Stewart Lonky, M.D., Q.M.E.

DIPLOMATE, AMERICAN BOARD OF INTERNAL MEDICINE AND PULMONARY MEDICINE
QUALIFIED MEDICAL EXAMINER

All Correspondence To:
11620 Wilshire Boulevard, Suite 340
Los Angeles, CA 90025
Tel: (888) 853-7944
Fax: (213) 377-5152

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

June 10, 2019

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

George SooHoo
2506 Lighthouse Lane
Corona Del Mar, CA 92625

Re:	George SooHoo
Applicant's DOB:	11/28/1953
Employer:	California Institute for Men
Date of Injury:	07/06/2018
Claim/File No.:	06380832
Panel No.:	2303154

Billed under ML-106, time spent includes:

1. Review of medical records **14.00 hours**
2. Preparation, writing and editing of this report. **1.50 hours**

Dear Parties:

As you will recall, I had the opportunity to serve as the Panel Qualified Medical Evaluator in the specialty of Internal Medicine for this patient on 11/14/2018 in my Garden Grove office. At that time, I evaluated this gentleman and issued a report that was dated 12/14/2018. In that report, I outlined the factors of his history, including the stressful events that occurred during the course of his employment at the facility in Chino, California, specifically the stress of that employment that occurred between 08/01/2015 and 07/06/2018 as well as a specific injury that occurred on 07/06/2018. It was my opinion that there was clearly hypertension, and at that time I was awaiting the results of some testing and forwarding of complete medical records.

I am now in receipt of echocardiogram as well as a carotid duplex scan. I am also in receipt of additional medical records. The following is a review of those records and results of testing and my comments.

REVIEW OF LABORATORY DATA

A two-dimensional echocardiogram was obtained on this gentleman. At the time of my initial evaluation, the results were pending. At this time, the echocardiogram was read by Dr. Ronald Carlish, an echocardiographer. There was hypertrophy of the posterior left ventricular wall with mild left ventricular and left atrial enlargement. The ejection fraction was 60%, but there was diastolic dysfunction that was noted as well. This echocardiogram is consistent with hypertension-induced ventricular hypertrophy and diastolic dysfunction.

A carotid duplex scan was also obtained on this gentleman. There were mild bilateral linear plaquing that was seen not exceeding 25%. Flow velocities were entirely within normal limits. This is a normal carotid duplex scan.

REVIEW OF MEDICAL RECORDS

REVIEW OF FILE

Approximately 1832 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:

Cover Letter, signed by Gabrielle Akierman, claims representative, dated April 11, 2019.

Since the last evaluation, the applicant's prior medical records had been obtained for review. A CD copy of records from Kaiser Permanente would be delivered in a separate package. The package would be sent by the copy service vendor, Ontellus.

It was requested that this examiner review the records and issue a supplemental report with the findings. It was also recommended that all medical and non-medical records reviewed be listed, pursuant to Section 10606(b) (4) of the California Code of Regulations. Records should be disposed in a manner that ensured medical confidentiality or be returned to State Fund for disposal.

This examiner was asked to examine the applicant because there was a dispute over compensability of the reported injury. The injured had been alleged as a cumulative trauma that began on August 1, 2015 and ended on July 6, 2018 while employed as a supervising dentist with CA Institution of Men. He alleged headaches as well as injuries to the circulatory system, back, ears, hands, right hip, and psyche. This examiner was advised to revisit discussion of causation in the supplemental report and only address the body parts within the field of expertise.

Lastly, this examiner was asked to discuss if the additional records changed any of the opinions made in the December 14, 2018 report. A basis for opinion should be provided.

Bill and original report should be submitted to State Compensation Insurance Fund. Likewise, a copy of the report was to be sent to the applicant's attorney.

MEDICAL RECORDS:

Office Visit, signed by Kevin Yuhan, M.D., 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: Floaters, left eye, with no "RD" [retinal detachment] or "RT" [retinitis pigmentosa]. No instructions were given.

Progress Note, signed by Jeff Tracy, M.D., 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, signed by Pauline Chang, O.D., 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.

Progress Note, signed by Zahra Ghiasi, M.D., 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 Note, by Michele Rios, M.A., 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.

Progress Note, signed by Jeff Tracy, M.D., 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, signed by Pauline Chang, O.D., 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.

Progress Note, signed by Zahra Ghiasi, M.D., 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.

Email addressed to the applicant, by Deborah Falcon, N.P., dated February 20, 2008.

The applicant's most recent blood pressure was elevated. He was overdue for hypertension management. He was advised to make an appointment with his physician or with the nurse practitioner.

Progress Note, signed by Khang Nguyen, M.D., 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.

Call Documentation, signed by Lady Plaza, M.A., dated March 4, 2008.

The applicant called, stating that his blood pressure had been high for 2 days after his blood pressure medication was switched from Vytorin to Lisinopril-Hydrochlorothiazide. He wanted to have an appointment scheduled for tomorrow.

Call Documentation, signed by Khang Nguyen, M.D., dated March 5, 2008.

The applicant developed dry cough and headaches after Lisinopril. He was advised to stop Lisinopril and restart Potassium and Hydrochlorothiazide.

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.

Progress Note, signed by Khang Nguyen, M.D., 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.

Progress Note, signed by Rana Sajjadian, M.D., 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, signed by Rana Sajjadian, M.D., 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, signed by Sajjad Syed, M.D., dated October 21, 2008.

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

Call Documentation, signed by Khang Nguyen, M.D., dated October 23, 2008.

The applicant was due for labs.

Call Documentation, signed by Lady Plaza, M.A., dated October 24, 2008.

The applicant was worried about his recent blood test. Lipid, glucose, and urine albumin came back high. He discontinued Vytorin about a few months ago. His current medications included Amlodipine 10 mg, K-Tab 10 mEq, and Hydrochlorothiazide 25 mg.

Call Documentation, signed by Khang Nguyen, M.D., dated October 26, 2008.

The applicant was advised to put on hold Amlodipine 10 mg. He was prescribed Amlodipine 5 mg per day, Cozaar 25 mg 2 pills at night, and Lopid 600 mg twice per day. He was given number for high cholesterol class. He was to present to nurse clinic in 1 week for blood pressure check as well as for non-fasting labs. He was to repeat fasting labs in 2 months.

Progress Note, signed by Beny Tadina-Himes, R.N., dated November 4, 2008.

The applicant presented for blood pressure check. He had a blood pressure of 140/70 mmHg and a pulse rate of 63 bpm. He was asymptomatic. He was encouraged to exercise, engage in stress relieving activities, and follow sodium diet.

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

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

Progress Note, By Diann Pedregon, C.H.E., dated November 11, 2008.

The applicant did not attend Lifestyle and Weight Management class.

Progress Note, signed by Mary Jane Leones, R.N., dated December 10, 2008.

The applicant was seen for blood pressure check. He had a blood pressure of 141/76 mmHg and a pulse rate of 72 bpm. His medications included Amlodipine 5 mg, Cozaar 25 mg, and Hydrochlorothiazide 25 mg. He was compliant with medications; however, blood pressure was not at goal. He had an appointment with his primary care physician.

Call Documentation, signed by Julie Rivera, R.N., dated December 10, 2008.

The applicant's wife called stating her husband had "painful vein" on the left side of chest that had been present for 4 to 5 days. It was tender to touch. There was no history of injury to the chest. He was offered appointment, but he wanted to wait to see Dr. Nguyen on December 12, 2008. He wanted to have labs done so that results would be available for Dr. Nguyen.

Progress Note, signed by Khang Nguyen, M.D., dated December 11, 2008.

The applicant developed left upper abdominal after strenuous exercise for military training. He was getting better at this time. He had improved microalbumin and was tolerating ARB. He complained of left-sided chest pressure that had been present for 2 weeks, not exertional. He noted heaviness, which was lasting 10-15 minutes.

Physical Exam: Cardiovascular exam revealed normal rate and regular rhythm. His blood pressure was 126/69 mmHg and pulse rate was 65 bpm. He weighed 195 pounds.

Assessment: 1) Atypical chest pain. 2) Abdominal pain resolving. 3) Allergic rhinitis. 4) Essential hypertension.

Plan: ECG was obtained. Treadmill stress test was ordered. Fluticasone 50 mcg/actuation nasal spray was refilled. Cozaar was increased to 100 mg. Laboratory studies including creatinine, BUN, random glucose, electrolytes, and urine microalbumin were ordered.

ECG, 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.

Email addressed to Khang Nguyen, M.D., by the applicant, dated December 17, 2008.

The applicant had taken Cozaar for a week and had been getting headaches. He felt "strange" and a little dizzy. Nonetheless, he would keep taking it for another week and see if his symptoms were due to cold he had previously or the increased strength of Cozaar. If the headaches persisted, he would go back to Cozaar 25 mg twice per day. He read a research indicating that it was better to take Cozaar twice per day vs. once per day.

Email addressed to the applicant, by Khang Nguyen, M.D., dated December 21, 2008.

The applicant was advised that Cozaar should work the same twice or once per day.

Call Documentation, signed by Khang Nguyen, M.D., dated February 16, 2009.

The applicant was due for non-fasting labs.

Email addressed to Khang Nguyen, M.D., by the applicant, dated February 17, 2009.

The applicant reported he was taking Cozaar 100 mg once per day, Amlodipine 10 mg once per day, Gemfibrozil 600 mg twice per day, K-Tab 10 mEq once per day, Hydrochlorothiazide 25 mg once per day, as well as vitamins. He complained of occasional coughing, which might be caused by the Cozaar.

Email addressed to the applicant, by Khang Nguyen, M.D., dated February 17, 2009.

The applicant was advised that his laboratory results were acceptable. He would be seen end of June. He was to do fasting labs 1-2 weeks ahead of time.

Progress Note, signed by Jeff Tracy, M.D., 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 Hands, signed by Alfonso Pham, M.D., dated March 24, 2009.

Impression: Unremarkable study of the hands.

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

Uric acid was high at 7.5. Lipid panel revealed decreased HDL at 31 with increased levels of triglyceride at 199 and cholesterol/HDL at 5.1. Fasting glucose and ALT were elevated at 127 and 76, respectively. Rheumatoid factor and ESR Westergren were normal.

Email addressed to Jeff Tracy, M.D., by the applicant, dated May 18, 2009.

The applicant was requesting glucose test. His medications included Gemfibrozil 600 mg, Amlodipine 5 mg, K-Tab 10 mEq, Hydrochlorothiazide 25 mg, Simvastatin 20 mg, Cozaar 100 mg, Derma-Smoothe/FS Oil, Triamcinolone 0.1% cream, and Triamcinolone 0.025% ointment.

Email addressed to the applicant, by Jeff Tracy, M.D., dated May 18, 2009.

The applicant was advised that his medications were working very well regarding the hyperlipidemia and high triglycerides; therefore, he was to continue same dosage. Regarding his blood sugar, it was too high and in the diabetes category. He needed to be diligent as possible with diet, exercise, and weight loss. He would have repeat labs in 3 months, along with a glucose tolerance test.

Progress Note, signed by Saeed Torabzadeh, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

ED Provider Note, signed by Bradley de Marquette, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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, Au.D., 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.

Consultation, signed by Annette Luetzow, M.D., 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.

Progress Note, signed by Annette Luetzow, M.D., 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.

MRI of the Brain without Contrast and Internal Auditory Canals with and without Contrast, signed by Peter Abdel-Sayed, M.D., dated October 21, 2009.

Findings: The ventricles and sulci were normal. No acute infarct or hemorrhage was seen. Normal flow voids were seen in the intracranial vessels. Posterior fossa structures were normal. The internal auditory canal images demonstrated no abnormal enhancement. No cerebellopontine angle mass was seen. The VII and VIII cranial nerves were grossly unremarkable. There was minimal thickening of the bilateral sphenoid sinuses and ethmoid air cells as well as the left frontal sinus.

Impression: Unremarkable MRI of the internal auditory canals.

Progress Note, signed by Annette Luetzow, M.D., dated October 28, 2009.

The applicant was seen for third Dexamethasone injection. He thought his tinnitus was less. His MRI was normal.

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: Third Dexamethasone injection was done. He was to return to clinic for audiogram.

Progress Note, signed by Annette Luetzow, M.D., 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.

Audiology Report, signed by Mehrnaz Karimi, Au.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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., dated December 4, 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.

Progress Note, signed by Roberto Cueva, M.D., 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.

Physical Therapy Shoulder Initial Evaluation, signed by Ruth Millan, P.T., 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.

Audiologic Evaluation, signed by Rosalia Aiello, Au.D., dated January 12, 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.

Progress Note, signed by Annette Luetzow, M.D., dated January 13, 2010.

The applicant was seen in follow-up after hearing test. On examination, his blood pressure was 96/54 mmHg and pulse rate was 90 bpm. He weighed 200 pounds.

Assessment: Sudden hearing loss in the left ear, status post 3 Dexamethasone injections and oral steroids. His hearing was without much change, but tinnitus was less and discrimination score significantly improved. He was medically cleared for hearing aid in the left ear.

Plan: He had appointment at HeaRX. He was to return in 6-12 months for audiogram, but immediately if there was any new sudden loss.

Progress Note, signed by Ruth Millan, P.T., dated January 27, 2010.

The applicant was discharged from physical therapy due to lack of attendance. He was evaluated for shoulder pain on December 18, 2009 and then canceled all

scheduled appointments thereafter. Apparently, he had been too busy to attend sessions. He would require a new referral from his doctor to resume treatment.

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.

Email addressed to the applicant, by Jeff Tracy, M.D., dated February 12, 2010.

The applicant was advised that all laboratory results looked good with stable liver function test. Diabetes was at goal, but worse control. However, there was still no need for diabetes medication. His LDL was above goal of 100. He should either improve diet or increase Simvastatin to 40 mg every night. Since he was "pretty close," he was to improve diet, exercise, and habits. Repeat lab in 1-2 months was recommended.

Email addressed to the applicant, by Roberto Cueva, M.D., dated February 22, 2010.

The test indicated that the applicant's diabetes was not in particularly good control. As discussed, high blood pressure, high cholesterol, and diabetes were all factors that might affect microcirculation. He was advised to follow up with his primary doctor to work on these problems.

Email addressed to the applicant, by Jeff Tracy, M.D., dated March 7, 2010.

The applicant's laboratory results were improved regarding diabetes and stable regarding cholesterol, triglycerides, and liver function test. He was to schedule a routine follow-up within the next 2-3 months or so.

Email addressed to Jeff Tracy, M.D., by the applicant, dated May 28, 2010.

The applicant developed tinnitus in September or October of last year. He was started on Simvastatin 20 mg and Cozaar 100 mg around the same time. He spoke with Dr. Jack Shonet, ENT specialist, who told him that the high blood pressure medications would have an impact on loss of hearing and tinnitus. Other medications included Gemfibrozil 600 mg, Amlodipine 5 mg,

Hydrochlorothiazide 25 mg, and K-Tab 10 mEq. He was in the midst of refilling the prescriptions. He wanted to know if he needed to hold up on these refills.

Email addressed to the applicant, by Jeff Tracy, M.D., dated May 31, 2010.

The applicant was advised that Cozaar was first received in October 2008 and Simvastatin in May 2009. He was on Vytorin dating back to May 2007. The case would be discussed to the head and neck surgery department to see if they felt that the medications could be causal, and if so, one could certainly give a trial off of them to see if the symptoms improved. He would need to stop one of the medications for 1 month or so, and then resume, to see if the symptoms improved then recurred.

Email addressed to the applicant, by Jeff Tracy, M.D., dated August 30, 2010.

As the laboratory results looked very good, there would be no changes to the applicant's treatment. He was advised to schedule an appointment for a routine visit.

Progress Note, signed by Jeff Tracy, M.D., 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.

Call Documentation, signed by Marielle Bautista, L.V.N., dated January 11, 2011.

At last visit in September 2010, the applicant was told to come in for fasting labs. He was unable to present as he was on military duty. He was requesting that laboratory studies be authorized at this time.

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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Saisiri Chaichan, R.N., dated February 4, 2011.

The applicant had undergone One Touch Ultra2 Blood Glucose Monitoring Education.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Philip Quirk, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Email Addressed to Jeff Tracy, M.D., signed by the Applicant dated May 23, 2012.

The applicant was requesting referral to Dr. Hege Sarpa for his dermatological evaluation and treatment.

Progress Note, signed by Hege Sarpa, M.D., 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.

Progress Note, 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.

Progress Note, 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.

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 Note, 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.

Progress Note, signed by Philip Quirk, M.D., Kaiser Permanente dated September 18, 2013.

The applicant was seen for diabetic eye examination.

Impression: No retinopathy.

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

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.

Progress Note, 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 Note, 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 Ribs, 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.

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

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.

Therapy Progress Note, 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.

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

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

Therapy Progress Note, 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.

Therapy Progress Note, 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.

Progress Note, signed by Robert Andrew, 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.

Therapy Progress Note, 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.

Therapy Progress Note, 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.

Therapy Progress Note, 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.

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.

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

X-rays of the Lumbar Spine, signed by David Alavarez, M.D., Kaiser Permanente dated September 25, 2015.

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.

Dermatology Progress Note, signed by Aparche Yang, M.D., Kaiser Permanente dated December 11, 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 montsn.

Ultrasound of the Left Axilla, 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.

Progress Note, signed by Eve Stebila, R.N., dated January 5, 2016.

The applicant presented for patch testing, which was applied to upper back. He was advised to avoid heavy exercise as well as to avoid getting the area wet until patch test reading.

Progress Note, signed by Eve Stebila, R.N., dated January 7, 2016.

The applicant was seen for 48-hour check of allergen patch test. He had weak reaction to #4 (Potassium Dichromate) and #15 (Carba Mix) as well as strong reaction to #28 (Gold Sodium Thiosulfate) and #35 (Disperse Blue 106).

MRI of the Left Axilla, signed by Michael Kabiri, M.D., dated January 11, 2016.

Impression: No significant abnormality.

Dermatology Progress Note, signed by Aparche Yang, M.D., 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.

Progress Note, signed by Jeff Tracy, M.D., 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.

Progress Note, signed by Alan Evans, M.D., 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.

Internal Medicine Office Visit Progress Note, signed by Alexander Berdy, M.D., 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.

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

Internal Medicine Office Visit Progress Note, signed by Alexander Berdy, M.D., 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.

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.

Internal Medicine Office Visit Progress Note, signed by Alexander Berdy, M.D., 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.

Progress Note, signed by Richard Kim, D.O., 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.

Progress Note, signed by Loretta Lee, Au.D., dated January 11, 2017.

The applicant had a history of occupational and military noise exposure. He had an episode of sudden hearing loss in the left ear. The high frequency hearing in the left ear had not recovered. He would like to hear better from the left side.

Impression: Testing suggested mild sloping to moderate high-frequency sensorineural hearing loss at 3 kHz-8 kHz. There was severe sensorineural hearing loss at 1 kHz-8 kHz in the left ear. There had been no significant change in the hearing sensitivity since January 12, 2010.

Hearing aid evaluation was recommended. Audiologic reevaluation would be in 3 years.

Progress Note, signed by Kevin Yuhan, M.D., dated January 22, 2017.

The applicant was seen in follow-up for ocular hypertension. Assessment: 1) Intraocular pressure at 23 bilaterally. 2) OCT/FDT was within normal limits. Plan: Use of high eyelid squeezer was recommended.

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

Impression: Colon polyp/s.

Pathology Report, signed by Albert Huang, M.D., 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.

Progress Note, signed by Sandra Herman, M.D., 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

Progress Note, signed by Sandra Herman, M.D., 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 Knee, signed by Anthony Caldarone, M.D., 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.

Internal Medicine Office Visit Progress Note, signed by Alexander Berdy, M.D., 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.

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

Internal Medicine Office Visit Progress Note, 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.

Progress Note, 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.

Internal Medicine Office Visit Progress Note, 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.

Progress Note, signed by Kristin Stevens, M.A., Kaiser Permanente dated July 13, 2018.

The applicant had a blood pressure if 157/84 mmHg. His pulse rate was 101 bpm.

Internal Medicine Office Visit Progress Note, 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 Office Visit Progress Note], 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.

Progress Note, signed by Violeta Martinez, L.V.N., Kaiser Permanente dated July 25, 2018.

The applicant had blood pressure of 130/58 mmHg. His pulse rate was 69 bpm.

Dermatology Progress Note, signed by Aparche Yang, M.D., Kaiser Permanente dated September 6, 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.

Progress Note, 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.

Internal Medicine Office Visit Progress Note, 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.

Progress Note, signed by Violeta Martinez, L.V.N., Kaiser Permanente dated October 4, 2018.

The applicant had blood pressure of 131/71 mmHg. His pulse rate was 65 bpm.

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

Progress Note, 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.

Progress Note, 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.

Progress Note, 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.

Progress Note, signed by Noubar Ouzounian, M.D., Kaiser Permanente dated November 21, 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.

Progress Note, 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-ray 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.

Dermatology Progress Note, 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.

Progress Note, 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.

That completes the review of records.

IMPRESSION AND DISCUSSION

I have had the opportunity to review the echocardiogram, which does show left ventricular hypertrophy. It should be stated at this time, therefore, that it is my opinion that there is an impairment regarding his hypertension, which is not a Class 2 impairment, as described previously in my initial report, but rather a Class 3 impairment, according to Table 4-2 in the AMA Guides. It is my opinion that there is a 30% whole-person impairment that is present with regard to Dr. Soohoo's hypertension. It is my opinion that this is at maximum medical improvement at this time, according to the blood pressure readings that I have seen in the medical records, although his blood pressure was modestly elevated at the time of my evaluation. This is most likely secondary to "white-coat hypertension" and the fact that he was in my office to recount stressful episodes that occurred during the course of his employment as described.

The medical records do demonstrate the fact that from at least 2007 until 2018, his medical therapy was fairly consistent. It has consisted of amlodipine at 5 mg a day, as well as losartan/hydrochlorothiazide at a fixed dose. His blood pressure

was reasonably well-controlled, starting approximately in December 2008 and lasting through an evaluation, which took place when he was complaining of significant stress at work, in 2018.

Given the history that I obtained from this gentleman, there is reason to believe that his blood pressure did transiently elevate at that time, requiring his physicians to increase his amlodipine from 5 mg to 7.5 mg. He is currently on this dose of medications, or at least was when I evaluated him in November 2018.

Overall, therefore, it is my opinion that there are some important factors to discuss regarding his hypertensive impairment and the disability associated with it.

Given these medical records, it is my opinion that the hypertension in Dr. Soohoo pre-existed the stressful events that occurred during the course of his employment. There has been a mild aggravation of his hypertension as a result of the emotional stress that he experienced, as described in the history in my initial report. The aggravation of his hypertension, however, is a minor part of the overall contribution to his current disability. Therefore, given all of the information I have and my experience as an internal medicine physician for over 35 years, that the contribution of the emotional stress during the course of his employment was a small part of his current disability.

Taking all of these facts into consideration, it is my opinion that with regard to apportionment, 85% of this gentleman's disability related to his hypertension should be attributed to pre-existing hypertension and considered not industrial. The remaining 15% of this gentleman's disability secondary to his hypertension should be considered industrial, and secondary to the aggravation of his hypertension secondary to the intense emotional stress experienced as a result of the poor interpersonal relationships with his supervisor/CEO, as well as specific events that occurred on 07/06/2018.

It is my opinion, given the industrial contribution to his hypertension, however, that future treatment for his hypertension be provided for on an industrial basis. This would include continued treatment with his medications, and monitoring renal function, as well as monitoring for cerebrovascular complications of his hypertension.

I appreciate the opportunity of evaluating these records and trust that this report, complete with a review of the testing, is helpful in the overall management of this gentleman's case.

If I can provide any further information regarding his condition or his disability, please feel free to contact me.

Finally, I note that the letter and records dated 04/11/2019, were received in my office on 04/11/2019; therefore, I am issuing this report within the 60 days required by the QME regulations.

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 examiner, including the applicant's direct anamnesis.

I, Stewart Lonky, M.D., Q.M.E., formulated all conclusions and opinions.

Thank you for the opportunity of serving as Qualified Medical Examiner, in the specialty of Internal Medicine, for this most interesting case and condition.

Sincerely,

Stewart A. Lonky MD

Stewart Lonky, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine and Pulmonary Medicine

SL/KX/sk

Attachments:
1. Appendix A: Declaration

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: June 10, 2019

Dated this 10th day of June 2019, at Los Angeles, California.

Stewart A. Lonky MD

Stewart Lonky, M.D., Q.M.E.
Diplomate, American Board of Internal Medicine and Pulmonary Medicine