Jonathan C. Ellis, M.D., Q.M.E.
QUALIFIED MEDICAL EVALUATOR

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PANEL QUALIFIED MEDICAL EVALUATION IN THE SPECIALTY OF INTERNAL MEDICINE AND GASTROENTEROLOGY

April 3, 2022

Robert E. Bull
State Compensation Insurance Fund
P.O. Box 65005
Fresno, CA 93650

Natalia Foley, Esq.
Workers Defenders Law Group
5753 E. Santa Ana Canyon Rd., Ste. G616
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George SooHoo
2506 Lighthouse Lane
Corona Del Mar, CA 92625

Re:	George SooHoo
Employer:	California Institution for Men
WCAB No.:	ADJ11816510
Panel No.:	7448594
Applicant DOB:	11/28/1953
Date of Injury:	06/11/2021
Claim No.:	06626670
Date of Evaluation:	03/17/2022
Place of Evaluation:	Remote

My discussion begins on page 104.

Dear Parties:

Pursuant to your authorization, Mr. George SooHoo underwent a remote Panel Qualified Medical Evaluation, in the specialty of Internal Medicine and Gastroenterology on 03/17/2022 at my Santa Ana office. The undersigned acted in the capacity of Panel Qualified Medical Evaluator, in the specialty of Internal Medicine and Gastroenterology.

This evaluation was conducted through California Medical Evaluators' secure HIPAA compliant remote evaluation platform in accordance with QME Emergency Regulations effective January 18, 2022. These regulations state, in relevant part:

§ 46.3 Emergency Regulation Regarding Medical-Legal Evaluations in Response to continued COVID-19 Pandemic

During the period that this emergency regulation is in effect, a QME, AME, or other medical-legal evaluation may be performed in the circumstance where the physician and the injured worker are not in the same physical space or site during the evaluation. The evaluation shall be performed by way of telehealth through the use of electronic means of creating a virtual meeting between the physician and the injured worker.

Dr. Ellis conducted the interview, reviewed all records, performed a physical examination, and formulated the diagnosis, conclusions, and discussion, including the opinion on causation, temporary disability, permanent disability, degree of disability, future care, work restrictions, and apportionment. The report was authored by Dr. Ellis. All opinions expressed herein are solely the opinions of Dr. Ellis.

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

"Any documents sent to the physician for record review must be accompanied by a declaration under penalty of perjury that the provider of the documents has complied with the provisions of Labor Code section 4062.3 before providing the documents to the physician. The declaration must also contain an attestation as to the total page count of the documents provided. A physician may not bill for review of documents that are not provided with this accompanying required declaration from the document provider. Any documents or records that are sent

to the physician without the required declaration and attestation shall not be considered available to the physician or received by the physician for purposes of any regulatory or statutory duty of the physician regarding records and report writing."

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

Before I began the examination, the applicant was informed that this evaluation was being done exclusively in connection with the Workers' Compensation claim at the request of an attorney, attorneys or insurance companies, and that no treatment relationship existed. The applicant was also made aware that any communication between us is not privileged (no doctor-patient confidentiality exists) and that any information provided, as well as the results of any testing and my conclusions regarding the case, would be included in a report that may be read by people involved in the resolution and/or litigation of the claim. The applicant was advised of his or her rights pursuant to QME regulation 40. The applicant stated that the aforementioned was understood, and agreed to proceed with the evaluation. The report belongs to the party or parties requesting the evaluation.

BILLING

This report has been prepared pursuant to the provisions of 8 Cal. Code Regulations §9795 as a **ML-201-95** Comprehensive Medical-Legal Evaluation conducted by a Qualified Medical Evaluator.

Time spent includes:

1. Face-to-face interview with the applicant : **1.00 hour**

The number of pages reviewed **3,593 pages.**

Pages reviewed from AA: 0
Pages reviewed from Defense: 3,593

IDENTIFYING DATA

Per the cover letter, the applicant is a dentist who has filed a DWC claim alleging

injuries involving his lungs, heart, soft tissue-head, teeth, feet, internal organs on 6/11/21. I have been asked to address this claim.

DWC forms indicate that the claim is made "on the basis of "stress and strain due to repetitive physically traumatic activities and continuing exposure to the harmful chemicals injuring lungs, skin, kidney, stomach, joints, allergies, headache, foot, heart, teeth."

Records indicate that there are other claims dated 1/1/15-6/10/21 and 8/1/15-7/6/18 which involve the applicant's neck, shoulders, hands, back, stress, anxiety, depression, PTSD.

The applicant states that another claim has been filed which is related to being struck by a door. The applicant was not certain of the date, but states that this claim was filed about 5 months ago.

The applicant has military service-connected disabilities of 50% for post-traumatic stress disorder, and 10% for tinnitus.

REVIEW OF RECORDS PROVIDED BY APPLICANT

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

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

REVIEW OF RECORDS PROVIDED BY DEFENSE

Approximately 3593 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 Robert Bull, dated March 1, 2022.

The examiner agreed to examine the applicant as the Qualified Medical Evaluator. The examiner was to determine if an industrial injury or illness had occurred.

You are being asked to examine George Soohoo because there exists a dispute over the compensability of the reported injury.

Background: The applicant had alleged an injury to his lungs, heart, soft tissue-head, teeth, feet (both), internal organs on June 11, 2021 while employed by Ca Institution for Men Attn: Return to Work Office as a supervising dentist, hired on January 24, 1994. Please address the injures related to your specialty

Medical Records: Medical record(s) enclosed for your review. Also enclosed for review were Claim Form, Application for Adjudication, and Medical records from Kaiser and VA Long Beach to be sent by Ontellus.

Please Address the Following in the Report:

1) A detailed medical and employment history, including any outside activities.

2) What is the diagnosis? Please describe the medical basis for your opinion.

3) Are your medical findings consistent with the mechanism of injury alleged by George Soohoo?

4) Please comment on the disputed findings of the treating physician. Do you agree or disagree with the treating physician's findings? Please be specific regarding the basis of your findings.

5) Is this a new injury or a continuation of a previous injury or illness?

6) What future medical treatment is reasonably necessary to cure or relieve the effects of the injury?

Workers' Compensation Claim Form (DWC 1), dated June 11, 2021.

The applicant suffered a cumulative trauma injury which began on June 11, 2020 and ended on June 11, 2021. He had stress and strain due to repetitive physically traumatic activities and continuing exposure to the harmful chemicals injuring lungs, skin, kidney, stomach, joints, allergies, headaches, foot, heart, and teeth.

Application for Adjudication of Claim, dated June 11, 2021.

The applicant while employed as dentist suffered a cumulative trauma injury which began on June 11, 2020 and ended on June 11, 2021. He had stress and strain due to repetitive physically traumatic activities and continuing exposure to the harmful chemicals injuring lungs, skin, kidney, stomach, joints, allergies, headaches, foot, heart, and teeth.

MEDICAL RECORDS:

Nocturnal Polysomnogram Report, Peter Fotinakes, M.D., University of California Sleep Disorders Center, dated September 13, 2000.

Impression: Severe obstructive sleep apnea.

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

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

He is allergic to Atorvastatin, Calcium, and Aspirin.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan: There was no change in spectacle prescription. Axis for the right eye lens seemed to be off by a little bit. It was recommended that a third party check it. On two of the lensometers, the right eye axis was off by 35 degrees. He was counseled about cataract and adaptation to new lenses. He was to follow up with ophthalmologist for glaucoma suspect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subjective: The applicant had hypertension, microalbuminuria and complained of left upper abdominal pain after strenuous exercise for military training. He was getting better. He also complained of left sided chest pressure for 2 weeks. 1 week after strenuous activity.

Vital Signs: He had a blood pressure of 126/69 mmHg, a pulse rate of 65 bpm and a weight of 195 pounds.

Assessment: 1) Chest pain, atypical. 2) Abdominal pain. 3) Allergic rhinitis. 4) Essential hypertension.

Plan: ECG and lab works were ordered. Fluticasone and Cozaar 100 mg were prescribed.

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

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

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

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

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

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

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

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

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

Impression: Unremarkable study of the hands.

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

Impression: Unremarkable study of the hands.

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

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

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

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

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

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

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

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

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

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

Diagnosis: Dyspepsia.

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

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

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

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

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

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

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

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

Assessment: Peripheral vertigo.

Plan: Meclizine 25 mg was prescribed.

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

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

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

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

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

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

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

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

Amoxicillin 500 mg was prescribed.

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

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

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

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

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

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

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

Results: On pure tone hearing evaluation, there was mild "HF" [high-frequency] sensorineural hearing loss in the right ear and mild to severe sensorineural hearing loss in the left ear. On speech discrimination performance, right ear was 100% at 55 dB and left ear 40% at 100 dB. On immittance measurements, type A tympanogram was suggestive of normal middle ear pressure and compliance, bilaterally.

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

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

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

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

Assessment: Sudden hearing loss, left, with vertigo.

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

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

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

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

Assessment: Sudden hearing loss, left, with vertigo.

Plan: Second Dexamethasone injection was done.

MRI of the Brain and Internal Auditory Canals, signed by Peter Abdel-Sayed, M.D., dated October 22, 2009.

Impression: Unremarkable MRI of the internal auditory canals.

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

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

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

Assessment: Sudden hearing loss, left, with vertigo.

Plan: Second Dexamethasone injection was done.

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

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

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

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

Office Visit/Progress Report, signed by Annette Luetzow, M.D., Kaiser Permanente, dated November 18, 2009.

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

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

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

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

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

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

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

Diagnosis: Sudden hearing loss.

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

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

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

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

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

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

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

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

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

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

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

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

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

Medications: These included Cozaar 25 mg 2 tablets daily, Gemfibrozil 600 mg 1 tablet 2 times daily 30 minutes before breakfast and dinner, K-Tab 10 mEq 1

tablet daily, Hydrochlorothiazide 25 mg 1 tablet daily, Simvastatin 20 mg 1 tablet daily at bedtime, and Amlodipine 5 mg 1 tablet daily.

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

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

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

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

HGB A1c was elevated at 6.7%.

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

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

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

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

Progress Note, signed by Rosalia Aiello, Au.D., dated January 12, 2010.

History: The applicant had been monitored for sudden hearing loss AS. Tinnitus AS. Noise exposure. Denied otalgia, dizziness.

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

Recommendations: Audiologic re-evaluation per HNS or in 1 year. Hearing aid evaluation with HEARx to discuss option of hearing aids with medical clearance.

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

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

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

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

Recommendations: Audiologic reevaluation and hearing aid evaluation were recommended.

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

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

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

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

His medications included Amlodipine 5 mg 1 tablet daily, Cozaar 25 mg 2 tablets daily, Gemfibrozil 600 mg 1 tablet 2 times daily 30 minutes before breakfast and 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan: The results of the laboratory test studies were reviewed with the applicant.

Office Visit/Progress Report, signed by Philip Quirk, M.D., Kaiser Permanente, dated February 21, 2011.

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

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

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

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

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

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

The ALT was elevated at 50.

The Hgb A1C was elevated at 6.4.

The fasting blood glucose was high at 103.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The fasting glucose was elevated at 104.

The Hgb A1C was 6.3.

The urine microalbumin was 27.9.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Hgb A1C was 6.2.

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

The ALT was otherwise within normal limits.

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

The applicant was seen due to sleep apnea.

Impression: No diagnosis found.

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

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

The BUN was elevated at 20.

The electrolyte panel and creatinine were otherwise within normal limits.

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

The Hgb A1C was 6.6.

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

The ALT was otherwise within normal limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

Physical Examination: Pulmonary examination showed wheezing.

Assessment: 1) Cough. 2) Rib contusion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Review of Systems: he had back pain.

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

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

Plan: He was placed off work.

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

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

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

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

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

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

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

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

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

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

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

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

Review of Systems: He had cyst in the neck.

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

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

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

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

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

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

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

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

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

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

The lipid panel showed increased levels of triglycerides at 241.

The Hgb A1C was elevated at 6.9.

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

The ALT and uric acid were otherwise within normal limits.

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

The applicant was seen for therapy.

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

Interventions include modalities and therapeutic exercise.

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

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

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

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

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

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

Assessment: 1) Severe obesity equivalent, BMI 35-35.9, adult with co-morbidity. 2) Diabetes mellitus type 2 with diabetic microalbuminuria. 3) Essential hypertension. 4) Hyperlipidemia. 5) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 (GFR 60-89). 6) Family history of colon cancer <50 years. 7) Low back pain.

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

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

The Hgb A1C was 6.8.

The ferritin was elevated at 506.

The BUN was elevated at 20.

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

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

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

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

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

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

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

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

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

The Alt was otherwise within normal limits.

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

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

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

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

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

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

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

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

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

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

On examination, he had diffuse rhonchi and wheezing.

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

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

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

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

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

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

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

Impression: Lymph node visualized.

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

The creatinine and BUN were within normal limits.

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

Impression: No significant abnormality.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hyperlipidemia. 4) Essential hypertension. 5) Severe obesity equivalent, BMI 35-35.9, adult, with co-morbidity. 6) Adult obstructive sleep apnea. 7) Screening exam for prostate cancer. 8) Diabetes mellitus type 2 with diabetic microalbuminuria.

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

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

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

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

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

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

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

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

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

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

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

The applicant was seen for eye examination.

Impression: No retinopathy.

Plan: He would be rechecked in 1 year.

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

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

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

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

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

Assessment: 1) Diabetes mellitus type 2. 2) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 3) Obesity with BMI of 32-32.9, adult. 4) Screening for diabetic foot disease, category 0 – normal diabetic foot. 5) Hyperlipidemia. 6) Essential hypertension. 7) Adult obstructive sleep apnea. 8) Screening exam for prostate cancer. 9) Left subjective tinnitus. 10) Screening for colon cancer.

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

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

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

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

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

Assessment: 1) Sinusitis. 2) Cough.

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

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

Impression: Colon polyp/s.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assessment: 1) Diabetes mellitus type 2 with diabetic chronic kidney disease stage 2 with GFR of 60-89. 2) Obesity with BMI of 32-32.9, adult. 3) Hyperlipidemia. 4) Essential hypertension. 5) Adult obstructive sleep apnea. 6) Diabetes mellitus type 2. 7) Myalgia due to statin.

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

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

The applicant was seen for therapy.

Diagnosis: Right ankle joint pain.

Interventions include therapeutic activity/exercise.

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

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

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

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

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

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

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

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

Assessment: Bacterial infection.

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

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

The applicant was seen for eye examination.

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

Plan: He needed glaucoma workup.

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

The applicant was seen for eye examination.

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

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

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

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

Assessment: 1) Sinusitis. 2) ABNL sputum.

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

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

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

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

Vital Signs: He weighed 195 pounds.

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

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

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

Subjective Complaints: The applicant was getting for Japan trip.

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

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

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

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

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

Objective Findings: He had pain with flexion extension.

Plan: He was to undergo diabetic foot exam.

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

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

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

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

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

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

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

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

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

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

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

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

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

Laboratory Report, Long Beach Healthcare, dated July 25, 2018.

Glucose had increased level at 130.0, SGPT at 48.0, triglycerides at 229 and HDL had decreased level at 34.

Primary Care Note, signed by Kartik Shah, M.D., Long Beach Healthcare, dated July 26, 2018.

History: The applicant had history of diabetes mellitus type 2, hypertension, hyperlipidemia, fatty liver disease, bilateral hearing loss, allergic rhinitis, dermatitis, chronic low back pain/lumbar DJD, OSA, depression and presented today for new patient visit. He was mainly here today to get his full records documented and service connected conditions documented. He was following on regular basis with his private PCP, and specialist on the outside. He stated that he works as a Dentist at local prison. He was scheduled with outside Psychiatrist for his depression. No other acute complaints today.

Allergies: He is allergic to Lisinopril, Aspirin related medications.

Vital Signs: He had a blood pressure of 149/82 mmHg, a pulse rate of 66 bpm and a weight of 193 pounds.

Assessment/Plan: 1) Diabetes mellitus type 2. Continue on Metformin XR 500mg. 2) Hyperlipidemia. Continue on Fenofibrate 54mg and Lovastatin 20mg. 3) Hypertension. Continue on Amlodipine 7.5mg and Losartan/HCTZ 50-12.5 mg. 4) Elevated LFTs/fatty liver disease. Advised extensively on weight loss, low fat diet, and decrease calorie intake. 5) Bilateral hearing loss. Will consult audiology. 6) Allergic rhinitis. Continue on Loratadine 10mg. 7) Dermatitis. Continue on Clindamycin, Triamcinolone and Hydrocortisone. 8) Chronic low back pain/lumbar DJD. Continue Diclofenac and back brace. 9) OSA. 10) Depression. He had psychiatrist scheduled on the outside. 11) History of colon polyps. 12) Prevention.

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

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

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

Vital Signs: He weighed 195 pounds.

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

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

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

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

Social History: He was a non-smoker.

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

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

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

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

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

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

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

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

Assessment: Sciatica, right side.

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

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

Chief Complaint: The applicant complained of glaucoma suspect.

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

Plan: He was to recheck in 6 months.

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

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

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

Impression: Epidermal inclusion cyst.

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

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

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

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

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

Impression: Aftercare for subcutaneous tissue surgery.

Plan: He was to return to clinic as needed.

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

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

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

Impression: Aftercare for subcutaneous tissue surgery.

Plan: He was to return to clinic as needed.

Psychiatry Attending Note, signed by Shaun Chung, M.D., Long Beach Healthcare, dated December 24, 2018.

The applicant had history of adjustment disorder last seen on November 21, 2018 at which time veteran was stable. He presented today on time and engaged. He was seen in MHTC for evaluation of recent anxiety, frustration and mood symptoms stemming from event which occurred between him and his boss in April 2017.

Assessment: Adjustment disorder.

Plan: Psychotherapy was recommended.

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

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

Social History: He was a non-smoker.

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

Diagnosis: Sciatica, right side.

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

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

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

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

Subjective Complaints: The applicant complained of itchy skin.

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

Family History: His mother had neuroleptic malignant syndrome.

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

Surgical History: He had undergone colonoscopy.

Social History: He was a non-smoker.

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

Vital Signs: He weighed 200 pounds.

Assessment: Pruritus.

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

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

Protein, urine was high at 34.

Psychology Consult, signed by Nicholas Brown, M.D., Long Beach Healthcare, dated February 1, 2019.

The applicant attended today's scheduled meeting in the BHIP Therapy Orientation clinic. Limits of confidentiality were discussed and he provided consent for assessment. Successfully completed battery of self-report measures including the DASS-21, PCL-5, AUDIT, and McLean BPD Screener. After completion of measures, he met individually with writer in order to score measures, obtain additional information regarding presenting problem and treatment interests, as well as develop an initial treatment plan based on clinical needs and client goals.

He reported an increase in PTSD symptomatology as most distressing to him. He stated that he was assaulted by his employer 2 years ago, and had since then been experiencing recurrent memories/associated distress, self-blame, low energy, and difficulties with trusting people. He indicated that he was regularly triggered due to continuing to work. He stated that he had at times dealt with his distress by overeating. His goal was to reduce his PTSD symptomatology and improve overall functioning.

Diagnosis: Adjustment disorder.

Plan: He was triaged to the Unified Protocol group with Dr. Nick Brown.

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

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

Tobacco History: He was a non-smoker.

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

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

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

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

The applicant was seen for skin rash.

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

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

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

Assessment: Dermatitis.

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

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

The applicant had his treatment.

Dose in MJ: 260.

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

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

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

He was working with a chiropractor on his own.

Medications: He was currently on Tylenol as needed.

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

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

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

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

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

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

The applicant had his treatment.

Dose in MJ: 300.

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

The applicant had his treatment.

Dose in MJ: 340.

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

The applicant had his treatment.

Dose in MJ: 380.

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

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

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

Cardiolipin IGM, EIA was elevated at 17.7 MPL units.

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

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

He would be starting physical therapy.

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

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

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

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

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

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

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

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

Assessment: Simple renal cyst.

Plan: Ultrasound of the kidney was requested.

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

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

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

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

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

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

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

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

The results were within normal limits.

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

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

This was well tolerated.

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

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

Vital Signs: He weighed 203 pounds.

Assessment: Allergic contact dermatitis.

Plan: Each ingredient was discussed.

Psychiatry Attending Note, signed by Shaun Chung, M.D., Long Beach Healthcare, dated April 3, 2019.

The applicant had history of adjustment disorder at which time he was stable. He presented today on time and engaged. He was doing much better. He had been attending group therapy for anxiety here at VA and finds it very helpful. He shared things he had learned including tenets of CBT and explained how it had helped in his life.

Assessment: Adjustment disorder.

Plan: He was to continue psychotropic treatment and continue with CBT group.

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

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

Laboratory Report, Long Beach Healthcare, dated April 9, 2019.

Sodium had decreased level at 134, glucose had increased level at 172, SGPT at 46, triglycerides at 429 and HDL had decreased level at 32.

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

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

Primary Care Note, signed by Kartik Shah, M.D., Long Beach Healthcare, dated April 16, 2019.

History: The applicant had history of diabetes mellitus type 2, hypertension, hyperlipidemia, fatty liver disease, bilateral hearing loss, allergic rhinitis, dermatitis, chronic low back pain/lumbar DJD, OSA, depression who presented today for follow-up visit. He had been under stress lately at his work. He was still following with outside PCP and specialists. He recently was diagnosed with kidney cyst, which he undergo ultrasound for further evaluation. He admits to not being compliant on his diet, and exercise. No other acute complaints today.

Vital Signs: He had a blood pressure of 144/89 mmHg, a pulse rate of 78 bpm and a weight of 201 pounds.

Assessment/Plan: 1) Diabetes mellitus type 2. Continue on Metformin XR 500mg. 2) Hyperlipidemia. Continue on Fenofibrate 54mg and Lovastatin 20mg. 3) Hypertension. Continue on Amlodipine 7.5mg and Losartan/HCTZ 50-12.5 mg. 4) Elevated LFTs/fatty liver disease. Advised extensively on weight loss, low fat diet, and decrease calorie intake. 5) Bilateral hearing loss. Will consult audiology. 6) Allergic rhinitis. Continue on Loratadine 10mg. 7) Dermatitis. Continue on Clindamycin, Triamcinolone and Hydrocortisone. 8) Chronic low back pain/lumbar DJD. Continue Diclofenac and back brace. 9)

OSA. 10) Depression. He had psychiatrist scheduled on the outside. 11) History of colon polyps. 12) Prevention.

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

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

Non-obstructing calculus visualized in the left kidney.

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

The applicant had itchy skin.

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

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

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

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

Assessment: 1) Dermatitis. 2) Verruca vulgaris.

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

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

The applicant had been off diet and exercise.

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

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

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

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

No pathologic lymphadenopathy or other convincing suspicious findings.

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

The applicant presented with incidentally found right renal mass.

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

Impression: Large right renal mass.

Plan: Only option was right lap nephrectomy.

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

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

Audiology Note, signed by David Nguyen, M.D., Long Beach Healthcare, dated May 24, 2019.

The applicant presented for HA adjustment following new audiogram.

Result: Following modifications, he expressed satisfaction with amplification and fit.

Plan: Return to clinic as needed to audiology. ENT consult as planned by Dr. Andreaggi.

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

The applicant presented with incidentally found right renal mass.

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

Assessment: Large right renal mass.

Plan: He was recommended right laparoscopic nephrectomy.

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

The results were within normal limits.

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

Pre and Postoperative Diagnosis: Right renal mass.

Procedure: Right laparoscopic nephrectomy

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

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

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

The applicant was doing well.

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

He voided this morning.

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

Plan: He would be discharged home.

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

Electrolyte panel showed decreased potassium at 3.2 mEq/L.

Creatinine was elevated at 1.48 mg/dL.

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

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

Principal Diagnosis: Renal mass.

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

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

Condition: Good.

Disposition: Home.

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

ENT Progress Note, signed by Jonathan Boyd, M.D., Long Beach Healthcare, dated June 17, 2019.

History: The applicant presented to the ENT clinic for evaluation of asymmetric hearing loss in left ear, he presented for decades since loud noise exposure to left side from explosive. Also, long history of rifle use. positive for tinnitus. He was using hearing aids.

Diagnoses: 1) SNHL. 2) Asymmetric hearing loss. 3) Tinnitus. 4) Cerumen removed.

Plan: Agreed with hearing aid use.

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

The applicant was seen and treated.

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

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

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

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

The applicant was seen and treated.

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

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

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

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

The applicant presented for refill for upper lip dermatitis.

He was recently diagnosed with renal cell carcinoma.

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

Vital Signs: He weighed 186 pounds.

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

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

Psychiatry Attending Note, signed by Shaun Chung, M.D., Long Beach Healthcare, dated July 24, 2019.

The applicant had history of adjustment disorder. He presented today 25 minutes later. He was doing well. He was exonerated with work related internal affairs issue with boss that had long been a stressor. He felt good, validated, some anxiety with returning back to work but tolerable with breathing exercises and felt therapy with LCSW was helpful. Sleep was fair. He had occasional nightmares of boss. Mood and anxiety responsive to Lexapro and Hydroxyzine. He recently ran out of Lexapro but amenable to keep taking.

Assessment: Adjustment disorder.

Plan: He was to continue current medications, therapy and CBT group.

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

The applicant had right low back pain.

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

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

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

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

The applicant was seen for eye examination.

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

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

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

Creatinine was elevated at 1.38 mg/dL.

Microalbumin/creatinine was high at 70.3 mcg/mg.

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

HGB A1c was normal at 6.0%.

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

The applicant had right low back pain.

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

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

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

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

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

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

He was doing physical therapy.

He was not taking medications.

He also had right thumb pain.

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

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

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

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

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

The applicant did not take blood pressure medication this morning.

He was exercising regularly.

He was having back pain on the right side.

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

MRI was planned.

He was better after stretching.

Medications: He was on Lovastatin 20 mg, Fenofibrate 54 mg, Clopidogrel 75 mg. Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Diclofenac

1%, Fluocinolone 0.01%, Clindamycin 1%, Hydrocortisone 2.5%, Sennosides 8.6 mg, Metformin 500 mg, and Triamcinolone 0.1%.

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

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

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

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

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

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

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

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

Atherosclerosis of the aorta.

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

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

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

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

Laboratory Report, ExamOne, dated September 30, 2019.

LDL had decreased level at 70 and triglycerides had increased level at 330.

Protein had increased level at 40, protein/creatinine ratio at 0.24, microalbumin at 17.8 and microalbumin/creatinine ratio at 105.0.

Urine glucose had increased level at 0.01.

Psychiatry Attending Note, signed by Shaun Chung, M.D., Long Beach Healthcare, dated October 9, 2019.

The applicant had history of adjustment disorder. He presented today on time and engaged. He was stable and doing well.

Assessment: Adjustment disorder.

Plan: He was to continue current medications and therapy.

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

The applicant was seen for therapy.

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

Interventions include manual therapy, therapeutic exercise, and modalities.

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

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

He follow up with urology.

His pain was improving with physical therapy.

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

He was not taking any meds.

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

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

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

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

Many years ago, he had vertigo attack.

He was seen in emergency department in 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The applicant was referred to rule out Meniere's disease. He had TAV with PCP with complaints of vertigo and sudden hearing loss. He was seen in ED in 2009 for vertigo. He had history of hearing loss and noise exposure. He used BICROS aids. He had obstructive sleep apnea. He got dizzy when lying down. He had last spinning sensation last week, which occurred when turning in bed. He had long standing left side tinnitus due to hearing loss. The spinning

sensation lasted few seconds. He had nephrectomy earlier this year. He hydrates regularly. He worked as a dentist and had issues with load drills. He did not know the decibel level.

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

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

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

The applicant was seen for therapy.

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

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

The applicant was seen for therapy.

He was discharged from therapy due to goals met.

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

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

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

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

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

The applicant was seen for lab review.

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

Plan: Laboratory work ups were ordered.

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

The applicant was seen for therapy.

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

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

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

Vital Signs: He weighed 193 pounds.

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

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

The applicant was seen for eye examination.

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

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

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

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

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

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

He saw urologist yesterday but results were not in yet.

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

Vital Signs: He weighed 191 pounds.

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

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

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

Impression: Status post right nephrectomy.

Left renal cyst.

Unchanged left adrenal adenoma measuring at 1 cm.

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

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

Moderate diffuse fatty infiltration of the liver.

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

Diffuse multilevel degenerative change of the spine.

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

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

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

Status post right nephrectomy.

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

Audiology Note, signed by Francisco Romero, M.D., Long Beach Healthcare, dated January 3, 2020.

The applicant took a hearing test with Kaiser and wanted the VA audiologist to look at it.

Plan: He reported his ENT told him he should only wear the left device. He was advised that the right ear did have hearing loss, but if he feels he did better without the right device than he did with it, he was more than welcome to try not wearing the right device. He then reported his ENT told him he should get a new device for the left ear, possibly a cros, however device was 1 year old and can be adjusted instead. He had signia devices which may be able to be converted to a cros system without new devices being ordered. He was advised this would be between him and his evaluating audiologist. He was offered an adjustment appointment to address these issues but declined, stating he had an evaluation scheduled for February 6.

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

The applicant was seen for health maintenance.

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

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

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

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

The applicant did not show for scheduled occupational therapy treatment session on this date.

Psychiatry Attending Note, signed by Shaun Chung, M.D., Long Beach Healthcare, dated January 9, 2020.

The applicant had history of adjustment disorder. He presented on time and engaged. He was doing well. He still with a lot of stress at work. A lot of bureaucracy which was frustrating. He enjoys clinical dentistry but did not like

how much admin and politics come into play with clinical practice. Overall function had been good.

Assessment: Adjustment disorder with anxiety and depression.

Plan: He was to continue medications and therapy.

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

The applicant had bump on his incision.

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

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

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

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

The applicant was seen for therapy.

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

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

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

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

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

Assessment: Sinusitis.

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

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

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

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

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

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

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

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

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

The results were within normal limits.

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

The applicant was seen for therapy.

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

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

The applicant presented for lab results.

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

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

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

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

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

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

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

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

Family History: Positive for colon cancer.

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

In context of underlying history of renal cell carcinoma, nodule could be metastatic lesion. Doubt infection or inflammatory. Discussed diagnosis of lung nodule. Size and location would make biopsy difficult technically and pose higher risk of complications. At <1 cm size, PET scan likely to be negative.

Follow up CT imaging in 3 months from last scan (already ordered by Dr. Choi) was reasonable next step. If there was interval increase in the nodule then PET CT likely next step versus resection. Check inflammatory and fungal markers.

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

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

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

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

Surgical History: He had colonoscopy and laparoscopic nephrectomy.

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

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

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

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

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

Plan: He was advised to continue good blood sugar control. He was advised to target blood pressure <130/80. He was to change Losartan-HCTZ to Losartan 100 mg daily and Chlorthalidone 25 mg daily. He would repeat labs and blood pressure in 1 week. He was to work on weight loss. He was advised nephrotoxins. He would be re-evaluated if renal function stable for IV contrast before July imaging. He was educated regarding the importance of blood pressure and blood sugar control to slow the progression of kidney disease. He

was advised to avoid nephrotoxic medications including NSAIDS.

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

The results were within normal limits.

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

BUN was elevated at 20 mg/dL.

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

Creatine was increased at 1.46 mg/dL.

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

Telephone Appointment Visit, signed by David Richardson, M.D., Kaiser Permanente, dated April 3, 2020.

The applicant would like a note stating that he was higher risk for contracting COVID 19, as the place where he works did not have good PPE. He also sent a message to the pulmonologist with the similar request.

Assessment: 1) Diabetes mellitus 2. 3) History of transitional cell carcinoma, right kidney.

Plan: Recommended care to avoid infection.

Doctor's First Report of Occupational Injury or Illness, signed by Nelson Flores, Ph.D., dated October 1, 2021.

The applicant reported that, while working for the California Institution for Men/State of California Institution for Med, he was exposed to work overload, work pressure, work stress, incidents of harassment, and an incident of physical assault by one of his supervisors. Overtime, he developed pain in his neck, shoulders, hands, and back which he attributed to the heavy and repetitive nature of his work. As a result of his pain and work exposure, he developed symptoms of anxiety and depression. His pre-existing Posttraumatic Stress Disorder further worsened.

The applicant reported feeling sad, helpless, hopeless, lonely, afraid, and irritable. He tended to socially withdraw from others. He had lost confidence in

himself. He had a decreased motivation to do things. He felt as though everything required a great deal of effort. At times, he felt pushed to complete tasks. He experienced crying episodes. He felt much more sensitive and emotional than he once was. He had a decreased appetite. He experienced sleep difficulties. He awakened throughout the night and early in the morning. He maintained a low energy level and feels easily tired and fatigued throughout the day. He experienced nightmares, distressing dreams, flashbacks, and intrusive recollections of the events surrounding his exposure to incidents of stress and harassment at the workplace. He felt nervous, restless, and tense. He had difficulty making decisions, concentrating, and remembering things. He was fearful without cause and worries excessively. He was bothered by episodes of dizziness, muscle tension, and heart palpitations. He felt apprehensive. He reported headaches, diabetes, hypertension, and chronic pain. His headaches are exacerbated and/or triggered when he felt under stress. He also reported lung cancer and a history of kidney cancer with removal of right kidney.

The applicant presented with an anxious and dysphoric mood, depressed affect, and preoccupation with physical limitations and pain and his cancer condition.

Axis I: Posttraumatic Stress Disorder, Chronic. Major Depressive Disorder, single episode, mild. Anxiety Disorder Not Otherwise Specified. Stress-Related Physiological Response Affecting Headaches.

Treatment Rendered: Cognitive Behavioral Group Psychotherapy once a week for 8 weeks. Hypnotherapy/ relaxation training once a week for 8 weeks. The applicant should continue to participate in mental health services at the VA Hospital with his current mental health providers.

Referral for an evaluation by Oncologist to determine whether the applicant's exposure to Asbestos while working for California Institution for Men/State of California Institution for Med, from 1998 through 2011, may be a contributing factor to the patient1s cancer condition.

Referral for an evaluation by Internist to determine whether the patient's exposure to Asbestos for approximately 13 years while working for California Institution for Men/State of California Institution for Med may have contributed to his diabetes and hypertension conditions.

Table A - Itemization of reports with blood pressure and weight:

Date of Encounter	Provider	Applicant's Blood Pressure	Applicant's Heart Rate	Hypertensive / DM Medications	HgA1c Value	Weight

July 3, 2007	Kevin Yuhan, M.D.	**119/63 mmHg**	**73 bpm**			
September 7, 2007	Jeff Tracy, M.D.	**119/65 mmHg**	**65 bpm**			**198 pounds**
October 23, 2007	Pauline Chang, O.D.	**126/81 mmHg**				
January 10, 2008	Jeff Tracy, M.D.	**117/68 mmHg**	**67 bpm**	**Amlodipine 10 mg; Hydrochlorothiazide 25 mg**		**196 pounds**
January 16, 2008	Pauline Chang, O.D.	**145/87 mmHg**				
February 28, 2008	Khang Nguyen, M.D.	**126/75 mmHg**	**77 bpm**	**Lisinopril-Hydrochlorothiazide 10-12.5 mg**		**196 pounds**
March 5, 2008	Khang Nguyen, M.D.			**Hydrochlorothiazide**		
March 27, 2008	Khang Nguyen, M.D.	**126/68 mmHg**	**82 bpm**			**196 pounds**
August 26, 2008	Rana Sajjadian, M.D.	**129/72 mmHg**	**69 bpm**			
October 21, 2008	Rana Sajjadian, M.D.	**130/78 mmHg**	**74 bpm**			
October 24, 2008	Lady Plaza, M.A.			**Amlodipine 10 mg; Hydrochlorothiazide 25 mg**		
October 26, 2008	Khang Nguyen, M.D.			**Amlodipine 5 mg; Cozaar 25 mg**		
November 4, 2008	Beny Tadina-Himes, R.N.	**140/70 mmHg**	**63 bpm**			
December 10, 2008	Mary Jane Leones, R.N.	**141/76 mmHg**	**72 bpm**	**Amlodipine 5 mg; Cozaar 25 mg; Hydrochlorothiazide 25 mg**		
December 11,	Khang	**126/69**	**65 bpm**	**Cozaar 100 mg**		**195**

2008	Nguyen, M.D.	**mmHg**				**pounds**
February 17, 2009	Applicant			**Cozaar 100 mg; Amlodipine 10 mg; Hydrochlorothiazide 25 mg**		
March 24, 2009	Jeff Tracy, M.D.	**121/77 mmHg**	**65 bpm**	**Cozaar 100 mg; Amlodipine 5 mg; Hydrochlorothiazide 25 mg**		**199 pounds**
May 18, 2009	Applicant			**Amlodipine 5 mg; Hydrochlorothiazide 25 mg; Cozaar 100 mg**		
July 28, 2009	Saeed Torabzadeh, M.D.	**120/73 mmHg**	**65 bpm**			**190 pounds**
July 30, 2009	Jeff Tracy, M.D.	**131/75 mmHg**	**64 bpm**			**195 pounds**
August 26, 2009	Bradley de Marquette, M.D.	**148/83 mmHg**	**65 bpm**			**192 pounds**
September 4, 2009	Jeff Tracy, M.D.	**125/73 mmHg**	**58 bpm**			**194 pounds**
September 14, 2009	Jeff Tracy, M.D.	**120/73 mmHg**	**67 bpm**			**199 pounds**
October 1, 2009	Annette Luetzow, M.D.	**117/68 mmHg**	**72 bpm**			**192 pounds**
October 21, 2009	Annette Luetzow, M.D.	**121/66 mmHg**	**91 bpm**			**197 pounds**
October 28, 2009	Annette Luetzow, M.D.	**121/66 mmHg**	**91 bpm**			**197 pounds**
November 18, 2009	Annette Luetzow, M.D.	**96/54 mmHg**	**90 bpm**			**200 pounds**
December 1, 2009	Jeff Tracy, M.D.	**117/70 mmHg**	**70 bpm**			**196 pounds**
December 4, 2009	Jeff Tracy, M.D.	**112/67 mmHg**	**63 bpm**	**Losartan 25 mg**		**198 pounds**
December 11,	Roberto	**145/80**	**68 bpm**	**Cozaar 25 mg 2**		

2009	Cueva, M.D.	**mmHg**		**tablets daily; Hydrochlorothiazide 25 mg; Amlodipine 5 mg**		
January 13, 2010	Annette Luetzow, M.D.	**96/54 mmHg**	**90 bpm**			**200 pounds**
February 11, 2010	Kaiser Permanente				**6.7**	
May 28, 2010	Applicant			**Cozaar 100 mg; Amlodipine 5 mg; Hydrochlorothiazide 25 mg**		
September 7, 2010	Jeff Tracy, M.D.	**126/73 mmHg**	**78 bpm**	**Amlodipine 5 mg; Cozaar 25 mg 2 tablets; Losartan 100 mg; Hydrochlorothiazide 25 mg**		**200 pounds**
January 11, 2010	Kaiser Permanente				**6.7**	
January 13, 2011	Jeff Tracy, M.D.	**132/75 mmHg**	**89 bpm**	**Norvasc 5 mg, HCTZ 25, mg Cozaar 100 mg, Lopid 600 mg,**		**200 pounds**
February 14, 2011	Jeff Tracy, M.D.	**109/67 mmHg**	**82 bpm**	**Norvasc 5 mg, HCTZ 25, mg Cozaar 100 mg, Lopid 600 mg**		**200 pounds**
February 21, 2011	Philip Quirk, M.D.	**128/72 mmHg**	**79 bpm**			
July 30, 2011	Kaiser Permanente				**6.4**	
October 17, 2011	Jeff Tracy, M.D.	**134/76 mmHg**	**82 bpm**	**Glucophage XR 500 mg, Norvasc 5 mg, Hydrochlorothiazide 25 mg, Cozaar 100 mg, and Lopid 600 mg**		**195 pounds**
May 25, 2012	Hege Sarpa, M.D.	**109/58 mmHg**	**89 bpm**			
January 22, 2013	Diane Kim, M.D.	**116/77 mmHg**	**93 bpm**	**Glucophage XR 500 mg, Norvasc 5 mg,**		**193 pounds**

				Hydrochlorothiazide 25 mg, and Cozaar 100 mg		
February 10, 2013	Kaiser Permanente				**6.3**	
February 26, 2013	Jeff Tracy, M.D.	**115/66 mmHg**	**81 bpm**	**Glucophage XR 500 mg, Norvasc 5 mg, Hydrochlorothiazide 25 mg, and Cozaar 100 mg**		**193 pounds**
June 27, 2017	Kaiser Permanente				**6.2**	
June 27, 2013	Jeff Tracy, M.D.	**130/68 mmHg**	**83 bpm**	**Metformin 500 mg, Cozaar 50 mg, HCTZ 25 mg, and Norvasc 5 mg**		**195 pounds**
December 19, 2013	Kaiser Permanente				**6.6**	
December 20, 2013	Jeff Tracy, M.D.	**123/77 mmHg**	**98 bpm**	**Hyzaar 50-12.5 mg, Glucophage XR 500 mg, and Norvasc 5 mg**		**197 pounds**
March 31, 2014	Ali Ghobadi, M.D.	**153/89 mmHg**	**73 bpm**			**195 pounds**
April 24, 2014	Jeff Tracy, M.D.	**114/69 mmHg**	**76 bpm**	**Glucophage XR 500 mg and Norvasc 5 mg**		**198 pounds**
June 17, 2014	Jeff Tracy, M.D.	**123/68 mmHg**	**69 bpm**	**Glucophage XR 500 mg, Hyzaar 50-12.5 mg, and Norvasc 5 mg**		**197 pounds**
June 24, 2014	Jeff Tracy, M.D.	**121/70 mmHg**	**66 bpm**	**Glucophage XR 500 mg, Hyzaar 50-12.5 mg, and Norvasc 5 mg**		**197 pounds**
July 8, 2014	Sepideh Mirfakhraie, M.D.	**132/68 mmHg**	**76 bpm**			**196 pounds**
September 8, 2014	Robert Andrew, M.D.	**134/83 mmHg**	**70 bpm**			**190 pounds**
March 12,	Jeff Tracy,	**133/53**	**83 bpm**	**Triglide 160 mg,**		**201**

2015	M.D.	**mmHg**		**Glucophage XR 500 mg, Hyzaar 50-12.5 mg, and Norvasc 5 mg**		**pounds**
May 23, 2015	Kaiser Permanente				**6.8**	
May 29, 2015	Jeff Tracy, M.D.	**128/73 mmHg**	**76 bpm**			**196 pounds**
July 2, 2015	Jeff Tracy, M.D.	**138/72 mmHg**	**66 bpm**	**Norvasc 5 mg, Hyzaar 50-12.5 mg, and Glucophage XR 500 mg**		**196 pounds**
October 5, 2015	Jeff Tracy, M.D.	**124/53 mmHg**		**Losartan-hydrochlorothiazide 50-12.5 mg, Metformin 500 mg, Amlodipine 5 mg, and Simvastatin 20 mg**		**195 pounds**
January 20, 2016	Aparche Yang, M.D.	**138/80 mmHg**	**78 bpm**	**Norvasc 5 mg, Hyzaar 50-12.5 mg, and Glucophage XR 500 mg**		**190 pounds**
March 1, 2016	Jeff Tracy, M.D.	**127/63 mmHg**	**76 bpm**			**187 pounds**
April 14, 2016	Alan Evans, M.D.	**130/69 mmHg**	**72 bpm**	**Norvasc 5 mg, Hyzaar 50-12.5 mg, and Glucophage XR 500 mg**		**184 pounds**
May 13, 2016	Alexander Berdy, M.D.	**121/70 mmHg**	**76 bpm**	**Norvasc 5 mg, Hyzaar 50-12.5 mg, and Glucophage XR 500 mg**		**182 pounds**
June 20, 2016	Alexander Berdy, M.D.	**138/78 mmHg**	**78 bpm**	**Metformin 500 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, and Amlodipine 5 mg**		**184 pounds**
December 16, 2016	Alexander Berdy, M.D.	**135/73 mmHg**	**88 bpm**	**Losartan-Hydrochlorothiazide 50-12.5 mg, Amlodipine 5 mg, and Metformin 500**		**198 pounds**

				mg		
December 27, 2016	Richard Kim, D.O.	**137/73 mmHg**	**79 bpm**			**193 pounds**
January 24, 2018	Aparche Yang, M.D.,					**195 pounds**
April 11, 2018	Daljeet Singh, M.D.,	**147/69 mmHg**	**70 bpm**			**200 pounds**
June 29, 2018	Alexander Berdy, M.D.,	**143/74 mmHg**	**66 bpm**			**202 pounds**
July 13, 2018	Kristin Stevens, M.A.,	**157/84 mmHg**	**101 bpm**			
July 25, 2018	Violeta Martinez, L.V.N.,	**130/58 mmHg**	**69 bpm**			
July 26, 2018	Kartik Shah, M.D.	**149/82 mmHg**	**66 bpm**			**193 pounds**
September 6, 2018	Aparche Yang, M.D.,			**Amlodipine 5 mg, Metformin 500 mg, and Losartan-HCTZ 12.5-50 mg**		**195 pounds**
September 25, 2018	Navyata Shah, D.O.,	**133/76 mmHg**				**199 pounds**
October 4, 2018	Violeta Martinez, L.V.N.,	**131/71 mmHg**	**65 bpm**	**Amlodipine 5 mg, Metformin 500 mg, and Losartan-HCTZ 12.5-50 mg**		
November 9, 2018	Noubar Ouzounian, M.D.,	**154/90 mmHg**	**90 bpm**			**202 pounds**
November 21, 2018	Noubar Ouzounian, M.D.,	**153/91 mmHg**				**202 pounds**
January 7, 2019	Samuel Chung, M.D.,	**138/71 mmHg**	**76 bpm**			**201 pounds**
January 23, 2019	Aparche Yang, M.D.,			**Amlodipine 5 mg, Metformin 500 mg, and Losartan-HCTZ 12.5-50 mg**		**200 pounds**

February 4, 2019	Alexander Berdy, M.D.	**131/76 mmHg**	**85 bpm**			**198 pounds**
February 12, 2019	Ashmi Doshi, M.D.			**Amlodipine 5 mg, Loratadine 10 mg, Losartan-hydrochlorothiazide 20-12.5 mg, Lovastatin 20 mg**		
February 15, 2019	Esther Cohen, M.D.	**134/67 mmHg**	**71 bpm**	**Amlodipine 5 mg, Loratadine 10 mg, Losartan-hydrochlorothiazide 20-12.5 mg, Lovastatin 20 mg**		**199 pounds**
March 14, 2019	Ricardo Bardales Mendoza, M.D.	**136/62 mmHg**	**67 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**202 pounds**
March 28, 2019	Ashmi Doshi, M.D.			**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**203 pounds**
April 16, 2019	Kartik Shah, M.D.	**144/89 mmHg**	**78 bpm**			**201 pounds**
April 24, 2019	Aparche Yang, M.D.	**130/79 mmHg**	**67 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**201 pounds**
May 9, 2019	Wesley Choi, M.D.	**134/70 mmHg**	**73 bpm**			**200 pounds**
May 30, 2019	Wesley Choi, M.D.	**147/75 mmHg**	**68 bpm**	**Metformin 500 mg, Amlodipine 5 mg, Losartan-hydrochlorothiazide 50-12.5 mg, Lovastatin 20 mg**		**200 pounds**

June 18, 2019	Wesley Choi, M.D.	**148/75 mmHg**	**62 bpm**			
June 28, 2019	Wesley Choi, M.D.	**121/64 mmHg**	**83 bpm**			**185 pounds**
July 22, 2019	Aparche Yang, M.D.			**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**186 pounds**
August 20, 2019	Kaiser Permanente				**6.0**	
August 21, 2019	Phi Vo, M.D.	**133/70 mmHg**	**77 bpm**			**188 pounds**
September 11, 2019	Alexander Berdy, M.D.	**147/72 mmHg**	**75 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**190 pounds**
November 5, 2019	Esther Cohen, M.D.	**130/71 mmHg**	**65 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**190 pounds**
November 18, 2019	Alexander Berdy, M.D.	**135/80 mmHg**	**78 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**193 pounds**
November 20, 2019	Syed Ahsan, M.D.	**159/81 mmHg**	**70 bpm**			
December 19, 2019	Wesley Choi, M.D.					**193 pounds**
December 20, 2019	Aparche Yang, M.D.	**136/70 mmHg**	**76 bpm**	**Lovastatin 20 mg, Amlodipine 5 mg, Losartan-Hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**191 pounds**

January 7, 2020	Alexander Berdy, M.D.	**150/80 mmHg**	**79 bpm**			**194 pounds**
January 16, 2020	Wesley Choi, M.D.	**140/67 mmHg**	**74 bpm**			
February 4, 2020	Guillermo Sturich, M.D.	**141/66 mmHg**	**72 bpm**	**Amlodipine 10 mg, Lovastatin 20 mg, Losartan-hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**193 pounds**
February 5, 2020	David Lou, M.D.	**139/84 mmHg**	**74 bpm**	**Amlodipine 10 mg, Lovastatin 20 mg, Losartan-hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**193 pounds**
February 21, 2020	Alexander Berdy, M.D.	**142/75 mmHg**	**69 bpm**	**Amlodipine 10 mg, Lovastatin 20 mg, Losartan-hydrochlorothiazide 50-12.5 mg, Metformin 500 mg**		**192 pounds**
February 27, 2020	George Yuen, M.D.	**136/70 mmHg**	**76 bpm**			**191 pounds**
March 3, 2020	William Chen, M.D.	**153/82 mmHg**	**64 bpm**	**Losartan-Hydrochlorothiazide 100-12.5 mg, Amlodipine 10 mg, Lovastatin 20 mg, Clopidogrel 75 mg, and Metformin 500 mg**		**191 pounds**

That completes the review of records.

HISTORY OF INJURY

The applicant worked as a dentist in a prison. His duties were primarily dental care. He was hired as a dentist, was promoted to chief dentist – a predominantly administrative position, later changed to Chief dentist, with less administrative duties, patient care duties and teaching duties as well. Initially he was assigned to Blythe, later transferred to headquarters in Sacramento, then to Dept. of

Juvenile Justice in Norwalk, then after changing the job description to Chief Dentist he was transferred to Rancho Cucamonga, then to the California Institution for Men in Chino, CA. Administrative duties as chief dentist varied. He set up clinics, established policies, hiring, personnel assignments. When his job description was changed to Supervising Dentist, administrative responsibilities were reduced to 40%.

While performing dental procedures, he bent at the waist, used his arms/hands, gripped/twisted/squeezed, flexed his neck, assumed different positions, squatted, kneeled, sat, and stood.

On a daily basis, he worked with chemicals including formaldehyde, eugenol, amalgams (mercury exposure associated with removing amalgam fillings). He states that the old buildings he worked in had asbestos and he was required to sign a waiver to work in these buildings. In the military over the years, he believed he was exposed to other chemicals. He also states that there is a chemical which is sprayed on inmates to control behavior; he cannot recall what this was.

In the 1980s, the applicant was attacked by three soldiers while on active military duty in Hawaii. He has PTSD related to this. He was exposed to the close detonation of a grenade in 1988 resulting in hearing loss.

The applicant reached the rank of Colonel in the military. He was a brigade commander of the 7214th Medical support unit in Garden Grove, CA, in the early 2000s. In this capacity he witnessed many maimed and deceased soldiers while in this command position. He feels this contributed to his PTSD symptoms.

In 2007, the applicant was taking Amlodipine 10 mg, Vytorin 10-20, Hydrochlorothiazide 25 mg, K-tab, Proair inhaler, fluticasone inhaler

In October 2008, the applicant was found to have a high glucose level, elevated lipid levels. His Amlodipine was reduced to 5 mg daily, Cozaar 50 mg daily was added, Lopid was started. In 2009, Cozaar was increased to 100 mg daily, Amlodipine 10 mg daily, HCTZ 25 mg daily.

Fasting glucose was 127 and triglycerides 407 in 2009. Simvastatin 20 mg was added. On 2/11/10 and 1/1/11 hemoglobin A1C was 6.7, treated beginning in 2011 with metformin 500 mg titrated upward as indicated by response. By July, 2011 Hemoglobin A1C was down to 6.4 on Metformin 1000 mg twice daily, 6.3 in January, 2013, 6.6 in December, 2013

The applicant was started on CPAP in August, 2013.

In 2015, he was taking 500 mg of Metformin twice daily, Losartan-HCTZ 50-12.5 daily, Amlodipine 5 mg daily, Zocor 20 mg daily, Fenofibrate 160 mg daily, Proair inhaler.

His hemoglobin A1C was 6.8 in October, 2015.

In May 2016, he was taking Plavix. The records state that this is for heart attack/stroke prevention. He has an aspirin allergy.

Records indicate that on 4/21/17, the applicant took his colleagues including boss' wife out to a work lunch due to the boss' wife retiring. The CEO arrived, a disagreement ensued which ended with the CEO striking the applicant in the face. After that time, he experienced ongoing harassment at work. He filed a report and a claim against his boss for this act. The CEO filed counterclaims. He left his job while this was resolved.

Throughout 2018, he was followed at Kaiser, continuing medications. He underwent resection of a neck cyst in 2018. On 7/25/18 his hemoglobin A1C was 6.9. On 4/9/19 it was 7.6.

In early-mid 2018, the applicant developed a persistent cough that was attributed to post nasal drip.

In July 2018, he claimed to be under severe stress with elevated blood pressure. He described many issues at work, predominantly administrative, which were responsible for his degree of stress and anxiety. The ultimate stressor was that he was called to his supervisor's office, asked to relinquish his keys, I.D. and was escorted off of the premises while the investigation into the incident with his CEO was carried out.

Blood pressure readings were generally 140s/70s. There was one reading 183/79. He asked for medical leave (FMLA). He wanted two days per week/eight days per month in order to see a psychologist, personal time, social worker, health care providers. Under FMLA he was offered 4 hours every two months. He was told that he must have a psychiatry evaluation in order to have more time off.

In March 2019, the applicant was taking hydralazine and was found to have a positive cardiolipin antibody, which his physicians believed was falsely positive.

In March 2019, the applicant underwent an MRI, which the applicant demanded to have performed for ongoing back pain. This imaging test revealed a complex

cystic structure in his right kidney. An ultrasound done on 3/13/19 termed this a simple cyst. Kidney ultrasound on 4/22/19 identified a complex structure. CT scan was performed revealing a 6+ by 5+ cm enhancing exophytic mass in the right kidney. Laparoscopic nephrectomy was performed on 6/6/19. Pathology/staging was T1b clear cell.

In April 2019, the applicant was evaluated at the VA clinic where it was noted that he had a kidney cyst that was to be evaluated at Kaiser, and that his hemoglobin A1C was 7.6, now 6.9, with issue of missing dosages ("often misses doses and skips doses") of medication having an impact on his glucose control. (pp 110/229)

In May 2019, he had a kidney resection for cancer. In June 2019, he was being followed at the VA Hospital for this issue as well as PTSD sustained in military in 1989.

He was evaluated for psychiatric issues related to a reported assault by his employer in 2017. He reported that administrative issues were complicated with his job. He reported that a hygienist was "targeting him" for a harassment claim. He was treated with Escitalopram 10 mg in 2019, diagnosis adjustment disorder. He described nightmares, panic attacks, headaches, intrusive thoughts, waking up screaming. In the VA, he was referred to a "Trauma Skills Group" and for PTSD treatment. VA records indicate that in late 2019 the applicant reported that he was exonerated in an internal affairs investigation and was returning to work.

Records state in July 2019 that the applicant "had some interpersonal problems at work and walked off of the job due to 2 EEO claims in July (2019). "Now assigned to regional".

In September 2019, his hemoglobin A1C was 5.9.

In December 2019, medications included Metformin 1000 mg twice daily, Loratadine 10 mg daily, Losartan-HCTZ 50-12.5 daily, Amlodipine 7.5 mg daily, Fenofibrate 54 mg, Plavix 75 mg, Lovastatin 20 mg daily, Nasalide spray, sinus rinse.

A Chest CT scan in December 2019 showed 8 mm and 6 mm lung lesions. Follow-up scan was pending as of April, 2020. No further records related to this are found.

On 10/1/21 the applicant was evaluated by Nelson Flores, Ph.D. who diagnosed PTSD (chronic), Major Depressive/Anxiety disorders, Stress-related physiological response affecting headaches. Dr. Flores recommended cognitive

behavioral therapy, hypnotherapy, relaxation training, and referral to oncologist and internist to determine whether or not exposure to asbestos at his workplace contributed to lung cancer, kidney cancer, diabetes, and hypertension.

CURRENT COMPLAINTS

Renal Cell Cancer (clear/transitional described stage 1b), metastatic to lungs: The applicant is under treatment as noted above. He has not discussed the possible relation of his renal cell cancer to his occupational exposures. The applicant states that he has 10-12 nodules in both lungs. He is receiving immunotherapy and chemotherapy with two different medications. Some nodules have grown, some have remained stable. He takes Carbametazide two pills daily, and one given by infusion once monthly. He has a C.T. scan every 12 weeks to assess his response.

Heart: The applicant states that he has atherosclerotic cardiovascular disease. He remains on Plavix for stroke/heart attack prevention.

Skin: The applicant states that he has always had dry skin. This has been much worse since chemotherapy. He has lost 48 pounds with chemotherapy, due to no appetite, diarrhea, many skin lesions, severely uncomfortable.

Hypertension: The applicant feels that when he lost control of the dental department his stress level went up dramatically because he felt that the department of dentistry was not being run professionally. Stress was significant related to administrators managing the department. He feels that the administrators did not have an understanding of the issues related to patient care. He feels that his hypertension worsened over the course of his career due to these stresses.

Diabetes mellitus: The applicant reports that his diabetes has actually been stable. He remains on two pills daily of Metformin 500 mg, actually less than in the past, although Jardiance has been added. He has some numbness in his hands in the morning, slight tingling and pain in left foot. He is not aware of a diagnosis of neuropathy.

Psych: The applicant continues to see a psychologist at the Long Beach VA hospital. He feels that he has had significant PTSD since being attacked in the 1980s. He feels that in association with bringing in administrators to run the department. The worst situation was the situation in which the CEO struck him in the face while at lunch. The CEO was not disciplined, the applicant believed in part because the CEO had the final say on the outcome of the investigation due to his position as CEO. The applicant states that the Chief Medical Officer

convinced the applicant not to file a police report. The applicant feels that he made a huge mistake in not reporting this for over a year.

Hearing: The applicant believes that high frequency drills used aggravated his hearing problem. He was not allowed to wear hearing protection due to needing to be aware of his surroundings.

Joint pains: The applicant has developed progressive joint pain in his hands and back pain related to the physical postures he assumed during his career. He reports having carpal tunnel and chronic back pain with arthritis and right hip immobility.

Stomach: The applicant has lost 40 pounds since he began cancer treatment. He has loss of appetite and nausea related to chemotherapy. Dyspeptic symptoms are not present.

Allergies/Skin: The applicant has had post-nasal drip and generalized itching for which he is treated with Hydroxyzine.

OCCUPATIONAL HISTORY

Current employment:

January 17, 1994: Dept of Corrections: Currently Supervising Dentist

Date off work: n/a

Prior employment history:

Private Practice in Carlsbad (Dentistry)
Taught Dental School 11 years at Oral Roberts University

PAST MEDICAL HISTORY

Hyperlipidemia
Essential hypertension
Diabetes Mellitus 2010
Obesity
Sleep apnea
Rotator Cuff syndrome
Asthma
Lung Cancer
Kidney cancer

Glaucoma
Vertigo with hearing loss 2010
Hepatic steatosis
Hearing impaired 80% left side, 30% right side
Colon polyps

PAST SURGICAL HISTORY

Right nephrectomy May 2019
Epidermal inclusion cyst (neck)

CURRENT MEDICATIONS

Carbometyx two pills daily
Other chemotherapy infusion as noted above
Metformin 500 mg twice daily
Losartan 100 mg
K tabs two daily
Amlodipine 10 mg daily
Lovastatin 40 mg daily
Gemfibrozil 600 mg tablet
Jardiance 12.5 mg daily ½ pill daily
Mirtazapine one daily for mood
Lorazepam 1mg as needed for anxiety
Escitalopram 20 mg daily or as needed
Hydroxyzine HCl 10 mg for sleep/pruritis

ALLERGIES

Atorvastatin
Aspirin
Lisinopril

ACTIVITIES OF DAILY LIVING

The applicant completed a questionnaire about their ability to perform Activities of Daily Living, both before and after their injury/injuries. The responses were reviewed with the applicant and are indicated below (See Table 1-2, 5th ed., page 4):.

Before the Injury:

Self-Care/Personal Hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating	x			
Communication	Writing, typing, seeing, hearing, speaking				
Physical Activity	Standing, sitting, reclining, walking, climbing stairs				
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling				
Non specialized hand activities	Grasping, lifting, tactile discrimination				
Travel	Riding, driving, flying				
Sexual function	Orgasm, ejaculation, lubrication, erection				
Sleep	Restful, nocturnal sleep pattern				

After the Injury/Over the Past Month:

Self-Care/Personal Hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself,				

	eating				
Communication	Writing, typing, seeing, hearing, speaking				
Physical Activity	Standing, sitting, reclining, walking, climbing stairs				
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling				
Non specialized hand activities	Grasping, lifting, tactile discrimination				
Travel	Riding, driving, flying				
Sexual function	Orgasm, ejaculation, lubrication, erection				
Sleep	Restful, nocturnal sleep pattern				

SMOKING

None

ALCOHOL USE

None

DIET

The applicant endeavors to maintain a healthy diet, avoiding excessive carbohydrates, spicy foods, fried/high fat foods.

PRIOR INDUSTRIAL INJURIES

See above

PRIOR NON INDUSTRIAL INJURIES, MOTOR VEHICLE ACCIDENTS OR OTHER INJURIES

6/12/14 MVA neck injury
Beating 1980s

Epworth Sleep Scale: The applicant was queried regarding the development of drowsiness or falling asleep under the following every day circumstances:

Sitting and reading 1
Watching TV 1
Sitting, inactive, public place 0
Passenger in a car for an hour 0
Lying down to rest in the afternoon 2
Sitting and talking 0
Sitting quietly after lunch 0
In a car while stopped for a few minutes in traffic 0

Total: 4 as long as uses BIPAP Machine

FAMILY HISTORY

Mother deceased at 99, Stroke/pneumonia
Father deceased at 75 of heart attack
Siblings: Sister died at 47 of colon cancer

Family history of diseases/disorders: Hypertension

EDUCATIONAL HISTORY

DDS (Doctor of Dentistry)
Masters degrees x 2
War College:

SOCIAL HISTORY

The applicant was born and raised in San Diego.
The applicant is married no children

REVIEW OF SYSTEMS

Gen: No constitutional symptoms including unintentional weight loss, night sweats,

Skin: Denies rashes, jaundice or lesions

HEENT: Denies changes in vision or hearing, epistaxis, dental problems, orbital pain

Cardiac: Denies chest pain at rest or on exertion, paroxysmal nocturnal dyspnea, orthopnea, peripheral edema, palpitations.

Respiratory: Denies dyspnea at rest or excessive dyspnea on exertion, cough, sputum production, hemoptysis, wheezing.

GI: No nausea, vomiting, dysphagia, odynophagia, melena, hematochezia, constipation, abdominal pain, heartburn, epigastric pain, bloating. Bowel movements regular.

GU: Denies dysuria, hematuria, incontinence, frequency, urgency.

Neuro: Denies loss of sense of taste or smell, headaches, seizures, loss of consciousness, focal weakness, numbness or tingling of the extremities, ataxia or vertigo symptoms.

PHYSICAL EXAMINATION

Due to the evaluation being performed remotely, the applicant was not examined.

DIAGNOSTIC STUDIES: None submitted for review

DISCUSSION OF CREDIBILITY OF THE APPLICANT:

The applicant is very well-versed in his history, is consistent and appeared entirely credible.

DISCUSSION OF DIAGNOSES AND IMPAIRMENTS:

Diagnoses:

Orthopedic: Deferred to orthopedic experts as this is outside of the area of my expertise

Psychological/Psychiatric: Deferred to psych experts as this is outside of the area of my expertise

Internal Medicine:

1) **Kidney Cancer with Lung metastases**: The applicant has stage 4 renal cell carcinoma with metastases to the lung, currently treated with chemotherapy.

   Risk factors for kidney cancer include smoking, **obesity**, hypertension, **workplace exposure**, specifically trichloroethylene, family history of renal cell cancer, **male gender**, race (African American), use of Tylenol, advanced kidney disease, genetic factors, von Hippel-Lindau disease, Hereditary leiomyoma-renal cell carcinoma. Bert-Hogg-Dube (BHD) syndrome, Cowden's syndrome and tuberous sclerosis. Exposure to **cadmium**, organic solvents and some herbicides increases kidney cancer risk. **(REFERENCE 2)**

   The applicant was obese throughout his life, had no other known risk factors for renal cell cancer.

   He has claimed workplace exposure as a risk.

   Asbestos was first linked to kidney cancer over 30 years ago. Small studies have suggested an association. A recent larger study suggests this as well. **(REFERENCE 6)** The applicant claims that he had to sign a waiver each year re: asbestos exposure in the building in which he worked.

   Trichloroethylene was used as an anesthetic, particularly in dental settings, but was banned in 1977, so this is not a factor.

   Amalgam (predominantly mercury) fillings, when removed, do result in exposure to mercury vapor. **Mercuric chloride and methylmercury** are potential human carcinogens per the FDA. Methylmercury chloride causes kidney tumors in male mice. Mercury chloride has shown some carcinogenic activity in male rats, but there are not adequate data in humans, per the FDA and CDC, to conclude that mercury is a risk factor for renal cell cancer. **(REFERENCE 1)**

   Dental amalgam has contained **cadmium**, per historical records. **(REFERENCE 5)**. This has been considered mainly to be a hazard to dental technicians **(REFERENCE 4).** I do not know whether or not dentists per se have been considered to be at risk for over-exposure to cadmium, but this would seem to be the more definite carcinogenic compound.

Methylene Chloride is alleged to have been a component of tear gas and pepper spray, to which the applicant states that he was exposed on a frequent basis. The EPA considered M.C. to be a carcinogen. Liver and lung cancer are considered possible results of over-exposure. I do not find renal cancer listed as a known sequelae.

Zinc oxide-eugenol cement (IRM) is a low-strength base used as a temporary cement filling in the event that the patient will return at a later date for a semi-permanent restoration. The powder is mainly zinc oxide and the liquid is eugenol with olive oil as a plasticizer. The applicant alleges chronic exposure to Eugenol which per CA Proposition 65 may be a carcinogen. Further discussion is deferred to toxicology. This is outside of the area of my expertise.

2) **Kidney**: The applicant's renal function changed after his surgery. This is a separate impairment from his cancer, although the Combined Values Chart would apply. Current testing is needed.

3) **Lung Cancer**: This is derivative of (1) above, as the disease is metastatic.

4) **Hypertension**: The applicant had brief periods of "spikes" in blood pressure, overall a mild rise since his injury, requiring increase in dosage of Losartan from 50 mg to 100 mg. This continued, in spite of weight loss associated with cancer treatment. He had inordinate stress associated with the investigation which was initiated after he was attacked physically by his CEO. Repeated stressful work-related events may lead to a rise in blood pressure which to a reasonable medical probability occurred in association with the stressful events at work. Additionally, the loss of a kidney often results in increased blood pressure.

5) **Diabetes Mellitus**: The applicant has been diabetic since 2013. He was followed without medication for two years then started on Metformin in 2015. He had a high urinary microalbumin for years prior to that time. Urinary microalbumin high (44, normal to 20) in 2020

6) **Stomach/Weight Loss**: The applicant's weight loss may be entirely due to chemotherapy, however I would recommend upper endoscopy to rule out other causes.

7) **Headache**: These are clearly stress-related, having developed following being assaulted by his CEO, followed by an investigation, then fear over a

potential harassment claim, as well as related to his diagnosis of renal cell cancer.

8) **Allergies/Skin**: This is deferred to a dermatologist as this is outside of the area of my expertise., stomach, joints, allergies, headache, foot, heart, teeth."

DISABILITY STATUS

Periods of Temporary Disability: The week of surgery for his cancer and for two weeks after his return to home.

MAXIMUM MEDICAL IMPROVEMENT AND PERMANENT AND STATIONARY STATUS

Under SB 899, taking effect on April 19, 2004 for all dates of injury apportionment or current disability is now based upon causation. The new statutes are as follows:

Under Sec. 4663, "Apportionment of permanent disability shall be based on causation. The physician shall make an apportionment determination by finding what approximate percentage of permanent disability was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percentage of permanent disability was caused by other factors both before and subsequent to the industrial injury including, prior industrial injuries."

Under Sec. 4664, "The employer shall only be liable for the percentage of permanent disability directly caused by the injury arising out of and occurring in the course of employment. If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury."

In addition, the decisions in the Escobedo and Benson cases have further defined the burden on the evaluator in formulating an opinion on apportionment. In accordance with the Benson decision, I have considered apportionment for any and all injuries identified to me through the submitted information including the cover letter, the applicant's history, and the medical records. Further, I have specified percentages of apportionment for each injury or discussed why I am unable to arrive at percentages with any reasonable medical probability thus concluding that the injuries are inextricably intertwined for purposes of apportionment.

I am readily familiar with the referenced Labor Code sections and relevant case decisions, and these have been fully considered in formulating my opinion on apportionment as presented herein.

1) **Kidney Cancer with Lung metastases**: With regard to MMI and P&S status of the applicant's cancer, I must defer to an oncologist as this is outside of the area of my expertise. I note that the Guides do not include a section on renal cancer.

2) **Kidney (impaired function)**: The applicant has impaired kidney function. Of course there is some degree of renal function impairment post-nephrectomy, although the remaining kidney may compensate. Hypertension and Diabetes are also factors. Current testing is needed to evaluate MMI and P&S status. See conclusions.

3) **Lung Cancer**: The applicant does not have primary lung cancer, rather metastases from his renal cancer. However, I will state this nonetheless: Per the Guides page 106, section 5.9, for persons with lung cancer assessed one year (or more) after diagnosis, if the cancer is present, the applicant is considered to be severely impaired (Class 4), there MMI seems to be presumed at this point, which would be as of 12/31/20.

4) **Hypertension**: The applicant is at MMI and P&S as of 10/1/21 due to dosing of Losartan at 100 mg daily and reported stabilization of blood pressure.

5) **Diabetes Mellitus**: The applicant's diabetes has been at MMI and P&S as of 10/1/19 based on reduction of Hemoglobin A1C to 5.9 and the applicant's reporting of stability since that time.

6) **Stomach/Weight Loss**: The applicant's weight loss may be entirely due to chemotherapy, however I would recommend upper endoscopy to rule out other causes. This is not at MMI or P&S.

7) **Headache**: This diagnosis is at MMI and P&S as of the date of this interview (03/17/22) , based on ongoing symptoms for several years, review of recent psych evaluation.

8) **Allergies/Skin**: This is deferred to a dermatologist as this is outside of the area of my expertise., stomach, joints, allergies, headache, foot, heart, teeth."

IMPAIRMENT

The applicant is rated using the American Medical Association *Guides to the Evaluation of Permanent Impairment*, Fifth Edition.

1) **Kidney Cancer with Lung metastases**: I defer impairment discussion to Oncologist as this is outside of the area of my expertise.

2) **Kidney function**: Deferred pending testing.

3) **Lung Cancer**: Per the Guides page 106, section 5.9, for persons with lung cancer assessed one year (or more) after diagnosis, if the cancer is present, the applicant is considered to be severely impaired (Class 4). Testing is needed to proceed to specific impairment classification based on page 107, Table 5-12. See conclusions.

4) **Hypertension**: Testing is required.

5) **Diabetes Mellitus**: Per the Guides page 231 Table 10-8 the applicant meets class 2 criteria as he has Type 2, requires oral medication and has microangiopathy based on high urinary microalbumin, although the latter has fluctuated over the years. Testing is ordered, and this will be finalized after test results are available..

6) **Stomach/Weight Loss**: Deferred pending endoscopy. Note that if no findings are noted that indicate a primary stomach source for weight loss, then weight loss should be incorporated into WPI or renal cancer, not for gastrointestinal impairment.

7) **Headache**: Regarding headaches, Psychology evaluation sheds significant light on the applicant's headaches, which by history are mild to moderate, and are closely related to feeling psychologically stressed. I assessed the applicant's headaches using the guidelines stated in Chapter 18 of the Guides:

"Using the Guides, Table 18-3, the applicant meets criteria for mild (Class 1) pain. Using the procedures described in Tables 18-4 – 18-7 of the Guides, the individual's scores include a pain severity score of 5 (mostly due to frequent headaches), mean activity limitation = 1, mean mood related score = 1 (applicant feels that stress causes headaches, not vice versa). Pain behavior for headaches + 1. Total pain-related impairment score is with adjustment for credibility +1.

Total adjusted pain-related impairment score = 9, indicating mild impairment due to pain. There is no ratable impairment based on body part or function."

The above statement in boldface is derived from my reading of Chapter 18 Table 18-1 which classifies headaches as a "well-established pain syndrome without significant, identifiable organ dysfunction to explain the pain". On page 586, there is a statement, "these syndromes are not ratable under the conventional rating system....since there is no measureable organ dysfunction." Per the instructions on page 573, a formal pain related assessment was performed because of the absence of measureable dysfunction. Per 18.3d, "E", the applicant has a pain related syndrome which is unratable. Page 584 includes the finding that the pain is unratable as the final step in "How to rate pain-related impairment". Finally, I used Table 18-3 and followed the case examples on page 586-587.

WPI which would most reasonably be associated with this mild impairment is 1%.

CAUSATION OF INJURY

Causation has been addressed in this report with respect to proximate causation of the work injury whether specific or based on cumulative trauma and as required by SB 899, Labor Code 4663 and Labor Code 4664, I have looked at the causation of permanent disability. Apportionment of permanent disability is based causation, what is the cause of the disability or need for medical treatment, not necessarily the cause of the disease or injury. Apportionment looks at current disability and parcels out the causative sources, i.e. nonindustrial, prior industrial, current industrial, and decides the amount of disability caused by the current work injury. (LC 4663, Brodie, Escobedo and Gatten). Injury must arise out of and in the course of employment (LC 3600). With respect to the causation of disability, I have looked at whether there is any pathology separate from the traumatic event or cumulative trauma, which is contributing to the cause of disability. Causation assessment must focus on permanent disability in addition to the disease or injury process. Labor Code Sections 3208-1, 4663, 4664, deal specifically with causation of permanent disability, not causation of the disease and the need for medical treatment. There is a fundamental difference between causation of disease or injury and the causation of permanent disability. The latter is the correct approach. The determination of causation of permanent disability has been assigned to the physician only by the legislature and is separate from an employer accepting responsibility for the proximate cause of the injury or disease process.

1) **Kidney Cancer with Lung metastases**: I am not a toxicologist or oncologist. I can give a general internal medicine perspective, which is that the applicant's profession suggests that he was exposed to Cadmium, Mercury, Methylene Chloride and Eugenol, all of which are suspected carcinogens, with some suggested to be associated with renal cancer. Asbestos has been associated with renal cancer in multiple studies including one recent larger study.

   Because of specifics such as degree of exposure, degree of carcinogenic effect suspected and because of clinical experience in dealing with these questions, Causation is best determined by a toxicologist and/or oncologist. If these specialties are not available, then my opinion is that there is a component of industrial causation, with significant non-industrial components of obesity and pre-existing hypertension and male sex which are accepted as definite associations.

2) **Kidney function**: This depends directly on (1), with hypertension and diabetes mellitus as other factors.

3) **Lung Cancer**: This is derivative of (1) and the conclusion would be identical.

4) **Hypertension**: Industrial aggravation occurred. The major factor in causation is pre-existing hypertension, non-industrial. Whether nephrectomy will be an industrially-related component or not remains to be determined.

5) **Diabetes Mellitus**: No industrial component is identified.

6) **Stomach/Weight Loss**: To be determined. If no primary problem is found on endoscopy, then this is derivative of (1) above.

7) **Headache**: The applicant did not have headaches prior to his claimed injuries. Industrial component would include stress over harassment, the assault incident and the investigation into it. Stress over kidney cancer diagnosis is a significant factor and would be affected by decision regarding Causation of that problem.

APPORTIONMENT

Apportionment was performed taking into consideration Labor Code Sections 4663, 4664 and the Escobedo decision. My report has been based upon

reasonable medical probability and the reasoning behind my opinion and conclusions is based upon the pertinent facts, adequate examination, history, record review, the following is concluded:

At this point the applicant is not yet permanent and stationary for some diagnoses and for others I have deferred to others for causation. Causation of Kidney cancer has an influence on causation and apportionment of several other diagnoses. As noted above, I suggested that toxicologist or oncologist opinion re: Causation would be most appropriate, although if these specialities are not available I am willing to address this diagnosis and related diagnoses if the parties agree for me to do so.

REGARDING RETURN TO WORK

From the standpoint of internal medicine, the applicant is able to return to work.

ABILITY TO RETURN TO USUAL AND CUSTOMARY EMPLOYMENT

From the standpoint of internal medicine, the applicant is able to return to work in his/her usual and customary employment.

WORK RESTRICTIONS

None related to internal diagnoses.

FUTURE MEDICAL TREATMENT

To be determined.

OTHER RECOMMENDED EVALUATIONS/TESTING

1. Bun, Creatinine, Urinalysis, urinary microalbumin, 2D Echocardiogram, 12 lead EKG, creatinine clearance rate
2. Pulmonary Function testing to include FVC, FEV1, Dco, VO2 Max
3. Upper gastrointestinal endoscopy is recommended.
4. Oncology or Toxicology QME are recommended to evaluate kidney cancer for reasons discussed extensively above. See conclusions.

CONCLUSIONS

1. The applicant alleged internal injuries including lungs, skin, kidney, stomach, allergies, headache, foot, heart.

2. Diagnoses include: Primary renal cell cancer (Kidney cancer) with pulmonary metastases, Kidney insufficiency due to nephrectomy, Lung cancer (secondary, i.e. metastatic), Nausea/weight loss, Tension headache, Hypertension, Pruritis.

3. Skin/pruritis is deferred to dermatologist.

4. Hypertension (Hypertensive Cardiovascular Disease) is at MMI and P&S as of 10/1/21, impairment rating pending testing, causation/apportionment pending same for kidney cancer.

5. I provided an extensive discussion of possible workplace-related risks for kidney cancer. I provided this by way of explanation that I think it is best to defer, if possible, kidney cancer MMI and P&S status, impairment rating, causation and apportionment to oncologist. Toxicologist opinion re: environmental exposures would be most relevant.

6. "Kidney" claim should also include, in my opinion, impairment rating based on the Guides method of assessing impairment due to compromised kidney function. This requires updated laboratory testing.

7. Lung cancer discussion of causation and apportionment is derivative of that for kidney cancer.

8. I provided a proposed MMI and P&S status and proposed impairment rating scheme for Lung Cancer based on the Guides, as there does not appear to be a requirement that the Lung cancer be of primary origin. See above. However, causation and apportionment will be the same as for kidney cancer.

9. Headache is at MMI and P&S as of 03/17/22, WPI 1%, Causation and Apportionment pending opinion re: Causation of Kidney Cancer

10. Stomach (weight loss/nausea) is not at MMI or P&S. Upper gastrointestinal endoscopy is recommended.

11. Upon completion of testing please submit results with a request for supplemental evaluation.

12. As stated above, if Oncology and/or Toxicology opinions are not obtainable I will be willing to address MMI/P&S status, Causation, Impairment and Apportionment of Kidney cancer, which influences the evaluation of multiple other claims. I do think that toxicology and oncology specialists are more equipped, background-wise, to assess workplace related exposures that may have contributed to kidney and lung cancer, however.

SPECIAL COMMENTARY

The above responses and opinions are based on reasonable medical probabilities, as viewed from the perspective of available documentation and information submitted to this evaluator, including the applicant's direct anamnesis.

I, Jonathan C. Ellis, M.D., F.A.C.P., Q.M.E., formulated all conclusions and opinions.

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

Sincerely,

Jonathan C. Ellis, M.D., F.A.C.P., Q.M.E.
Qualified Medical Evaluator
Board Certified, American Boards of Internal Medicine and Gastroenterology

Attachments:

1. Appendix A: Declaration
2. Appendix B: References
3. Appendix C: CL from ADJ
4. Appendix D: Declaration from ADJ

APPENDIX A - DECLARATION

Pursuant to AB 1300, LC Sec. 5703, I have not violated Labor Code section 139.3, and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

DATE OF REPORT: April 3, 2022

Dated this 3rd day of April 2022, at Los Angeles County, California.

Jonathan C. Ellis

Jonathan C. Ellis, M.D., F.A.C.P., Q.M.E.
Qualified Medical Evaluator
Board Certified, American Boards of Internal Medicine and Gastroenterology

APPENDIX B - REFERENCES

1) https://wwwn.cdc.gov/TSP/ToxFAQs/ToxFAQsDetails.aspx?faqid=113&toxid=24

ATSDR: Agency for Toxic Substances and Disease Registry

The nervous system is very sensitive to all forms of mercury. Methylmercury and metallic mercury vapors are more harmful than other forms, because more mercury in these forms reaches the brain. Exposure to high levels of metallic, inorganic, or organic mercury can permanently damage the brain, kidneys, and developing fetus. Effects on brain functioning may result in irritability, shyness, tremors, changes in vision or hearing, and memory problems.

Short-term exposure to high levels of metallic mercury vapors may cause effects including lung damage, nausea, vomiting, diarrhea, increases in blood pressure or heart rate, skin rashes, and eye irritation.

Excerpts: There are inadequate human cancer data available for all forms of mercury. Mercuric chloride has caused increases in several types of tumors in rats and mice, and methylmercury has caused kidney tumors in male mice. The EPA has determined that mercuric chloride and methylmercury are possible human carcinogens.

2) https://www.cancer.org/cancer/kidney-cancer/causes-risks-prevention/risk-factors.html

3) https://www.cityofhope.org/clinical-program/kidney-cancer/kidney-cancer-facts#KCFactTAG2

Excerpt: What increases your risk of kidney cancer? Workplace chemicals: Exposure to cadmium, organic solvents and some herbicides increases kidney cancer risk.

4) ADVERSE HEALTH EFFECTS OF EXPOSURE TO CADMIUM IN DENTAL TECHNICIANS

Prof. AHLAM EL-SHARKAWY, Dr. NEVIEN MAHMOUD, Dr. IMAN MATTAR

JOURNAL OF INTERNATIONAL ACADEMIC RESEARCH FOR MULTIDISCIPLINARY

Impact Factor 1.625, ISSN: 2320-5083, Volume 3, Issue 5, June 2015

Excerpt: Cadmium pigments may present a problem in dental laboratory in which large quantities of acrylic powders are inhaled. To evaluate the side effects of cadmium which used during processing appliances on the health of dental technicians.

Cadmium which is widely used as a coloring agent for acrylic resin materials present a problem in the dental laboratory as it is toxic to every system in the body specially lung and kidneys.

5) A survey of the elemental composition of alloy for dental amalgam, J F de Freitas

Aust Dent J, . 1979 Feb;24(1):17-25.

A rapid and precise procedure was developed that relied on wet-way methods for silver and tin while copper, zinc, mercury, indium and low-level constituents, such as lead, cadmium and antimony, were determined by atomic absorption spectroscopy. The conventional alloys, with two minor exceptions, all complied with the compositional requirements of modern standards and little quantitative variations was noted when the range of the major component was compared with the values obtained in two surveys made over thirty years ago. The high-copper contained, among other factors, an average copper concentration about four times that of conventional alloys. Rather surprising were the contents of mercury, indium, and cadmium found in some of the alloys as well as the low-level concentration of lead, and in a few cases antimony.

6) Workplace exposure to asbestos and the risk of kidney cancer in Canadian men, Cheryl E Peters 1 2, Marie-Élise Parent 3, Shelley A Harris 4 5, Linda Kachuri 4 5, Lidija Latifovic 4 5, Laura Bogaert 5, Paul J Villeneuve 6, Canadian Cancer Registries Epidemiology Group, Can J Public Health, . 2018 Aug;109(4):464-472.

Excerpt: Previous studies considered the role of occupational causes in kidney cancer but were limited by small sample sizes and imprecise exposure assessment. This study examined the relationship between occupational exposure to asbestos and the risk of kidney cancer across a range of jobs in a large, population-based case-control study in Canada.

This study found some evidence for an association between occupational exposure to asbestos and kidney cancer. Higher intensity of exposure to asbestos had the strongest relationship with kidney cancer risk.

March 1, 2022

Jonathan Ellis, M.D.
11620 Wilshire Blvd
Ste 340
Los Angeles CA 90025-1769

Claim Number: 06626670
Employee: George Soohoo
Date of Injury: 06/11/2021

Dear Jonathan Ellis, M.D.,

Thank you for agreeing to examine George Soohoo on March 17, 2022 at 09:00 as the Qualified Medical Evaluator. Please determine if an industrial injury or illness has occurred as described in the background section.

You are being asked to examine George Soohoo because there exists a dispute over the compensability of the reported injury.

BACKGROUND:

George Soohoo has alleged an injury to his lungs, heart, soft tissue-head, teeth, feet (both), internal organs on June 11, 2021 while employed by Ca Institution For Men Attn: Return To Work Office as a supervising dentist, cf hired on January 24, 1994.Please address the injures related to your specialty

MEDICAL RECORDS:

Medical record(s) enclosed for your review..

Also enclosed for your review are Claim Form
Application for Adjudication
Medical records from Kaiser and Va Long Beach to be sent by Ontellus

Please list all medical and non-medical records that you review in preparing your report pursuant to Section 10682(b)(4) of the California Code of Regulations (CCR). Please dispose of the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

PLEASE ADDRESS THE FOLLOWING IN YOUR REPORT:

1. A detailed medical and employment history, including any outside activities.
2. What is the diagnosis? Please describe the medical basis for your opinion.
3. Are your medical findings consistent with the mechanism of injury alleged by George Soohoo?
4. Please comment on the disputed findings of the treating physician. Do you agree or disagree with the treating physician's findings? Please be specific regarding the basis of your findings.
5. Is this a new injury or a continuation of a previous injury or illness?
6. What future medical treatment is reasonably necessary to cure or relieve the effects of the injury?

In accordance with Labor Code §4604.5, the Medical Treatment Utilization Schedule is to be utilized and shall be presumptively correct on the issue of extent and scope of medical treatment. Please use the Medical Treatment Utilization Schedule or other evidence-based criteria to substantiate your medical opinion and to describe the scope, frequency, and duration of such treatment.

7. Are there any periods of temporary total (TTD) or temporary partial disability (TPD) as a result of the industrially caused or aggravated injury? Please indicate these periods and the basis of your opinion.

8. Is George Soohoo capable of returning to work with temporary modifications to his position during recovery from the injury? If so, please describe in detail the type and duration of the modifications. If not, when would you expect him to be able to return to modified work?

9. Pursuant to recent changes to Labor Code Section 4663, apportionment of permanent disability shall be based on causation. Any physician preparing reports on the issue of permanent disability must address the issue of causation. The physician must make an apportionment determination by finding what approximate percentage of the permanent disability was caused as a direct result of the work-related injury, and what portion was caused by other factors, including prior industrial injuries or other non-industrial factors.

   Pursuant to recent changes to Labor Code Section 4664, if an injured worker has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. Based on the foregoing, please indicate what the approximate percentage of the applicant's current disability is due to the industrial injuries alleged in this case and which percentage is due to a) any previous industrial injuries; b) any subsequent industrial injuries; c) and any non-industrial injuries including asymptomatic prior conditions, retroactive prophylactic work preclusions, illnesses or pathology.

   If the percentage of disability set forth in the prior Award or Compromise and Release was determined pursuant to a pre-2005 rating schedule, please review all settlement papers and medical reports and provide an opinion as to the appropriate rating for the percentage of disability pursuant to the 2013 rating schedule that is attributable to the prior award.If the injured worker has received a prior Award or Compromise and Release, please review the medical reports regarding the prior injury or illness and indicate percentage of disability, if any, that reasonably medically caused by the prior injury.If reasonably medically indicated, please include the percentage of disability that is attributable to heredity or genetic factors and not the industrial injury. Please determine the medically probably percentage of each causal factor of permanent disability including industrial, non-industrial, and prior injuries and advise what percentage of permanent disability is directly caused by the current industrial injury.

   Please provide a basis for any apportionment you give in your report. To be substantial evidence on the issue of apportionment, "a medical report must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and must set forth reasoning in support of its conclusions." [WCAB En Banc Decision Escobedo v. Marshalls]

   Although this case may apply a presumption statute, we still require your opinion as to all causative factors.

10. Has George Soohoo's disability reached maximum medical improvement (MMI) and considered permanent and stationary? If yes, please note as of what date and list all factors of permanent residuals and or if requires future medical care. Please complete the "Physician's Return-to-Work & Voucher Report" (DWC-AD Form 10133.36). If not yet considered at maximum medical improvement, please provide an estimate of when his MMI status can be expected.

11. For permanent disability evaluations performed pursuant to the 2005 Permanent Disability Rating Schedule, your report concerning the existence and extent of permanent impairment shall describe the impairment in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th Edition. Your narrative permanent impairment evaluation report must include the

following:

- Narrative history
- Current clinical status
- Diagnostic study results
- Medical basis for determining Maximum Medical Improvement
- Diagnoses, impairments
- Impairment rating criteria, prognosis, residual function, and limitations

When listing your medical findings, please use the applicable reporting forms found in the AMA Guides to the Evaluation of Permanent Impairment, Fifth edition:

- Cervical range of motion - page 422
- Thoracic range of motion- page 416
- Lumbar range of motion - page 410
- Upper extremity - page 436
- Lower extremity - page 561

12. Records Sent by A Copy Service
I am informed and believe State Fund has complied with Labor Code section 4062.3. I further attest that a good faith estimate of the total number of pages provided is 3284 pages. I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date 03/01/2022 Signature Robert Bull

Records Sent by State Fund
State Fund has complied with Labor Code section 4062.3. I further attest the total number of pages provided herein is 39 pages. I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date 3/1/22 Signature _____

13. In your interview if you determine that there are additional outside records that are necessary to address the issues of the claim, please provide detailed information so that we may obtain the records and forward to you for your review and comment.

You have the authority to conduct diagnostic tests that are necessary to complete your evaluation.

Please submit your bill and the original of your report to State Compensation Insurance Fund, PO BOX 65005 Fresno CA 93650-5005. Also, send a copy of the report to the applicant's attorney, Natalia Foley, at the address listed below.

Per Labor Code 139.2(j)(1), you are required to submit your report within 30 days of the exam date.

Your bill will be paid in accordance with the Medical/Legal Fee Schedule set forth in Section 9795 of the Division of Workers' Compensation Administrative Director Rules.

California Senate Bill 863 established California Labor Code §139.32, effective January 1, 2013, which requires interested parties to disclose financial interests in other entities in the administration of workers' compensation claims. State Fund utilizes medical cost containment conventions for services provided by outside vendors as permitted by law including, but not limited to, utilization review,

1302

1504

interpretation, transportation, bill review, photocopy, and pharmacological services. State Fund is not in violation of Labor Code §139.32 in the payment or provision of any of these services.

Except as otherwise permitted by law, Labor Code §139.32 prohibits any interested party other than a claims administrator or a network service provider from referring a person for services relating to workers' compensation provided by another entity, if the interested party has a financial interest in the other entity.

PLEASE NOTE THE ABOVE CLAIM NUMBER ON ALL CORRESPONDENCE AND BILLING.

Sincerely

Robert E. Bull

Robert E. Bull
Claims Adjuster
(951) 697-6317

Natalia Foley
5753 E Santa Ana Canyon Rd., Ste G616 Anaheim CA 92807

Enc: Physician's Return-to-Work & Voucher Report (DWC-AD form 10133.36 - Eff. 1/1/14)
Application For Adjudication of 06/11/2021
3301 of 06/11/2021
List of Medical Reports

cc: Natalia Foley, 5753 E Santa Ana Canyon Rd., Ste G616, Anaheim, CA 92807

2 5676355 000000001 004 039 06626670
2 5711094 000000001 124 135 05626670

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1504

Claim Number: 06626670
Employee: George Soohoo
Date of Injury: 06/11/2021

ATTENTION: MEDICAL PROVIDERS
COPIES - Please dispose the records in a manner that ensures medical confidentiality or return them to State Fund for disposal.

ATTENTION : STATE FUND
If records are returned, do not reimage.

Name	Date
Dr Flores	10/01/2021

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Physician's Return-to-Work & Voucher Report

FOR INJURIES OCCURRING ON OR AFTER 1/1/13

☐ The Employee is P&S from all conditions and the injury has caused permanent partial disability

Employee Last Name | Employee First Name | MI | Date of Injury

Claims Administrator | Claims Representative

Employer Name | Employer Street Address

Employer City | State | Zip Code | Claim No.

☐ The Employee can return to regular work

☐ The Employee can work with the following restrictions:

	hours: 1-2	2-4	4-6	6-8	None
Standing	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Climbing	☐	☐	☐	☐	☐
Forward Bending	☐	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐	☐
Crawling	☐	☐	☐	☐	☐
Twisting	☐	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Grasping*	☐	☐	☐	☐	☐
R/L/Bilat Hand(s) (circle): *Pushing/ Pulling*	☐	☐	☐	☐	☐
Other: _____ (See below)	☐	☐	☐	☐	☐

Lift/Carry Restrictions: May not lift/carry at a height of _____ more than _____ lbs. for more than _____ hours per day.

Describe in what ways the impaired activities are limited:

If a Job Description has been provided, please complete: ☐ *Regular* ☐ *Modified* ☐ *Alternative Work*

Job Title: _____ *Work Location:* _____

Are the work capacities and activity restrictions compatible with the *physical requirements* set forth in the provided job description? ☐ *Yes* ☐ *No, explain below*

Physician's Name _____ Role of Doctor (PTP, QME, AME) _____

Physician's Signature _____ Date _____

DWC AD Form 10133.36 (SJD5) Eff: 1/1/14

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2 5676355 0000000001 006 029 06626670
2 5711094 0000000001 126 135 06626670

State of California
Division of Workers' Compensation

Physician's Return-to-Work & Voucher Report Instructions
FOR INJURIES OCCURRING ON OR AFTER 1/1/13
DWC - AD 10133.36

Who is responsible for filling out this form? The first physician (primary treating physician, Agreed Medical Evaluator, or Qualified Medical Evaluator) who finds that the disability from all conditions for which compensation is claimed has become permanent and stationary (or has reached maximum medical improvement) and finds that the injury has caused permanent partial disability.

What is the purpose of this form? The purpose of the form is to fully inform the employer of the work capacities and activity restrictions resulting from the injury that are relevant to potential regular work, modified work, or alternative work. The information contained on the form is for voucher purposes and is not considered in any permanent impairment rating or any permanent disability indemnity.

Is this a mandatory form? This is a mandatory attachment to the first medical report finding that the disability from all conditions for which compensation is claimed has become permanent and stationary and that the injury has caused permanent partial disability. This form should be attached to a comprehensive medical-legal evaluation and does not replace such comprehensive medical-legal evaluations.

When does the form need to be completed? This form does not need to be completed until all conditions for which compensation is claimed have become permanent and stationary.

If the employer or claims administrator has provided the physician with a job description providing physical requirements of the employee's regular work, proposed modified work, or proposed alternative work, the physician will evaluate and describe in the form whether the work capacities and activity restrictions are compatible with the physical requirements set forth in that job description. The bottom portion of the form does not need to be completed if the physician has not been provided with a job description.

Completing the employee's work restrictions: The physician should indicate work restrictions in terms of how many hours a particular activity is restricted during an 8-hour work day. For hand restrictions, the physician should indicate whether the restrictions are for the right hand, left hand, or both.

Other restrictions can include psychiatric restrictions, chemical exposure, use of equipment, or any other restrictions.

How does the employer receive the form? The claims administrator will forward the form to the employer.

KAISER PERMANENTE
Southern California Permanente Medical Group
Kaiser Foundation Hospitals-Southern California

Central Release of Information Ur
Unit 10740 4th Street, 2nd Floc
Rancho Cucamonga, CA 9173
Phone: (909) 367-77C
Email: CentralROIUnit@kp.o

DECLARATION OF CUSTODIAN OF MEDICAL RECORDS

Patient Name: GEORGE M SOOHOO

Date of Birth: 11/28/1953 **Kaiser Permanente Medical Record Number:** 8075404

Plaintiff: GEORGE M SOOHOO **Defendant:** STATE OF CALIFORNIA INSTITUTION FOR MEN STATE FUND-RIVERSIDE STAT CONTRACT

Case or Reference Number: ADJ11815610 -REF# 1665699

Says as follows (checked sections apply):

The declarant is the duly authorized Custodian of Medical Records for **Kaiser Foundation Hospital-Southern California and Southern California Permanente Medical Group**, and has the authority to certify said records.

☑ The copy or original of the medical records attached to this declaration is a true copy of the records described in the subpoena duces tecum, court order, or other request, that are permitted to be disclosed by law, and include the following record types:

Electronic: ☑ Medical office ☑ Hospital ☐ Mental health ☐ Addiction medicine ☐ Pharmacy

Paper: ☐ Medical office ☐ Hospital ☐ Mental health ☐ Addiction medicine

☑ These records are:

☑ Limited to the dates, or date range of: all Electronic medical records from 02-01-2019 to present.

☐ Limited to specific provider(s) or department type: _____

☐ **Paper records have been ordered to be retrieved from storage and are pending.**

☐ The following requested records that are permitted to be disclosed by law ☐ do not exist; ☐ have been destroyed; ☐ could not be located after an exhaustive search:

Electronic Records: ☐ Medical office ☐ Hospital ☐ Mental health ☐ Addiction medicine ☐ Pharmacy

Paper: ☐ Medical office ☐ Hospital ☐ Mental health ☐ Addiction medicine

☐ Paper records may exist. The following paper records that were requested, and are permitted to be disclosed by law may exist but were not produced:

Paper: ☐ Medical office ☐ Hospital ☐ Mental health ☐ Addiction medicine

A new request is not needed to obtain these paper records. Just **send an email to address shown above within 30 days of the date of this declaration**, and provide the specific date range of the required paper records. If you wait more than 30 days after the date of this declaration to request any paper records, you must submit a new request with a $15 payment.

The records were prepared by the personnel of the hospital, staff physicians, or persons acting under the control of either, in th ordinary course of business at or near the time of the act, condition, or event.

Pursuant to state and federal law, records which contain information pertaining to the treatment of inpatient psychiatric, chemic dependency, and HIV testing are subject to strict confidentiality and may not be disclosed in response to a routine subpoena. Suc material may be obtained only upon a special court order or specific written authorization that meets federal or state guidelines.

I, Mandeep Singh, declare under penalty of perjury that the foregoing is true and correct.

Mandeep Singh Digitally signed by Mandeep Singh DN: cn=Mandeep Singh, o=Kaiser Permanente, ou=Central ROI Unit, email=mandeep.k.singh@kp.org, c=US Date: 2020.03.27 07:46:09 -07'00'

Signature of Declarant

Date: 04/16/2020

KPSC ROI Unit Declaration 11-2-15

LABOR CODE SECTION 4062.3
ATTESTATION

GEORGE M SOOHOO VS STATE OF CALIFORNIA INSTITUTION FOR MEN

CARRIER: STATE FUND - RIVERSIDE - STATE CONTRACTS

ADJUSTER: ROBERT BULL

CL# ADJ11815610, 06380832

REF# 1665699

LABOR CODE SECTION 4062.3

As it pertains to copies of documents provided to the AME, Agreed panel QME or QME:

I am informed and believe our client has complied with Labor Code section 4062.3.

I further attest the total number of pages provided herein is _1469__ pages.

I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Jeannie Goslengflao
Deposition Officer(s)

ONTELLUS
27450 YNEZ RD STE 300
TEMECULA, CA 92591
(800) 660-1107

GEORGE M SOOHOO, KPH / SCPMG , Order# : 1665699

Proof of Service

STATE OF CALIFORNIA

COUNTY OF RIVERSIDE

GEORGE M SOOHOO VS STATE OF CALIFORNIA INSTITUTION FOR MEN

CL# ADJ11815610, 06380832

I, the undersigned, am employed in the County of Riverside, State of California. I am over the age of eighteen years and not a party to the within action. My business address is: 27450 Ynez Rd Ste 300, Temecula, CA 92591.

On 3/2/2022 I shipped records and/or films in the above case matter to the parties below:

Medical Examiner
ELLIS, JONATHAN M.D., 11620 WILSHIRE BLVD STE 340, LOS ANGELES, CA 90025

I am readily familiar with this business' practice of collection and processing correspondence for shipping. Under that practice it would be deposited with the FedEx/USPS service on that same day postage thereon fully prepaid at Temecula, California, in the ordinary course of business.

Jeannie Gosiengfiao
Deposition Officer(s)

ONTELLUS
27450 YNEZ RD STE 300
TEMECULA, CA 92591
(800) 660-1107

GEORGE M SOOHOO, KFH / SCPMG , Order# : 1665699

Ontellus
Accelerating Insight

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of: Los angeles

I, the undersigned, state that I served the forgoing authorization by showing the original and delivering a true copy thereof, together with a copy of the Declaration in support thereof, to each of the following named persons, personally, at the date and place set forth opposite each
name.

Name of Person Served	Date	Place
Kelley.T	January, 28 2020	5901 E 7TH ST BLDG 8 2ND FL RM 207

I declare under penalty of perjury that the forgoing is true and correct.

Executed on January, 28 2020 at LONG BEACH, California

Signature

Claimant: GEORGEM SOOHOO

Location: VA LONG BEACH HEALTHCARE SYSTEM

Order Ref #: 1641396

1641396

ONTELLUS, 27450 YNEZ ROAD SUITE 300 TEMECULA, CA 92591-4680
www.ontellus.com lab@ontellus.com
PHONE (800) 660-1107 FAX (951) 595-4875
PHONE (951) 694-5770

LABOR CODE SECTION 4062.3
ATTESTATION

GEORGE M SOOHOO VS STATE OF CALIFORNIA INSTITUTION FOR MEN

CARRIER: STATE FUND - RIVERSIDE - STATE CONTRACTS

ADJUSTER: ROBERT BULL

CL# ADJ11815610, 06380832

REF# 1641396

LABOR CODE SECTION 4062.3

As it pertains to copies of documents provided to the AME, Agreed panel QME or QME:

I am informed and believe our client has complied with Labor Code section 4062.3.

I further attest the total number of pages provided herein is _229__ pages.

I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Jeannie Gosiengfiao
Deposition Officer(s)

ONTELLUS
27450 YNEZ RD STE 300
TEMECULA, CA 92591
(800) 660-1107

GEORGE M SOOHOO, VA LONG BEACH HEALTHCARE SYSTEM, Order# : 1641396

Proof of Service

STATE OF CALIFORNIA

COUNTY OF RIVERSIDE

GEORGE M SOOHOO VS STATE OF CALIFORNIA INSTITUTION FOR MEN

CL# ADJ11815610, 06380832

I, the undersigned, am employed in the County of Riverside, State of California. I am over the age of eighteen years and not a party to the within action. My business address is: 27450 Ynez Rd Ste 300, Temecula, CA 92591.

On 3/2/2022 I shipped records and/or films in the above case matter to the parties below:

Medical Examiner
ELLIS, JONATHAN M.D., 11620 WILSHIRE BLVD STE 340, LOS ANGELES, CA 90025

I am readily familiar with this business' practice of collection and processing correspondence for shipping. Under that practice it would be deposited with the FedEx/USPS service on that same day postage thereon fully prepaid at Temecula, California, in the ordinary course of business.

Jeannie Gosiengfiao
Deposition Officer(s)

ONTELLUS
27450 YNEZ RD STE 300
TEMECULA, CA 92591
(800) 660-1107

GEORGE M SOOHOO, VA LONG BEACH HEALTHCARE SYSTEM, Order# : 1641396

LABOR CODE SECTION 4062.3
ATTESTATION

GEORGE M SOCHOO VS STATE OF CALIFORNIA INSTITUTION FOR MEN

CARRIER: STATE FUND - RIVERSIDE - STATE CONTRACTS

ADJUSTER: ROBERT BULL

CL# ADJ11815610, 06380832

REF# 1504964

LABOR CODE SECTION 4062.3

As it pertains to copies of documents provided to the AME, Agreed panel QME or QME:

I am informed and believe our client has complied with Labor Code section 4062.3.

I further attest the total number of pages provided herein is _1834___ pages.

I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Jeannie Gosiengfiao
Deposition Officer(s)

ONTELLUS
27450 YNEZ RD STE 300
TEMECULA, CA 92591
(800) 660-1107

GEORGE M SOOHOO, KFH / SCPMG , Order# : 1504964

following:

- Narrative history
- Current clinical status
- Diagnostic study results
- Medical basis for determining Maximum Medical Improvement
- Diagnoses, impairments
- Impairment rating criteria, prognosis, residual function, and limitations

When listing your medical findings, please use the applicable reporting forms found in the AMA Guides to the Evaluation of Permanent Impairment, Fifth edition:

- Cervical range of motion - page 422
- Thoracic range of motion- page 416
- Lumbar range of motion - page 410
- Upper extremity - page 436
- Lower extremity - page 561

12. Records Sent by A Copy Service
I am informed and believe State Fund has complied with Labor Code section 4062.3. I further attest that a good faith estimate of the total number of pages provided is 3284 pages. I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date 03/01/2022 Signature Robert Bull

Records Sent by State Fund
State Fund has complied with Labor Code section 4062.3. I further attest the total number of pages provided herein is 39 pages. I certify that the same is true of my own knowledge, except as to those matters which upon my information or belief I believe them to be true. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date 3/1/22 Signature _____

13. In your interview if you determine that there are additional outside records that are necessary to address the issues of the claim, please provide detailed information so that we may obtain the records and forward to you for your review and comment.

You have the authority to conduct diagnostic tests that are necessary to complete your evaluation.

Please submit your bill and the original of your report to State Compensation Insurance Fund, PO BOX 65005 Fresno CA 93650-5005. Also, send a copy of the report to the applicant's attorney, Natalia Foley, at the address listed below.

Per Labor Code 139.2(j)(1), you are required to submit your report within 30 days of the exam date.

Your bill will be paid in accordance with the Medical/Legal Fee Schedule set forth in Section 9795 of the Division of Workers' Compensation Administrative Director Rules.

California Senate Bill 863 established California Labor Code §139.32, effective January 1, 2013, which requires interested parties to disclose financial interests in other entities in the administration of workers' compensation claims. State Fund utilizes medical cost containment conventions for services provided by outside vendors as permitted by law including, but not limited to, utilization review,

1302

1504

2 5676355 00000001 003 039 06626670
2 5711094 00000001 135 135 06626670

NATALIA FOLEY
5753 E SANTA ANA CANYON RD., STE G616
ANAHEIM CA 92807

STATE COMPENSATION INSURANCE FUND

2 5711094 000000001 001 135 06626670

April 14, 2022

Natalia Foley
5753 E Santa Ana Canyon Rd., Ste G616
Anaheim CA 92807

Claim Number: 06626670
Employee: George Soohoo
Date of Injury: 06/11/2021

Dear Natalia Foley

State Compensation Insurance Fund objects to the report of Dr. Ellis, dated 04/03/22. Dr. Ellis's report is not based on substantial evidence. State Compensation Insurance Fund disagrees with the doctor's opinion regarding industrial causation. Although Dr. Ellis's deposition is not being set at this time, State Compensation Insurance Fund reserves the right to take the doctor's deposition at a future date.

Sincerely

Robert E. Bull

Robert E. Bull
Claims Adjuster
(951) 697-6317

Enc: Jonathan C Ellis, M.D. of 03/17/2022

Mailing Address: PO Box 65005, Fresno CA 93650