesity, chronic low back pain, who was status post right nephrectomy in June 2019 revealing a 5.2 cm renal cell carcinoma (clear cell type). Margins were negative, no lymph nodes taken. Stage I (pT1b, Nx). The kidney mass was originally incidentally discovered on MRI imaging of his lower back for complaints of low back pain.

In December 2019, he had a routine CT abdominal/pelvis for the purpose of surveillance and was noted to have an 8 mm RLL pulmonary nodule and broad based 8 mm RLL subpleural nodule; these were confirmed on CT thorax and no other pulmonary lesion were found. There were no prior CT images of the chest to compare to.

He was getting over a cold, but otherwise had been feeling fine. He was trying to change his diet more towards a Vegan diet, and was working on reducing weight and controlling his blood pressure and blood sugar. He had chronic lower back pain attributed to spinal stenosis and bone spurs revealed on MRI.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Medications: He was on Fluticasone 50 mcg/act, Azithromycin 250 mg, Amlodipine 10 mg, Clindamycin 1%, Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Losartan-hydrochlorothiazide 50-12.5 mg, and Metformin 500 mg.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Vital Signs: He had a blood pressure of 139/84 mmHg with pulse rate of 74 bpm. He weighed 193 pounds.

Assessment: 1) Renal cell carcinoma, right kidney. 2) History of kidney cancer. 3) Diabetes mellitus with CKD stage 2 (GFR 60-89). 4) Spinal stenosis of lumbar spine. 5) Solitary pulmonary nodule.

Plan: He would be referred to pulmonary medicine for evaluation of lung nodule(s). He would repeat CT of chest in 3 months. He was prescribed Metformin, Amlodipine, Losartan/HCTZ, Lovastatin, Fenofibrate, Clopidogrel (ASA allergy). Laboratory work ups were ordered.

Laboratory Report, Kaiser Permanente, dated February 5, 2020.

The results were within normal limits.

Occupational Therapy Progress Report, signed by Kathleen Jefferies, O.T., Kaiser Permanente, dated February 19, 2020.

The applicant was seen for therapy.

Interventions include ice application, paraffin baths, ultrasound, ergonomic education, functional activities/training, home exercise program, postural education, and therapeutic exercise.

Office Visit/Progress Report, signed by Alexander Berdy, M.D., Kaiser Permanente, dated February 21, 2020.

The applicant presented for lab results.

Medications: He was on Fluticasone 50 mcg/act, Amlodipine 10 mg, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Triamcinolone 0.1%, Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac 1%, Sennosides 8.6 mg, Metformin 500 mg, and Flunisolide 25 mcg.

Vital Signs: He had a blood pressure of 142/75 mmHg with pulse rate of 69 bpm. He weighed 192 pounds.

Assessment: 1) Diabetes mellitus with CKD stage 3 (GFR 30-59) with hypertension. 2) Vaccination for strep pneumonia with pneumovax. 3) Essential hypertension. 4) Hyperlipidemia. 5) Obesity, BMI 32-32.9, adult. 6) Adult obstructive sleep apnea. 7) Diabetes mellitus 2. 8) History of transitional cell carcinoma, right kidney.

Plan: Vaccination was offered. Laboratory work ups were ordered. He was referred to nephrology. He was prescribed Losartan-Hydrochlorothiazide 100-12.5 mg.

Office Visit/Progress Report, signed by George Yuen, M.D., Kaiser Permanente, dated February 27, 2020.

The applicant had history of renal cell carcinoma status post nephrectomy in June 2019 – negative margins – Stage 1 (pT1b, Nx). CT of abdomen and pelvis on December 18, 2019 noted right lower lobe nodule – lobulated and solid – 8 mm. Follow up chest CT on December 30, 2019 with 8 mm right lower lobe nodule but no other nodules. Referred by Dr. Lou in oncology for evaluation of lung nodule.

He was no known lung disease. Very remote experimentation with smoking in the 1970's – minimal total exposure. No pulmonary symptoms – no chest pain, shortness of breath, and cough.

He worked as a dentist. He was in the military for 28 years.

Family History: Positive for colon cancer.

Medical History: Significant for hyperlipidemia, essential hypertension, sleep disorder/apnea, obesity (BMI 30-39.9), elevated transaminase, diabetes mellitus 2 (controlled), and left sensorineural hearing loss.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Family History: Positive for coronary artery disease, eczema, stroke, colon cancer, prostate cancer, allergic rhinitis, and asthma.

Vital Signs: He had a blood pressure of 136/70 mmHg with pulse rate of 76 bpm. He weighed 191 pounds.

Assessment/Plan: 1) Solitary pulmonary nodule. 2) Renal cell carcinoma, right kidney.

In context of underlying history of renal cell carcinoma, nodule could be metastatic lesion. Doubt infection or inflammatory. Discussed diagnosis of lung nodule. Size and location would make biopsy difficult technically and pose higher risk of complications. At <1 cm size, PET scan likely to be negative. Follow up CT imaging in 3 months from last scan (already ordered by Dr. Choi) was reasonable next step. If there was interval increase in the nodule then PET CT likely next step versus resection. Check inflammatory and fungal markers.

Office Visit/Progress Report, signed by William Chen, M.D., Kaiser Permanente, dated March 3, 2020.

The applicant had history of diabetic nephropathy with microalbuminuria. H also had recent kidney cancer status post nephrectomy. He had history of hypertension. He had progressive microalbuminuria and borderline blood pressure. He was increasing Losartan to 100 mg.

He was recently found to have nodule on CT chest. He was followed by pulmonary and oncology. He had repeat CT chest in April 2019.

Medical History: He had significant diabetes mellitus and hypertension for 10 years, obstructive sleep apnea on CPAP, obesity, and right transitional cell carcinoma status post nephrectomy in June 2019.

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

Family History: Positive for MI, diabetes mellitus, and colon cancer.

Allergies: He is allergic to Lisinopril, Aspirin, and Atorvastatin.

Medications: He was on Losartan-Hydrochlorothiazide 100-12.5 mg, Amlodipine 10 mg, Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg, and Metformin 500 mg.

Vital Signs: He had a blood pressure of 153/82 mmHg with pulse rate of 64 bpm. He weighed 191 pounds.

Assessment: 1) Chronic kidney disease 3. 2) Hypertension. 3) Diabetes mellitus for 10 years. 4) Obstructive sleep apnea. 5) Obesity, BMI 35. 6) Right transitional cell carcinoma status post nephrectomy in June 2019.

Plan: He was advised to continue good blood sugar control. He was advised to target blood pressure <130/80. He was to change Losartan-HCTZ to Losartan 100 mg daily and Chlorthalidone 25 mg daily. He would repeat labs and blood pressure

in 1 week. He was to work on weight loss. He was advised nephrotoxins. He would be re-evaluated if renal function stable for IV contrast before July imaging. He was educated regarding the importance of blood pressure and blood sugar control to slow the progression of kidney disease. He was advised to avoid nephrotoxic medications including NSAIDS.

Laboratory Report, Kaiser Permanente, dated March 20, 2020.

The results were within normal limits.

Laboratory Report, Kaiser Permanente, dated March 20, 2020.

BUN was elevated at 20 mg/dL.

Electrolyte panel revealed low chloride at 100 mEq/L and high anion gap at 13 mEq/L.

Creatine was increased at 1.46 mg/dL.

Glomerular filtration rate was decreased at 49 mL/min/BSA.

That completes the review of records.

IMPRESSIONS AND DISCUSSION

I have had the opportunity to review these medical records, some of which I have had the opportunity to review in the past. Updated newer medical records demonstrated this gentleman did develop a clear cell cancer of his kidney and did undergo a nephrectomy. There is no evidence of any spread of the cancer.

I have had an opportunity to review some of the medical literature, and although there are articles that show that some patients presenting with new onset hypertension, who have a renal cancer that is identified, can have a correction of this hypertensive condition after a nephrectomy and removal of the cancer, this is not present in this case. Mr. SooHoo did undergo a nephrectomy, but his blood pressure remains elevated, despite the use of anti-hypertensive medications.

In my previous reports dated June 10, 2019, it was my opinion that a 30% whole person impairment was present with regard to his hypertension, according to Table 4-2 in the AMA Guides. It was also my opinion that 85% of the disability associated with this impairment was, in fact, pre-existing, and non-industrial. I did apportion 15% of the disability related to his hypertension to the emotional stress

that he experienced during the course of his employment at the California Institute for Men.

The review of these additional medical records and the discovery of his renal cell cancer does not change my opinion regarding either the amount of impairment or the apportionment of disability in this case. It is my opinion that treatment for his renal cell cancer should be on a non-industrial basis. Treatment for his hypertension should continue on an industrial basis as previously outlined.

I have not had the opportunity to re-evaluate this gentleman, and last saw him in 2018. I do not feel that a re-evaluation is necessary at this time unless the parties in this case wish for me to consider any other work-related internal medicine issues besides his hypertension.

I appreciate the opportunity of reviewing these medical records. I trust that this report is helpful in the overall management of this case. If I can provide any further information regarding his condition and disability, please fell free to contact me.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this evaluator.

I, Stewart Lonky, M.D., F.A.C.P., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as the qualified medical evaluator, in the specialty of Internal Medicine and Pulmonology, for this most interesting case and condition.

Sincerely,

Stewart A. Lonky MD

Stewart Lonky, M.D., F.A.C.P., Q.M.E.
California Medical Evaluators
Board-Certified in Internal Medicine and Pulmonology

Attachments:

1. Appendix A: Declaration
2. Appendix B: Declaration from ADJ

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained 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 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, that I believe it to be true.

DATE OF REPORT: March 3, 2022

Dated this 3rd day of March 2022, at Los Angeles County, California.

Stewart A. Lonky MD

Stewart Lonky, M.D., F.A.C.P., Q.M.E.
California Medical Evaluators
Board-Certified in Internal Medicine and Pulmonology

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: George SooHoo *(employee name)* v Gabrielle Akierman *(claims administrator name, or if none employer)*

Claim No: 6380832 **EAMS or WCAB Case No. (*if any*):** ADJ11815610

I, Liz Arellano *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My Business address is: 11620 Wilshire Blvd Ste. 340, Los Angeles, CA. 90025
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:

A	depositing the sealed envelope with the U.S. Postal Service with postage fully prepaid.
B	placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.
C	placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.
D	placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*
E	personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	03/02/2022	George SooHoo 2506 Lighthouse Lane, Corona Del Mar, CA 92625
A	03/02/2022	Gabrielle Akierman P.O. Box 65005 Fresno, CA 93650
A	03/02/2022	
A	03/02/2022	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: March 2, 2022

(signature of declarant)

Liz Arellano *(print name)*

Declaration of Service of Medical – Legal Report (Lab. Code § 4062.3(i))

Case Name: George SooHoo *(employee name)* v Gabrielle Akierman *(claims administrator name, or if none employer)*

Claim No: 6380832 **EAMS or WCAB Case No. (*if any*):** ADJ11815610

I, Liz Arellano *(Print Name)*, declare:

1. I am over the age of 18 and not a party to this action.
2. My Business address is: 11620 Wilshire Blvd Ste. 340, Los Angeles, CA. 90025
3. On the date shown below, I served this QME Findings Summary Form with the original or a true and correct copy of the original, comprehensive medical-legal report, which is attached, on each of the persons or firms named below, by placing it in a sealed envelope, addressed to the person or firm named below, and by:

A — depositing the sealed envelope with the U.S. Postal Service with postage fully prepaid.

B — placing the sealed envelope for collection and mailing following our ordinary business practices. I am readily familiar with this business's practice for collecting and processing correspondence for mailing, it is deposited in the ordinary course of business with the U.S. Postal Service in a sealed envelope with postage fully prepaid.

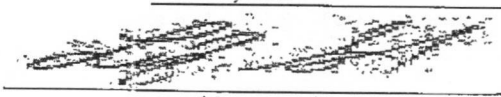
C — placing the sealed envelope for collection and overnight delivery at an office or a regularly utilized drop box of the overnight delivery carrier.

D — placing the sealed envelope for pick up by a professional messenger service for service. *(Messenger must return to you a completed declaration of personal service.)*

E — personally delivering the sealed envelope to the person or firm named below at the address shown below.

Means of service: *(For each addressee, enter A – E as appropriate)*	Date Served:	Addressee and Address Shown on Envelope:
A	03/02/2022	George SooHoo
A	03/02/2022	Gabrielle Akierman P.O. Box 65005 Fresno, CA 93650
A	03/02/2022	
A	03/02/2022	

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Date: March 2, 2022



(signature of declarant)

Liz Arellano *(print name)*

QME Form 111 (rev. February 2009)

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