Worker's Compensation Court

Back to Digital Index

SANDRA ROQUEMORE
Plaintiff

vs

AMERICAN GUARD SERVICES, DBA
Defendant

Case Number: **ADJ13818144**

Worker's Compensation Subpoena Duces Tecum

Claim Number: **UW2000031101**

RECORDS PERTAINING TO:
SANDRA ROQUEMORE

RECORDS FROM:
BENEVOLENCE HEALTH CENTERS

ATTN: CUSTODIAN OF RECORDS
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016

☐ **CLIENT ORDERING RECORDS:**
DJG LAW GROUP, INC.
ATTN: SHAWN PETROTTA, ESQ
8181 EAST KAISER BLVD #100
ANAHEIM HILLS, CA 92808

☒ **OPPOSING PARTY:**
WORKERS DEFENDERS
ATTN:
8018 E. SANTA ANA CANYON RD. # 100-215
ANAHEIN, CA 92808

STATEWIDE RECORD SERVICES, INC.
P.O. BOX 15617
SACRAMENTO, CA 95852-0617
(916) 344-0446 FAX (916) 344-0104

Order#: 52918-10/STCVR

PHOTOCOPIED RECORDS - COMPLETED REPORT

DJG LAW GROUP, INC.
SHAWN PETROTTA, ESQ
8181 EAST KAISER BLVD #100
ANAHEIM HILLS, CA 92808

RE: CASE NAME:	SANDRA ROQUEMORE vs. AMERICAN GUARD SERVICES, DBA
COURT:	Worker's Compensation Court
CASE NUMBER:	ADJ13818144
YOUR FILE #:	UW2000031101
OUR FILE #:	52918
FACILITY:	BENEVOLENCE HEALTH CENTERS
PATIENT NAME:	SANDRA ROQUEMORE

Dear Mr. Petrotta:

Your request to photocopy records at the above referenced location has been completed. A copy of the records has been shipped to:

☒ **SHAWN PETROTTA, ESQ**
DJG LAW GROUP, INC.
8181 EAST KAISER BLVD #100
ANAHEIM HILLS, CA 92808
Date Shipped: APR 0 5 2021

☒ **PATRICIA CARRUTHERS**
NEXT LEVEL ADMINISTRATORS
P.O. BOX 1061
BRADENTON, FL 34206
Date Shipped: APR 0 5 2021

☒ **WORKERS DEFENDERS**
8018 E. SANTA ANA CANYON RD. # 100-215
ANAHEIN, CA 92808
Date Shipped: APR 0 5 2021

Thank you for choosing STATEWIDE RECORD SERVICES, INC. to assist you.
If you have any questions or coments, please feel free to contact our office.

Respectfully Submitted,

Alfonso Velasco

Order#: 52918-10/CPROOF36

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION APPEALS BOARD

SANDRA ROQUEMORE

Claimant/Applicant

vs.

AMERICAN GUARD SERVICES, DBA

Employer/Insurance Carrier/Defendant

CASE NO. ADJ13818144

(If application has been filed, case number must be indicated regardless of date of injury.)

SUBPOENA DUCES TECUM

(When records are mailed, identify them by using the above Case No. or attaching copy of the subpoena.)

Where no application has been filed for injuries on or after January 1, 1990 and before January 1, 1994, subpoena will be valid without a case number, but subpoena must be served on claimant and employer and/or insurance carrier.

See Instructions below.*

The People of the State of California Send Greetings to:

BENEVOLENCE HEALTH CENTERS

WE COMMAND YOU to appear before: **STATEWIDE RECORD SERVICES, INC.**
at **P.O. BOX 15617, SACRAMENTO, CA 95852-0617 Phone:(916) 344-0446**

on **April 15, 2021** ,at **10:00 AM** ,to testify in the above-entiltled matter and to bring with you and produce the following described documents, papers, books and records:

ANY & ALL MEDICAL RECORDS (IN-PATIENT/OUT-PATIENT) INCLUDING BUT NOT LIMITED TO PHARMACY/PRESCRIPTION RECORDS, DOCTORS/NURSES NOTES, RADIOLOGY REPORTS, ECHOCARDIOGRAMS, CHART NOTES, HANDWRITTEN NOTES, QUESTIONNAIRES, INTAKE FORMS, REPORTS, WRITINGS, CORRESPONDENCE, INDUSTRIAL & NON INDUSTRIAL INJURIES, PRIOR INJURIES, STORAGE RECORDS OR ANY OTHER DOCUMENTS PERTAINING TO: SANDRA ROQUEMORE, DOB: 02/11/1955, SSN#: 564-92-3586

(Do not produce X-rays unless specifically mentioned above)

For failure to attend and to produce said documents you may be deemed guilty of a contempt and liable to pay to the parties aggrieved all damages sustained thereby and forfeit one hundred dollars in addition thereto.

This subpoena is issued at the request of the person making the declaration on the reverse hereof, or on the copy which is served herewith.

Date: **March 31, 2021**

WORKERS' COMPENSATION APPEALS BOARD
OF THE STATE OF CALIFORNIA

Secretary/Assistant Secretary, Worker's Compensation Judge

***FOR INJURIES OCCURRING ON OR AFTER JANUARY 1,1990 AND BEFORE JANUARY 1, 1994:**

If no Application for Adjucation of Claim has been filed, a declaration under penalty of perjury that the Employee's Claim for Workers' Compensation Benefits (Form DWC-1) has been filed pursuant to Labor Code Section 5401 must be executed properly.

SEE REVERSE SIDE
[SUBPOENA INVALID WITHOUT DECLARATION]

You may fully comply with this subpoena by mailing the records described (or authenticated copies, Evid. Code 1561) to the person and place stated above within (10) days of the date of service of this subpoena.

This subpoena does not apply to any member of the Highway Patrol, Sheriff's Office or city Police Department unless accompanied by notice from this Board that deposit of the witness fee has been made in accordance with Gov't Code 68097.2 et seq.

DECLARATION FOR SUBPOENA DUCES TECUM

Case No. ADJ13818144

STATE OF CALIFORNIA, County of ORANGE

The undersigned states:

That **STATEWIDE RECORD SERVICES, INC.** is (one of) **DJG LAW GROUP, INC.** representative(s) for the Defendant in the action captioned on the reverse hereof.

That **BENEVOLENCE HEALTH CENTERS**

has in his/her possession or under his/her control the documents described on the reverse hereof. That said documents are material to the issues involved in the case for the following reasons:

The records sought are relevant to the claim/case and may lead to discoverable evidence.
These records may contain information that will help in the resolution of this claim/case.

Declaration for Injuries on or After January 1, 1990 and before January 1,1994.

o That an Employee's Claim for Workers' Compensation Benefits (DWC FORM 1) has been filed in accordance with Labor Code Section 5401 by the alleged injured worker whose records are sought, or if the worker is deceased, by the dependent(s) of the decedent, and that a true copy of the form filed is attached hereto. (Check box if applicable and part of declaration below. See instructions on front of subpoena.)

I declare under penalty of perjury that the foregoing is true and correct.

March 31, 2021 at ANAHEIM HILLS ,California.

/S/ SHAWN PETROTTA, ESQ	DJG LAW GROUP, INC. 8181 EAST KAISER BLVD #100 ANAHEIM HILLS, CA 92808	(714) 637-4100
Signature	Address	Telephone

DECLARATION OF SERVICE

STATE OF CALIFORNIA, County of Sacramento

I, the undersigned, state that: I served the foregoing subpoena 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 of service	Place
email	3/31	3631 Crenshaw Blvd. Los Angeles, CA 90016

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 3/31/21 at Sacramento , California.

Signature

DIA WCAB 32 (Page 2)(Rev. 06/18)

Order#: 52918-10/CPROOF34

PROOF OF SERVICE BY MAIL CCP 1013A

Case No. ADJ13818144

Case Name: SANDRA ROQUEMORE
vs.
AMERICAN GUARD SERVICES, DBA

I am a resident of the State of California, County of Sacramento. I am over the age of eighteen years and not a party to the entitled action; my business address is P.O. BOX 15617, SACRAMENTO, CA 95852-0617.

On March 31, 2021 I served this Notice of Taking Deposition (if applicable)/ Notice to Consumer (if applicable) along with the Subpoena and Affidavit in Support of Issuance (if applicable) on the attorneys for all appearing parties in said action, by placing a true copy thereof enclosed in a sealed envelope; with postage thereon fully prepaid, in the United States mail at SACRAMENTO, CA, addresses as follows:

WORKERS DEFENDERS
8018 E. SANTA ANA CANYON RD. # 100-215
ANAHEIN, CA 92808

I declare under penalty of purjury that the forgoing is true and correct. Executed on March 31, 2021, at SACRAMENTO, CA.

Sincerely,

JESSE BONILLA

Order#: 52918-10/CPROOF23

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, state bar number, and address)*:
DJG LAW GROUP, INC.
SHAWN PETROTTA, ESQ, SBN 284224
8181 EAST KAISER BLVD #100
ANAHEIM HILLS, CA 92808
TELEPHONE NO.: **(714) 637-4100** FAX NO.: **(714) 637-4102**
E-MAIL ADDRESS:
ATTORNEY FOR *(Name)*: **Defendant**

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF ORANGE
STREET ADDRESS: **1065 N. PacifiCenter Dr., Suite #170**
MAILING ADDRESS:
CITY AND ZIP CODE: **Anaheim 92806**
BRANCH NAME: **Anaheim**

PLAINTIFF/PETITIONER: SANDRA ROQUEMORE

DEFENDANT/RESPONDENT: AMERICAN GUARD SERVICES, DBA

CASE NUMBER:
ADJ13818144

NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION
(Code Civ. Proc.,§§ 1985.3, 1985.6)

NOTICE TO CONSUMER OR EMPLOYEE

TO *(name)*: **SANDRA ROQUEMORE AND/OR ATTORNEY OF RECORD**

1. PLEASE TAKE NOTICE THAT **REQUESTING PARTY** *(name)*: **DJG LAW GROUP, INC.**
SEEKS YOUR RECORDS FOR EXAMINATION by the parties to this action on *(specify date)*: **April 15, 2021**
The records are described in the subpoena directed to **witness** *(specify name and address of person or entity from whom records are sought)*:
BENEVOLENCE HEALTH CENTERS 3631 CRENSHAW BLVD, LOS ANGELES, CA 90016
A copy of the subpoena is attached.

2. IF YOU OBJECT to the production of these records, YOU MUST DO ONE OF THE FOLLOWING BEFORE THE DATE SPECIFIED IN ITEM a. OR b. BELOW:
   a. If you are a party to the above-entiltled action, you must file a motion pursuant to Code of Civil Procedure section 1987.1 to quash or modify the subpoena and give notice of that motion to the **witness** and the **deposition officer** named in the subpoena at least five days before the date set for the production of the records.
   b. If you are not a party to this action, you must serve on the **requesting party** and on the **witness,** before the date set for production of the records, a written objection that states the specific grounds on which production of such records should be prohibited. You may use the form below to object and state the grounds for your objection. You must complete the Proof of Service on the reverse side indicating whether you personally served or mailed the objection. The objection should **not** be filed with the court. **WARNING:** IF YOUR OBJECTION IS NOT RECEIVED BEFORE THE DATE SPECIFIED IN ITEM 1, YOUR RECORDS MAY BE PRODUCED AND MAY BE AVAILABLE TO ALL PARTIES.

3. YOU OR YOUR ATTORNEY MAY CONTACT THE UNDERSIGNED to determine whether an agreement can be reached in writing to cancel or limit the scope of the subpoena. If no such agreement is reached, and if you are not otherwise represented by an attorney in this action, YOU SHOULD CONSULT AN ATTORNEY TO ADVISE YOU OF YOUR RIGHTS OF PRIVACY.

Date: **March 31, 2021**

SHAWN PETROTTA, ESQ
(TYPE OR PRINT NAME)

▶ **/S/ SHAWN PETROTTA, ESQ**
(SIGNATURE OF [XX] REQUESTING PARTY [ ] ATTORNEY

OBJECTION BY NON-PARTY TO PRODUCTION OF RECORDS

1. [ ] I object to the production of all of my records specified in the subpoena.
2. [ ] I object only to the production of the following specified records:

3. The specific grounds for my objection are as follows:

Date:

(TYPE OR PRINT NAME)

▶
(SIGNATURE)

(See next page for proof of service)

Form Adopted for Mandatory Use
Judicial Council of California
SUBP-025 [Rev. January 1, 2008]

NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION

Code of Civil Procedure,
§§1985.3, 1985.6,
2020.010-2020.510
www.TristarSoftware.com
Order#: 52918-10/CPROOF15

PLAINTIFF/PETITIONER: SANDRA ROQUEMORE	CASE NUMBER:
DEFENDANT/RESPONDENT: AMERICAN GUARD SERVICES, DBA	ADJ13818144

PROOF OF SERVICE OF NOTICE TO CONSUMER OR EMPLOYEE AND OBJECTION

(Code Civ. Proc.,§§ 1985.3, 1985.6)

☐ **Personal Service** ☑ **Mail**

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Notice to Consumer or Employee and Objection* as follows *(check either a or b):*

a. ☐ **Personal service.** I personally delivered the *Notice to Consumer or Employee and Objection* as follows:
   (1) Name of person served: (3) Date served:
   (2) Address: (4) Time served:

b. ☑ **Mail.** I deposited the *Notice to Consumer or Employee and Objection* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
   (1) Name of person served: **WORKERS DEFENDERS** (3) Date of mailing: **3/31/2021**
   (2) Address: **8018 E. SANTA ANA CANYON RD. # 100-215, ANAHEIN, CA 92808** (4) Place of mailing: **SACRAMENTO, CA**
   (5) I am a resident of or employed in the county where the *Notice to Consumer or Employee and Objection* was mailed.

c. My residence or business address is *(specify):* **P.O. BOX 15617, SACRAMENTO, CA 95852-0617**

d. My phone number is *(specify):* **(916) 344-0446**

I declare under penalty of perjury under the laws of the laws of the State of California that the foregoing is true and correct.

Date: 3/31/2021

JESSE BONILLA
(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

PROOF OF SERVICE OF OBJECTION TO PRODUCTION OF RECORDS

(Code of Civ. Proc.,§§ 1985.3, 1985.6)

☐ **Personal Service** ☐ **Mail**

1. At the time of service I was at least 18 years of age and **not a party to this legal action.**
2. I served a copy of the *Objection to Production of Records* as follow *(complete either a or b):*

a. ON THE REQUESTING PARTY
   (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
      (i) Name of person served: (iii) Date served:
      (ii) Address where served: (iv) Time served:
   (2) ☐ **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
      (i) Name of person served: (iii) Date of mailing:
      (ii) Address: (iv) Place of mailing *(city and state:*
      (v) I am resident of or employed in the county where the *Objection to Production of Records* was mailed.

b. ON THE WITNESS:
   (1) ☐ **Personal service.** I personally delivered the *Objection to Production of Records* as follows:
      (i) Name of person served: (iii) Date served:
      (ii) Address where served: (iv) Time served:
   (2) ☐ **Mail.** I deposited the *Objection to Production of Records* in the United States mail, in a sealed envelope with postage fully prepaid. The envelope was addressed as follows:
      (i) Name of person served: (iii) Date of mailing:
      (ii) Address: (iv) Place of mailing *(city and state):*
      (v) I am a resident of or employed in the county where the *Objection to Production of Records* was mailed.

3. My residence or business address is (specify):
4. My phone number is (specify):

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

(TYPE OR PRINT NAME OF PERSON WHO SERVED)

▶ _____
(SIGNATURE OF PERSON WHO SERVED)

STATEWIDE RECORD SERVICES, INC.

DECLARATION OF CUSTODIAN OF RECORDS

(X) I HEREBY DECLARE under penalty of perjury that the following statements are true to the best of my knowledge and belief.

I am the duly authorized custodian of records of the below named and I certify that the accompanying records are true and complete copies of records maintained in the regular course and scope of business of my employer and were prepared by authorized personnel at or near the time of the acts, conditions or events which they intend to convey. As custodian, I testify to the records identity and method of preparation. The source of the information and method of preparation were such as to indicate their trustworthiness. If I were called as a witness in this matter, I could and would testify under oath to these facts. No documents, records or other things have been withheld except as noted below.

Certain records were omitted because they were not requested. (Billing)

* *

OR IN THE ALTERNATIVE:

( ) I HEREBY DECLARE under penalty of perjury that I have NO RECORDS concerning SANDRA ROQUEMORE.

Please explain if you have no records: _____

(X) I have no X-RAYS or other diagnostic films.

( ) I have no BILLING RECORDS.

Records Subpoenaed From: **BENEVOLENCE HEALTH CENTERS**

Concerning: **SANDRA ROQUEMORE**
DOB: [redacted]
ID No.: **564-92-3586**

HOW ORIGINAL RECORDS WERE PREPARED:
( ) Handwritten notes
( ) Typed or Data Entered
( ) Transcribed
(X) Other: electronically

Records were made during, or promptly after the act, condition or event reflected in such records.

04/02/21
Date

Signature of Custodian

A. Reghier
Print Name

Order#:52918-10/CPROOF7

P.O. BOX 15617 SACRAMENTO, CA 95852-0617 (916) 344-0446 FAX:(916) 344-0104

R quemore, Sandra

65 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Central Medical Clinic

04/17/2020

PHONE: Sina Tebi, MD

Current Medications

Taking

- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day

Not-Taking/PRN

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day

Reason for Appointment

1. Endo F/u

History of Present Illness

HPI:

8/24/19- in may 2019 has tsh slightly above normal and t4 and t3 was normal, not on medications

needs tb screening for new job

10/18/19-repeat labs show TSH 4.7 and fre t4 is 1.3, clinically asymptomatic.

Follow Up

no response- reschedule

Sina Tebi M.D

Electronically signed by Sina Tebi , MD on 04/17/2020 at 05:28 PM PDT

Sign off status: Completed

Central Medical Clinic
3533 W Pico Blvd
Los Angeles, CA 90019-4534
Tel: 323-734-1600
Fax: 323-734-1666

R quemore, Sandra

64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

11/11/2019

Progress Notes: David Ghods, D.O.

Current Medications

Taking
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day

Not-Taking/PRN
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV- deceased 06/2019.

Social History

Reason for Appointment

1. Results

History of Present Illness

Todays Visit:

64F presenting for lab results. States that she had the cataract removal in the R eye and she is seeing much better now. Will go for L eye next month.

Advised that LDL is 125, recommend cutting back on high cholesterol and fried foods. Advised that urine culture did not results. Will repeat today. Patient states that she has nicottine patches which she will try herself.

CDSS: Breast Cancer Screening
Last Mammogram Date *Date in Notes: 2018*
Results *Normal*
Requesting *No*
Refused *No*

CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago 2018*
Results? *Negative*

CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.

CDSS: Tdap Vaccine (Adult)
less than 10 yrs *No*
Refused *No*
Requesting *Yes*

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 129 lbs, Wt-kg 58.51 kg, BMI 21.80 Index, BP 141/73 mm Hg, Temp 98.8 F, HR 62 /min, RR 17 /min, Taken by m.lopez ma.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.

HEAD normocephalic, atraumatic.

EYES sclera non-icteric, pupils equal, round, reactive to light and

Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Tobacco use other than smoking
Are you an other tobacco user? *No*

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
General/Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, lightheadedness, night sweats, sleep disturbance, weight gain, weight loss, dizziness.
Respiratory:
Patient denies chest pain, pain with inspiration, shortness of breath at rest, shortness of breath with exertion.
Cardiovascular:
Patient denies chest pain at rest, chest pain with exertion, difficulty laying flat, dyspnea on exertion, irregular heartbeat, palpitations, weight gain.

accomidation.
NECK neck supple, full range of m[illegible]on, no cervical lymphadenopathy, No JVD, no enlarged thyroid glands.
SKIN warm and dry, no suspicious lesion .
HEART regular rate and rhythm , S1, S2 normal, no murmurs.
Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.
EXTREMITIES/HIPS no clubbing, cyanosis, or edema.
MUSCULOSKELETAL full range of motion .

Assessments
1. Hyperlipidemia, unspecified - E78.5 (Primary)
2. Unspecified abnormal findings in urine - R82.90

Treatment
1. Unspecified abnormal findings in urine

LAB: UA Dip

Color	yellow
Appearance	clear
Leukocytes	neg
Nitrite	neg
Urobilinogen	normal
Protein	neg
pH	5.0
Blood	trace
Specific Gravity	1.000
Ketones	neg
Bilirubin	neg
Glucose	neg

LAB: URINALYSIS, COMPLETE
LAB: URINE CULTURE

2. Others
Refill Aspirin Tablet Delayed Release, 81 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3
Refill Fish Oil Capsule, 1000 MG, 1 capsule, Orally, Once a day, 90 days, 90 Capsule, Refills 3
Refill Vitamin D3 Tablet, 2000 UNIT, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3

Preventive Medicine
Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products.
Exercise at least 30 min/day on at least 5 days/week.

Procedure Codes
81000 URINALYSIS

Follow Up
prn, 1 Week (Reason: f/u lab results)

Electronically signed by David Ghods on 11/11/2019 at 12:21 PM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

R quemore, Sandra
64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

10/31/2019 Progress Notes: David Ghods, D.O.

Current Medications

Taking

- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day

Not-Taking/PRN

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV- deceased 06/2019.

Reason for Appointment

1. Pt states here for physical exam

History of Present Illness

Todays Visit:

64F presenting for screening physical exam. Advised that some of the tests from her prevous visit are missing and we need them to send to optho for her upcomming cataract surgery. EKG was read as normal by Dr. Javdan however it seems to have not been added to the chart. We will repeat this today and send to optho. CMP was ordered by Dr. Javdan but seems to have not resulted. Will perform this today for the physical but this is not required for Optho as they indicated it is optional.

Patient states that she with think about Chantix for smoking cessation.

Patient advised that UA shows blood and leukocytes. Denies any hematuria. Denies dysuria. We will perform UCx to assess for possible UTI.

Patient requests mammogram.

CDSS: Breast Cancer Screening
Last Mammogram Date *Date in Notes: 2018*
Results *Normal*
Requesting *No*
Refused *No*

CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago 2018*
Results? *Negative*

CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.

CDSS: Tdap Vaccine (Adult)
less than 10 yrs *No*
Refused *No*
Requesting *Yes*

Depression Screening:

PHQ-2 (2015 Edition)
Little interest or pleasure in doing things? *Not at all*
Feeling down, depressed, or hopeless? *Not at all*
Total Score *0*

Social History

Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Tobacco use other than smoking
Are you an other tobacco user? *No*

Gyn History

Date of Last Period No Cycle since 2018 .
Last pap smear date 2018, normal .

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

Review of Systems

General/Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, lightheadedness, night sweats, sleep disturbance, weight gain, weight loss, dizziness.
Respiratory:
Patient denies chest pain, pain with inspiration, shortness of breath at rest, shortness of breath with exertion.
Cardiovascular:
Patient denies chest pain at rest, chest pain with exertion, difficulty laying flat, dyspnea on exertion, irregular heartbeat, palpitations, weight gain.

Depression Screening:
PHQ-9
Little interest or pleasure in doing things *Not at all*
Feeling down, depressed, or hopeless *Not at all*
Trouble falling or staying asleep, or sleeping too much *Not at all*
Feeling tired or having little energy *Not at all*
Poor appetite or overeating *Not at all*
Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Not at all*
Trouble concentrating on things, such as reading the newspaper or watching television *Not at all*
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Not at all*
Thoughts that you would be better off dead or of hurting yourself in some way *Not at all*
Total Score *0*

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 127 lbs, Wt-kg 57.61 kg, BMI 21.46 Index, BP 148/76 mm Hg, Temp 98.1 F, HR 54 /min, RR 16 /min, repeat bp by MD 134/85, Taken by M.Howard/MA, Oxygen sat % 97 %.

Examination

General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.
HEAD normocephalic, atraumatic.
EYES sclera non-icteric, pupils equal, round, reactive to light and accomidation, **bilateral cateracts**.
THROAT clear, no erythema, no edema, uvula midline, normal tonsils, dentures in good repair.
NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD, no enlarged thyroid glands.
SKIN warm and dry, no suspicious lesion .
HEART regular rate and rhythm , S1, S2 normal, no murmurs.
Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.
ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.
EXTREMITIES/HIPS no clubbing, cyanosis, or edema.
MUSCULOSKELETAL full range of motion .
NEUROLOGIC No focal neurological deficit observed.

Assessments

1. Encounter for general adult medical examination with abnormal findings - Z00.01 (Primary)
2. Encounter for screening mammogram for malignant neoplasm of breast - Z12.31
3. Encounter for examination of eyes and vision with abnormal findings - Z01.01
4. Encounter for screening for depression - Z13.31
5. Encounter for other preprocedural examination - Z01.818

6. Unspecified abnormal findings in urine - R82.90

Treatment

1. Encounter for general adult medical examination with abnormal findings

LAB: * Hemoglobin A1c LABCORP
LAB: * Lipid Panel LABCORP
LAB: * COMPREHENSIVE METABOLIC PANEL QUEST

2. Encounter for screening mammogram for malignant neoplasm of breast

IMAGING: MAMMOGRAM, SCREENING
Referral To:Radiology
Reason:screening mammogram

3. Encounter for examination of eyes and vision with abnormal findings

Notes: pending cataract surgery. optho following.

4. Encounter for screening for depression

Notes: PHQ9 negative.

5. Encounter for other preprocedural examination

LAB: * COMPREHENSIVE METABOLIC PANEL QUEST
PROCEDURE: EKG
Notes: EKG shows sinus bradycardia to 44. Recheck of pulse 54. Regular. No skipped QRS. No ST elevation. No chest pain.

6. Unspecified abnormal findings in urine

LAB: URINALYSIS
LAB: URINE CULTURE

Procedures

Vision screen:
Right eye 20/60, with corrective lenses.
Left eye 20/60, with corrective lenses.
Both eyes 20/50, with corrective lenses.
Colors Green - Yes, Red - NO.

Labs

Lab: UA Dip

Color	yellow
Appearance	clear
Leukocytes	trace
Nitrite	neg
Urobilinogen	norm
Protein	trace
pH	6.5
Blood	5-10
Specific Gravity	1.005
Ketones	neg
Bilirubin	neg
Glucose	neg

Preventive Medicine
Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products.
Exercise at least 30 min/day on at least 5 days/week.

Procedure Codes
81000 URINALYSIS

Follow Up
prn, 1 Week (Reason: f/u lab results)

Electronically signed by David Ghods on 10/31/2019 at 04:20 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

R quemore, Sandra

64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

10/18/2019 EstEndo: Sina Tebi, MD

Current Medications

Taking

- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day

Not-Taking/PRN

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Allergies

N.K.D.A.

Reason for Appointment

1. Pt here for lab results

History of Present Illness

HPI:

8/24/19- in may 2019 has tsh slightly above normal and t4 and t3 was normal, not on medications

needs tb screening for new job

10/18/19-repeat labs show TSH 4.7 and fre t4 is 1.3, clinically asymptomatic.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 126 lbs, Wt-kg 57.15 kg, BMI 21.29 Index, BP 131/81 mm Hg, Temp 98.0 F, HR 72 /min, RR 17 /min, Taken by lpueco/cma, Oxygen sat % 97 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.

HEAD normocephalic, atraumatic.

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

EXTREMITIES/HIPS no clubbing, cyanosis, or edema.

Assessments

1. Abnormal results of thyroid function studies - R94.6 (Primary)

Treatment

1. Abnormal results of thyroid function studies

LAB: TSH+Free T4 (Ordered for 04/18/2020)

Notes:
labs in 6 mo
no treatment at this time
education.

Follow Up

6 Months, labs

Sina Tebi M.D

Electronically signed by Sina Tebi , MD on 10/18/2019 at 05:41 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

10/15/2019

Progress Notes: Ron Javdan, MD

Current Medications

Taking
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day

Not-Taking/PRN
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV- deceased 06/2019.

Reason for Appointment

1. Pt states here for pre-op clearence.

History of Present Illness

Todays Visit:

64 yo female presents today for preop clearance. Pt is suppossedly scheduled for a cataract surgery. She currently has no complaint(s).

CDSS: Breast Cancer Screening
Last Mammogram Date *Date in Notes: 2018*
Results *Normal*
Requesting *No*
Refused *No*

CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago 2018*
Results? *Negative*

CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.

CDSS: Tdap Vaccine (Adult)
less than 10 yrs *No*
Refused *No*
Requesting *Yes*

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 126 lbs, Wt-kg 57.15 kg, BMI 21.29 Index, BP 113/76 mm Hg, Temp 98.5 F, HR 87 /min, RR 18 /min, Taken by LTF/MA, Oxygen sat % 96 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.

HEAD normocephalic, atraumatic.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

Social History

Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Tobacco use other than smoking
Are you an other tobacco user? *No*

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

Review of Systems

General/Constitutional:
Patient denies change in appetite, chills, fatigue, fever, headache, lightheadedness, night sweats, sleep disturbance, weight gain, weight loss, dizziness.
Respiratory:
Patient denies chest pain, pain with inspiration, shortness of breath at rest, shortness of breath with exertion. Coughing up blood Denies. Denies Breathing pattern. Denies Chest pain. Denies Cough. Denies Hemoptysis. Denies Pain with inspiration. Denies Shortness of breath at rest. Denies Shortness of breath with exertion. Denies Sputum production. Denies Wheezing.
Cardiovascular:
Patient denies chest pain at rest, chest pain with exertion, difficulty laying flat, dyspnea on exertion, irregular heartbeat, palpitations, weight gain. chest discomfort denies. Blood clot in artery or vein Denies. Aneurysm of blood vessel denies. Heart surgery Denies. Black out spells Denies. Heart murmur Denies. Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath.

EXTREMITIES/HIPS no clubbing, cyanosis, or edema.
MUSCULOSKELETAL full range of motion.
NEUROLOGIC No focal neurological deficit observed.

Assessments

1. Encounter for other preprocedural examination - Z01.818 (Primary)

Treatment

1. Encounter for other preprocedural examination
LAB: * CBC With Differential/Platelet LABCORP
LAB: Comp. Metabolic Panel (12)
PROCEDURE: EKG
Notes: EKG- Normal
Bloodwork- PENDING.....

Follow Up

1 Week, prn (Reason: F/u on labs for surgery clearance)

Electronically signed by Ron Javdan , MD on 10/15/2019 at 01:24 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Denies Weakness. Denies Weight gain.
Gastrointestinal:

Patient denies abdominal pain, blood in stool, change in bowel habits, constipation, diarrhea, difficulty swallowing, heartburn, ulcer Denies . Haital hernia Denies . frequent heartburn /indigestion Denies . Gall bladderattacks/gall stones Denies . Abnormal stool Denies . Acid reflux Denies . Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting. Denies Weight loss.

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 64 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

vider: Haleh Toutounchi, DPM
Date: 09/17/2019

Subjective:

Chief Complaints:

1. Podiatry f/u; c/o painful, long, thick, discolored toenails that are hard to cut.

HPI:

Podiatry:

64 yo female pt rtc for f/u and c/o of painful, elongated, thick, discolored toenails that are hard to cut. Pt did use Clotrimazole and Lac-Hydrin with some improvements noted on the skin and toenails of feet. Otherwise, pt reports no new skin changes. Pt denies accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker. Pt says that she did see the dermatologist and was given topical medication (she does not remember name.) Pt says that she has eczema.

Medical History:

Medications: Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020, Not-Taking/PRN Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Not-Taking/PRN Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day, Not-Taking/PRN Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day, Not-Taking/PRN Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Asprin , Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day

Objective:

Examination:

General Examination ;

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. trimmed hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet. hyperpigmented skin lesions of foot.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1, Trimmed at this time.
5. Xerosis cutis - L85.3
6. Disorder of the skin and subcutaneous tissue, unspecified - L98.9

Plan:

1. Tinea unguium

Notes: Trimmed and debrided toenails..

2. Tinea pedis

Continue Clotrimazole Cream, 1 %, Apply to affected area as directed, Externally, Twice a day, 30 Gram,

Refills 3 .

3. Xerosis cutis
Continue Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

4. Disorder of the skin and subcutaneous tissue, unspecified
Notes: Pt was seen by dermatolgy and said that she plans to f/u with dermatology. .

5. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted/as needed. Pt was advised against smoking. .

Procedure Codes: 11720 DEBRIDE NAIL, 1-5

Follow Up: prn

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 09/17/2019

Electronically signed by HALEH TOUTOUNCHI , DPM on 09/17/2019 at 11:03 AM PDT
Sign off status: Completed

R quemore, Sandra
64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Central Medical Clinic

08/26/2019 **Progress Note: Omid Nassim, MD**

Current Medications

Taking

- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020

Not-Taking/PRN

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Nicoderm CQ 14 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day, stop date 08/27/2019
- Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day

Reason for Appointment

1. Tb reading

History of Present Illness

Todays Visit:

PT IS A 64 Y/O F PRESENT TO CLINIC FOR PPD READING ADMINISTER ON 08/24/2019.

PPD (-).

Assessments

1. Encounter for screening for respiratory tuberculosis - Z11.1 (Primary)

Treatment

1. Encounter for screening for respiratory tuberculosis

Notes: PPD READING, (-).

Follow Up

prn

Electronically signed by Omid Nassim , MD on 08/26/2019 at 09:25 AM PDT

Sign off status: Completed

Central Medi Clinic
3533 W Pico Blvd
Los Angeles, CA 90019-4534
Tel: 323-734-1600
Fax: 323-734-1666

Patient: Roquemore, Sandra DOB: 02/11/1955 Progress Note: Omid Nassim, MD 08/26/2019

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 64 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Sina Tebi, MD
Date: 08/24/2019

Subjective:

Chief Complaints:
1. Pt is here for thyroid check.

HPI:
CDSS: Todays Visit:
CDSS: Breast Cancer Screening Last Mammogram Date Date in Notes: 2018, Results Normal, Requesting No, Refused No.
CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago 2018, Results? Negative.
CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.
CDSS: Tdap Vaccine (Adult) less than 10 yrs No, Refused No, Requesting Yes.
HPI:
8/24/19- in may 2019 has tsh slightly above normal and t4 and t3 was normal, not on medications needs tb screening for new job.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020, Not-Taking/PRN Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Not-Taking/PRN Nicoderm CQ 14 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day, stop date 08/27/2019, Not-Taking/PRN Clotrimazole 1 % Cream Apply to affected area as directed Externally Twice a day, Not-Taking/PRN Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day, Not-Taking/PRN Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Asprin , Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 131 lbs, Wt-kg 59.42 kg, BMI 22.14 Index, BP 114/68 mm Hg, Temp 98.4 F, HR 62 /min, RR 19 /min, Taken by K.Garcia/ma, Oxygen sat % 98 %.

Examination:
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.
HEAD normocephalic, atraumatic.
HEART regular rate and rhythm , S1, S2 normal, no murmurs.
Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.
ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.
EXTREMITIES/HIPS no clubbing, cyanosis, or edema.

Assessment:

Assessment:

1. Abnormal results of thyroid function studies - R94.6 (Primary)
2. Encounter for screening for r[illegible]iratory tuberculosis - Z11.1

Plan:

1. Abnormal results of thyroid function studies

LAB: TSH+Free T4
LAB: THYROGLOBULIN AB
LAB: TPO ANTIBODIES

Immunizations:

PPD : 0.1 mL (Dose No:1) (Route: Intradermal) given by Kimberly Garcia,MA on Left Arm (Encounter for screening for respiratory tuberculosis)

Labs:

Lab: Thyroid Peroxidase (TPO) Ab

Thyroid Peroxidase (TPO) Ab	14	0-34 - IU/mL

eclinicalworks, support 09/10/2019 05:06:01 : This order was created by the Interface.

Lab: TSH+Free T4

Free T4 by Dialysis/Mass Spec	1.3	- ng/dL
TSH-ICMA	4.7	- uU/mL

eclinicalworks, support 09/10/2019 05:06:01 : This order was created by the Interface.

Lab: Thyroglobulin Antibody

Thyroglobulin Antibody	<1.0	0.0-0.9 - IU/mL

eclinicalworks, support 09/10/2019 05:06:01 : This order was created by the Interface.

Procedure Codes: 86580 TB INTRADERMAL TEST

Follow Up: 2 Weeks, labs, 2 days TB reading

Provider: Sina Tebi, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/24/2019

Electronically signed by Sina Tebi , MD on 04/02/2021 at 08:38 AM PDT
Sign off status: Pending

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 64 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

vider: Haleh Toutounchi, DPM
Date: 08/06/2019

Subjective:

Chief Complaints:

1. Podiatry f/u; c/o painful, long, thick, discolored toenails that are hard to cut.

HPI:

Podiatry:

64 yo female pt rtc for f/u and c/o of painful, elongated, thick, discolored toenails that are hard to cut. Pt also presents with flaky, dry skin of feet. Pt reports being out of Clotrimazole cream and requests refill. Pt has missed her appointment/s with me. Pt did use Clotrimazole and Lac-Hydrin with some improvements noted on the skin and toenails of feet. Otherwise, pt denies new skin changes. Pt denies accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker. Pt says that she did see the dermatologist and was given topical medication (she does not remember name.) Pt says that she has eczema.

Medical History:

Medications: Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020, Taking Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day, Taking Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Taking Nicoderm CQ 14 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day, stop date 08/27/2019, Not-Taking/PRN Asprin , Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day

Objective:

Examination:

General Examination :

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. trimmed hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet. hyperpigmented skin lesions of foot.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1, Trimmed at this time.
5. Xerosis cutis - L85.3
6. Disorder of the skin and subcutaneous tissue, unspecified - L98.9

Plan:

1. Tinea unguium

Continue Clotrimazole Solution, 1 %, Apply to affected toenails as directed, Externally, Twice a day, 30 Milliliter, Refills 3 .

Notes: Trimmed and debrided toenails..

2. Tinea pedis
Refill Clotrimazole Cream, 1 %, Apply to affected area as directed, Externally, Twice a day, 30 Gram, Refills 3 .

3. Xerosis cutis
Continue Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

4. Disorder of the skin and subcutaneous tissue, unspecified
Notes: Pt was seen by dermatolgy and says that she plans to f/u with dermatology. .

5. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted/as needed. Pt was advised against smoking. .

Procedure Codes: 11720 DEBRIDE NAIL, 1-5

Follow Up: prn

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/06/2019

Electronically signed by HALEH TOUTOUNCHI , DPM on 09/17/2019 at 11:06 AM PDT
Sign off status: Completed

R quemore, Sandra
64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

07/31/2019 **Progress Notes: Omid Nassim, MD**

Current Medications

Taking
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020
- Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Nicoderm CQ 14 MG/24HR Patch 24 Hour 1 patch to skin Transdermal Once a day, stop date 08/27/2019

Not-Taking/PRN
- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.

Reason for Appointment

1. Pt states here for referral for eye doctor

History of Present Illness

Todays Visit:

CDSS: Breast Cancer Screening
Last Mammogram Date *Date in Notes: 2018*
Results *Normal*
Requesting *No*
Refused *No*

CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago 2018*
Results? *Negative*

CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.

CDSS: Tdap Vaccine (Adult)
less than 10 yrs *No*
Refused *No*
Requesting *Yes*

pt is a 64 y/o F present to clinic requesting ophthalmologist referral. pt feels well has no other concerns.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 126 lbs, Wt-kg 57.15 kg, BMI 21.29 Index, BP 103/69 mm Hg, Temp 98.1 F, HR 72 /min, RR 18 /min, Taken by M.Howard/MA, Oxygen sat % 98 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

Assessments

1 Son Has HIV- deceased 06/2019.

Social History

Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Tobacco use other than smoking
Are you an other tobacco user? *No*

Gyn History

Date of Last Period No Cycle since 2018 .
Last pap smear date 2018, normal .

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

1. Low vision, both eyes - H54.2
2. Unspecified subjective visual distu .ces - H53.10
3. Unspecified disorder of eye and adnexa - H57.9
4. Unspecified glaucoma - H40.9

Treatment

1. Low vision, both eyes
Referral To:Ophthalmology
Reason:eval/manage; please submit with CPT codes requested|Acuity Eye Group; Retina Institute; Dr. Sahar Bedrood MD Tel: 213-413-7301|1127 Wilshire Blvd ste 504 LA,CA 90017

2. Unspecified subjective visual disturbances
Referral To:Ophthalmology
Reason:eval/manage; please submit with CPT codes requested|Acuity Eye Group; Retina Institute; Dr. Sahar Bedrood MD Tel: 213-413-7301|1127 Wilshire Blvd ste 504 LA,CA 90017

3. Unspecified disorder of eye and adnexa
Referral To:Ophthalmology
Reason:eval/manage; please submit with CPT codes requested|Acuity Eye Group; Retina Institute; Dr. Sahar Bedrood MD Tel: 213-413-7301|1127 Wilshire Blvd ste 504 LA,CA 90017

4. Unspecified glaucoma
Referral To:Ophthalmology
Reason:eval/manage; please submit with CPT codes requested|Acuity Eye Group; Retina Institute; Dr. Sahar Bedrood MD Tel: 213-413-7301|1127 Wilshire Blvd ste 504 LA,CA 90017

Preventive Medicine

Informed pt that he/she will receive the referral(s) in the mail within 7 - 10 days; instructed pt to call BHC and ask to speak to the referral department if he/she hasn't received the referral in that timeframe.

Follow Up

after seeing specialist(s),physical

Electronically signed by Omid Nassim , MD on 07/31/2019 at 12:11 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra DOB: 02/11/1955 Progress Note: Omid Nassim, MD 07/31/2019

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 64 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Ron Javdan, MD
Date: 06/28/2019

Subjective:

Chief Complaints:

1. Pt states here for lab results .

HPI:

Todays Visit:

CDSS: Breast Cancer Screening
Last Mammogram Date *Date in Notes: 2018*
Results *Normal*
Requesting *No*
Refused *No*

CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago 2018*
Results? *Negative*

CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past.

CDSS: Tdap Vaccine (Adult)
less than 10 yrs *No*
Refused *No*
Requesting *Yes*

64yo female presents for a review of lab results. She smokes 3-4 cigarettes a day.
T4 and T3 - normal
TSH - 4.9
A1C - 5.1
She has no new complains.

ROS:

General/Constitutional:

Patient denies change in appetite, chills, fatigue, fever, headache, lightheadedness, night sweats, sleep disturbance, weight gain, weight loss, dizziness. daytime drowsiness denies . Denies Change in appetite. Denies Chills, denies. Denies Fatigue. Denies Fever. Denies Headache. Denies Lightheadedness. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.

Cardiovascular:

Patient denies chest pain at rest, chest pain with exertion, difficulty laying flat, dyspnea on exertion, irregular heartbeat, palpitations, weight gain. chest discomfort denies . Blood clot in artery or vein Denies . Aneurysm of blood vessel denies . Heart surgery Denies . Black out spells Denies . Heart murmur Denies . Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.

Gastrointestinal:

Patient denies abdominal pain, blood in stool, change in bowel habits, constipation, diarrhea, difficulty swallowing, heartburn. ulcer Denies . Haital hernia Denies . frequent heartburn /indigestion Denies . Gall bladderattacks/gall stones Denies . Abnormal stool Denies . Acid reflux Denies . Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting. Denies Weight loss.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Clotrimaz 1 % Cream Apply to affected area Exte ly Twice a day, Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020, Taking Clotrimazole 1 % Solution Apply to affected toenails as directed Externally Twice a day, Taking Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Asprin , Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 130 lbs, Wt-kg 58.97 kg, BMI 21.97 Index, BP 118/71 mm Hg, Temp 98.5 F, HR 78 /min, RR 16 /min, Taken by M.Howard/MA, Oxygen sat % 94 %.

Examination:

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

EXTREMITIES/HIPS no clubbing, cyanosis, or edema.

MUSCULOSKELETAL full range of motion .

NEUROLOGIC No focal neurological deficit observed.

Assessment:

Assessment:

1. Nicotine dependence, unspecified, uncomplicated - F17.200 (Primary)
2. Person consulting for explanation of examination or test findings - Z71.2

Plan:

1. Nicotine dependence, unspecified, uncomplicated

Start Nicoderm CQ Patch 24 Hour, 14 MG/24HR, 1 patch to skin, Transdermal, Once a day, 30 day(s), 30, Refills 1 .

2. Person consulting for explanation of examination or test findings

Notes:

Results explained to patient

Follow Up: 3 Months, prn (Reason: repeat labwork)

Provider: Ron Javdan, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 06/28/2019

Electronically signed by Ron Javdan , MD on 06/28/2019 at 03:36 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 64 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Haleh Toutounchi, DPM
Date: 06/25/2019

Subjective:

Chief Complaints:

1. c/o painful, long, thick, discolored toenails that are hard to cut.

HPI:

Podiatry:

64 yo female pt presents to the clinic for foot exam and care and c/o of painful, elongated, thick, discolored toenails that are hard to cut. Pt also presents with flaky, dry skin of feet. Pt has missed her appointment/s with me. Pt is out of Clotrimazole solution and Lac-Hydrin cream. Pt did use Clotrimazole and Lac-Hydrin with some improvements noted on the skin and toenails of feet. Otherwise, pt denies new skin changes. Pt denies accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker. Pt says that she did see the dermatologist and was given topical medication (she does not remember name.) Pt says that she has eczema.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Spinal Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV- deceased 06/2019.

Social History:

Tobacco Use: Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Drugs/Alcohol: Drugs Have you used drugs other than those for medical reasons in the past 12 months? No, Opiates No.

Medications: Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 05/22/2020, Not-Taking/PRN Asprin , Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Not-Taking/PRN Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day

Allergies: N.K.D.A.

Objective:

Examination:

General Examination :

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. trimmed hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet. hyperpigmented skin lesions of foot.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1, Trimmed at this time.
5. Xerosis cutis - L85.3
6. Disorder of the skin and subcutaneous tissue, unspecified - L98.9

Plan:

1. Tinea unguium
Refill Clotrimazole Solution, 1 %, Apply to affected toenails as directed, Externally, Twice a day, 30 Milliliter, Refills 3 .
Notes: Trimmed and debrided toenails..

2. Tinea pedis
Notes: Continue with Clotrimazole cream as needed. .

3. Xerosis cutis
Refill Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

4. Disorder of the skin and subcutaneous tissue, unspecified
Notes: Pt was seen by dermatolgy and says that she plans to f/u with dermatology. .

5. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted/as needed. Pt was advised against smoking. .

Procedure Codes: 11720 DEBRIDE NAIL, 1-5

Follow Up: 3 Months

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 06/25/2019

Electronically signed by HALEH TOUTOUNCHI , DPM on 06/25/2019 at 01:00 PM PDT
Sign off status: Completed

R quemore, Sandra
64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

05/28/2019

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day

Not-Taking/PRN

- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:

Reason for Appointment

1. Pt states here for lab result

History of Present Illness

HPI:

Pt here for lab results; ldl 105, tsh slightly elevated, pt asympt. no other clinical complaints/concerns, feels well.

Todays Visit:

CDSS: Breast Cancer Screening Last Mammogram Date Date in Notes: 2018, Results Normal, Requesting No, Refused No. CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago 2018, Results? Negative. CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past. CDSS: Tdap Vaccine (Adult) less than 10 yrs No, Refused No, Requesting Yes.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 131 lbs, Wt-kg 59.42 kg, BMI 22.14 Index, BP 112/64 mm Hg, Temp 98.6 F, HR 86 /min, RR 16 /min, Taken by M.Howard/MA, Oxygen sat % 98 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD, no enlarged thyroid glands. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

Assessments

1. Pure hypercholesterolemia - E78.0 (Primary)
2. Abnormal results of thyroid function studies - R94.6
3. Vitamin D deficiency, unspecified - E55.9

Treatment

1. Others

Refill Vitamin D3 Tablet, 2000 UNIT, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3

Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Gyn History

Date of Last Period No Cycle since 2018 . Last pap smear date 2018, normal .

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

Review of Systems

12 point review of the systems negative other than what mentioned in HPI.

Refill Aspirin Tablet Delayed Release, 8- MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3
Refill Fish Oil Capsule, 1000 MG, 1 capsule, Orally, Once a day, 90 days, 90 Capsule, Refills 3

Labs

Lab: TSH+Free T4 (Ordered for 06/25/2019)

Lab: T3 TOTAL (Ordered for 06/25/2019)

Preventive Medicine

Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products.
Exercise at least 30 min/day on at least 5 days/week., Continue healthy habits.

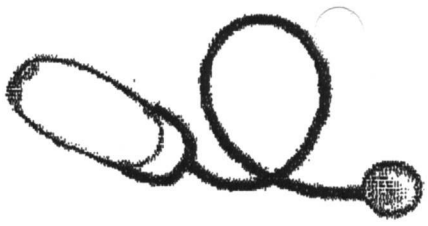
Follow Up

6 Weeks (Reason: lab results)

Electronically signed by Sabrina Moiseyev , FNP on 05/28/2019 at 03:42 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104



R quemore, Sandra
64 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

05/13/2019 **Progress Notes: Sabrina Moiseyev, FNP**

Current Medications

Taking

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day

Not-Taking/PRN

- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:

Reason for Appointment

1. Pt states here for referral for pain management and eyes Dr.

History of Present Illness

HPI:

Pt here for referrals. No clinical complaints/concerns, feels well.

Todays Visit:

CDSS: Breast Cancer Screening Last Mammogram Date Date in Notes: 2018, Results Normal, Requesting No, Refused No. CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago 2018, Results? Negative. CDSS: TB risk/PPD test Never had TB skin test, denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, No TB Risk , Negative Reading in the past. CDSS: Tdap Vaccine (Adult) less than 10 yrs No, Refused No, Requesting Yes.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 134 lbs, Wt-kg 60.78 kg, BMI 22.64 Index, BP 102/62 mm Hg, Temp 98.3 F, HR 77 /min, RR 16 /min, Taken by M.Howard/MA, Oxygen sat % 99 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

Assessments

1. Low vision, both eyes - H54.2 (Primary)
2. Low back pain - M54.5
3. Cervical disc disorder with myelopathy, unspecified cervical region - M50.00

Treatment

1. Low vision, both eyes

Referral To:Optometrist

Reason:201 S Alvarado St, Los Angeles, CA 90057|eval and manage

Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Gyn History

Date of Last Period No Cycle since 2018 . Last pap smear date 2018, normal .

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

Review of Systems

12 point review of the systems negative other than what mentioned in HPI.

2. Low back pain

Referral To:Pain Medicine

Reason:323 N Prairie Ave #417, Inglewood, CA 90301|eval and manage

3. Cervical disc disorder with myelopathy, unspecified cervical region

Referral To:Pain Medicine

Reason:323 N Prairie Ave #417, Inglewood, CA 90301|eval and manage

Labs

Lab: CBC, CMP, LIPID, TSH, HgA1C

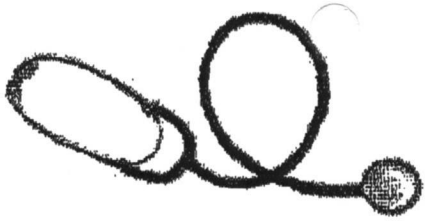
Follow Up

1 Week (Reason: lab results)

Electronically signed by Sabrina Moiseyev , FNP on 05/13/2019 at 05:02 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
STE 109
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104



Roquemore, Sandra
63 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

12/10/2018

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day

Not-Taking/PRN

- Asprin
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:

Reason for Appointment

1. Pt states here for lab results 11/28/2018

History of Present Illness

HPI:

Pt here for HIV results, (-). No complaints/concerns, feels well.

Todays Visit:

CDSS: Breast Cancer Screening Last Done? Less than 2 years ago , Results? Requesting Pt states is getting one next month 10/29/2018 . CDSS: Cervical Cancer Screening Last Done? More than 3 years ago (Due), Results? Negative. CDSS: HIV screening Requesting. CDSS: TB risk/PPD test Last done: Pt states it been a while , denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, denies fever and night sweats, Negative Reading in the past. CDSS: Tdap Vaccine (Adult) less than 10 yrs Yes, Refused No, Requesting No.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 131 lbs, Wt-kg 59.42 kg, BMI 22.14 Index, BP 107/80 mm Hg, Temp 98.4 F, HR 75 /min, RR 16 /min, Taken by G.Dominguez/sma.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

Assessments

1. Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)

Follow Up

prn, 2 Months

Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

1 week 2011

Review of Systems

12 point review of the systems negative other than what mentioned in HPI.

Electronically signed by Sabrin oiseyev , FNP on 12/10/2018 at 10:39 AM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Roquemore, Sandra

63 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSMo1
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

10/29/2018

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Asprin
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day

Unknown

- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, Are you interested in quitting? Ready to

Reason for Appointment

1. Pt states here for 3 MONTHS F/U

History of Present Illness

HPI:

(see last 2 progress notes). Pt here for f/u HIV screening. No complaints/concerns, feels well.

Todays Visit:

CDSS: Breast Cancer Screening Last Done? Less than 2 years ago , Results? Requesting Pt states is getting one next month 10/29/2018 . CDSS: Cervical Cancer Screening Last Done? More than 3 years ago (Due), Results? Negative. CDSS: HIV screening Requesting. CDSS: TB risk/PPD test Last done: Pt states it been a while , denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, denies fever and night sweats, Negative Reading in the past. CDSS: Tdap Vaccine (Adult) less than 10 yrs Yes, Refused No, Requesting No.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 130 lbs, Wt-kg 58.97 kg, BMI 21.97 Index, BP 131/79 mm Hg, Temp 98.3 F, HR 74 /min, RR 16 /min, Taken by M.Howard/MA.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. EXTREMITIES/HIPS no clubbing, cyanosis, or edema. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed. PERIPHERAL PULSES 2+ pedal, 2+ radial. PSYCH speech: normal, oriented, affect: appropriate.

Assessments

1. Encounter for screening for human immunodeficiency virus [HIV] - Z11.4 (Primary)

quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wa up do you smoke your first cigarette? 6-3 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit.
05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.
Drugs/Alcohol:
Drugs Have you used drugs other than those for medical reasons in the past 12 months? No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Labs
Lab: HIV 1/2 AB

Follow Up
1 Week (Reason: lab results)

Electronically signed by Sabrina Moiseyev , FNP on 10/29/2018 at 12:35 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 63 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Samuel Smith, MD
Date: 07/30/2018

Subjective:

Chief Complaints:
1. Depression Screening.

HPI:
Depression Screening:
PHQ-9
Little interest or pleasure in doing things *Not at all*
Feeling down, depressed, or hopeless *Not at all*
Trouble falling or staying asleep, or sleeping too much *Not at all*
Feeling tired or having little energy *Not at all*
Poor appetite or overeating *Not at all*
Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Not at all*
Trouble concentrating on things, such as reading the newspaper or watching television *Not at all*
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Not at all*
Thoughts that you would be better off dead or of hurting yourself in some way *Not at all*
Total Score *0*
Intervention
Follow-up for Depression *Patient follow-up to return when and if necessary*
Individual Psychotherapy Progress Note:
Other Notes: See mental health assessment. Also, Pt disclosed that her son has cancer and that she is his caregiver..

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018, Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019, Taking Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Not-Taking/PRN Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day

Objective:

Examination:
General Examination :
PSYCH speech: normal, oriented, affect: appropriate, cooperative, mood: euthymic.

Assessment:

Assessment:
1. Encounter for screening for other disorder - Z13.89

Plan:

1. Encounter for screening for other disorder
Notes: LCSW reviewed results of PHQ9 with pt. LCSW reminded pt of BHC's mental health program.

Provider: Samuel Smith, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 07/30/2018

Electronically signed by jacqueline saenz , LCSW on 07/30/2018 at 12:59 PM PDT
Sign off status: Completed

Roquemore, Sandra

63 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

07/30/2018

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Asprin
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Vitamin D3 2000 UNIT Tablet 1 tablet Orally Once a day, stop date 07/18/2019
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day

Not-Taking/PRN

- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:

Reason for Appointment

1. Pt coming in for lab results

History of Present Illness

Todays Visit:

(-) hiv and rpr. no complaints/feels well.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 128 lbs, Wt-kg 58.06 kg, BMI 21.63 Index, BP 110/70 mm Hg, Temp 98.3 F, HR 71 /min, RR 18 /min, Taken by c.pablo/ma.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. EXTREMITIES/HIPS no clubbing, cyanosis, or edema. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed. PERIPHERAL PULSES 2+ pedal, 2+ radial. PSYCH speech: normal, oriented, affect: appropriate.

Assessments

1. Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)
2. Constipation, unspecified - K59.00

Treatment

1. Others

Start Lactulose Solution, 10 GM/15ML, 15 ml, Orally, Once a day, 30 day(s), 450, Refills 2

Follow Up

3 Months (Reason: repeat hiv)

Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Electronically signed by Sabrina Moiseyev , FNP on 07/30/2018 at 03:06 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

I quemore, Sandra

63 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Health Smart
MSO Payer ID: HSM01
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

07/23/2018 Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018
- Asprin

Not-Taking/PRN
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake

Reason for Appointment

1. Pt is requesting medication refill

History of Present Illness

HPI:

Pt here for med refills. Requesting to be tested for HIV; pt injected son with his sq anticoagulant and she ended up pricking herself, no break in skin, no bleeding occured after. Son is HIV (+). No complaints/concerns, feels well.

Todays Visit:

CDSS: Colorectal Cancer Screening Last Done Less than 10 years ago; colonoscopy , Result Negative, Type of screening Colonoscopy . CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Positive. CDSS: HIV screening Last Done:2017. CDSS: Pneumoccol Vaccine Refused. CDSS: TB risk/PPD test Negative Reading in the past.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 129 lbs, Wt-kg 58.51 kg, BMI 21.80 Index, BP 124/82 mm Hg, Temp 98.6 F, HR 76 /min, RR 18 /min, Taken by c.pablo/ma.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age, normal gait. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. EXTREMITIES/HIPS no clubbing, cyanosis, or edema. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed. PERIPHERAL PULSES 2+ pedal, 2+ radial. PSYCH speech: normal, oriented, affect: appropriate.

Assessments

1. Dermatitis, unspecified - L30.9 (Primary)
2. Hyperlipidemia, unspecified - E78.5

Treatment

1. Others

up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigare every day, Patient counselled on the dang of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.
Drugs/Alcohol:
Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Refill Fish Oil Capsule, 1000 MG, 1 capsule, Orally, Once a day, 90 days, 90 Capsule, Refills 3
Refill Clotrimazole Cream, 1 %, Apply to affected area, Externally, Twice a day, 30 g, Refills 3
Start Vitamin D3 Tablet, 2000 UNIT, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3
Start Aspirin Tablet Delayed Release, 81 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 3
Notes: will repeat HIV test in 2 months.

Labs
Lab: RPR
Lab: HIV

Follow Up
1 Week (Reason: lab results)

Electronically signed by Sabrina Moiseyev , FNP on 07/23/2018 at 10:29 AM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Roquemore, Sandra
62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

02/09/2018

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018
- Asprin

Not-Taking/PRN

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Lexapro 10 MG Tablet 1 tablet Orally Once a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Review of Systems

12 point review of the systems negative other than what mentioned in HPI.

Reason for Appointment

1. Lab results

History of Present Illness

HPI:

Pt here for lab results; unremarkable. Has no complaints, feels well.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 135 lbs, Wt-kg 61.24 kg, BMI 22.81 Index, BP 130/80 mm Hg, Temp 98.1 F, HR 63 /min, RR 18 /min, Taken by t.ochoa/ma.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

Assessments

1. Encounter for general adult medical examination without abnormal findings - Z00.00 (Primary)

Preventive Medicine

Continue healthy habits., Instructed to continue all meds as prescribed.

Follow Up

prn, 6 Months

Electronically signed by Sabrina Moiseyev , FNP on 02/09/2018 at 12:55 PM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra DOB: 02/11/1955 Progress Note: Sabrina Moiseyev, FNP 02/09/2018

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 62 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Sabrina Moiseyev, FNP
Date: 01/30/2018

Subjective:

Chief Complaints:
1. pt is here for PRE OPS . 2. Pt is here for mamoram results.

HPI:
HPI:
Pt here for pre-op; will be having dilation and curettage with hysteroscopy on 2/23/18. Was dx with trich, currently on appropriate tx regimen. Pt BIB letter from United Medical Imaging of L.A stating her L breast mammo came back abnormal (no further info provided).
CDSS: Todays Visit:
CDSS: Colorectal Cancer Screening Last Done Less than 10 years ago; colonoscopy, Result Negative, Type of screening Colonoscopy. CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago, Results? Positive. CDSS: Pneumoccol Vaccine Refused. CDSS: TB risk/PPD test Negative Reading in the past.

ROS:
12 point review of the systems negative other than what mentioned in HPI.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Spinal Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV.

Social History:
Tobacco Use: Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Medications: Taking Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018, Taking Asprin , Not-Taking/PRN Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Not-Taking/PRN Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Not-Taking/PRN Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Not-Taking/PRN Pravachol 40 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Lexapro 10 MG Tablet 1 tablet Orally Once a day, Not-Taking/PRN Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Not-Taking/PRN Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 132 lbs, Wt-kg 59.87 kg, BMI 22.31 Index, BP 124/82 mm Hg, Temp 98.2 F, HR 66 /min, RR 18 /min, Taken by sgarcia/ma, Oxygen sat % 98 %.

Examination:
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. HEAD normocephalic, atraumatic. EYES sclera non-icteric, pupils equal, round, reactive to light and accomidation. EARS/NOSE tympanic membranes intact, patent, no bulging/redness, ear cannal, clear, no discharge/redness, gross hearing intact, Nose: normal

turbinates. Oral Pharynx mucosa moist, good dentition. THROAT clear, no erythema, no edema, uvula midline, normal tonsils. NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD, no enlarged thyroid glands. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly. EXTREMITIES/HIPS no clubbing, cyanosis, or edema. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed. PERIPHERAL PULSES 2+ pedal, 2+ radial. PSYCH speech: normal, oriented, affect: appropriate. FEMALE GENITOURINARY (-) suprapubic tenderness, (-) CVAT.

Assessment:

Assessment:
1. Encounter for other preprocedural examination - Z01.818 (Primary)

Plan:

1. Encounter for other preprocedural examination

Referral To:Radiology
Reason:cxr|outside radiology

Labs:

Lab: PT AND PTT

Lab: UA Dip

Lab: CBC, CMP, LIPID, HgA1C

Lab: TSH

TSH	4.280	0.450-4.500 - uIU/mL

Lab: **DO NOT USE** RPR

RPR	Non Reactive	Non Reactive -

Follow Up: 1 Week (Reason: lab results)

Provider: Sabrina Moiseyev, FNP
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 01/30/2018

Electronically signed by Sabrina Moiseyev , FNP on 04/02/2021 at 08:40 AM PDT
Sign off status: Pending

Roquemore, Sandra

62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

11/06/2017 Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018
- Asprin

Not-Taking/PRN
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, stop date 11/15/2017
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake

Reason for Appointment

1. Spotting blood x1 week

History of Present Illness

HPI:

Pt here c/o min pink vag spotting x 1 week; denies odor, vaginal pruritis, genital lesions, dysuria, hematuria, polyuria, f/c, or pelvic pain. PMP x > 20 years. States she believes the spotting occured d/t stress of dealing with son; reports she took her bf's valium and helped with anxiety. Requesting rx for valium.

Todays Visit:

CDSS: Colorectal cancer screening Last Done Less than 10 years ago; colonoscopy , Result Negative, Type of screening Colonoscopy . CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Negative. CDSS: HIV screening Last Done:,2017 negative. CDSS: TB risk/PPD test Negative Reading in the past, denies fever and night sweats, denies weight loss, anorexia, loss of appetite, denies coughing of blood, denies traveling out of country, denies any contact with person with TB. CDSS: Tdap Vaccine (Adult) Last done Less than 10 years ago , Is the patient requesting the Tdap vaccice? Received in the past.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 134 lbs, Wt-kg 60.78 kg, BMI 22.64 Index, BP 124/60 mm Hg, Temp 96.6 F, HR 69 /min, RR 18 /min, Taken by mhernandez/,a, Oxygen sat % 96 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. PSYCH speech: normal, oriented, affect: appropriate. FEMALE GENITOURINARY (-) suprapubic tenderness, (-) CVAT.

Assessments

1. Anxiety disorder, unspecified - F41.9 (Primary)

up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigare? every day, Patient counselled on the dang of tobacco use and urged to quit. 05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

2. Abnormal uterine and vaginal bleeding, unspecified - N93.9

Treatment

1. Anxiety disorder, unspecified
Start Lexapro Tablet, 10 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 3

2. Abnormal uterine and vaginal bleeding, unspecified
Referral To:OB - Gynecology
Reason:female provider|eval and manage

Labs

Lab: UA Dip

Color	Yellow
Appearance	Clear
Leukocytes	++
Nitrite	nrg
Urobilinogen	normal
Protein	neg
pH	5.0
Blood	++/80
Specific Gravity	1.030
Ketones	neg
Bilirubin	trace
Glucose	neg

Lab: URINE CULTURE

Procedure Codes
81000 URINALYSIS

Follow Up
after seeing specialist

Electronically signed by Sabrina Moiseyev , FNP on 11/06/2017 at 10:31 AM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

R quemore, Sandra
62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

09/02/2017 **Progress Notes: Sabrina Moiseyev, FNP**

Current Medications

Taking

- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Aspirin 81 MG Tablet 1 tablet Orally Once a day, stop date 09/16/2017
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Fish Oil 1000 MG Capsule 1 capsule Orally Once a day, stop date 08/21/2018

Not-Taking/PRN

- Asprin
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, stop date 11/15/2017
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, Are you interested in quitting? Ready to

Reason for Appointment

1. Pt is here for lab results

History of Present Illness

HPI:

Here for lab results, unremarkable, ldl 103. Has no complaints, feels well.

Todays Visit:

CDSS: Colorectal cancer screening Last Done Less than 10 years ago; colonoscopy , Result Negative, Type of screening Colonoscopy . CDSS: Cervical Cancer Screening Last Done? More than 3 years ago (Due), Results? Negative. CDSS: HIV screening Last Done: 01/17/2017, Negative. CDSS: TB risk/PPD test denies any contact with person with TB, denies traveling out of country, denies coughing of blood, denies weight loss, anorexia, loss of appetite, denies fever and night sweats, No TB Risk , Negative Reading in the past. CDSS: Tdap Vaccine (Adult) Last done More than 10 years ago (due), Is the patient requesting the Tdap vaccice? Received in the past.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 126 lbs, Wt-kg 57.15 kg, BMI 21.29 Index, BP 112/78 mm Hg, Temp 98.6 F, HR 84 /min, RR 18 /min, Taken by Jmartinez/ma, Oxygen sat % 97 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

Assessments

1. Pure hypercholesterolemia - E78.0 (Primary)
2. Person consulting for explanation of examination or test findings - Z71.2

Labs

Lab: TSH (Ordered for 03/02/2018)

quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wa[illegible] up do you smoke your first cigarette? 6-3[illegible] minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit.
05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.
Sexual History:
Sexual History Have you ever had a Sexually transmitted disease? Yes, Other?
No, Syphilis? No, Herpes? No, GC?
No, Chlamydia? Yes, have you had sex in the past 12 months Yes.
Drugs/Alcohol:
Drugs Have you used drugs other than those for medical reasons in the past 12 months?
No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? Yes, How often did you have 6 or more drinks on one occasion in the past year?
Never (0 point), How many drinks did you have on a typical day when you were drinking in the past year? 1 or 2 drinks (0 point), How often did you have a drink containing alcohol in the past year? 2 to 4 times a month (2 points), Points 2, Interpretation Negative.
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Lab: FECAL OCCULT BLOOD,GU[illegible]C (Ordered for 03/02/2018)
Lab: CBC, CMP, LIPID, HgA1C (Ordered for 03/02/2018)

Preventive Medicine
Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products.
Exercise at least 30 min/day on at least 5 days/week., Continue healthy habits.

Follow Up
prn, 6 Months

Electronically signed by Sabrina Moiseyev , FNP on 09/02/2017 at 11:42 AM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Roquemore, Sandra
62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

08/26/2017

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Asprin
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Aspirin 81 MG Tablet 1 tablet Orally Once a day, stop date 09/16/2017
- Pravachol 40 MG Tablet 1 tablet Orally Once a day
- Aspirin 81 MG Tablet Delayed Release 1 tablet Orally Once a day, stop date 11/15/2017
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30

Reason for Appointment

1. 1. pt is here to Discuss Cholesterol medication

History of Present Illness

HPI:

Pt states feeling unwell since starting statin. Has no other complaints/concerns, feels well.

Depression Screening:

PHQ-2 In last 2 weeks have you been bothered by Little interest or pleasure in doing things No, Feeling down, depressed, or hopeless No. PHQ-9 Little interest or pleasure in doing things Not at all, Feeling down, depressed, or hopeless Not at all, Trouble falling or staying asleep, or sleeping too much Not at all, Feeling tired or having little energy Not at all, Poor appetite or overeating Not at all, Feeling bad about yourself or that you are a failure, or have let yourself or your family down Not at all, Trouble concentrating on things, such as reading the newspaper or watching television Not at all, Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual Not at all, Thoughts that you would be better off dead or of hurting yourself in some way Not at all, Total Score 0.

Todays Visit:

CDSS: Colorectal cancer screening Last Done Less than 10 years ago; colonoscopy , Result Negative, Type of screening Colonoscopy . CDSS: Cervical Cancer Screening Last Done? More than 3 years ago (Due), Results? Negative. CDSS: HIV screening Last Done: 01/17/2017.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 130 lbs, Wt-kg 58.97 kg, BMI 21.97 Index, BP 120/80 mm Hg, Temp 98.5 F, HR 74 /min, RR 17 /min, Taken by JMariona/MA, Oxygen sat % 98 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. HEAD normocephalic, atraumatic. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales,

minutes, How often do you smoke cigarettes? every day, Patient counselled on the dan of tobacco use and urged to quit.
05/05/2017. Tobacco use other than smoking Are you an other tobacco user? No.
Drugs/Alcohol:
Drugs Have you used drugs other than those for medical reasons in the past 12 months? No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? Yes, How often did you have 6 or more drinks on one occasion in the past year? Never (0 point), How many drinks did you have on a typical day when you were drinking in the past year? 1 or 2 drinks (0 point), How often did you have a drink containing alcohol in the past year? 2 to 4 times a month (2 points), Points 2, Interpretation Negative.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

or rhonchi, normal respiratory effort. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal n ological deficit observed. PSYCH speech: normal, oriented, affect: appropriate.

Treatment
1. Others
Start Fish Oil Capsule, 1000 MG, 1 capsule, Orally, Once a day, 90 days, 90 Capsule, Refills 3
Notes: stop statin in meantime.

Labs
Lab: TSH

Lab: VIT D 1,25 OH2 T

Lab: CBC, CMP, LIPID, HgA1C

Preventive Medicine
Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products.
Exercise at least 30 min/day on at least 5 days/week.

Follow Up
1 Week (Reason: lab results)

Electronically signed by Sabrina Moiseyev , FNP on 08/28/2017 at 09:37 AM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 62 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Ron Javdan, MD
Date: 08/17/2017

Subjective:

Chief Complaints:
1. Rx refill.

HPI:
Todays Visit:
WANT CHANE LIPITOR.AFTER TAKING DO NOT FEELS GOOD.

ROS:
12 point review of the systems negative other than what mentioned in HPI.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Spinal Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV.

Social History:
Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Tobacco use other than smoking
Are you an other tobacco user? *No*
Sexual History:
Sexual History
Have you ever had a Sexually transmitted disease? *Yes*
Other? *No*
Syphilis? *No*
Herpes? *No*
GC? *No*
Chlamydia? *Yes*
have you had sex in the past 12 months *Yes*
Drugs/Alcohol:
Drugs
Have you used drugs other than those for medical reasons in the past 12 months? *No*
Opiates *No*
Alcohol Screen
Did you have a drink containing alcohol in the past year? *Yes*
How often did you have 6 or more drinks on one occasion in the past year? *Never (0 point)*
How many drinks did you have on a typical day when you were drinking in the past year? *1 or 2 drinks (0 point)*
How often did you have a drink containing alcohol in the past year? *2 to 4 times a month (2 points)*
Points *2*
Interpretation *Negative*
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Medications: Taking Asprin , Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Seroquel XR 150 MG Tab Extended Release 24 Hour 1 tablet at b me Orally Once a day, Taking Atorvastatin Calcium 10 MG Tab. 1 tablet Orally Once a day, Taking Albut. ol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 130 lbs, Wt-kg 58.97 kg, BMI 21.97 Index, BP 110/70 mm Hg, Temp 98.3 F, HR 78 /min, RR 18 /min, Taken by L Banks CMA, Oxygen sat % 98 %.

Examination:

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.

HEAD normocephalic, atraumatic.

EYES sclera non-icteric, pupils equal, round, reactive to light and accomidation.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

Assessment:

Assessment:

1. Hyperlipidemia, unspecified - E78.5 (Primary)

Plan:

1. Hyperlipidemia, unspecified

Stop Atorvastatin Calcium Tablet, 10 MG, 1 tablet, Orally, Once a day ; Start Pravachol Tablet, 40 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 3 ; Refill Aspirin Tablet Delayed Release, 81 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 2 .

2. Others

Start Aspirin Tablet, 81 MG, 1 tablet, Orally, Once a day, 30 day(s), 30 .

Follow Up: prn, 4 Weeks

Provider: Ron Javdan, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/17/2017

Electronically signed by Ron Javdan , MD on 08/26/2017 at 08:59 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 62 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Haleh Toutounchi, DPM
Date: 08/15/2017

Subjective:

Chief Complaints:

1. Podiatry f/u; c/o painful, long, thick, discolored toenails that are hard to cut.

HPI:

Todays Visit:

62 yo female pt rtc for f/u and c/o of painful, elongated, thick, discolored toenails and flaky, dry skin of feet. Pt says that she is using Clotrimazole and Lac-Hydrin with some improvements noted on the skin and toenails of feet. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker. Pt says that she did see the dermatologist and was given topical medication (she does not remember name.) Pt says that she will f/u with the dermatologist.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Taking Atorvastatin Calcium 10 MG Tablet 1 tablet Orally Once a day, Taking Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 132 lbs, Wt-kg 59.87 kg, BMI 22.31 Index, BP 120/60 mm Hg, Temp 97.1 F, HR 90 /min, RR 18 /min, Taken by M.Lopez MA.

Examination:

Neurologic:

SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.

General Examination :

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. trimmed hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet. hyperpigmented skin lesions of foot.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1, Trimmed at this time.
5. Xerosis cutis - L85.3
6. Disorder of the skin and subcutaneous tissue, unspecified - L98.9

Plan:

1. Tinea unguium

Continue Clotrimazole Solution, 1 %, Apply to affected toenails, Externally, Twice a day, 30 ml, Refills 3 .
Notes: Trimmed and debrided toenails.

2. Tinea pedis

Notes: Continue with Clotrimazole cream as needed.

3. Xerosis cutis
Continue Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

4. Disorder of the skin and subcutaneous tissue, unspecified
Notes: Pt is seeing a dermatologist.

5. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11720 DEBRIDE NAIL, 1-5

Follow Up: 9 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/15/2017

Electronically signed by HALEH TOUTOUNCHI , DPM on 08/15/2017 at 03:45 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 62 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Haleh Toutounchi, DPM
Date: 05/23/2017

Subjective:

Chief Complaints:

1. Podiatry f/u; c/o painful, long, thick, discolored toenails that are hard to cut.

HPI:

CDSS:

62 yo female pt rtc for f/u and c/o of painful, elongated, thick, discolored toenails and flaky, dry skin of feet. Pt says that she is using Clotrimazole and Lac-Hydrin with some improvements noted on the skin and toenails of feet. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker. Pt says that his son has skin cancer and she has missed her appointment/s with me because she had to take him to the hospital. She says that her son can not walk and is on chemo.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Taking Atorvastatin Calcium 10 MG Tablet 1 tablet Orally Once a day, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day, Taking Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs, Taking Colace 100 MG Capsule 1 capsule as needed Orally Once a day, stop date 08/03/2017, Taking Preparation H 0.25-3-85.5 % Suppository as directed Rectal 1 suppository up to QID PRN, stop date 07/04/2017

Objective:

Examination:

Neurologic:

SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.

General Examination :

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. trimmed hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet. hyperpigmented skin lesions of foot.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1, Trimmed at this time.
5. Xerosis cutis - L85.3
6. Disorder of the skin and subcutaneous tissue, unspecified - L98.9

Plan:

1. Tinea unguium

Continue Clotrimazole Solution, 1 %, Apply to affected toenails, Externally, Twice a day, 30 ml, Refills 3 .
Notes: Trimmed and debrided toenails.

2. Tinea pedis

Notes: Continue with Clotrimazole cream as needed.

3. Xerosis cutis

Continue Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

4. Disorder of the skin and subcutaneous tissue, unspecified

Referral To:Outside Provider Dermatology
Reason:Please evaluate and treat as needed.

5. Others

Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11720 DEBRIDE NAIL, 1-5

Follow Up: 6 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 05/23/2017

Electronically signed by HALEH TOUTOUNCHI , DPM on 05/23/2017 at 04:57 PM PDT
Sign off status: Completed

Roquemore, Sandra
62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

05/05/2017

Progress Notes: Sina Tebi, MD

Current Medications

Taking
- Asprin
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Atorvastatin Calcium 10 MG Tablet 1 tablet Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Albuterol Sulfate HFA 108 MCG/ACT Aerosol Solution 2 puffs as needed Inhalation every 4 hrs
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use
Status: *current smoker*
How often do you smoke cigarettes? *every day*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How many cigarettes a day do you smoke? *5 or less*
Are you interested in quitting? *Ready to*

Reason for Appointment

1. Pt c/o has been having vaginal bleeding x3 days on and off was heavy now it is a light pink color
2. pt requesting to be tested on Hepetits C

History of Present Illness

HPI:

Pt here with c/o rectal bleeding bright red blood with bm x 2-3 days. Reports had same episodee about 6m ago. Also noticed bright red blood on toilet paper when she wipes after having a bm. Statess has issues with constipation. Denies any abd painor any other s/sxs at this time.

CDSS:

CDSS: Colorectal cancer screening
Last Done *Less than 10 years ago; colonoscopy*
Result *Negative*
Type of screening *Colonoscopy*
CDSS: Cervical Cancer Screening
Last Done? *Less than 3 years ago*
Results? *Negative*
CDSS: HIV screening Last Done: 2 months ago , Negative.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 122/80 mm Hg, Temp 98.3 F, HR 91 /min, RR 19 /min, Taken by T.Rivers,MA, Oxygen sat % 97 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

PSYCH speech: normal, oriented, affect: appropriate.

Assessments

1. Constipation, unspecified - K59.00 (Primary)
2. Unspecified hemorrhoids - K64.9

quit
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/20..*
Tobacco use other than smoking
Are you an other tobacco user? *No*
Drugs/Alcohol:
Drugs
Have you used drugs other than those for medical reasons in the past 12 months? *No*
Opiates *No*
Alcohol Screen
Did you have a drink containing alcohol in the past year? *Yes*
How often did you have a drink containing alcohol in the past year? *2 to 4 times a month (2 points)*
How many drinks did you have on a typical day when you were drinking in the past year? *1 or 2 drinks (0 point)*
How often did you have 6 or more drinks on one occasion in the past year? *Never (0 point)*
Points *2*
Interpretation *Negative*
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI

Treatment
1. Others
Start Colace Capsule, 100 MG, 1 capsule as needed, Orally, Once a day, 30 day(s), 30, Refills 2
Start Preparation H Suppository, 0.25-3-85.5 %, as directed, Rectal, 1 suppository up to QID PRN, 30 days, 120, Refills 1

Preventive Medicine
Counseling:
Smoking:
Patient counselled on the dangers of tobacco use and urged to quit. *05/05/2017*
Educated patient on constiaption managment, advised to consume more liquids in diet to increase gastric motility., Continue healthy habits.
Instructed to RTC if no relief if constupation or if rectal bleeding worsens or doesn't improve.

Follow Up
prn, 4 Weeks

Electronically signed by Sabrina Moiseyev , FNP on 05/05/2017 at 01:38 PM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

I quemore, Sandra

62 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

03/15/2017

Progress Note: Omid Nassim, MD

Current Medications

Taking

- Asprin
- Clotrimazole 1 % Cream Apply to affected area Externally Twice a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day
- Atorvastatin Calcium 10 MG Tablet 1 tablet Orally Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day
- Lac-Hydrin 12 % Cream apply to affected area as directed Externally Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol.
Cataracts.
Glaucoma.

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy, 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use
Status: *current smoker*
How often do you smoke cigarettes? *every day*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How many cigarettes a day do you smoke? *5 or less*
Are you interested in quitting? *Ready to quit*
Patient counselled on the dangers of tobacco use and urged to quit. *03/15/2017*

Reason for Appointment

1. 1. Cold, Congestion, Cough x 1week
2. 2. Referral to Physical Therapy per Pain Management

History of Present Illness

CDSS:

CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Negative. CDSS: HIV screening Last Done: 2 wks ago Negative.

Patient is a 62 y/o f present to clinic c/o cold for 1 week. Admits congestion/ cough. Patient states pain management is requesting physical therapy due to low back pain.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 125 lbs, Wt-kg 56.7 kg, BMI 21.12 Index, BP 112/70 mm Hg, Temp 98.3 F, HR 78 /min, RR 18 /min, Taken by A.Mendoza,LVN, Oxygen sat % 98 %.

Examination

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

LUNGS (+) cough, accessory muscle use, wheezing bilat anteriorly and posteriorly.

Assessments

1. Low back pain - M54.5 (Primary)
2. Acute upper respiratory infection, unspecified - J06.9

Treatment

1. Low back pain

Referral To:Physical Medicine
Reason:eval and manage 7 sessions

2. Acute upper respiratory infection, unspecified

Start Albuterol Sulfate HFA Aerosol Solution, 108 MCG/ACT, 2 puffs as needed, Inhalation, every 4 hrs, 10 days, 1 Inhaler, Refills 0
Start Zithromax Z-Pak Tablet, 250 MG, 2 tablets on the first day, then 1 tablet daily for 4 days, Orally, Once a day, 5 day(s), 6 Tablet, Refills 0

Tobacco use other than smoking
Are you an other tobacco user? *No*
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Allergies
N.K.D.A.

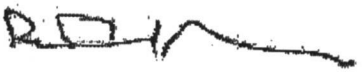
Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
Respiratory:
Admits Breathing pattern. Denies Chest pain. Admits Cough, with exertion, worse at night, productive with clear/white phlegm. Denies Hemoptysis. Denies Pain with inspiration. Denies Shortness of breath at rest. Denies Shortness of breath with exertion. Admits Sputum production, that is clear. Admits Wheezing, with exertion.
Cardiovascular:
Patient denies chest pain at rest, chest pain with exertion, difficulty laying flat, dyspnea on exertion, irregular heartbeat, palpitations, weight gain. Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.
Gastrointestinal:
Patient denies abdominal pain, blood in stool, change in bowel habits, constipation, diarrhea, difficulty swallowing, heartburn. Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting. Denies Weight loss.
Musculoskeletal:
Admits Muscle aches.
Admits Sciatica, affecting both lower sides of the body.

Referral To:Radiology
Reason:CXR

Preventive Medicine
Water:
Water Drink at least 8 cups of water a day.
Counseling:
Diet: Eat a low fat diet consisting of plenty of fruits and vegetables, whole grains, lean meats, and low fat dairy products, Avoid spicy, greasy, and acidic foods. Avoid caffeine and alcohol, Limit salt intake, Avoid junk food and fast food, Eat more "good" fats: avocado, nuts, olive oil, salmon, Avoid starchy food such as white rice, potatoes, pasta, bread, etc..
Diet/Vitamins discussed including high doses of Vitamins A, C, E and Zinc: .
Smoking:
Patient counselled on the dangers of tobacco use and urged to quit. *03/15/2017*
Relapse prevention: *Discussed the importance of a supportive environment and helped identify them., Discussed the possibility of negative mood or depression after quitting.*
Smoking cessation *Call 1-800-NO-BUTTS for smoking cessation counseling*

Follow Up
1 Week (Reason: f/u)



Electronically signed by Omid Nassim , MD on 03/16/2017 at 09:38 AM PDT

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 62 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Haleh Toutounchi, DPM
Date: 03/07/2017

Subjective:

Chief Complaints:
1. F/u; painful callus of L 5th toe and painful, elongated, thick, discolored toenails.

HPI:
CDSS:
62 yo female pt rtc for f/u and c/o painful callus of L 5th toe. Pt also c/o of elongated, thick, discolored toenails and flaky, dry skin of feet. Pt says that she is using Clotrimazole with some improvements noted on the skin and toenails of feet. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Spinal Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV.

Social History:
Tobacco Use: Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 01/23/2017. Tobacco use other than smoking Are you an other tobacco user? No.

Medications: Taking Asprin , Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Orally Once a day, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Anusol-HC 2.5 % Cream 1 application to affected area Rectal Twice a day, stop date 03/13/2017, Taking Atorvastatin Calcium 10 MG Tablet 1 tablet Orally Once a day

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 129 lbs, Wt-kg 58.51 kg, BMI 21.80 Index, BP 120/60 mm Hg, Temp 98.1 F, HR 80 /min, Taken by M.Lopez MA.

Examination:
Neurologic:
SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.
General Examination :
Podiatry:
Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: elongated, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet.

Assessment:

Assessment:
1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1

3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1
5. Xerosis cutis - L85.3

Plan:

1. Tinea unguium
Continue Clotrimazole Solution, 1 %, Apply to affected toenails, Externally, Twice a day, 30 ml, Refills 3 .
Notes: Trimmed and debrided toenails.

2. Tinea pedis
Notes: Continue with Clotrimazole cream as needed.

3. Acquired keratosis [keratoderma] palmaris et plantaris
Notes: Debrided hyperkeratosis.

4. Xerosis cutis
Start Lac-Hydrin Cream, 12 %, apply to affected area as directed, Externally, Twice a day, 1 Tube, Refills 3 .

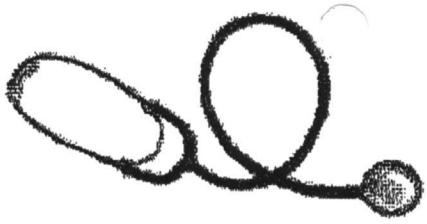
5. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11720 DEBRIDE NAIL, 1-5, 11055 TRIM SKIN LESION

Follow Up: 9 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 03/07/2017

Electronically signed by HALEH TOUTOUNCHI , DPM on 03/07/2017 at 11:04 AM PST
Sign off status: Completed



I quemore, Sandra

61 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

01/23/2017

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking
- Asprin
- Clotrimazole 1 % Cream Apply to affected area Twice a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Twice a day
- Anusol-HC 2.5 % Cream 1 application to affected area Twice a day, stop date 03/13/2017
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol
Cataracts
Glaucoma

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, How often do you smoke cigarettes? every day, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How many cigarettes a day do you smoke? 5 or less, Are you interested in quitting? Ready to quit, Patient counselled on the dangers of tobacco use and urged to quit. 01/23/2017. Tobacco use other than smoking Are you an other tobacco user? No.
Drugs/Alcohol:
Drugs Have you used drugs other than those for medical reasons in the past 12 months?

Reason for Appointment

1. Lab Results

History of Present Illness

Constitutional:
Pt here for lab results; elevated total chol, trigs, ldl, vit d low. HIV and RPR (-). Has no complaints, feels well.
Depression Screening:
PHQ-2 In last 2 weeks have you been bothered by Little interest or pleasure in doing things No, Feeling down, depressed, or hopeless No. PHQ-9 Little interest or pleasure in doing things Not at all, Feeling down, depressed, or hopeless Not at all, Trouble falling or staying asleep, or sleeping too much Not at all, Feeling tired or having little energy Not at all, Poor appetite or overeating Not at all, Feeling bad about yourself or that you are a failure, or have let yourself or your family down Not at all, Trouble concentrating on things, such as reading the newspaper or watching television Not at all, Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual Not at all, Thoughts that you would be better off dead or of hurting yourself in some way Not at all, Total Score 0.
CDSS:
CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Negative. CDSS: HIV screening Last Done: 2 wks ago Negative.

Vital Signs

Ht 64.5 in, Ht-cm 163.83 cm, Wt 130 lbs, Wt-kg 58.97 kg, BMI 21.97 Index, BP 122/80 mm Hg, Temp 98.1 F, HR 75 /min, RR 17 /min, Taken by A.Castillo-Trejo,MA.

Examination

General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed.

No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negat.
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Assessments
1. Vitamin D deficiency, unspecified - [illegible]9 (Primary)
2. Hyperlipidemia, unspecified - E78.5

Treatment
1. Others
Start Atorvastatin Calcium Tablet, 10 MG, 1 tablet, Orally, Once a day, 90 days, 90 Tablet, Refills 1
Notes: Vitamin D3 50,000 iu 1 cap weekly x 10 weeks, #10, 0 refills then Vitamin D3 2,000 iu 1 tab daily #90 with 4 refills.

Labs
Lab: CBC (Ordered for 04/23/2017)
Lab: CMP, LIPID (Ordered for 04/23/2017)
Lab: VIT D 1,25 OH2 T (Ordered for 04/23/2017)

Follow Up
prn, 3 Months

Electronically signed by Sabrina Moiseyev , FNP on 01/23/2017 at 10:38 AM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

F quemore, Sandra
61 Y old Female, DOB: 02/11/1955
Account Number: 50469
1763 Exposition Blvd, Los Angeles, CA-90018
Home: 323-643-4539
Guarantor: Roquemore, Sandra Insurance: Angeles IPA
Payer ID: SYMED
PCP: Health Center Benevolence
Appointment Facility: Crenshaw Community Clinic

01/12/2017

Progress Notes: Sabrina Moiseyev, FNP

Current Medications

Taking

- Asprin
- Clotrimazole 1 % Cream Apply to affected area Twice a day
- Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day
- Clotrimazole 1 % Solution Apply to affected toenails Twice a day
- Medication List reviewed and reconciled with the patient

Past Medical History

High Cholesterol
Cataracts
Glaucoma

Surgical History

Spinal Fusion 2011
Injection in her neck 03/10/2016

Family History

Mother: alive
Father: deceased
Siblings: alive
1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History

Tobacco Use:
Tobacco Use Status: current smoker, How often do you smoke cigarettes? every day, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How many cigarettes a day do you smoke? 5 or less, Are you interested in quitting? Ready to quit, Patient counselled on the dangers of tobacco use and urged to quit. 01/12/2017.
Sexual History:
Sexual History have you had sex in the past 12 months Yes, Have you ever had a Sexually transmitted disease? Yes, Chlamydia? Yes, GC? No, Herpes? No, Syphilis? No, Other? No.
Drugs/Alcohol:

Reason for Appointment

1. 1. Annual Wellness Exam
2. 2. Mammogram/Biopsy Results scanned, needs to be rechecked in 6months
3. 3. Referral for Opth, needs Glasses

History of Present Illness

Constitutional:

Pt here for physical; requesting opthalm referral. Denies dysuria, hematuria, polyuria, urgency, f/c/n/v, pelvic pain, flank pain.

Reports constipation and stratining with Norco; bright red blood on wiping.

1. Pain Assessment:

Do you have pain or hurting now? No, just took Pain Medication: Norco

Lower Back & Neck . Have you had any pain in the las 5 days? Yes. Tell me what the pain feels like. Sharp Throbbing Unconfortable. How would you rate the intesity for you pain 5. How does your pain affect your everyday life Sleep Self Care Activites. What medications have relieved your pain in the past Norco, has appointment with Pain Management 01/13/2017.

2. Functional Status Assessment/ADLS:

Transportation Bus/taxi. Ambulation Walk w/o assistance. Ability to take medication by self? Yes. Have a caregiver? No. Ability to prepare food? Yes. Ability to feed self? Yes. Martial Status Single. Assistance in grooming? No. Homelessness No. Assistance in toileting? No. Risk of placement to SNF (skilled nursing facility) No. Bladder incontinence Yes . Risk of admission to hospital No. Risk for Falls No. Preferred Language English. Excercise Walking.

3. Cognitive Functioning:

Oriented Yes. Memory Deficit No. Immediate Recall Good . Inappropiate Behavior No. Confusion Not at all.

4. Nutrition/Weight Assessment:

Recent weight change No.

CDSS:

CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Negative. CDSS: HIV screening Requesting.

Vital Signs

Drugs Have you used drugs other than those for medical reasons in the past 12 months? No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.
Miscellaneous:
Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Allergies
N.K.D.A.

Hospitalization/Major Diagnostic Procedure
1 week 2011

Review of Systems
12 point review of the systems negative other than what mentioned in HPI.

Ht 64.5 in, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 122/80 mm Hg, Temp 98.3 IR 76 /min, RR 16 /min, Taken by A.Mendoza, LVN.

Examination
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. MUSCULOSKELETAL full range of motion . NEUROLOGIC No focal neurological deficit observed. FEMALE GENITOURINARY (-) suprapubic tenderness, (-) CVAT, (-) pelvic pain on palpation.

Assessments
1. Low vision, both eyes - H54.2 (Primary)
2. Constipation, unspecified - K59.00
3. Other abnormal findings in urine - R82.99

Treatment
1. Low vision, both eyes
Referral To:Ophthalmology
Reason:20/70 and 20/50 vision

2. Constipation, unspecified
Start Anusol-HC Cream, 2.5 %, 1 application to affected area, Rectal, Twice a day, 30 day(s), 60 Grams, Refills 1

3. Other abnormal findings in urine
Referral To:Urology
Reason:Leukocytes in urine and hematuria

Procedures
Vision screen:
Right eye 20/70, with corrective lenses. Left eye 20/50, with corrective lenses. Both eyes 20/50, with corrective lenses. Colors Red - Yes, Green - Yes.

Labs
Lab: Chlamydia/GC, Urine

Lab: UA Dip

Color	yellow
Appearance	clear
Leukocytes	+++
Nitrite	negt
Urobilinogen	normal
Protein	neg
pH	5.0
Blood	++/200
Specific Gravity	1.020
Ketones	neg
Bilirubin	neg

Glucose neg

Lab: Hgb A1c with eAG Estimation

Lab: CBC, CMP, LIPID, TSH

Lab: SYPHILLIS SCREEN, EIA

Lab: HIV 1/2 AB

Lab: URINE CULTURE

Lab: VIT D 1,25 OH2 T

Procedure Codes
81000 URINALYSIS

Follow Up
1 Week for lab results

Electronically signed by Sabrina Moiseyev , FNP on 01/12/2017 at 04:09 PM PST

Sign off status: Completed

Crenshaw Community Clinic
3631 CRENSHAW BLVD
LOS ANGELES, CA 90016-4869
Tel: 323-732-0100
Fax: 323-732-0104

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Haleh Toutounchi, DPM
Date: 01/03/2017

Subjective:

Chief Complaints:

1. F/u; painful callus of L 5th toe .

HPI:

CDSS:

61 yo female pt rtc for f/u and c/o painful callus of L 5th toe. Pt is also here for f/u of thick, discolored toenails and flaky, dry skin of feet. Pt says that she is using Clotrimazole with some improvements noted on the skin and toenails of feet. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems. Pt is a smoker.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: aliveFather: deceasedSiblings: alive1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History:

Tobacco Use: Tobacco Use Status: current smoker, Are you interested in quitting? Ready to quit, How many cigarettes a day do you smoke? 5 or less, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How often do you smoke cigarettes? every day, Patient counselled on the dangers of tobacco use and urged to quit. 10/24/2016.

Medications: Taking Asprin , Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day, Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 In, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 128/70 mm Hg, Temp 98.1 F, HR 80 /min, Taken by m.lopez MA.

Examination:

Neurologic:

SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.

General Examination :

Podiatry:

Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: trimmed, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet.

Assessment:

Assessment:

1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1

Plan:

1. Tinea unguium
Continue Clotrimazole Solution, _ %, Apply to affected toenails, Externally, . .vice a day, 30 ml, Refills 3 .

2. Tinea pedis
Notes: Continue with Clotrimazole cream as needed.

3. Acquired keratosis [keratoderma] palmaris et plantaris
Notes: Debrided hyperkeratosis. Dispensed pads for L 5th toe; to be used as directed and tolerated.

4. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11055 TRIM SKIN LESION

Follow Up: 9 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 01/03/2017

Electronically signed by HALEH TOUTOUNCHI , DPM on 01/03/2017 at 11:40 AM PST
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

vider: Haleh Toutounchi, DPM
Date: 11/01/2016

Subjective:

Chief Complaints:
1. F/u of painful, long, thick, discolored toenails and painful callus of left .

HPI:
CDSS:
61 yo female pt rtc for f/u and c/o painful callus of L 5th toe. Pt also c/o painful, long, thick, discolored toenails that are hard to cut. Pt is also here for f/u of flaky, dry skin of feet. Pt says that she is using Clotrimazole with some improvements noted on the skin and toenails of feet. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt denies numbness in her feet. Pt has eye problems.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 130/80 mm Hg, Temp 98.2 F, HR 80 /min, RR 18 /min, Taken by A.Herrera(ma).

Examination:
Neurologic:
SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.
General Examination :
Podiatry:
Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: long, thick, discolored toenails. elongated toenails x 10. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet.

Assessment:

Assessment:
1. Pain in unspecified foot - M79.673 (Primary)
2. Tinea unguium - B35.1
3. Tinea pedis - B35.3
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1

Plan:

1. Tinea unguium
Continue Clotrimazole Solution, 1 %, Apply to affected toenails, Externally, Twice a day, 30 ml, Refills 3 .
Notes: Trimmed toesnails x 10. Debrided toesnails as needed.

2. Tinea pedis
Notes: Continue with Clotrimazole cream as needed.

3. Acquired keratosis [keratoderma] palmaris et plantaris
Notes: Debrided hyperkeratosis.

4. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11720 DEBRIDE NAIL, 1-5, 11056 TRIM SKIN LESIONS, 2 TO 4, 11719 TRIM NAIL(S)

Follow Up: 9 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 11/01/2016

Electronically signed by HALEH TOUTOUNCHI , DPM on 11/01/2016 at 01:11 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Sabrina Moiseyev, FNP
Date: 10/24/2016

Subjective:

Chief Complaints:
1. 1. Breast US results.

HPI:
Constitutional:
Pt here for mammogram results; indeterminate calcifications in upper outer R breast. Biopsy recommended.
CDSS:
CDSS: Cervical Cancer Screening Last Done? Less than 3 years ago , Results? Negative. CDSS: HIV screening Last Done: unknown. CDSS: Tdap Vaccine (Adult) Last done Less than 10 years ago , Is the patient requesting the Tdap vaccice? Yes.

ROS:
12 point review of the systems negative other than what mentioned in HPI.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: aliveFather: deceasedSiblings: alive1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History:
Tobacco Use: Tobacco Use Status: current smoker, How often do you smoke cigarettes? every day, How soon after you wake up do you smoke your first cigarette? 6-30 minutes, How many cigarettes a day do you smoke? 5 or less, Are you interested in quitting? Ready to quit, Patient counselled on the dangers of tobacco use and urged to quit. 10/24/2016.
Sexual History: Sexual History Have you ever had a Sexually transmitted disease? Yes, Other? No, Syphilis? No, Herpes? No, GC? No, Chlamydia? Yes, have you had sex in the past 12 months Yes.
Drugs/Alcohol: Drugs Have you used drugs other than those for medical reasons in the past 12 months? No, Opiates No. Alcohol Screen Did you have a drink containing alcohol in the past year? No, Points 0, Interpretation Negative.
Miscellaneous: Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Medications: Taking Asprin , Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day, Taking Seroquel XR 150 MG Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 130/70 mm Hg, HR 78 /min, RR 18 /min, Taken by A.Mendoza/LVN.

Examination:
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. SKIN warm and dry, no suspicious lesion . HEART regular rate and rhythm , S1, S2 normal, no murmurs. LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort. ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

Assessment:

Assessment:
1. Mammographic calcification found on diagnostic imaging of breast - R92.1 (Primary)

Plan:

1. Mammographic calcification found on diagnostic imaging of breast

Referral To:Surgery
Reason:Biopy of R breast; indeterminate calcifications in upper outer R breast

Follow Up: f/u for biopsy results

Provider: Sabrina Moiseyev, FNP
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 10/24/2016

Electronically signed by Sabrina Moiseyev , FNP on 10/24/2016 at 11:40 AM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Samuel Smith, MD
Date: 09/30/2016

Subjective:

Chief Complaints:
1. Mental Health.

HPI:
INITIAL PHYCHIATRIC ASSESSMENT :
Insomnia and poor concentration
Further Questioning:
Depression, racing thoughts, irritated easily, poor impulse control, paranoia, A/V/T/hal, anxiety, panic attacks, mood swings, crying spells and hyperactive.
History of Complaints Pt dates the onset of her symptoms to 1976 following her divorce. She first sought treatment at the county clinic at Stocker and was placed on Risperdal and had poor response. She later had outpatient visit in Long Beach and was placed on Abilify which she last took 6 months ago.
Past Psychiatric History and Hospitalizations Pt has been hospitalized twice at the Long Beach Memorial hospital for suicide attempt. Pt does not recall what was making her suicidal.
Medications: Taking Asprin , Taking Lactulose 10 GM/15ML Solution 15 ml Once a day PRN, stop date 10/14/2016, Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day.
Medical History High Cholesterol, Cataracts, Glaucoma and S/P cervical fusion.
Allergies Dust and grass.
Education Pt studied computer science in college
Work History:
Pt last worked as a manager in computer system and stopped because family member began to die month after month.
Family History Pt was born in California. Father former construction worker is deceased. Pt has minimum information about the father. Mother is 89 years old and has minimum information about the mother too. Pt has 2 deceased brothers and 1 surving twin brother. Pt also has a 59 year old sister and has minimum information about her. Pt is widowed and first got married at the age of 19 to the husband who was 41 years old that worked as a book maker. Marriage lasted 10 years and separated because of infidelity. Pt has a 35 year old son that has a history of skin cancer and a 37 year old daughter that is unemployed.
History of Abuse Pt was physically abuse by the husband.
Legal History Pt denies any legal history.
Substance Abuse Pt is current smoker, started drinking at the age of 25 and last drank the night before the appointment and drinks 3 cans of beer a day. Pt tried marijuana at the age of 26.
Mental Status:
Appearance Casually dressed.
Behavior Angry, guarded and easily irritated.
Speech Normal.
Mood Depressed.
Affect Flat.
Thought process Intact.
Thought content paranoid and denies any recent S/I and H/I.
Disturbances of perception A/V/T/hal.
Impulse control poor.
intellect average.

Cognitive function Poor.
Insight Fair.
Judgment Poor.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Lactulose 10 GM/15ML Solution 15 ml Orally Once a day PRN, stop date 10/14/2016, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day

Objective:

Assessment:

Assessment:
1. Major depressive disorder, recurrent, severe with psychotic symptoms - F33.3 (Primary)
R/O bipolar.

Plan:

1. Major depressive disorder, recurrent, severe with psychotic symptoms
Start Seroquel XR Tablet Extended Release 24 Hour, 150 MG, 1 tablet at bedtime, Orally, Once a day, 15 days, 15 Tablet, Refills 0 .

Follow Up: 2 Weeks

Provider: Samuel Smith, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 09/30/2016

Electronically signed by Samuel Smith , MD on 04/02/2021 at 08:43 AM PDT
Sign off status: Pending

Progress Note

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Ron Javdan, MD
Date: 09/19/2016

Subjective:

Chief Complaints:
1. Rectal Bleeding today, had a difficult time going to bathroom, started bleeding, then got loose stools. 2. States she had to push son in wheelchair to probation office last week states hee back and right side hurts.

HPI:
CDSS:
SLIGHT RECTAL BLEED TODAY WHEN WIPE HERSELF.

ROS:
General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Denies Headache. Denies Lightheadedness. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.
Respiratory:
Denies Breathing pattern. Denies Chest pain. Denies Cough. Denies Hemoptysis. Denies Pain with inspiration. Denies Shortness of breath at rest. Denies Shortness of breath with exertion. Denies Sputum production. Denies Wheezing.
Cardiovascular:
Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.
Gastrointestinal:
Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Admits Rectal bleeding. Denies Vomiting. Denies Weight loss.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: aliveFather: deceasedSiblings: alive1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy.
1 Son Has HIV.

Social History:
Tobacco Use:
Tobacco Use
Status: *current smoker*
How often do you smoke cigarettes? *every day*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How many cigarettes a day do you smoke? *5 or less*
Are you interested in quitting? *Ready to quit*
Patient counselled on the dangers of tobacco use and urged to quit. *09/19/2016*
Sexual History:
Sexual History
Have you ever had a Sexually transmitted disease? *Yes*
Other? *No*
Syphilis? *No*
Herpes? *No*

GC? *No*
Chlamydia? *Yes*
have you had sex in the t 12 months *Yes*

Drugs/Alcohol:

Drugs

Have you used drugs other than those for medical reasons in the past 12 months? *No*
Opiates *No*

Alcohol Screen

Did you have a drink containing alcohol in the past year? *No*
Points *0*
Interpretation *Negative*

Miscellaneous:

Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016, Taking Lactulose 10 GM/15ML Solution 15 ml Once a day PRN, stop date 10/14/2016, Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 133 lbs, Wt-kg 60.33 kg, BMI 22.47 Index, BP 104/64 mm Hg, Temp 97.8 F, HR 72 /min, RR 14 /min, Taken by T. Rivers,MA.

Examination:

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.

HEAD normocephalic, atraumatic.

EYES sclera non-icteric, pupils equal, round, reactive to light and accomidation.

ORAL CAVITY/TEETH mucosa moist, good dentition.

THROAT clear, no erythema, no edema, uvula midline, normal tonsils.

NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

EXTREMITIES/HIPS no clubbing, cyanosis, or edema.

MUSCULOSKELETAL full range of motion .

NEUROLOGIC No focal neurological deficit observed.

Assessment:

Assessment:

1. Low back pain - M54.5 (Primary)
2. Hyperlipidemia, unspecified - E78.5
3. Unspecified hemorrhoids - K64.9

Plan:

1. Unspecified hemorrhoids

Notes: OBSERVE
ADVISED RETURN IF BLEEDING CONTINUE..WANT WAIT FOR COLONOSCOPY.

Follow Up: 4 Weeks

Provider: Ron Javdan, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 09/19/2016

Electronically signed by Ron Javdan , MD on 09/20/2016 at 02:14 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Samuel Smith, MD
Date: 09/07/2016

Subjective:

Chief Complaints:
1. Mental Health.

HPI:
Individual Psychotherapy Progress Note:
Certification of clients cognitive ability to actively partI I certify the client's level of cognition is adequate to actively participate in and benefit from this service.
Current Risk Factors None.
Therapeutic Goals worked on this session Increase coping skills.
Interventions Used Building rapport & reflective listening.
Theraputic Gains noted this session (observational terms) Increased self-disclosure.
Ongoing Symptomatic/Functional Impairment Persisting problems with social environment; Persisting isolation; Persisting Anxious thoughts and symptoms; Persisting financial problems; lack of resources; Persisting psychosis.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016, Taking Lactulose 10 GM/15ML Solution 15 ml Once a day PRN, stop date 10/14/2016, Taking Clotrimazole 1 % Solution Apply to affected toenails Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Twice a day

Objective:

Examination:
General Examination :
PSYCH speech: normal, oriented, affect: appropriate; casually dressed; cooperative; mood:anxious.

Assessment:

Assessment:
1. Schizoaffective disorder, unspecified - F25.9 (Primary)

Plan:

1. Schizoaffective disorder, unspecified
Notes: Pt to continue to participate in monthly mental health therapy to improve coping skills and address sx's, per her request and availability.

Provider: Samuel Smith, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 09/07/2016

Electronically signed by jacqueline saenz , LCSW on 09/07/2016 at 01:39 PM PDT
Sign off status: Completed

Progress Note

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Omid Nassim, MD
Date: 09/07/2016

Subjective:

Chief Complaints:
1. Lab results.

HPI:
Depression Screening:
PT PRESENTS TO CLINIC FOR MEDICATION REFILLS AND COMPLAINS OF BACK PAIN. PT HAS TRIED OVER THE COUNTER MEDS TO RELIEVE HER BACK BUT NOTHING HAS WORKED.
CDSS: Todays Visit:
CDSS: Breast Cancer Screening Last Done Less than 2 years ago, Results Negative.
CDSS: Cervical Cancer Screening Last Done Less than 3 years ago, Results Negative.
CDSS: HIV screening Last Done: 1 month ago.

ROS:
General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Denies Headache. Denies Lightheadedness. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.
Respiratory:
Denies Breathing pattern. Denies Chest pain. Denies Cough. Denies Hemoptysis. Denies Pain with inspiration. Denies Shortness of breath at rest. Denies Shortness of breath with exertion. Denies Sputum production. Denies Wheezing.
Cardiovascular:
Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV.

Social History:
Tobacco Use:
Tobacco Use
Status: *current smoker*
Are you interested in quitting? *Ready to quit*
How many cigarettes a day do you smoke? *5 or less*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How often do you smoke cigarettes? *every day*
Patient counselled on the dangers of tobacco use and urged to quit. *07/28/2016*

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Orally Once a day, stop date 09/26/2016, Taking Lactulose 10 GM/15ML Solution 15 ml Orally Once a day PRN, stop date 10/14/2016, Taking Clotrimazole 1 % Solution Apply to affected toenails Externally Twice a day, Taking Clotrimazole 1 % Cream Apply to affected area Externally Twice a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 In, Ht-cm 163.8[illegible]m, Wt 134 lbs, Wt-kg 60.78 kg, BMI 22.[illegible] Index, BP 110/80 mm Hg, Temp 98.1 F, HR 88 /min, RR 22 /min, Taken by I Banks CMA, Oxygen sat % 96 %.

Examination:

General Examination :

GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.

HEAD normocephalic, atraumatic.

EYES sclera non-icteric, pupils equal, round, reactive to light and accomidation.

EARS/NOSE tympanic membranes intact, patent, no bulging/redness, ear cannal, clear, no discharge/redness, gross hearing intact.

Oral Pharynx mucosa moist, good dentition.

THROAT clear, no erythema, no edema, uvula midline, normal tonsils.

NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD.

SKIN warm and dry, no suspicious lesion .

HEART regular rate and rhythm , S1, S2 normal, no murmurs.

Lungs clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.

ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.

EXTREMITIES/HIPS no clubbing, cyanosis, or edema.

MUSCULOSKELETAL full range of motion .

NEUROLOGIC No focal neurological deficit observed.

FEMALE GENITOURINARY Cervix pink, round, soft, no nodules, no abnormal vaginal discharge, no pelvic pain on palpation.

Assessment:

Assessment:

1. Low back pain - M54.5 (Primary)

DIET FOR HYPERLIPIDEMIA.

Plan:

1. Low back pain

Start Tramadol HCl Tablet, 50 MG, 1 tablet as needed, Orally, every 8 hrs, 45 days .

Follow Up: 1 Week

Provider: Omid Nassim, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 09/07/2016

Electronically signed by Omid Nassim , MD on 04/02/2021 at 08:44 AM PDT
Sign off status: Pending

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

vider: Haleh Toutounchi, DPM
Date: 08/30/2016

Subjective:

Chief Complaints:
1. 1. Painful callus of L 5th toe. 2. 2. Thick, discolored toenails.

HPI:
CDSS:
61 yo female pt c/o painful callus of L 5th toe. Pt also c/o thick, discolored toenails. Pt reports no accidents or injuries to b/l feet and ankles. Pt reports no N/V/F/C. Pt reports no signs of bacterial infection. Pt also c/o flaky, dry skin of feet. Pt denies numbness in her feet.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016, Taking Lactulose 10 GM/15ML Solution 15 ml Once a day PRN, stop date 10/14/2016

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, BP 110/70 mm Hg, Temp 97.6 F, HR 80 /min, RR 18 /min, Taken by A.Herrera(ma).

Examination:
Neurologic:
SEMMES-WEINSTEIN 5.07 MONOFILAMENT positive, bilateral feet.
General Examination :
Podiatry:
Vasc: palpable pedal pulses b/l feet
Neuro: intact epicritic sensation b/l feet
Msk: 5/5 msk strength in all 4 quadrants b/l feet
Derm: trimmed, thick, discolored toenails. flaky, dry skin of feet. no open wounds or lesions noted b/l feet. hyperkeratosis of L 5th toe. no pus noted, no drainage noted b/l feet.

Assessment:

Assessment:
1. Tinea unguium - B35.1
2. Tinea pedis - B35.3
3. Pain in unspecified foot - M79.673 (Primary)
4. Acquired keratosis [keratoderma] palmaris et plantaris - L85.1

Plan:

1. Tinea unguium
Start Clotrimazole Solution, 1 %, Apply to affected toenails, Externally, Twice a day, 30 ml, Refills 3 .

2. Tinea pedis
Start Clotrimazole Cream, 1 %, Apply to affected area, Externally, Twice a day, 30 g, Refills 3 .

3. Acquired keratosis [keratoderma] palmaris et plantaris
Notes: Debrided hyperkeratosis.

4. Others
Notes: Pt was educated. Pt to rtc or go to ER if signs of bacterial infection noted.

Procedure Codes: 11055 TRIM SKIN LESION

Follow Up: 9 Weeks

Provider: Haleh Toutounchi, DPM
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/30/2016

Electronically signed by HALEH TOUTOUNCHI , DPM on 08/30/2016 at 11:50 AM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Ron Javdan, MD
Date: 08/16/2016

Subjective:

Chief Complaints:
1. IHSS PAPERWORK.

HPI:
CDSS:
CDSS: Breast Cancer Screening Requesting.
CDSS: Colorectal cancer screening Requesting.
CDSS: Cholesterol Screening Requesting.
CDSS: HIV screening Requesting.
LOW VISION
BACK PAIN
OCC SOB.

ROS:
General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Admits Headache. Denies Lightheadedness. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.
Respiratory:
Denies Breathing pattern. Denies Chest pain. Admits Cough. Denies Hemoptysis. Denies Pain with inspiration. Admits Shortness of breath at rest, intermitt. Admits Shortness of breath with exertion, intermitt. Denies Sputum production. Denies Wheezing.
Cardiovascular:
Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.
Gastrointestinal:
Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting. Denies Weight loss.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016, Taking Levaquin 750 MG Tablet 1 tablet Once a day, stop date 08/20/2016, Taking Lactulose 10 GM/15ML Solution 15 ml Once a day PRN, stop date 10/14/2016

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 135 lbs, Wt-kg 61.24 kg, BMI 22.81 Index, BP 122/78 mm Hg, Temp 97.5 F, HR 70 /min, RR 18 /min, Taken by A.Mendoza, LVN, Oxygen sat % 75 %.

Examination:
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age.
ORAL CAVITY/TEETH mucosa moist, good dentition.
THROAT clear, no erythema, no edema, uvula midline, normal tonsils.
NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD.

SKIN warm and dry, no suspicious lesion .
HEART regular rate and rhythm , S1, S2 normal, no murmurs.
LUNGS clear to auscultation bilaterally, no wheezes, rales, or rhonchi, normal respiratory effort.
ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly.
PSYCH speech: normal, oriented, affect: appropriate.

Assessment:

Assessment:

1. Decreased white blood cell count, unspecified - D72.819 (Primary)
2. Cervical disc disorder with myelopathy, unspecified cervical region - M50.00
3. Hyperlipidemia, unspecified - E78.5
4. Other specified symptoms and signs involving the circulatory and respiratory systems - R09.89, R/O PNA

Plan:

1. Decreased white blood cell count, unspecified

Referral To:Radiology
Reason:mammogram

2. Others

Referral To:Radiology
Reason:mammogram

Follow Up: 4 Weeks, prn

Provider: Ron Javdan, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/16/2016

Electronically signed by Ron Javdan , MD on 08/22/2016 at 09:38 AM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Sabrina Moiseyev, FNP
Date: 08/15/2016

Subjective:

Chief Complaints:
1. 1. Lab Results.

HPI:
Constitutional:
Pt here for lab results; wbc 1.4, neutrophils 0. Elevated hgb, hct, mch. Low platelets.
CDSS:
CDSS: TB risk/PPD test denies any contact with person with TB denies traveling out of country denies coughing of blood denies weight loss, anorexia, loss of appetite denies fever and night sweats No TB Risk . CDSS: Tdap Vaccine (Adult) Refused.
CDSS: Breast Cancer Screening Last Done: 2 yrs ago.
CDSS: Colorectal cancer screening Last Done: 1 yr ago.
CDSS: Cervical Cancer Screening Last Done: 2 yrs ago Normal.
CDSS: Cholesterol Screening Last Done: 2 yrs ago.
CDSS: HIV screening Last Done: Unknown.

ROS:
General/Constitutional:
Denies Change in appetite. Denies Chills. Denies Fatigue. Denies Fever. Admits Headache. Denies Lightheadedness. Denies Sleep disturbance. Denies Weight gain. Denies Weight loss.
Respiratory:
Denies Breathing pattern. Denies Chest pain. Admits Cough. Denies Hemoptysis. Denies Pain with Inspiration. Admits Shortness of breath at rest, Intermitt. Admits Shortness of breath with exertion, Intermitt. Denies Sputum production. Denies Wheezing.
Cardiovascular:
Denies Chest pain at rest. Denies Chest pain with exertion. Denies Claudication. Denies Cyanosis. Denies Difficulty laying flat. Denies Dizziness. Denies Dyspnea on exertion. Denies Fluid accumulation in the legs. Denies Irregular heartbeat. Denies Orthopnea. Denies Palpitations. Denies Shortness of breath. Denies Weakness. Denies Weight gain.
Gastrointestinal:
Denies Abdominal pain. Denies Blood in stool. Denies Change in bowel habits. Denies Constipation. Denies Decreased appetite. Denies Diarrhea. Denies Difficulty swallowing. Denies Exposure to hepatitis. Denies Heartburn. Denies Hematemesis. Denies Nausea. Denies Rectal bleeding. Denies Vomiting. Denies Weight loss.

Medical History: High Cholesterol, Cataracts, Glaucoma. .
Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 135 lbs, Wt-kg 61.24 kg, BMI 22.81 Index, BP 112/60 mm Hg, Temp 97.9 F, HR 68 /min, RR 18 /min, Taken by A.Mendoza, LVN, Oxygen sat % 96 %.

Examination:
General Examination :
GENERAL APPEARANCE well developed, well nourished, in no acute distress, alert and oriented, appears stated age. ORAL CAVITY/TEETH mucosa moist, good dentition. THROAT clear, no erythema, no edema, uvula midline, normal tonsils. NECK neck supple, full range of motion, no cervical lymphadenopathy, No JVD. SKIN warm and dry, no suspicious lesion . HEART regular rate and

rhythm , S1, S2 normal, no murmurs. LUNGS crackles auscultated bilaterally posteriorly at bases, no wheezes, normal respiratory effort. ABDOMEN soft, nontender, nondistended, bowel sounds present, no organomegaly. PSYCH speech: normal, oriented, affect: appropriate.

Assessment:

Assessment:

1. Cervical disc disorder with myelopathy, unspecified cervical region - M50.00 (Primary)
2. Low vision, both eyes - H54.2
3. Decreased white blood cell count, unspecified - D72.819
4. Neutropenia, unspecified - D70.9
5. Other abnormality of red blood cells - R71.8
6. Other specified symptoms and signs involving the circulatory and respiratory systems - R09.89, R/O PNA

Plan:

1. Cervical disc disorder with myelopathy, unspecified cervical region

Referral To:Pain Medicine
Reason:Eval and manage.

2. Low vision, both eyes

Referral To:Optometrist
Reason:Eval and manage

3. Decreased white blood cell count, unspecified

Referral To:Hematology
Reason:Eval and manage

4. Neutropenia, unspecified

Referral To:Hematology
Reason:Eval and manage

5. Other abnormality of red blood cells

Referral To:Hematology
Reason:Eval and manage

6. Others

Start Levaquin Tablet, 750 MG, 1 tablet, Orally, Once a day, 5 days, 5 Tablet, Refills 0 ; Start Lactulose Solution, 10 GM/15ML, 15 ml, Orally, Once a day PRN, 30 day(s), 450, Refills 1 .

Labs:

Lab: Hgb A1c with eAG Estimation

Lab: CBC, CMP, LIPID, TSH

Follow Up: 1 Week

Provider: Sabrina Moiseyev, FNP
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/15/2016

Electronically signed by Sabrina Moiseyev , FNP on 08/15/2016 at 04:14 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Samuel Smith, MD
Date: 08/10/2016

Subjective:

Chief Complaints:
1. Mental Health.

HPI:
Individual Psychotherapy Progress Note:
Current Obserable Symptomatic and Funtional Impairments Tearfulness.
Certification of clients cognitive ability to actively parti I certify the client's level of cognition is adequate to actively participate in and benefit from this service.
Current Risk Factors No Suicidaily - denied; No Homicidality.
Therapeutic Goals worked on this session Initial assessment.
Interventions Used Building rapport & reflective listening.
Theraputic Gains noted this session (observational terms) Increased self-disclosure.
Ongoing Symptomatic/Functional Impairment Persisting depressive symptoms; Persisting Anxious thoughts and symptoms; Persisting problems with social environment; Persisting financial problems; lack of resources; Persisting isolation; persisting psychosocial stressors.
Other Notes: See Intake Assessment under Patient Docs..

Medical History: High Cholesterol, Cataracts, Glaucoma.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016

Objective:

Examination:
General Examination :
PSYCH speech: normal, oriented, affect: appropriate;; casually dressed; cooperative; mood: anxious and depressed.

Assessment:

Assessment:
1. Schizoaffective disorder, unspecified - F25.9 (Primary)

Plan:

1. Schizoaffective disorder, unspecified
Notes: Pt to continue to participate in monthly mental health therapy to improve coping skills and address sx's, per her request and availability.

Provider: Samuel Smith, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 08/10/2016

Electronically signed by jacqueline saenz , LCSW on 08/10/2016 at 02:18 PM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: SELF PAY ALL

Provider: Samuel Smith, MD
Date: 07/28/2016

Subjective:

Chief Complaints:
1. Depression Screening.

HPI:
Depression Screening:
PHQ-9
Little interest or pleasure in doing things *Nearly every day*
Feeling down, depressed, or hopeless *Nearly every day*
Trouble falling or staying asleep, or sleeping too much *Nearly every day*
Feeling tired or having little energy *Nearly every day*
Poor appetite or overeating *Nearly every day*
Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Nearly every day*
Trouble concentrating on things, such as reading the newspaper or watching television *Nearly every day*
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Nearly every day*
Thoughts that you would be better off dead or of hurting yourself in some way *Nearly every day (Consider Suicide Assessment Risk)*
Total Score *27*
Interpretation *Severe Depression*
Individual Psychotherapy Progress Note:
Certification of clients cognitive ability to actively parti I certify the client's level of cognition is adequate to actively participate in and benefit from this service.
Current Risk Factors Pt indicated that she has thoughts of death but denied having plans to hurt herself.
Therapeutic Goals worked on this session Psychological screening.
Interventions Used Building rapport & reflective listening; Care coordination.
Theraputic Gains noted this session (observational terms) Increased self-disclosure.
Ongoing Symptomatic/Functional Impairment Persisting depressive symptoms.

Medical History: High Cholesterol, Cad, Glo.

Medications: Taking Asprin , Taking Mobic 15 MG Tablet 1 tablet Once a day, stop date 09/26/2016

Objective:

Examination:
General Examination :
PSYCH speech: normal, oriented, affect: appropriate; casually dressed; cooperative; mood: depressed.

Assessment:

Assessment:
1. Encounter for screening for other disorder - Z13.89

Plan:

1. Encounter for screening for other disorder
Notes: LCSW reviewed results of PHQ9 with pt. LCSW encouraged pt to pursue mental health tx given disclosures made. LCSW informed pt of BHC's mental health program. LCSW offered pt an appt for today but pt declined. LCSW provided pt with next available appt with LCSW.

Provider: Samuel Smith, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 07/28/2016

Electronically signed by Jacqueline saenz , LCSW on 07/28/2016 at 10:56 AM PDT
Sign off status: Completed

Patient: Roquemore, Sandra
Account Number: 50469
DOB: 02/11/1955 **Age:** 61 Y **Sex:** Female
Phone: 323-643-4539
Address: 1763 Exposition Blvd, Los Angeles, CA-90018
Pcp: Health Center Benevolence

Provider: Ron Javdan, MD
Date: 07/28/2016

Subjective:

Chief Complaints:
1. New pt;medication. 2. Pain In Left Toe . 3. Pain In neck.

HPI:

Depression Screening:

PHQ-9

Little Interest or pleasure in doing things *Nearly every day*
Feeling down, depressed, or hopeless *Nearly every day*
Trouble falling or staying asleep, or sleeping too much *Nearly every day*
Feeling tired or having little energy *Nearly every day*
Poor appetite or overeating *Nearly every day*
Feeling bad about yourself or that you are a failure, or have let yourself or your family down *Nearly every day*
Trouble concentrating on things, such as reading the newspaper or watching television *Nearly every day*
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual *Nearly every day*
Thoughts that you would be better off dead or of hurting yourself in some way *Nearly every day (Consider Suicide Assessment Risk)*
Total Score *27*
Interpretation *Severe Depression*

61 yo bf
h/o neck fusion.HAD DIC DISEADE.

CDSS: Todays Visit:

CDSS: Breast Cancer Screening Last Done: 2 yrs ago.
CDSS: Colorectal Cancer Screening Last Done: 1 yr ago.
CDSS: Cervical Cancer Screening Last Done: 2 yrs ago Normal.
CDSS: Cholesterol Screening Last Done: 2 yrs ago.
CDSS: HIV screening Last Done: Unknown.

Medical History: High Cholesterol, Cataracts, Glaucoma.

Surgical History: Fusion 2011, Injection in her neck 03/10/2016.

Hospitalization/Major Diagnostic Procedure: 1 week 2011.

Family History: Mother: alive. Father: deceased. Siblings: alive. 1 brother(s) , 1 sister(s) - healthy. 1 son(s) , 2 daughter(s) - healthy. .
1 Son Has HIV.

Social History:

Tobacco Use:

Tobacco Use
Status: *current smoker*
How often do you smoke cigarettes? *every day*
How soon after you wake up do you smoke your first cigarette? *6-30 minutes*
How many cigarettes a day do you smoke? *5 or less*
Are you interested in quitting? *Ready to quit*
Patient counselled on the dangers of tobacco use and urged to quit. *07/28/2016*

Sexual History:

Sexual History
have you had sex in the past 12 months *Yes*
Have you ever had a Sexually transmitted disease? *Yes*

Chlamydia? *Yes*
GC? *No*
Herpes? *No*
Syphilis? *No*
Other? *No*

Drugs/Alcohol:

Alcohol Screen

Did you have a drink containing alcohol in the past year? *No*
Points *0*
Interpretation *Negative*

Drugs

Have you used drugs other than those for medical reasons in the past 12 months? *No*
Opiates *No*

Miscellaneous:

Abuse: admits verbal abuse Husband, admits physical abuse Husband.

Medications: Taking Asprin , Taking Triamcinolone Acetonide 0.1 % Ointment 1 application to affected area Externally Twice a day, Taking Calcium-Vitamin D3 500-400 MG-UNIT Tablet 1 tablet with food Orally twice a day, Taking Oxycodone-Acetaminophen 5-325 MG Tablet 1 tablet as needed Orally every 6 hrs, Taking DiphenhydrAMINE HCl 50 MG Capsule 1 capsule as needed Orally every 6 hrs, Taking Cyclobenzaprine HCl 10 MG Tablet 1 tablet Orally every 6hrs PRN pain, Taking Latanoprost 0.005 % Solution 1 drop into affected eye in the evening Ophthalmic Once a day, Taking Brimonidine Tartrate 0.15 % Solution 1 drop into affected eye Ophthalmic Three times a day, Taking Dorzolamide HCl 2 % Solution 1 drop into affected eye Ophthalmic Three times a day, Taking Atorvastatin Calcium 20 MG Tablet 1 tablet Orally Once a day, Taking Timolol Maleate 0.25 % Solution 1 drop into affected eye Ophthalmic Once a day, Taking Fish Oil 1200 MG Capsule Delayed Release 1 capsule Orally Once a day, Medication List reviewed and reconciled with the patient

Allergies: N.K.D.A.

Objective:

Vitals: Ht 64.5 in, Ht-cm 163.83 cm, Wt 136 lbs, Wt-kg 61.69 kg, BMI 22.98 Index, BP 120/80 mm Hg, Temp 97.7 F, HR 60 /min, RR 15 /min, Taken by L Banks CMA, Oxygen sat % 98 %.

Assessment:

Assessment:

1. Cervical disc disorder with myelopathy, unspecified cervical region - M50.00
2. Hyperlipidemia, unspecified - E78.5

Plan:

1. Cervical disc disorder with myelopathy, unspecified cervical region

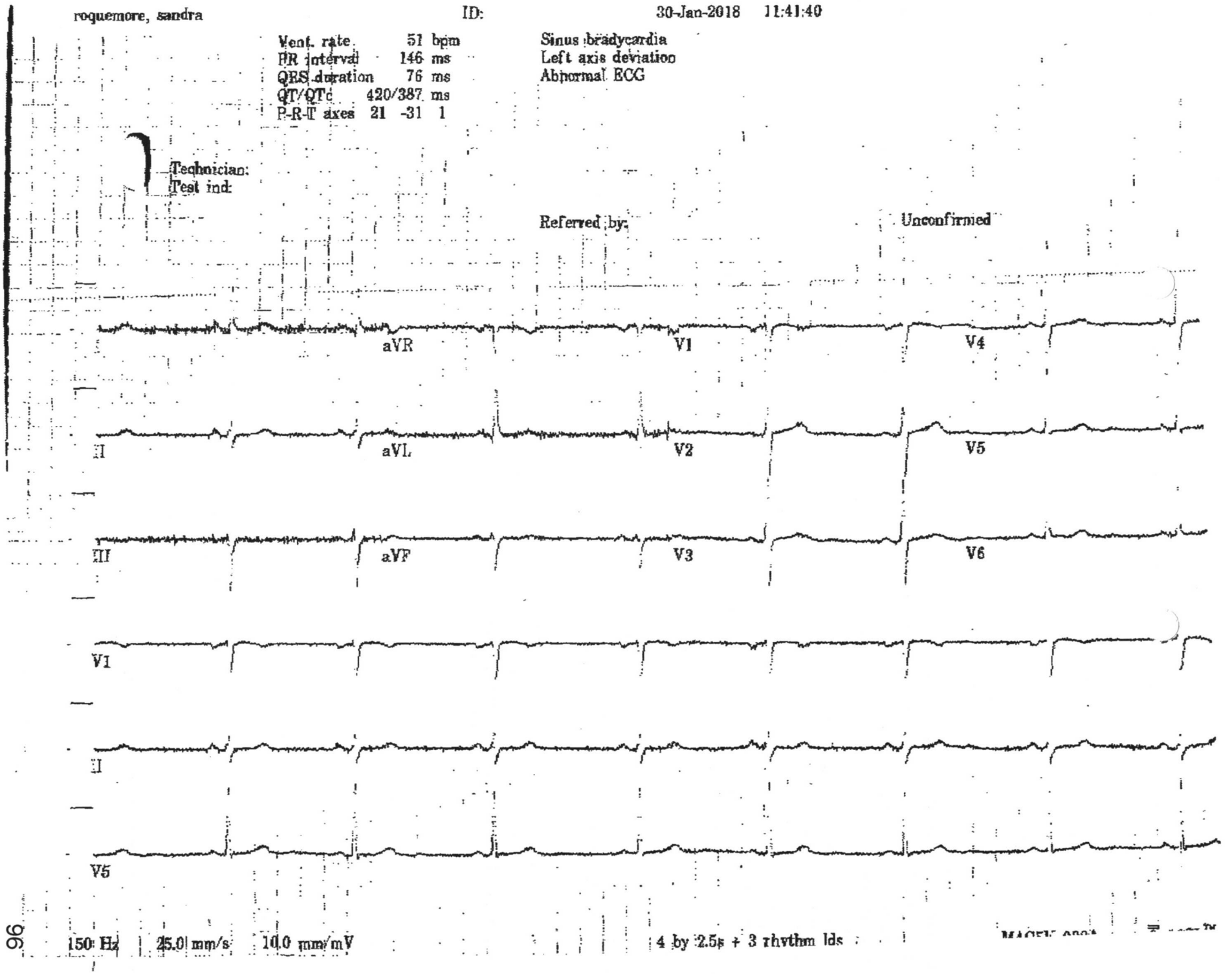
Start Mobic Tablet, 15 MG, 1 tablet, Orally, Once a day, 30 day(s), 30, Refills 1 .
Referral To:Outside Provider
Reason:Consultation & Follow ups|Effective 08/01/2016

2. Hyperlipidemia, unspecified

LAB: CBC, CMP, LIPID, TSH

Provider: Ron Javdan, MD
Patient: Roquemore, Sandra **DOB:** 02/11/1955 **Date:** 07/28/2016

Electronically signed by Ron Javdan , MD on 04/02/2021 at 08:45 AM PDT
Sign off status: Pending


roquemore, sandra
ID:
30-Jan-2018 11:41:40
Vent. rate 51 bpm
PR interval 146 ms
QRS duration 76 ms
QT/QTc 420/387 ms
P-R-T axes 21 -31 1
Sinus bradycardia
Left axis deviation
Abnormal ECG
Technician:
Test ind:
Referred by:
Unconfirmed
aVR
V1
V4
I
aVL
V2
V5
III
aVF
V3
V6
V1
II
V5
150 Hz
25.0 mm/s
10.0 mm/mV
4 by 2.5s + 3 rhythm lds

Patient Name: SANDRA ROQUEMORE
Date of Birth: 02/11/1955
Medical Record #: 60521
Attending Physician: Arati Chand (Hematology/Oncology)
Location: Los Angeles
Referring Physician: Nassim Omid M.D. (Family Practice)

Follow-Up
Date of Visit: 02/15/2017

History of Present Illness
61 y/o AAF referred to us for anemia

Review of labs did not show any anemia. There is some macrocytosis noted on labs. She denied any problems with fatigue, weakness, loss of weight, peripheral neuropathy or memory issues. She eats a normal diet and is not a vegetarian.
serum folate and B12 wnl.
TSh was mildly elevated on labs. . Pt is asymptomatic.
She has been on Levotyroxine now. Breast biopsy R breast 12.19.16: benign
She stated that she has been compliant with her meds. She is here for a routine f/u. Doing well otherwise.

Medical History

- Macrocytosis

Surgical History

- Procedure: Spinal fusion with graft (procedure)

Medications
Levothyroxine Oral 75 mcg tablet 50 mcg orally once.

Smoking History
Current every day smoker

Social History

Family History

- Father: No History of Disease
- Mother: No History of Disease

Allergies
No known medication allergies

Review of Systems

Constitutional: Denies fever, weight loss, fatigue
Eyes: Denies visual changes
ENT/Mouth: Denies hearing problems, oral problems
Cardiovascular: Denies chest pain, palpitations
Respiratory: Denies shortness of breath, cough
Breast: Denies pain, masses, discharge
Gastrointestinal: Denies abdominal pain, nausea, vomiting, constipation, diarrhea
Genitourinary: Denies burning, pain on urination, blood in urine, incontinence
Gynecological: Denies vaginal discharge, abnormal vaginal bleeding
Musculoskeletal: Denies muscle pain, bone pain, joint pain
Skin: Denies rashes, itchiness, ulcers
Neurologic: Denies headaches, dizziness, confusion, seizures, weakness or numbness
Psychiatric: Denies depression, anxiety
Hematologic/Lymphatic: Denies other bleeding, bruising, swollen lymph nodes

Physical Examination
Blood pressure: , Pulse: , Temperature: , Respirations: , O2 sat: , Pain Scale: , Height: , Weight: , BSA: , BMI:
General: Well developed, well nourished, no acute distress
Lymph nodes: No cervical, supraclavicular, axillary or inguinal lymphadenopathy
Skin: Unremarkable
HEENT: Pupils equal, round and reactive to light. Oral cavity, oropharynx clear
Neck: Supple, no JVD, thyromegaly or bruit
Extremities: No clubbing, cyanosis, or edema, pulses 2+

Laboratory
CBC
(02/03/2017) WBC x 10^3/uL : 7.6; RBC x 10^6/uL : 4.53; NRBC % /100 wbc : N; HGB g/dL : 14.6; HCT % : 43.8; MCV fL : 97; MCH pg : 32.2; MCHC g/dL : 33.3; RDW % : 12.1 (L); PLT x 10^3/uL : 243; Neu % : 50; LY % : 43; MO % : 4; EO % : 3; BA % : 0; IG % : 0; Neu # (ANC) x 10^3/uL : 3.8; LY # x 10^3/uL : 3.2 (H); MO # x 10^3/uL : 0.3; EO # x 10^3/uL : 0.2; BA # x 10^3/uL : 0.0; IG # x 10^3/uL : 0.0
Anemia Labs
(09/27/2016) Vitamin B12 pg/mL : 443; Folate, serum ng/mL : 8.1
Hormones
(02/03/2017) TSH uIU/mL : 2.960; T4, free ng/dL : 1.45
(10/14/2016) TSH, mIU/L : 5.21 (H)
Other
(02/03/2017) CBC Comments : N; Immature Cells : N
(10/14/2016) Clinical PDF Report EN406296Y-1 : See attached

Radiology

Pathology

Impression and Recommendations
61 y/o female referred to us for anemia.
Although she does not have anemia. She was noted to have macrocytosis.
2/2 hypothyroidism. continue with 75mcg of levothyroxine.
resolved now.
Polycythemia noted: 2/2 tobacco smoking.
RTC prn
Thank you for the opportunity in allowing me to care for this patient. Please do not hesitate to call with any questions or concerns.
Diagnosis

- Macrocytosis

cc

Patient: SANDRA ROQUEMORE

Note Date: 02/15/2017

Nassim Omid M.D.

Electronically signed by Arati Chand MD 02/15/2017 08:00 PM PST

A RadNet Imaging Center

Phone: (213) 487-4077
Fax: (213) 487-7517

ROQUEMORE, SANDRA
MRN: 1355036BR1
DOB: 02-11-1955 Sex: F
Phone:(323) 643-4539

Date of Service: 03-09-2018

Ordered By

OMID NASSIM, MD
3631 CRENSHAW BLVD, STE 109
LOS ANGELES CA, 90016

FAX: (323) 732-0104

EXAM: X-RAY CHEST, PA AND LATERAL

HISTORY: Preoperative

TECHNIQUE: 2 views; PA and lateral.

COMPARISON: None available.

FINDINGS: There are linear interstitial densities at the bases bilaterally. The heart size is normal. There are no infiltrates. The central airways and mediastinal contour are unremarkable. Altered level spurs are seen along the thoracic spine. No pleural effusions are seen.

IMPRESSION: Bilateral atelectasis/fibrosis

End of diagnostic report for accession: 13786103
Dictated: 03-11-2018 5:22:00 PM
Dictated By: Loya, Alma, MD
Signed By: Loya, Alma, MD 03-11-2018 5:22:00 PM

8540 South Sepulveda Blvd., Suite 111
Los Angeles, California 90045
Phone: (310) 645-9050
Fax: (310) 216-2683

PATIENT: ROQUEMORE, SANDRA NUMBER: 160775
DOB: 02/11/55 50Y SEX - F

DOCTOR: JAY THOMPSON, M.D.

CT OF THE CERVICAL SPINE: 11/09/05

Reason for Exam: Right-sided neck pain and numbness

Helical scanning of the cervical spine was performed at 2 mm collimation. Axial images were reconstructed at 2.4 mm intervals. Sagittal reconstructions were performed. Images were filmed at bone and soft tissue windows.

FINDINGS:

Overview of the spine shows loss of normal lordosis with sclerotic changes at C4-5 and C5-6 with anterior spurring. The discs are also narrowed at C4-5 and C5-6.

C2-3: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C3-4: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C4-5: A 3 mm central irregular osteophytic ridge encroaches on the anterior cord, causing mild central stenosis. The cord is otherwise normal. Uncinate spurring is causing moderate bilateral foraminal narrowing.

C5-6: There is a calcified left posterolateral 2 mm protrusion. There is no evidence for central bulge or herniation. Uncinate spurring is causing moderate bilateral foraminal narrowing.

C6-7: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C7-T1: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

IMPRESSION:

Loss of lordosis.

Sclerotic vertebral bodies at C4-5 and C5-6 with anterior spurring and disc space narrowing at these levels.

(CONTINUED)

CHESTER ADVANCED IMAGING MEDICAL GROUP

South Sepulveda Blvd., Suite 111
Angeles, California 90045
Phone: (310) 645-9050
Fax: (310) 216-2683

Magnetic Resonance Imaging
Computed Tomography
Ultrasound

Di Mammography
X-
Fluoroscopy

PATIENT: ROQUEMORE, SANDRA
DOB: 02/11/55 50Y

NUMBER: 160775
SEX - F

DOCTOR: JAY THOMPSON, M.D.

CT OF THE CERVICAL SPINE: 11/09/05

(CONTINUED - PAGE 2)

IMPRESSION CONTINUED.....

C4-5 central 3 mm osteophytic ridge with mild central stenosis and moderate bilateral foraminal narrowing.

C5-6 calcified left posterolateral 2 mm protrusion; uncinate spurring with moderate bilateral foraminal narrowing.

Thank you for referring this patient.

kg
d: 11/10/05
t: 11/10/05
Tech: Leticia Orozco,
RHT#66547

WILLIAM AULL, M.D.

The Patient Health Questionnaire (PHQ-9)

Patient Name Sandra Rogermore Date of Visit 7/28/16

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	(3)
2. Feeling down, depressed or hopeless	0	1	2	(3)
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	(3)
4. Feeling tired or having little energy	0	1	2	(3)
5. Poor appetite or overeating	0	1	2	(3)
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	(3)
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	(3)
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	(3)
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	(3)

Column Totals ____ + ____ + 27

Add Totals Together 27

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth		Today's Date
SANDRA ROQUEMORE	02-11-1955	☒ Female ☐ Male	07-28-2016

Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☒ Other (Specify) Self

Need help with form? ☐ Yes ☒ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only: Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	(No)	Skip	
2	Do you eat fruits and vegetables every day?	Yes	(No)	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	(Yes)	No	Skip	
4	Are you easily able to get enough healthy food?	(Yes)	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	(No)	Yes	Skip	
6	Do you often eat too much or too little food?	No	(Yes)	Skip	
7	Are you concerned about your weight?	(No)	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	(No)	Skip	Physical Activity
9	Do you feel safe where you live?	(Yes)	No	Skip	Safety
10	Have you had any car accidents lately?	No	(Yes)	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	(No)	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	(Yes)	No	Skip	
13	Do you keep a gun in your house or place where you live?	(No)	Yes	Skip	
14	Do you brush and floss your teeth daily?	(Yes)	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	(Yes)	Skip	Mental Health
16	Do you often have trouble sleeping?	No	(Yes)	Skip	
17	Do you smoke or chew tobacco?	No	(Yes)	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	(Yes)	Skip	

19	In the past year, have you had: ☐ (men) 5 or more alcohol drinks in one day? ☑ (women) 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
					Sexual Issues
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital-warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions
	If yes, please describe:				

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ Patient Declined the SHA

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: SANDRA ROQUEMORE DATE: 07-31-2018

DOB: 2/11/55

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ✓	1	2	3
2. Feeling down, depressed, or hopeless	0 ✓	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0 ✓	1	2	3
4. Feeling tired or having little energy	0 ✓	1	2	3
5. Poor appetite or overeating	0 ✓	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 ✓	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ✓	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0 ✓	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0 ✓	1	2	3

add columns [ ] + [ ] + [ ]

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: [ ]

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ✓ Somewhat difficult Very difficult Extremely difficult

A2663B 10-04-2005

[illegible] MENTAL HEALTH ASSESSMENT

Patient Name: Sandra Roquemore Phone #: 323643-4539

Clinic: Crenshaw DOB: 2/11/55 Referral Source: Depression Screening

Reason for Referral/Chief Complaint: 61 y/o

Depression. Boyfriend left her for her neighbor. Pain in neck

Mental Health History:

Outpatient Treatment: [✓] Yes [ ] No [ ] Unable to Assess

Psychiatric Hospitalizations: [✓] Yes [ ] No [ ] Unable to Assess

Family History of Mental Illness:
Denies

Risk and Safety Concerns

Suicidal Ideation: [ ] Yes [✓] No
Homicidal Ideation: [ ] Yes [✓] No
History of Substance Abuse: [ ] Yes [✓] No - Denied.
Current Substance Abuse: [ ] Yes [✓] No
Recent/Past Trauma Exposure: [✓] Yes [ ] No

Victim of Violence/Abuse: [✓] Yes [ ] No
Perpetrator of Violence/Abuse: [ ] Yes [✓] No
DCFS Involvement: [ ] Yes [✓] No
Homeless: [ ] Yes [✓] No
Other (specify):

For any risk/safety concerns marked yes, please explain.
Ex boyfriend used to batter pt. Two siblings were killed.

Medications:	Effects/Reactions:
Abilify	No side effects noted by pt.
Risperdal	

APPEARANCE: [✓] Groomed [ ] Disheveled [ ] Dirty [ ] Odorous
BEHAVIOR: [ ] Friendly [✓] Cooperative [ ] Hostile [ ] Suspicious
SPEECH: [✓] Clear [ ] Pressured [ ] Mute [ ] Disorganized
ORIENTATION: [✓] x4 [ ] Only to: _____
MEMORY: [✓] Good [ ] Fair [ ] Adequate [ ] Poor
FUND OF KNOWLEDGE: [✓] Average [ ] Above Average [ ] Below Average
CONCENTRATION: [✓] Good [ ] Fair [ ] Adequate [ ] Poor
THOUGHT FLOW: [✓] Coherent [ ] Loose [ ] Tangential [ ] Circumstantial
INSIGHT: [ ] Good [✓] Fair [ ] Poor JUDGMENT: [ ] Good [✓] Fair [ ] Poor
MOOD: [ ] Euthymic [✓] Depressed [✓] Anxious [ ] Angry
AFFECT: [✓] Appropriate [ ] Flat [ ] Blunt [ ] Anxious
HALLUCINATIONS: [✓] Yes [ ] No DELUSIONS: [ ] Yes [✓] No
Auditory hallucinations

Admission Diagnosis:

Axis I: Schizoaffective DO

Axis II:

Axis III: High cholesterol

Axis IV:

[✓] Primary Support Group
[ ] Social Environment
[ ] Educational/Occupational
[ ] Housing
[✓] Economics
[ ] Access to health care
[ ] Interaction w/legal system
[ ] Other psychosocial/environmental
[ ] Inadequate information

Axis V. GAF: 55

Disposition/Recommendation/Plan:

Pt to participate in mental health counseling to address SX & improve coping skills.

BENEVOLENCE HEALTH CENTERS ASSESSMENT ADDENDUM

Psychosocial History

A. Family & Relationships: Alcohol/Drug Abuse in Immediate Family [ ] Yes [X] No
Family constellation; family of origin and current family; family dynamics; cultural factors; nature of relationships; domestic violence, physical or sexual abuse; home safety issues (i.e., presence of firearms.)

See progress note

B. Dependent Care Issues: [ ] ____ of Adults, [ ] 3 dependent children, age(s) of child(ren), school attendance/behavior problems; learning problems; special need(s), including physical impairments, discipline issues, juvenile court history; any unattended needs of children; child support; child custody; and guardianship issues; foster care/group home placement.

35 - 41 years old, ~~kids~~ children. One of her sons was in the hospital due to his being HIV+

C. Current Living Arrangements & Social Support Systems: Support from community, religious, government agencies, and other sources; type of setting and associated problems, etc.

Pt is living by herself.

D. Education: Highest grade level completed, educational goals. Skill level: literacy level, vocabulary, general knowledge, math skills, school problems, motivation.

Pt completed 4 years of college (computer science.)

E. Employment History/Employment Readiness/Means of Financial Support: Longest period of employment, employment history, military service, work-related problems, money management, source of income. Areas of strength.

Pt last worked in 1995 ~~of~~ as a manager. Pt worked there for 13 years.

F. Legal History and Current Legal Status: Parole, arrests, DUI, convictions, divorce, child custody, conservatorship.

Pt was arrested for possession of cocaine.

G. Medical History

High cholesterol.

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIP AA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	

Pt was born in CA. Pt has 4 siblings, thought 2 are deceased. Grandparents raised pt because Mom & Dad "did not want" her. Parents used to want to beat up pt. Mom stabbed pt in eye with ice pick when pt was about 5 y/o. Then mom broke pt's arm when pt was about 7 y/o. Pt got married for 1st time @ 19 y/o. Pt was married about a year. 2nd marriage lasted 5 years, 2nd husband was violent towards pt. 3rd marriage lasted about 15 years. They were together until he passed away. Then pt got into a rel. ship of 10 years, who used to be violent.

EMR Fax Message

To: Nassim Omid M.D.

Fax: (323) 734-1666

From: Chand, Aratl
The Oncology Institute of Hope and Innovation
Los Angeles
1700 E. Cesar Chavez Ave.
Los Angeles, CA 90033
323-284-4077

Date: 10/19/2016 01:05 PM

Subject: Lab Results

ATTENTION: This report may contain Protected Health Information as defined by HIPAA, and should be managed in accordance with your organization's policies for Protected Health Information

Result_Report

Patient: ROQUEMORE, SANDRA A
MRN: 60521

DOB: 02/11/1955 Sex: F
TSH

The Oncology Institute of Hope and Innovation
Anaheim-Downey-Glendale-Los [illegible]eles-Los Alamitos-Long Beach-Lynwood, Montebello-Santa An[illegible] Pedro-Torrance-Upland-West Covina-Whittier
Downey, CA 90241
Status: FINAL | Spec Recvd: 10/14/2016 12:54 PM
Collection: 10/14/2016 12:53 PM | Reported: 10/15/2016 02:10 AM
Laboratory: Quest Diagnostics-West Hills, 8401 Fallbrook Ave West Hills CA 91304-3226 Enrique Terrazas M.D.

Test	Result	Units	Flag	Ref. Range	Comments	Lab
TSH_mIU/L	5.21	mIU/L	H	0.40 - 4.50		

Reviewed by Chand, Arati at 10/17/2016 06:41 AM

JAN W. DUNCAN, M.D.
ORTHOPAEDIC SURGERY

Comprehensive Treatment of the Cervical,
Thoracic & Lumbar Spine.

INITIAL EVALUATION

SANDRA ROQUEMORE
October 6, 2016

CHIEF COMPLAINT:

Pain in the neck.

PRESENT ILLNESS:

This 61-year-old woman has pain in the neck area. It radiates into the fingers of both hands. She says all of the fingers are numb from the ring toward the radial side.

Past History: The patient had a surgery in 2011 which apparently was a corpectomy at C5 and had a graft from C4 to C6.

PHYSICAL EXAMINATION:

The patient is of thin build.

She has limited motion of the neck. It is as follows:

Flexion	35 degrees
Extension	40 degrees

There is good range of motion of the shoulders.

In the upper extremities, the patient describes numbness over the radial aspect of both hands.

On motor evaluation, there appears to be some weakness to dorsiflexion of the wrist and thumb as well as flexion of the elbow.

In the lower extremities, the patient has no clonus or hyperactive reflexes.

X-RAY:

X-ray shows that the patient has a strut graft from C4 to C6 which appears to be solidly fused.

On the MRI, the patient has still significant compression of the cord at C4-C5 and C5-C6.

IMPRESSION:

1. Cord and probable nerve root compression residual in the cervical spine.

DISPOSITION:

The patient shows clear cut cord compression as well as some edema of the cord. However, she does not have specific neurologic loss in the legs at this time.

I have recommended that the patient have a posterior decompression. She will think about this. We will see her in a week for follow-up.

JAN W. DUNCAN, M.D.

Richy Agajanian, MD
Nelly Awkar-Lazo, MD
Kamila Bakirhan, MD
Arati Chand, MD
Eric Cheung, DO
Michael Chung, MD
Jack Freimann Jr., MD
Anthony Giorgio, MD, FACP
Daniel Huang, MD
Stephen Huang, MD
Seong Kim, MD

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Omkar Marathe, MD
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Lynwood 310.667.4300 • Montebello 323.278.4400 • San Pedro 310.547.2445 • Santa Ana 714.542.0102 • Torrance 310.925.4525 • Upland 909.906.1519 • West Covina 626.283.5192 • Whittier 562.699.5992

Patient Name: SANDRA ROQUEMORE
Date of Birth: 02/11/1955
Medical Record #: 60521
Attending Physician: Arati Chand (Hematology/Oncology)
Location: Los Angeles
Referring Physician: Nassim Omid M.D. (Family Practice)

Follow-Up
Date of Visit: 10/19/2016

History of Present Illness
61 y/o AAF referred to us for anemia

Review of labs did not show any anemia. There is some macrocytosis noted on labs. She denied any problems with fatigue, weakness, loss of weight, peripheral neuropathy or memory issues. She eats a normal diet and is not a vegetarian.
serum folate and B12 wnl.
TSh was mildly elevated on labs. Discussed clinical signs of hypoothyroidism. Pt is asymptomatic.

Medical History

- Macrocytosis

Surgical History

- Procedure: Spinal fusion with graft (procedure)

Medications
Levothyroxine Oral 50 mcg capsule 50 mcg orally once.

Smoking History
Current every day smoker

Social History

Family History

- Father: No History of Disease
- Mother: No History of Disease

Allergies
No known medication allergies

Review of Systems

Constitutional: Denies fever, weight loss, fatigue
Eyes: Denies visual changes
ENT/Mouth: Denies hearing problems, oral problems
Cardiovascular: Denies chest pain, palpitations
Respiratory: Denies shortness of breath, cough
Breast: Denies pain, masses, discharge
Gastrointestinal: Denies abdominal pain, nausea, vomiting, constipation, diarrhea
Genitourinary: Denies burning, pain on urination, blood in urine, incontinence
Gynecological: Denies vaginal discharge, abnormal vaginal bleeding
Musculoskeletal: Denies muscle pain, bone pain, joint pain
Skin: Denies rashes, itchiness, ulcers
Neurologic: Denies headaches, dizziness, confusion, seizures, weakness or numbness
Psychiatric: Denies depression, anxiety
Hematologic/Lymphatic: Denies other bleeding, bruising, swollen lymph nodes

Physical Examination
Blood pressure: 128/81, Pulse: 61, Temperature: 97.6 F, Respirations: 18, O2 sat: , Pain Scale: 0, Height: 66 in, Weight: 131.8 lb, BSA: 1.68, BMI: 21.27 kg/m2
General: Well developed, well nourished, no acute distress
Lymph nodes: No cervical, supraclavicular, axillary or inguinal lymphadenopathy
Skin: Unremarkable
HEENT: Pupils equal, round and reactive to light. Oral cavity, oropharynx clear
Neck: Supple, no JVD, thyromegaly or bruit
Extremities: No clubbing, cyanosis, or edema, pulses 2+
Genitourinary: Deferred
Rectal: Deferred
Neurologic: Alert and oriented x 4, bilateral upper and lower extremity motor strength and sensation intact

Laboratory
Anemia Labs
(09/27/2016) Vitamin B12 pg/mL : 443; Folate, serum ng/mL : 8.1
Hormones
(10/14/2016) TSH, mIU/L : 5.21 (H)
Other
(10/14/2016) Clinical PDF Report EN406296Y-1 : See attached

Radiology

Pathology

Impression and Recommendations
61 y/o female referred to us for anemia.
Although she does not have anemia. She was noted to have macrocytosis.
Mildly elevated TSH. She may have subclinical hypothyroidism. This can cause macrocytosis at times.
Started Levothyroxine at 50 mg PO daily.
RTC 4-6 weeks with labs.
Thank you for the opportunity in allowing me to care for this patient. Please do not hesitate to call with any questions or concerns.
Diagnosis

- Macrocytosis

CC
Nassim Omid M.D.

Electronically signed by Arati Chand MD 10/26/2016 08:05 PM PDT

Staying Healthy Assessmen

Adult

Patient's Name (first & last)	Date of Birth	☒ Female ☐ Male	Today's Date
Andrea Roquemore	02-11-1955		10-31-2017
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☒ No
Self			

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	(No)	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	(No)	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	(Yes)	No	Skip	
4	Are you easily able to get enough healthy food?	(Yes)	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	(No)	Yes	Skip	
6	Do you often eat too much or too little food?	No	(Yes)	Skip	
7	Are you concerned about your weight?	(No)	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	(Yes)	No	Skip	Physical Activity
9	Do you feel safe where you live?	(Yes)	No	Skip	Safety
10	Have you had any car accidents lately?	(No)	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	(No)	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	(Yes)	No	Skip	
13	Do you keep a gun in your house or place where you live?	(No)	Yes	Skip	
14	Do you brush and floss your teeth daily?	(Yes)	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	(Yes)	Skip	Mental Health
16	Do you often have trouble sleeping?	No	(Yes)	Skip	
17	Do you smoke or chew tobacco?	No	(Yes)	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	(Yes)	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☒ **(women)** 4 or more alco. drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date: 10/31/19
SHA ANNUAL REVIEW		
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

NAME: Sandra Figueroa DATE: 10-31-2019

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	✓ 0	1	2	3
2. Feeling down, depressed, or hopeless	✓ 0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	✓ 0	1	2	3
4. Feeling tired or having little energy	✓ 0	1	2	3
5. Poor appetite or overeating	✓ 0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	✓ 0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	✓ 0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	✓ 0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	✓ 0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).			TOTAL:	

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	✓
	Somewhat difficult	
	Very difficult	
	Extremely difficult	

A2663B 10-04-2005

Richy Agajanian, MD
Nely Andar-Lazo, MD
Kamila Balcirlan, MD
Arati Chand, MD
Eric Cheung, DO
Michael Chung, MD
Jack Freiman Jr., MD
Anthony Giorgio, MD, FACP
Daniel Huang, MD
Stephen Huang, MD
Seong Kim, MD
Mauro Jamoid, MD, FACP

Catherine Jones, MD
Oskar Marelle, MD
Reza Mostofi, MD
Aileen Novero, MD
Edgardo R. Cruz-Flores, MD
Thomas Reynolds, MD, FACP
Ravin Rupani, MD
Merrill Stum, MD
Eddie Thara, DO
Rodina Vatamparast, MD
Yunfei Wei, MD

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Anaheim 714.998.0600 • Corona 951.270.3400 • Downey [illegible] • Glendale [illegible] • Long Beach [illegible] • Los Alamitos [illegible] • Los Angeles [illegible] • Lynwood [illegible]
Montclair 909.278.4400 • Riverside [illegible] • San Pedro [illegible] • Santa Ana [illegible] • Torrance [illegible] • Upland [illegible] • West Covina [illegible] • Whittier [illegible]

Patient Name: SANDRA ROQUEMORE
Date of Birth: 02/11/1955
Medical Record #: 60521
Attending Physician: Arati Chand (Hematology/Oncology)
Location: Los Angeles
Referring Physician: Nassim Omid M.D. (Family Practice)

Follow-Up
Date of Visit: 12/21/2016

History of Present Illness
61 y/o AAF referred to us for anemia

Review of labs did not show any anemia. There is some macrocytosis noted on labs. She denied any problems with fatigue, weakness, loss of weight, peripheral neuropathy or memory issues. She eats a normal diet and is not a vegetarian, serum folate and B12 wnl.
TSh was mildly elevated on labs. . Pt is asymptomatic.
She has been on Levotyroxine now. Breast biopsy R breast done 2 days ago. No results at this time.
She stated that she has been compliant with her meds
She continues to smoke

Medical History

- Macrocytosis

Surgical History

- Procedure: Spinal fusion with graft (procedure)

Medications
Levothyroxine Oral 75 mcg tablet 50 mcg orally once.

Smoking History
Current every day smoker

Social History

Family History

- Father: No History of Disease

- Mother: No History of Disease

Allergies
No known medication allergies

Review of Systems

Constitutional: Denies fever, weight loss, fatigue
Eyes: Denies visual changes
ENT/Mouth: Denies hearing problems, oral problems
Cardiovascular: Denies chest pain, palpitations
Respiratory: Denies shortness of breath, cough
Breast: Denies pain, masses, discharge
Gastrointestinal: Denies abdominal pain, nausea, vomiting, constipation, diarrhea
Genitourinary: Denies burning, pain on urination, blood in urine, incontinence
Gynecological: Denies vaginal discharge, abnormal vaginal bleeding
Musculoskeletal: Denies muscle pain, bone pain, joint pain
Skin: Denies rashes, itchiness, ulcers
Neurologic: Denies headaches, dizziness, confusion, seizures, weakness or numbness
Psychiatric: Denies depression, anxiety
Hematologic/Lymphatic: Denies other bleeding, bruising, swollen lymph nodes

Physical Examination
Blood pressure: 128/82, Pulse: 61, Temperature: 98.5 F, Respirations: 18, O2 sat: , Pain Scale: 0, Height: 66 in, Weight: 134.4 lb, BSA: 1.69, BMI: 21.69 kg/m2
General: Well developed, well nourished, no acute distress
Lymph nodes: No cervical, supraclavicular, axillary or inguinal lymphadenopathy
Skin: Unremarkable
HEENT: Pupils equal, round and reactive to light. Oral cavity, oropharynx clear
Neck: Supple, no JVD, thyromegaly or bruit
Extremities: No clubbing, cyanosis, or edema, pulses 2+
Genitourinary: Deferred
Rectal: Deferred
Neurologic: Alert and oriented x 4, bilateral upper and lower extremity motor strength and sensation intact

Laboratory
CBC
(12/16/2016) WBC x 10^3/uL : 8.6; RBC x 10^6/uL : 4.84; NRBC % /100 wbc : N; HGB g/dL : 16.5 (H); HCT % : 48.0 (H); MCV fL : 99 (H); MCH pg : 34.1 (H); MCHC g/dL : 34.4; RDW % : 12.3; PLT x 10^3/uL : 242; Neu % : 62; LY % : 31; MO % : 6; EO % : 1; BA % : 0; IG % : 0; Neu # (ANC) x 10^3/uL : 5.3; LY # x 10^3/uL : 2.7; MO # x 10^3/uL : 0.5; EO # x 10^3/uL : 0.1; BA # x 10^3/uL : 0.0; IG # x 10^3/uL : 0.0
Anemia Labs
(09/27/2016) Vitamin B12 pg/mL : 443; Folate, serum ng/mL : 8.1
Hormones
(12/16/2016) TSH uIU/mL : 8.190 (H); T4, free ng/dL : 0.96
(10/14/2016) TSH, mIU/L : 5.21 (H)
Other
(12/16/2016) CBC Comments : N; Immature Cells : N
(10/14/2016) Clinical PDF Report EN406296Y-1 : See attached

Radiology

Pathology

Impression and Recommendations
61 y/o female referred to us for anemia.
Although she does not have anemia. She was noted to have macrocytosis.
Mildly elevated TSH. She may have subclinical hypothyroidism. This can cause macrocytosis at times.
Started Levothyroxine at 50 mg PO daily, will increase the dose to 75 mg PO daily.
Polycythemia noted: 2/2 tobacco smoking.
RTC 4-6 weeks with labs.
Thank you for the opportunity in allowing me to care for this patient. Please do not hesitate to call with any questions or concerns.

Diagnosis

- Macrocytosis

CC
Nassim Omid M.D.

Electronically signed by Arati Chand MD 12/21/2016 09:26 AM PST

Saint Ana Women's Medical Clinic
Norma C. Saloeda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB:02/11/1955 Sex: F Account No.:
Encounter ID: 160249172 Encounter Date: 02/13/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

SUBJECTIVE:

Chief Complaint:	63 year old female presented with HERE FOR COLPOSCOPY. HAS NO C/O . MM /LL LNMP AGE 50 PAPSMEAR 11/30/2017 NEG HPV POS MAMMOGRAM 2015 NEG PER PT
History Of Present Illness:	HERE FOR COLPOSCOPY COMPLAINIO OF ON AND OFF VAGINAL BLEEDING
Medical History:	NONE
Surgical History:	SPINE SURGERY (INFUSIONS) 4 5 6 &7 2011 C/SECTION X 3 1971 1979 1980
Family History:	Cancer MOTHER
Social History:	Smoking Status: Smoker Frequency: 6-10
Allergies:	No known allergies
Current Medications:	ASPIRIN; ; Qty: 0; Refills: 0 OMEGA3; ; Qty: 0; Refills: 0 VITAMIN C; ; Qty: 0; Refills: 0 VITAMIN D; ; Qty: 0; Refills: 0
OBSTETRICAL HISTORY:	Gravida 3 Para 3 Term 3 SAB 0 TAB 0 Living 3
Vital Signs:	Height: 64.00 in Weight: 130.00 lbs BMI: 22.31 Blood Pressure: 114/83 mmHg Pulse: 79 beats/min
Physical Exam:	Chest/Breasts: DEFER Gastrointestinal (Abdomen): Soft Genitourinary: Bartholins Gland Normal Urethra Normal Skene Gland Normal CERVIX Clean -CMT RECTAL No Bleeding Hemorrhoids No Extremities: No edema Varicosities No Calf Tenderness No PERINEUM: Good Support

Saint Ana Women's Medical Clinic
Norma C. Salceda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB:02/11/1955 Sex: F Account No.:
Encounter ID: 160249172 Encounter Date: 02/13/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

Cystocele No
Rectocele No
VAGINA: No Discharge
No Odor
UTERUS: Size Normal
Position Normal
ADNEXAE: Right No mass felt
Left: No mass felt
Cul de sac Non Tender

ASSESSMENT:

Diagnosis: ICD-10 Codes:
1); + HPV
2); POST MENOPAUSAL BLEEDING
3); SUBMUCOSAL FIBROID

PLAN:

Procedure Notes: COLPOSCOPY BIOPSY AND ECC DONE WITHOUT PROBLEM SEE COLPO SHEET

Care Plan: Procedure Risk, Benefits and Alternatives Discussed
Consent Signed
NO SEX PELVIC REST 3 DAYS

Patient Instructions: Patient counseled
Patient instructed
Patient understood completely and all questions were answered
Return Appointment: 2 weeks

_____ Date: _____

[Electronically Signed] - Date: 2/13/2018 4:33:09 PM

[Physician Extender]:

[Provider]: Norma Salceda, MD

Richy Agajanian, MD
Nelly Awkar-Lazo, MD
Kamila Bakhrhan, MD
Arati Chand, MD
Eric Cheung, DO
Michael Chung, MD
Jack Freimann Jr., MD
Anthony Giorgio, MD, FACP
Daniel Huang, MD
Stephen Huang, MD
Seong Kim, MD

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Yunfei Wei, MD

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Lynwood 310.667.4000 • Montebello 323.278.4409 • San Pedro 310.547.2445 • Santa Ana 714.542.0102 • Torrance 310.325.4525 • Upland 909.906.1519 • West Covina 626.283.5193 • Whittier 562.696.5999

Patient Name: SANDRA ROQUEMORE
Date of Birth: 02/11/1955
Medical Record #: 60521
Attending Physician: Arati Chand (Hematology/Oncology)
Location: Glendale
Referring Physician: Nassim Omid M.D. (Family Practice)

Follow-Up
Date of Visit: 10/05/2016

History of Present Illness
61 y/o AAF referred to us for anemia

Review of labs did not show any anemia. There is some macrocytosis noted on labs. She denied any problems with fatigue, weakness, loss of weight, peripheral neuropathy or memory issues. She eats a normal diet and is not a vegetarian.
serum folate and B12 wnl.
Patiet stated that she has another appointment and could not wait any longer. Visit was very hurried.

Medical History

- Macrocytosis

Surgical History

- Procedure: Spinal fusion with graft (procedure)

Medications

Smoking History
Current every day smoker

Social History

Family History

- Father: No History of Disease
- Mother: No History of Disease

Allergies
No known medication allergies

Review of Systems

Constitutional: Denies fever, weight loss, fatigue
Eyes: Denies visual changes
ENT/Mouth: Denies hearing problems, oral problems
Cardiovascular: Denies chest pain, palpitations
Respiratory: Denies shortness of breath, cough
Breast: Denies pain, masses, discharge
Gastrointestinal: Denies abdominal pain, nausea, vomiting, constipation, diarrhea
Genitourinary: Denies burning, pain on urination, blood in urine, incontinence
Gynecological: Denies vaginal discharge, abnormal vaginal bleeding
Musculoskeletal: Denies muscle pain, bone pain, joint pain
Skin: Denies rashes, itchiness, ulcers
Neurologic: Denies headaches, dizziness, confusion, seizures, weakness or numbness
Psychiatric: Denies depression, anxiety
Hematologic/Lymphatic: Denies other bleeding, bruising, swollen lymph nodes

Physical Examination
Blood pressure: 124/79, Pulse: 56, Temperature: 98.4 F, Respirations: 18, O2 sat: , Pain Scale: 0, Height: 66 in, Weight: 124 lb, BSA: 1.63, BMI: 20.01 kg/m2
not done as pt was in a hurry to leave

Laboratory
Anemia Labs
(09/27/2016) Vitamin B12 pg/mL : 443; Folate, serum ng/mL : 8.1
Other
(09/27/2016) Clinical PDF Report EN405296Y-1 : See attached

Radiology

Pathology

Impression and Recommendations
61 y/o female referred to us for anemia.
Although she does not have anemia, She was noted to have macrocytosis.
serum folate, B12 levels wnl.. check TSH and T4.
RTC 2 weeks.
Thank you for the opportunity in allowing me to care for this patient. Please do not hesitate to call with any questions or concerns.
Diagnosis

- Macrocytosis

CC
Nassim Omid M.D.

Electronically signed by Arati Chand MD 10/13/2016 05:47 AM PDT

11/29/16

Augusto A. Zablan, M.D., F.A.C.S.

DIPLOMATE AMERICAN BOARD OF SURGERY
GENERAL SURGERY

FAX# (213)413-1860

FAX COVER LETTER

Please deliver the following pages to:

ATTN:
DR. NASSIM
FAX#:
323)734-1666
Total # of pages including cover letter: 2
Date: 11/29/16 **From:** MAIRA
RE: ROCQUEMORE, SANDRA
DOB: 02/11/1955

SEE ATTACHED:

- CONSULTATION REPORT FOR YOUR RECORDS

NOTE:

THANK YOU.
If you have any questions or problems regarding this transmission,
Please call us as soon as possible.
Tel# (213)413-1752

AUGUSTO A. ZABLAN, M.D., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF SURGERY
2105 Beverly Blvd., Suite 213
Los Angeles, CA 90057-2216
(213) 413-1752 phone
(213) 413-1860 fax

11/29/16

Date 11-28-16

RE: SANDRA ROQUEMORE Age 61

Date of Examination 11-28-16

Dear Dr. OMID NASSIM MD

Thank you for referring your patient. The following is a summary of essential findings:

History 61 yr. old (F) is evaluated for indeterminate calcifications in the right breast 11 oclock upper outer quadrant. In the left breast there are benign calcification in the inner lower breast

Physical Findings
ph. neg. for diabetes or hypertension

Diagnosis Exam: wt 138 lbs BP HR T 98
Heart - no neck mass
Heart - [illegible]
breasts - no palpable breasts

Treatment or Disposition mass - in either breasts.

Impression: indeterminate suspicious calcifications (R) breast 11-12 oclock

recommend:
Stereotactic (R) breast core biopsy of RUQ breast by radiology : benign (L) breast calcification

- ☐ Remarks:
- ☐ More Complete Letter to Follow
- ☐ See Attached Diagram, X-ray, Blood Test, Etc.

will follow after diagnosis is established by biopsy

Signed

AUGUSTO A. ZABLAN, M.D., F.A.C.S.

[signature]

Saint Ana Women's Medical Clinic
Norma C. Salceda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB:02/11/1955 Sex: F Account No.:
Encounter ID: 161514262 Encounter Date: 03/16/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

SUBJECTIVE:

Chief Complaint:	63 year old female presented with PT HERE FOR PREOP . HAS NO CO. NG LNMP; AGE OF 50 PAPSMEAR: 11/30/2017 NEG HPV POS MAMMOGRAM: 2017 NEG
History Of Present Illness:	DENIES ANY MORE VAGINAL BROWN DISCHARGE
Medical History:	NONE
Surgical History:	SPINE SURGERY (INFUSIONS) 4 5 6 &7 2011 C/SECTION X 3 1971 1979 1980
Family History:	Cancer
Social History:	Smoking Status: Smoker Frequency: 6-10
Allergies:	No known allergies
Current Medications:	ASPIRIN; ; Qty: 0; Refills: 0 OMEGA3; ; Qty: 0; Refills: 0 VITAMIN C; ; Qty: 0; Refills: 0 VITAMIN D; ; Qty: 0; Refills: 0
OBSTETRICAL HISTORY:	Gravida 3 Para 3 Term 3 Living 3

OBJECTIVE:

Vital Signs:	Height: 64.00 in Weight: 135.00 lbs BMI: 23.17 Blood Pressure: 134/83 mmHg Pulse: 77 beats/min

ASSESSMENT:

Diagnosis:	ICD-10 Codes: 1)D250; Submucous leiomyoma of uterus 2)N859; ENDOMETRIAL THICKENING 3); POST MENOPAUSE BLEEDING 4); PRE OP

PLAN:

Care Plan:	Procedure Risk, Benefits and Alternatives Discussed Consent Signed PT UNDERSTOOD FOR DILATATION AND CURETTAGE HYSTEROSCOPY SUCTION CURETTAGE ON 03/23/18

Saint Ana Women's Medical Clinic
Norma C. Salceda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB: 02/11/1955 Sex: F Account No.:
Encounter ID: 161514262 Encounter Date: 03/16/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

Patient Instructions: Patient counseled
Patient instructed
Patient understood completely and all questions were answered
Return Appointment: POST OP

[Electronically Signed] - Date: 3/16/2018 4:00:11 PM

[Physician Extender]: Leticia Heal Hopley, NP

_____ Date: _____

[Provider]: Norma Salceda, MD

Saint Ana Women's Medical Clinic
Norma C. Salceda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB:02/11/1955 Sex: F Account No.:
Encounter ID: 160795742 Encounter Date: 02/27/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

SUBJECTIVE:

Chief Complaint:	63 year old female presented with HERE FOR LAB RESULTS LAST PERIOD 50 YRS OLD LAST PAP11/30/17 NEG + HPV LAST MAMMOGRAM 01/18 NEEDS BREAST US HAS APPT 03/18 JB
History Of Present Illness:	HERE FOR RESULTS COMPLAINING OF STILL HAVING BROWNISH DISCHARGE
Medical History:	NONE
Surgical History:	SPINE SURGERY (INFUSIONS) 4 5 6 &7 2011 C/SECTION X 3 1971 1979 1980
Family History:	Cancer
Social History:	Smoking Status: Smoker Frequency: 6-10
Current Medications:	ASPIRIN; ; Qty: 0; Refills: 0 OMEGA3; ; Qty: 0; Refills: 0 VITAMIN C; ; Qty: 0; Refills: 0 VITAMIN D; ; Qty: 0; Refills: 0
OBSTETRICAL HISTORY:	Oravida 3 Para 3 Term 3 Living 3

OBJECTIVE:

Vital Signs:	Height: 64.50 in Weight: 134.00 lbs BMI: 22.64 Blood Pressure: 126/93 mmHg Pulse: 66 beats/min
Laboratory:	COLPOSCOPY AND BIOPSY NEGATIVE

ASSESSMENT:

Diagnosis:	ICD-10 Codes: 1); POST MENOPAUSAL BLEEDING 2); SUBMUCOSAL UTERINE FIBROID 3); ENDOMETRIAL THICKENING

PLAN:

Care Plan:	TO BE SCHEDULED FOR D&C HYSTEROSCOPY

Saint Ana Women's Medical Clinic
Norma C. Saloeda, M.D., F.A.C.O.G.
ASSISTANT CLINICAL PROFESSOR-UCLA

SANDRA ROQUEMORE
Patient ID: 72329297 DOB: 02/11/1955 Sex: F Account No.:
Encounter ID: 160795742 Encounter Date: 02/27/2018
Encounter Type: Office Visit

Referring Provider: DR. OMID NASSIM (PICO)

Patient Instructions: Patient counseled
Patient instructed
Patient understood completely and all questions were answered
Return Appointment: PRE OP

[Electronically Signed] - Date: 2/27/2018 5:09:56 PM
[Physician Extender]: Leticia Heal Hopley, NP

Date: 6.27.18
[Provider]: Norma Saloeda, MD

LabCorp
Laboratory Corporation of America

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Specimen Number	Patient ID	Control Number	Account Number	Account Phone Number	Route
012-229-3922-0		0122293922	04267185	323-732-0100	00

Patient Last Name	Patient First Name	Patient Middle Name
ROQUEMORE	SANDRA	

Patient SS#	Patient Phone	Total Volume
	323-643-4539	

Age (Y/M/D)	Date of Birth	Sex	Fasting
61/11/01	02/11/55	F	No

Patient Address
1763 EXPOSITION BLVD
LOS ANGELES CA 90018

Account Address
Omid Nassium MD

3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Additional Information

Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID
01/12/17 00:00	01/13/17	01/13/17 16:14ET	MOISEYEV , S	1932568284	

Tests Ordered
CBC With Differential/Platelet; Comp. Metabolic Panel (14); Lipid Panel; Hgb A1c with eAG Estimation; TSH; Vitamin D, 25-Hydroxy; Panel 083935; RPR; Ambig Abbrev CMP14 Default; Ambig Abbrev Lp Default; Cardiovascular Report

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	7.6		x10E3/uL	3.4 - 10.8	01
RBC	4.32		x10E6/uL	3.77 - 5.28	01
Hemoglobin	14.5		g/dL	11.1 - 15.9	01
Hematocrit	43.1		%	34.0 - 46.6	01
MCV	**100**	**High**	fL	79 - 97	01
MCH	**33.6**	**High**	pg	26.6 - 33.0	01
MCHC	33.6		g/dL	31.5 - 35.7	01
RDW	**12.0**	**Low**	%	12.3 - 15.4	01
Platelets	256		x10E3/uL	150 - 379	01
Neutrophils	52		%		01
Lymphs	39		%		01
Monocytes	6		%		01
Eos	3		%		01
Basos	0		%		01
Neutrophils (Absolute)	4.0		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	2.9		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.4		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
Comp. Metabolic Panel (14)					
Glucose, Serum	90		mg/dL	65 - 99	01
BUN	16		mg/dL	8 - 27	01
Creatinine, Serum	0.60		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	99		mL/min/1.73	>59	
eGFR If Africn Am	114		mL/min/1.73	>59	
BUN/Creatinine Ratio	**27**	**High**		11 - 26	
Sodium, Serum	143		mmol/L	134 - 144	01
Potassium, Serum	4.2		mmol/L	3.5 - 5.2	01
Chloride, Serum	105		mmol/L	96 - 106	01

LabCorp

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Patient Name					Specimen Number		
ROQUEMORE, SANDRA					012-229-3922-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
04267185		0122293922	01/12/17 00:00	01/13/17	F	61/11/01	02/11/55

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Carbon Dioxide, Total	24		mmol/L	18 - 29	01
Calcium, Serum	9.8		mg/dL	8.7 - 10.3	01
Protein, Total, Serum	7.1		g/dL	6.0 - 8.5	01
Albumin, Serum	4.3		g/dL	3.6 - 4.8	01
Globulin, Total	2.8		g/dL	1.5 - 4.5	
A/G Ratio	1.5			1.1 - 2.5	
Bilirubin, Total	0.3		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase, S	78		IU/L	39 - 117	01
AST (SGOT)	17		IU/L	0 - 40	01
ALT (SGPT)	13		IU/L	0 - 32	01
Lipid Panel					
Cholesterol, Total	**201**	**High**	mg/dL	100 - 199	01
Triglycerides	**194**	**High**	mg/dL	0 - 149	01
HDL Cholesterol	48		mg/dL	>39	01
VLDL Cholesterol Cal	39		mg/dL	5 - 40	
LDL Cholesterol Calc	**114**	**High**	mg/dL	0 - 99	
Hgb A1c with eAG Estimation					
Hemoglobin A1c	5.3		%	4.8 - 5.6	01
Please Note:					01
Pre-diabetes: 5.7 - 6.4 Diabetes: >6.4 Glycemic control for adults with diabetes: <7.0					
Estim. Avg Glu (eAG)	105		mg/dL		
TSH	3.650		uIU/mL	0.450 - 4.500	01
Vitamin D, 25-Hydroxy	**15.1**	**Low**	ng/mL	30.0 - 100.0	01

Vitamin D deficiency has been defined by the Institute of Medicine and an Endocrine Society practice guideline as a level of serum 25-OH vitamin D less than 20 ng/mL (1,2). The Endocrine Society went on to further define vitamin D insufficiency as a level between 21 and 29 ng/mL (2).

1. IOM (Institute of Medicine). 2010. Dietary reference intakes for calcium and D. Washington DC: The National Academies Press.
2. Holick MF, Binkley NC, Bischoff-Ferrari HA, et al. Evaluation, treatment, and prevention of vitamin D deficiency: an Endocrine Society clinical practice guideline. JCEM. 2011 Jul; 96(7):1911-30.

Panel 083935				
HIV Screen 4th Generation wRfx	Non Reactive		Non Reactive	01

LabCorp

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Patient Name					Specimen Number		
ROQUEMORE, SANDRA					012-229-3922-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
04267185		0122293922	01/12/17 00:00	01/13/17	F	61/11/01	02/11/55

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
RPR	Non Reactive			Non Reactive	01

Ambig Abbrev CMP14 Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Cardiovascular Report

Interpretation Note 02

Supplement report is available.

PDF Image 02

01	SO	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Jenny Galloway, MD
02	LITIL	Litholink Corporation 2250 West Campbell Park Drive, Chicago, IL 60612-3502	Dir: Mitchell Laks, PhD

For inquiries, the physician may contact **Branch:** 800-859-6046 **Lab:** 858-668-3700

Accessions: 01222939220

DISCLAIMER: *These assessments and treatme gestions are provided as a convenience in support of th ician-patient relationship and are not intended to replace the physician's clinical judgment. They are derived from the national guidelines in addition to other evidence and expert opinion. The clinician should consider this information within the context of clinical opinion and the individual patient*

SEE GUIDANCE FOR CARDIOVASCULAR REPORT: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002 NIH publication 02-5215); Brunzell et al Diabetes Care 2008, 31(4):811-82; Contois et al. Clin Chem 2009, 55(3):407-419; Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;129(suppl 2):S1-S45.

Note: *Please refer to your LabCorp Report for all results as well as any test-specific and specimen-specific comments.*

Cardiovascular Report

Patient Assessment

Current available clinical information suggests the patient's risk is at least LOW. One major CHD risk factor is present (age over 55). If the patient has CHD or a CHD risk equivalent, the risk category is high. If patient does not have CHD or a CHD risk equivalent, consider use of the Pooled Cohort Equations to estimate 10-year CVD risk, as individuals with greater than 7.5% risk may warrant more intensive therapy. The calculator can be found at: http://tools.cardiosource.org/ASCVD-Risk-Estimator/

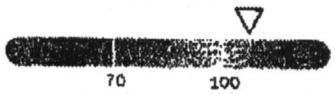
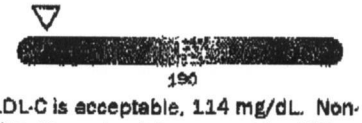
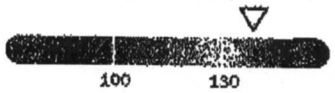
Insulin resistance, obesity, excessive alcohol use, smoking, nephrotic syndrome, liver disease, and certain medications can cause secondary dyslipidemia. Consider evaluation if clinically indicated.

Patient was not fasting, interpret assessment and treatment suggestions with caution. Therapeutic lifestyle changes are always valuable to achieve optimal blood lipid status (diet, exercise, weight management).

Lipid Management

Select one patient risk category based upon medical history and clinical judgment. Additional risk factors such as personal or family history of premature CHD, smoking, and hypertension modify a patient's goals of therapy. In CVD prevention, the intensity of therapy should be adjusted to the level of patient risk. MODERATE intensity statin therapy generally results in an average LDL-C reduction of 30% to less than 50% from the untreated baseline. Examples include (daily doses): atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg. HIGH intensity statin therapy generally results in an average LDL-C reduction of 50% or more from the untreated baseline. Examples include (daily doses): atorvastatin 40-80 mg and rosuvastatin 20 mg.

▽ = PATIENT'S RESULT

ANALYTE / RESULT	Patient Risk Category (select one)		
	LOW	**INTERMEDIATE**	**HIGH**
LDL-C **114 mg/dL**			
non-HDL **153 mg/dL**			
Lipid Assessment	LDL-C is acceptable, 114 mg/dL. Non-HDL Cholesterol is acceptable, 153 mg/dL.	LDL-C is acceptable, 114 mg/dL. Non-HDL Cholesterol is acceptable, 153 mg/dL.	LDL-C is borderline high, 114 mg/dL. Non-HDL Cholesterol is borderline high, 153 mg/dL.
Treatment Suggestions	Considerations for use of statin therapy include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated 10-year CVD risk. Blood was non-fasting; non-fasting may contribute to hypertriglyceridemia. Triglycerides should only be measured in a fasting state.	Consider measurement of LDL particle number or Apo B to adjudicate need for further LDL lowering therapy. Consider beginning or increasing statin. Factors that may influence statin use include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated 10-year CVD risk. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant), niacin, and/or fish oil.	Begin statin. If statin already in use, consider increasing dose to achieve at least a 50% LDL reduction from baseline. Moderate or high intensity statin is preferred. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant), niacin, and/or fish oil.

Patient Results Summary

Cholesterol comes in different forms and has varying effects on your heart health. Some cholesterol is "good" and not known to cause disease, this is HDL. The rest of cholesterol causes disease by clogging your arteries, this is non-HDL. LDL cholesterol is the largest component of the non-HDL cholesterol. Lowering your levels of "bad" cholesterol will lower your risk for disease.

- **LDL cholesterol (LDL-C)** is the largest component of the non-HDL cholesterol ("bad" cholesterol).
- **non-HDL** is composed of many different types of cholesterol (not just LDL-C) and high levels cause disease.

The level to which your LDL must be lowered depends on the risk for developing heart disease or having a heart attack. The higher your risk for heart disease, the lower your LDL goal.

Contributing Risk Factors For Heart Disease

- ☐ Heart and/or vascular disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Chronic kidney disease
- ☐ Obesity
- ☐ Cigarette (tobacco) smoking
- ☐ Low HDL (men less than 40 mg/dL, women less than 50 mg/dL)
- ☐ Family history of early onset heart disease
- ☐ Man over 45 years or woman over 55 years
- ☐ Familial Hypercholesterolemia

Your Goal (As selected by your physician based upon your risk factors and clinical judgement)

Test / Your Results	☐ Low	☐ Intermediate	☐ High
LDL-C **114 mg/dL**	<160	100 - 130	70 - 100
non-HDL **153 mg/dL**	<190	130 - 160	100 - 130

▽ = Your Result: Left (Green) = Optimal, Center = Acceptable, Right (Red) = High Risk

Your Care Plan (As selected by your physician)

- ☐ Eat less trans fats and saturated fats, red meat, and sugary foods/drinks
- ☐ Eat more vegetables, fruits, whole grains, low-fat dairy products, poultry, fish, and nuts
- ☐ Exercise
- ☐ Lose weight
- ☐ Control any other medical conditions: such as diabetes, high blood pressure
- ☐ Visit your doctor as scheduled and obtain all follow-up tests/treatments recommended
- ☐ Take all of your medications your doctor(s) have prescribed
- ☐

DISCLAIMER: You should discuss this information with your physician. Litholink does not have a doctor-patient relationship with you, nor does it have access to a complete medical history or a physical examination that would be necessary for a complete diagnosis and comprehensive treatment plan. Neither you nor your physician should rely solely on this guidance. REFERENCES: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002, NIH publication 02-5215). National Heart, Lung, and Blood Institute's Your Guide to Lowering Your Cholesterol with TLC (2005 NIH publication 06-5235); Stone NJ et al 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013; 00:000-000.

LabCorp

Patient Report

Specimen ID: 032-494-3432-0
Control ID: 60034116066

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Patient Details
DOB: 02/11/1955
Age(y/m/d): 062/11/21
Gender: F SSN:
Patient ID:

Specimen Details
Date collected: 02/01/2018 1239 Local
Date received: 02/01/2018
Date entered: 02/01/2018
Date reported: 02/02/2018 1111 ET

Physician Details
Ordering: S MOISEYEV
Referring:
ID:
NPI: 1932568284

General Comments & Additional Information
Total Volume: Not Provided

Fasting: Yes

Ordered Items
CBC/Diff Ambiguous Default; Comp. Metabolic Panel (14); Lipid Panel; PT and PTT; Hemoglobin A1c; TSH; RPR; Ambig Abbrev
CMP14 Default; Ambig Abbrev LP Default; Venipuncture; Non LCA Req

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC/Diff Ambiguous Default					
WBC	6.7		x10E3/uL	3.4 - 10.8	01
RBC	4.53		x10E6/uL	3.77 - 5.28	01
Hemoglobin	14.5		g/dL	11.1 - 15.9	01
Hematocrit	43.5		%	34.0 - 46.6	01
MCV	96		fL	79 - 97	01
MCH	32.0		pg	26.6 - 33.0	01
MCHC	33.3		g/dL	31.5 - 35.7	01
RDW	13.1		%	12.3 - 15.4	01
Platelets	216		x10E3/uL	150 - 379	01
Neutrophils	56		%	Not Estab.	01
Lymphs	38		%	Not Estab.	01
Monocytes	4		%	Not Estab.	01
Eos	2		%	Not Estab.	01
Basos	0		%	Not Estab.	01
Neutrophils (Absolute)	3.7		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	2.5		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.3		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%	Not Estab.	01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have assigned CBC with Differential/Platelet, Test Code #005009 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/ Technical Services Department to clarify the test order. We appreciate your business.

Comp. Metabolic Panel (14)

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID:
Control ID: 60034116066
Specimen ID: 032-494-3432-0
Date collected: 02/01/2018 1239 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Glucose, Serum	84		mg/dL	65 - 99	01
BUN	7	Low	mg/dL	8 - 27	01
Creatinine, Serum	0.60		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	98		mL/min/1.73	>59	
eGFR If Africn Am	113		mL/min/1.73	>59	
BUN/Creatinine Ratio	12			12 - 28	
Sodium, Serum	144		mmol/L	134 - 144	01
Potassium, Serum	3.8		mmol/L	3.5 - 5.2	01
Chloride, Serum	105		mmol/L	96 - 106	01
Carbon Dioxide, Total	24		mmol/L	18 - 29	01
Calcium, Serum	9.9		mg/dL	8.7 - 10.3	01
Protein, Total, Serum	6.7		g/dL	6.0 - 8.5	01
Albumin, Serum	4.3		g/dL	3.6 - 4.8	01
Globulin, Total	2.4		g/dL	1.5 - 4.5	
A/G Ratio	1.8			1.2 - 2.2	
Bilirubin, Total	0.6		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase, S	86		IU/L	39 - 117	01
AST (SGOT)	15		IU/L	0 - 40	01
ALT (SGPT)	9		IU/L	0 - 32	01
Lipid Panel					
Cholesterol, Total	151		mg/dL	100 - 199	01
Triglycerides	72		mg/dL	0 - 149	01
HDL Cholesterol	50		mg/dL	>39	01
VLDL Cholesterol Cal	14		mg/dL	5 - 40	
LDL Cholesterol Calc	87		mg/dL	0 - 99	
PT and PTT					
INR	1.1			0.8 - 1.2	01
Reference interval is for non-anticoagulated patients. Suggested INR therapeutic range for Vitamin K antagonist therapy:					
Standard Dose (moderate intensity therapeutic range):				2.0 - 3.0	
Higher intensity therapeutic range				2.5 - 3.5	
Prothrombin Time	10.7		sec	9.1 - 12.0	01
aPTT	29		sec	24 - 33	01
This test has not been validated for monitoring unfractionated heparin therapy. aPTT-based therapeutic ranges for unfractionated heparin therapy have not been established. For general guidelines on Heparin monitoring, refer to the LabCorp Directory of Services.					
Hemoglobin A1c					
Hemoglobin A1c	5.1		%	4.8 - 5.6	01
Please Note:					01

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID:
Control ID: 60034116066
Specimen ID: 032-494-3432-0
Date collected: 02/01/2018 1239 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
	Pre-diabetes: 5.7 - 6.4 Diabetes: >6.4 Glycemic control for adults with diabetes: <7.0				
TSH	4.280		uIU/mL	0.450 - 4.500	01
RPR	Non Reactive			Non Reactive	01

Ambig Abbrev CMP14 Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA
92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

LabCorp

Patient Report

Specimen ID: 133-229-5507-0
Control ID: 855793

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/03/02
Gender: F SSN:
Patient ID: 50469

Specimen Details
Date collected: 05/13/2019 0000 Local
Date received: 05/14/2019
Date entered: 05/14/2019
Date reported: 05/14/2019 1608 ET

Physician Details
Ordering: S MOISEYEV
Referring:
ID:
NPI: 1932568284

Ordered Items
CBC With Differential/Platelet; Comp. Metabolic Panel (14); Lipid Panel; Hgb A1c with eAG Estimation; TSH; Ambig Abbrev CMP14 Default; Ambig Abbrev LP Default

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	7.7		x10E3/uL	3.4 - 10.8	01
RBC	4.18		x10E6/uL	3.77 - 5.28	01
Hemoglobin	12.8		g/dL	11.1 - 15.9	01
Hematocrit	39.3		%	34.0 - 46.6	01
MCV	94		fL	79 - 97	01
MCH	30.6		pg	26.6 - 33.0	01
MCHC	32.6		g/dL	31.5 - 35.7	01
RDW	13.5		%	12.3 - 15.4	01
Platelets	233		x10E3/uL	150 - 379	01
	Effective May 20, 2019 the reference interval for Platelets will be changing to:				
	0 - 7 d			140 - 396 x10E3/uL	
	8 - 30 d			139 - 531 x10E3/uL	
	31 d - 999 yrs			150 - 450 x10E3/uL	
Neutrophils	50		%	Not Estab.	01
Lymphs	40		%	Not Estab.	01
Monocytes	6		%	Not Estab.	01
Eos	4		%	Not Estab.	01
Basos	0		%	Not Estab.	01
Neutrophils (Absolute)	3.9		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	3.1		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.5		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.3		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%	Not Estab.	01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
Comp. Metabolic Panel (14)					
Glucose	95		mg/dL	65 - 99	01
BUN	13		mg/dL	8 - 27	01
Creatinine	0.69		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	92		mL/min/1.73	>59	

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469
Control ID: 855793
Specimen ID: 133-229-5507-0
Date collected: 05/13/2019 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
eGFR If Africn Am	106		mL/min/1.73	>59	
BUN/Creatinine Ratio	19			12 - 28	
Sodium	144		mmol/L	134 - 144	01
Potassium	4.1		mmol/L	3.5 - 5.2	01
Chloride	108	High	mmol/L	96 - 106	01
Carbon Dioxide, Total	24		mmol/L	20 - 29	01
Calcium	10.0		mg/dL	8.7 - 10.3	01
Protein, Total	6.6		g/dL	6.0 - 8.5	01
Albumin	3.8		g/dL	3.6 - 4.8	01
Globulin, Total	2.8		g/dL	1.5 - 4.5	
A/G Ratio	1.4			1.2 - 2.2	
Bilirubin, Total	0.3		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase	94		IU/L	39 - 117	01
AST (SGOT)	12		IU/L	0 - 40	01
ALT (SGPT)	9		IU/L	0 - 32	01
Lipid Panel					
Cholesterol, Total	165		mg/dL	100 - 199	01
Triglycerides	91		mg/dL	0 - 149	01
HDL Cholesterol	42		mg/dL	>39	01
VLDL Cholesterol Cal	18		mg/dL	5 - 40	
LDL Cholesterol Calc	105	High	mg/dL	0 - 99	
Hgb A1c with eAG Estimation					
Hemoglobin A1c	5.1		%	4.8 - 5.6	01
Please Note:					01
Prediabetes: 5.7 - 6.4					
Diabetes: >6.4					
Glycemic control for adults with diabetes: <7.0					
Estim. Avg Glu (eAG)	100		mg/dL		
TSH	4.930	High	uIU/mL	0.450 - 4.500	01
Ambig Abbrev CMP14 Default					01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 855793
Specimen ID: 133-229-5507-0
Date collected: 05/13/2019 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA
92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

LabCorp

Patient Report

Specimen ID: 175-494-6680-0
Control ID: 60034138082

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/04/13
Gender: F SSN:
Patient ID:

Specimen Details
Date collected: 06/24/2019 1416 Local
Date received: 06/24/2019
Date entered: 06/24/2019
Date reported: 06/25/2019 1106 ET

Physician Details
Ordering: S MOISEYEV
Referring:
ID:
NPI: 1932568284

General Comments & Additional Information
Total Volume: Not Provided

Fasting: Yes

Ordered Items
TSH+Free T4; Triiodothyronine (T3); Venipuncture; Non LCA Req

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
TSH+Free T4					
TSH	5.820	High	uIU/mL	0.450 - 4.500	01
T4, Free (Direct)	1.19		ng/dL	0.82 - 1.77	01
Triiodothyronine (T3)	106		ng/dL	71 - 180	01

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA
92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Date Issued: 06/25/19 1109 ET

FINAL REPORT

LabCorp

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Specimen Number	Patient ID	Control Number	Account Number	Account Phone Number	Route
214-229-4303-0			04267185	323-732-0100	00

Patient Last Name: ROQUEMORE
Patient First Name: SANDRA
Patient Middle Name:
Patient SS#:
Patient Phone: 323-643-4539
Total Volume:
Age (Y/M/D): 61/05/17
Date of Birth: 02/11/55
Sex: F
Fasting:

Patient Address:
1763 EXPOSTION BLVD
LOS ANGELES CA 90018

Account Address:
Omid Nassium MD

3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Additional Information:

Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID
07/28/16 00:00	08/02/16	08/03/16 19:13ET	JAVDAN , R	1578824256	

Tests Ordered:
CBC/Diff Ambiguous Default; Comp. Metabolic Panel (14); Lipid Panel; Cardiovascular Report; TSH; Ambig Abbrev CMP14 Default; Ambig Abbrev LP Default; Request Problem

General Comments:
Test(s) Neutrophils (Absolute) called to Maria H MA on 08/02/2016 at 15:21 EST

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC/Diff Ambiguous Default					
WBC	***1.4***	***Alert***	x10E3/uL	3.4 - 10.8	01
RBC	4.92		x10E6/uL	3.77 - 5.28	01
Hemoglobin	**16.6**	**High**	g/dL	11.1 - 15.9	01
Hematocrit	**50.8**	**High**	%	34.0 - 46.6	01
MCV	**103**	**High**	fL	79 - 97	01
MCH	**33.7**	**High**	pg	26.6 - 33.0	01
MCHC	32.7		g/dL	31.5 - 35.7	01
RDW	13.4		%	12.3 - 15.4	01
Platelets	**146**	**Low**	x10E3/uL	150 - 379	01
Neutrophils	2		%		01
Lymphs	68		%		01
Monocytes	23		%		01
Eos	6		%		01
Basos	1		%		01
Neutrophils (Absolute)	***0.0***	***Critical***	x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	1.0		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.3		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
NRBC	0		%	0 - 0	01
Hematology Comments:	Note:				01

Verified by microscopic examination.
A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have assigned CBC with Differential/Platelet, Test Code #005009 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/ Technical Services Department to clarify the test order. We

Mr call pt for appt · 8/4/16 ab

Patient Name					Specimen Number		
ROQUEMORE, SANDRA					214-229-4303-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
04267185			07/28/16 00:00	08/03/16	F	61/05/17	02/11/55

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

appreciate your business.

Comp. Metabolic Panel (14) 01
Glucose, Serum
Testing not performed due to the age of this specimen.

Lipid Panel 01
Cholesterol, Total
Testing not performed due to the age of this specimen.

Cardiovascular Report 02
Interpretation
Note
Medical Director's Note: A CV Risk Assessment Report was not sent because both LDL cholesterol and non-HDL cholesterol results are required to generate a report.
Supplement report is available.

PDF Image 02

TSH 4.250 uIU/mL 0.450 - 4.500 01

Ambig Abbrev CMP14 Default 01
A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01
A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Request Problem 01
Testing not performed due to the age of this specimen.
TEST: 322000 Comp. Metabolic Panel (14)
303756 Lipid Panel

LabCorp
Laboratory Corporation of America

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108

Phone: 858-668-3700

Patient Name					Specimen Number		
ROQUEMORE, SANDRA					214-229-4303-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
04267185			07/28/16 00:00	08/03/16	F	61/05/17	02/11/55

01	SO	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Qinghong Yang, MDPhD
02	LITIL	Litholink Corporation 2250 West Campbell Park Drive, Chicago, IL 60612-3502	Dir: Mitchell Laks, PhD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Accessions: 21422943030

DISCLAIMER. *These assessments and treatment suggestions are provided as a convenience in support of the physician-patient relationship and are not intended to replace the physician's clinical judgment. They are derived from the national guidelines in addition to other evidence and expert opinion. The clinician should consider this information within the context of clinical opinion and the individual patient*
SEE GUIDANCE FOR CARDIOVASCULAR REPORT: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002. NIH publication 02-5215): Brunzell et al Diabetes Care 2008; 31(4):811-82, Contois et al Clin Chem 2009, 55(3):407-419: Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;129(suppl 2):S1-S45.

Note. *Please refer to your LabCorp Report for all results as well as any test-specific and specimen-specific comments.*

Laboratory Director's Notes

Laboratory test values flagged with an asterisk (*) within this report refer to the following commentary from our physicians and quality assurance staff.

COLLECTION DATE	ITEM	RELATED NOTES
07/28/2016		A CV Risk Assessment Report was not sent because both LDL cholesterol and non-HDL cholesterol results are required to generate a report.
07/28/2016	**Anion Gap**	Unable to perform calculation - at least one of the variables is non-numeric.
07/28/2016	**non-HDL cholesterol**	Unable to perform calculation - at least one of the variables is non-numeric.

Mitchell S. Laks, PhD - Laboratory Director

LabCorp

Patient Report

Specimen ID: 204-229-6849-0
Control ID: 670589

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

ROQUEMORE, SANDRA

(323) 643-4539

Patient Details
DOB: 02/11/1955
Age(y/m/d): 063/05/12
Gender: F SSN:
Patient ID: 50469

Specimen Details
Date collected: 07/23/2018 0000 Local
Date received: 07/24/2018
Date entered: 07/24/2018
Date reported: 07/25/2018 0310 ET

Physician Details
Ordering: S MOISEYEV
Referring:
ID:
NPI: 1932568284

General Comments & Additional Information
Total Volume: Not Provided

Fasting: No

Ordered Items
Panel 083935; RPR

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Panel 083935					
HIV Screen 4th Generation wRfx	Non Reactive			Non Reactive	01
RPR	Non Reactive			Non Reactive	01

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA
92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Date Issued: 07/25/18 0310 ET

FINAL REPORT

LabCorp

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Specimen Number	Patient ID	Control Number	Account Number	Account Phone Number	Route
214-229-4303-0			04267185	323-732-0100	00

Patient Last Name	Patient First Name	Patient Middle Name	Patient SS#	Patient Phone	Total Volume	Age (Y/M/D)	Date of Birth	Sex	Fasting
ROQUEMORE	SANDRA			323-643-4539		61/05/17	02/11/55	F	

Account Address
Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Address

Additional Information
UPIN: A26005

Date and Time Collected	Date Entered	Date and Time Reported	Physician Name	NPI	Physician ID
07/28/16 00:00	08/02/16	08/02/16 15:17ET	JAVDAN, R	1093878258	

Tests Ordered
CBC/Diff Ambiguous Default; Comp. Metabolic Panel (14); Lipid Panel; TSH; Ambig Abbrev CMP14 Default; Ambig Abbrev LP Default; Cardiovascular Report

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC/Diff Ambiguous Default					
WBC	***1.4***	***Alert***	x10E3/uL	3.4 - 10.8	01
RBC	4.92		x10E6/uL	3.77 - 5.28	01
Hemoglobin	**16.6**	**High**	g/dL	11.1 - 15.9	01
Hematocrit	**50.8**	**High**	%	34.0 - 46.6	01
MCV	**103**	**High**	fL	79 - 97	01
MCH	**33.7**	**High**	pg	26.6 - 33.0	01
MCHC	32.7		g/dL	31.5 - 35.7	01
RDW	13.4		%	12.3 - 15.4	01
Platelets	**146**	**Low**	x10E3/uL	150 - 379	01
Neutrophils	2		%		01
Lymphs	68		%		01
Monocytes	23		%		01
Eos	6		%		01
Basos	1		%		01
Neutrophils (Absolute)	***0.0***	***Critical***	x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	1.0		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.3		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.1		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
NRBC	0		%	0 - 0	01
Hematology Comments:	Note:				01

Verified by microscopic examination.
A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have assigned CBC with Differential/Platelet, Test Code #005009 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/ Technical Services Department to clarify the test order. We appreciate your business.

LabCorp

LabCorp San Diego
13112 Evening Creek Dr So Ste 200
San Diego, CA 92128-4108
Phone: 858-668-3700

Patient Name					Specimen Number		
ROQUEMORE, SANDRA					214-229-4303-0		
Account Number	Patient ID	Control Number	Date and Time Collected	Date Reported	Sex	Age(Y/M/D)	Date of Birth
04267185			07/28/16 00:00	08/02/16	F	61/05/17	02/11/55

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Comp. Metabolic Panel (14)	Will Follow				
Lipid Panel	Will Follow				
TSH	4.250		uIU/mL	0.450 - 4.500	01

Ambig Abbrev CMP14 Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Cardiovascular Report

Interpretation	Will Follow	02
PDF Image	Will Follow	02

01	SO	LabCorp San Diego Dir: Qinghong Yang, MDPhD 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108
02	LITIL	Litholink Corporation Dir: Mitchell Laks, PhD 2250 West Campbell Park Drive, Chicago, IL 60612-3502

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

LabCorp
Laboratory Corporation of America

Patient Report

Specimen ID: 231-544-8396-0
Control ID: 60034191114

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 061/06/07
Gender: F SSN:
Patient ID:

Specimen Details
Date collected: 08/18/2016 1035 Local
Date entered: 08/18/2016
Date reported: 08/19/2016 1009 Local

Physician Details
Ordering: O NASSIM
Referring:
ID:
NPI: 1760466270

General Comments & Additional Information
Total Volume: Not Provided

Fasting: Yes

Ordered Items
CBC/Diff Ambiguous Default; Comp. Metabolic Panel (14); Lipid Panel; Hemoglobin A1c; TSH; Ambig Abbrev CMP14 Default; Ambig Abbrev LP Default; Venipuncture; Non LCA Req

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC/Diff Ambiguous Default					
WBC	6.9		x10E3/uL	3.4 - 10.8	01
RBC	4.48		x10E6/uL	3.77 - 5.28	01
Hemoglobin	15.5		g/dL	11.1 - 15.9	01
Hematocrit	45.9		%	34.0 - 46.6	01
MCV	**103**	**High**	fL	79 - 97	01
MCH	**34.6**	**High**	pg	26.6 - 33.0	01
MCHC	33.8		g/dL	31.5 - 35.7	01
RDW	13.1		%	12.3 - 15.4	01
Platelets	236		x10E3/uL	150 - 379	01
Neutrophils	54		%		01
Lymphs	37		%		01
Monocytes	5		%		01
Eos	4		%		01
Basos	0		%		01
Neutrophils (Absolute)	3.8		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	2.5		x10E3/uL	0.7 - 3.1	01
Monocytes (Absolute)	0.3		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01

Call PT

5 M

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have assigned CBC with Differential/Platelet, Test Code #005009 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/ Technical Services Department to clarify the test order. We appreciate your business.

Comp. Metabolic Panel (14)

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID:
Control ID: 60034191114
Specimen ID: 231-544-8396-0
Date collected: 08/18/2016 1035 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Glucose, Serum	92		mg/dL	65 - 99	01
BUN	9		mg/dL	8 - 27	01
Creatinine, Serum	0.78		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	82		mL/min/1.73	>59	
eGFR If Africn Am	95		mL/min/1.73	>59	
BUN/Creatinine Ratio	12			11 - 26	
Sodium, Serum	143		mmol/L	134 - 144	01
Potassium, Serum	**5.5**	**High**	mmol/L	3.5 - 5.2	01
Chloride, Serum	101		mmol/L	97 - 108	01
Carbon Dioxide, Total	24		mmol/L	18 - 29	01
Calcium, Serum	**11.1**	**High**	mg/dL	8.7 - 10.3	01
****Verified by repeat analysis****					
Protein, Total, Serum	6.6		g/dL	6.0 - 8.5	01
Albumin, Serum	4.2		g/dL	3.6 - 4.8	01
Globulin, Total	2.4		g/dL	1.5 - 4.5	
A/G Ratio	1.8			1.1 - 2.5	
Bilirubin, Total	0.6		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase, S	78		IU/L	39 - 117	01
AST (SGOT)	16		IU/L	0 - 40	01
ALT (SGPT)	12		IU/L	0 - 32	01
Lipid Panel					
Cholesterol, Total	**212**	**High**	mg/dL	100 - 199	01
Triglycerides	**166**	**High**	mg/dL	0 - 149	01
HDL Cholesterol	41		mg/dL	>39	01
Comment					01
According to ATP-III Guidelines, HDL-C >59 mg/dL is considered a negative risk factor for CHD.					
VLDL Cholesterol Cal	33		mg/dL	5 - 40	
LDL Cholesterol Calc	**138**	**High**	mg/dL	0 - 99	
Hemoglobin A1c					
Hemoglobin A1c	5.4		%	4.8 - 5.6	01
Please Note:					01
Pre-diabetes: 5.7 - 6.4					
Diabetes: >6.4					
Glycemic control for adults with diabetes: <7.0					
TSH	4.390		uIU/mL	0.450 - 4.500	01
Ambig Abbrev CMP14 Default					01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID:
Control ID: 60034191114
Specimen ID: 231-544-8396-0
Date collected: 08/18/2016 1035 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

01	SO	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Qinghong Yang, MD PhD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-868-3700

LabCorp

Patient Report

Specimen ID: 249-494-0003-0
Control ID: 899368

Acct #: 04266725 Phone: (323) 734-1600 Rte: 00

ROQUEMORE, SANDRA A.
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 529-7546

Benevolence Health Center
3533 W Pico Blvd
LOS ANGELES CA 90019

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/06/26
Gender: F SSN:
Patient ID: 50469

Specimen Details
Date collected: 09/06/2019 1016 Local
Date received: 09/06/2019
Date entered: 09/06/2019
Date reported: 09/10/2019 2005 ET

Physician Details
Ordering: S TEBI
Referring:
ID:
NPI: 1437380789

General Comments & Additional Information
Alternate Control Number: 899368
Total Volume: Not Provided

Alternate Patient ID: Not Provided
Fasting: No

Ordered Items
TSH+Free T4; Thyroglobulin Antibody; Thyroid Peroxidase (TPO) Ab; Venipuncture

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
TSH+Free T4					
TSH-ICMA	4.7		uU/mL		01
Reference Range: Pubertal Children and Adults: 0.5 - 4.8 Pregnancy First Trimester 0.100-4.000 Second Trimester 0.200-4.000 Third Trimester 0.300-4.500 Non-Pregnant Adult 0.450-4.500					
Free T4 by Dialysis/Mass Spec	1.3		ng/dL		01
Reference Range: Pubertal Children and Adults: 0.8 - 1.7					
Thyroglobulin Antibody	<1.0		IU/mL	0.0 - 0.9	02
Thyroglobulin Antibody measured by Beckman Coulter Methodology					
Thyroid Peroxidase (TPO) Ab	14		IU/mL	0 - 34	02

01	ES	Esoterix Inc 4301 Lost Hills Road, Calabasas Hills, CA 91301-5368	Dir: Samuel Pepkowitz, MD
02	SO	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Data Issued: 09/10/19 2006 ET

FINAL REPORT

LabCorp — Patient Report

Specimen ID: 238-229-1162-0
Control ID: 497812

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 062/06/15
Gender: F SSN:
Patient ID: 50469

Specimen Details
Date collected: 08/26/2017 0000 Local
Date received: 08/27/2017
Date entered: 08/27/2017
Date reported: 08/29/2017 1220 ET

Physician Details
Ordering: S MOISEYEV
Referring:
ID:
NPI: 1932568284

General Comments & Additional Information
Total Volume: Not Provided
Fasting: No

Ordered Items
CBC With Differential/Platelet; Comp. Metabolic Panel (14); Lipid Panel; Hgb A1c with eAG Estimation; TSH; Calcitriol(1,25 di-OH Vit D); Ambig Abbrev CMP14 Default; Ambig Abbrev LP Default; Cardiovascular Report

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	7.6		x10E3/uL	3.4 - 10.8	01
RBC	4.22		x10E6/uL	3.77 - 5.28	01
Hemoglobin	13.8		g/dL	11.1 - 15.9	01
Hematocrit	42.3		%	34.0 - 46.6	01
MCV	100	High	fL	79 - 97	01
MCH	32.7		pg	26.6 - 33.0	01
MCHC	32.6		g/dL	31.5 - 35.7	01
RDW	12.8		%	12.3 - 15.4	01
Platelets	245		x10E3/uL	150 - 379	01
Neutrophils	52		%		01
Lymphs	39		%		01
Monocytes	6		%		01
Eos	3		%		01
Basos	0		%		01
Neutrophils (Absolute)	3.9		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	3.0		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.4		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%		01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
Comp. Metabolic Panel (14)					
Glucose, Serum	92		mg/dL	65 - 99	01
BUN	9		mg/dL	8 - 27	01
Creatinine, Serum	0.63		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	96		mL/min/1.73	>59	
eGFR If Africn Am	111		mL/min/1.73	>59	
BUN/Creatinine Ratio	14			12 - 28	

call pt 8 30 2017

Date Issued: 08/29/17 1220 ET — FINAL REPORT — Page 1 of 3

1 — 5

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 497812
Specimen ID: 238-229-1162-0
Date collected: 08/26/2017 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Sodium, Serum	142		mmol/L	134 - 144	01
Potassium, Serum	3.8		mmol/L	3.5 - 5.2	01
Chloride, Serum	104		mmol/L	96 - 106	01
Carbon Dioxide, Total	26		mmol/L	18 - 29	01
Calcium, Serum	9.8		mg/dL	8.7 - 10.3	01
Protein, Total, Serum	6.8		g/dL	6.0 - 8.5	01
Albumin, Serum	4.2		g/dL	3.6 - 4.8	01
Globulin, Total	2.6		g/dL	1.5 - 4.5	
A/G Ratio	1.6			1.2 - 2.2	
Bilirubin, Total	0.7		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase, S	80		IU/L	39 - 117	01
AST (SGOT)	9		IU/L	0 - 40	01
ALT (SGPT)	9		IU/L	0 - 32	01
Lipid Panel					
Cholesterol, Total	179		mg/dL	100 - 199	01
Triglycerides	130		mg/dL	0 - 149	01
HDL Cholesterol	50		mg/dL	>39	01
VLDL Cholesterol Cal	26		mg/dL	5 - 40	
LDL Cholesterol Calc	103	High	mg/dL	0 - 99	
Hgb A1c with eAG Estimation					
Hemoglobin A1c	4.8		%	4.8 - 5.6	01
Please Note: Pre-diabetes: 5.7 - 6.4 Diabetes: >6.4 Glycemic control for adults with diabetes: <7.0					01
Estim. Avg Glu (eAG)	91		mg/dL		
TSH	3.790		uIU/mL	0.450 - 4.500	01
Calcitriol(1,25 di-OH Vit D)	59.7		pg/mL	19.9 - 79.3	02
Ambig Abbrev CMP14 Default					01

2

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July

Call Patient

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 497812

Specimen ID: 238-229-1162-0
Date collected: 08/26/2017 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Cardiovascular Report

Interpretation	Note	03
Supplement report is available.		
PDF Image		03

01	SD	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Jenny Galloway, MD
02	BN	LabCorp Burlington 1447 York Court, Burlington, NC 27215-3361	Dir: William F Hancock, MD
03	LITIL	Litholink Corporation 2250 West Campbell Park Drive, Chicago, IL 60612-3502	Dir: Mitchell Laks, PhD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Accessions: 23822911620

DISCLAIMER: *These assessments and treatment suggestions are provided as a convenience in support of the physician-patient relationship and are not intended to replace the physician's clinical judgment. They are derived from the national guidelines in addition to other evidence and expert opinion. The clinician should consider this information within the context of clinical opinion and the individual patient.*
SEE GUIDANCE FOR CARDIOVASCULAR REPORT: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002. NIH publication 02-5215); Brunzell et al. Diabetes Care 2008; 31(4):811-82; Contois et al. Clin Chem 2009; 55(3):407-419; Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation 2014;129(suppl 2):S1-S45.

Note: *Please refer to your LabCorp Report for all results as well as any test-specific and specimen-specific comments.*

Cardiovascular Report

Patient Assessment

Current available clinical information suggests the patient's risk is at least LOW. One major CHD risk factor is present (age over 55). If the patient has CHD or a CHD risk equivalent, the risk category is high. If patient does not have CHD or a CHD risk equivalent, consider use of the Pooled Cohort Equations to estimate 10-year CVD risk, as individuals with greater than 7.5% risk may warrant more intensive therapy. The calculator can be found at: http://tools.cardiosource.org/ASCVD-Risk-Estimator/

Insulin resistance, obesity, excessive alcohol use, smoking, nephrotic syndrome, liver disease, and certain medications can cause secondary dyslipidemia. Consider evaluation if clinically indicated.

Patient was not fasting, interpret assessment and treatment suggestions with caution. Therapeutic lifestyle changes are always valuable to achieve optimal blood lipid status (diet, exercise, weight management).

Lipid Management

Select one patient risk category based upon medical history and clinical judgment. Additional risk factors such as personal or family history of premature CHD, smoking, and hypertension modify a patient's goals of therapy. In CVD prevention, the intensity of therapy should be adjusted to the level of patient risk. MODERATE intensity statin therapy generally results in an average LDL-C reduction of 30% to less than 50% from the untreated baseline. Examples include (daily doses): atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg. HIGH intensity statin therapy generally results in an average LDL-C reduction of 50% or more from the untreated baseline. Examples include (daily doses): atorvastatin 40-80 mg and rosuvastatin 20 mg.

▽ = PATIENT'S RESULT

	Patient Risk Category (select one)		
ANALYTE / RESULT	LOW	INTERMEDIATE	HIGH
LDL-C **103 mg/dL**	▽ 160	▽ 100 130	70 100 ▽
non-HDL **129 mg/dL**	▽ 190	▽ 130 160	100 130 ▽
Lipid Assessment	LDL-C is acceptable, was 114 and now is 103 mg/dL. Non-HDL Cholesterol is optimal, was 153 and now is 129 mg/dL.	LDL-C is acceptable, was 114 and now is 103 mg/dL. Non-HDL Cholesterol is optimal, was 153 and now is 129 mg/dL.	LDL-C is borderline high, was 114 and now is 103 mg/dL. Non-HDL Cholesterol is normal, was 153 and now is 129 mg/dL.
Treatment Suggestions	Considerations for use of statin therapy include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated 10-year CVD risk.	Consider measurement of LDL particle number or Apo B to adjudicate need for further LDL lowering therapy. Consider beginning or increasing statin. Factors that may influence statin use include family history of premature atherosclerotic disease, elevated coronary artery calcium score, ankle-brachial index < 0.9, elevated CRP, or elevated 10-year CVD risk. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.	Begin statin. If statin already in use, consider increasing dose to achieve at least a 50% LDL reduction from baseline. Moderate or high intensity statin is preferred. If statin cannot be tolerated or increased, alternatives include use of an intestinal agent (ezetimibe or bile acid sequestrant) or niacin.

Patient Results Summ[illegible]

Cholesterol comes in different forms and has varying effects on your heart health. Some cholesterol is "good" and not known to cause disease, this is HDL. The rest of cholesterol causes disease by clogging your arteries, this is non-HDL. LDL cholesterol is the largest component of the non-HDL cholesterol. Lowering your levels of "bad" cholesterol will lower your risk for disease.

- **LDL cholesterol (LDL-C)** is the largest component of the non-HDL cholesterol ("bad" cholesterol).
- **non-HDL** is composed of many different types of cholesterol (not just LDL-C) and high levels cause disease.

The level to which your LDL must be lowered depends on the risk for developing heart disease or having a heart attack. The higher your risk for heart disease, the lower your LDL goal.

Contributing Risk Factors For Heart Disease

☐ Heart and/or vascular disease	☐ Cigarette (tobacco) smoking
☐ High blood pressure	☐ Low HDL (men less than 40 mg/dL, women less than 50 mg/dL)
☐ Diabetes	☐ Family history of early onset heart disease
☐ Chronic kidney disease	☐ Man over 45 years or woman over 55 years
☐ Obesity	☐ Familial Hypercholesterolemia

Your [illegible]

Selected by your physician based upon your risk factors and clinical judgement.

Test / Your Results	☐ Low	☐ Intermediate	☐ High
LDL-C **103 mg/dL**	160	100 130	70 100
non-HDL **129 mg/dL**	190	130 160	100 130

▽ = Your Result: Left (Green) = Optimal, Center = Acceptable, Right (Red) = High Risk

Your Care Plan (as selected by your physician)

☐ Eat less trans fats and saturated fats, red meat, and sugary foods/drinks	☐ Control any other medical conditions: such as diabetes, high blood pressure
☐ Eat more vegetables, fruits, whole grains, low-fat dairy products, poultry, fish, and nuts	☐ Visit your doctor as scheduled and obtain all follow-up tests/treatments recommended
☐ Exercise	☐ Take all of your medications your doctor(s) have prescribed
☐ Lose weight	☐

DISCLAIMER: You should discuss this information with your physician. Litholink does not have a doctor-patient relationship with you, nor does it have access to a complete medical history or a physical examination that would be necessary for a complete diagnosis and comprehensive treatment plan. Neither you nor your physician should rely solely on this guidance. REFERENCES: National Heart, Lung, and Blood Institute's Third Report of the NCEP Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (ATP III) (2002, NIH publication 02-5215); National Heart, Lung, and Blood Institute's Your Guide to Lowering Your Cholesterol with TLC (2005, NIH publication 06-5235); Stone NJ et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013; 00:000-000.

LabCorp **Patient Report**

Specimen ID: 288-229-6261-0
Control ID: 863364

Acct #: 04267185 **Phone:** (323) 732-0100 **Rte:** 00

ROQUEMORE, SANDRA

(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/08/04
Gender: F **SSN:**
Patient ID: 50469

Specimen Details
Date collected: 10/15/2019 0000 Local
Date received: 10/16/2019
Date entered: 10/16/2019
Date reported: 10/16/2019 1306 ET

Physician Details
Ordering: R JAVDAN
Referring:
ID:
NPI: 1093878258

General Comments & Additional Information
Total Volume: Not Provided **Fasting:** No

Ordered Items
CBC With Differential/Platelet; Comp. Metabolic Panel (14); Ambig Abbrev CMP14 Default

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
WBC	8.4		x10E3/uL	3.4 - 10.8	01
RBC	4.58		x10E6/uL	3.77 - 5.28	01
Hemoglobin	14.0		g/dL	11.1 - 15.9	01
Hematocrit	44.4		%	34.0 - 46.6	01
MCV	97		fL	79 - 97	01
MCH	30.6		pg	26.6 - 33.0	01
MCHC	31.5		g/dL	31.5 - 35.7	01
RDW	12.7		%	12.3 - 15.4	01
Platelets	264		x10E3/uL	150 - 450	01
Neutrophils	61		%	Not Estab.	01
Lymphs	32		%	Not Estab.	01
Monocytes	5		%	Not Estab.	01
Eos	2		%	Not Estab.	01
Basos	0		%	Not Estab.	01
Neutrophils (Absolute)	5.1		x10E3/uL	1.4 - 7.0	01
Lymphs (Absolute)	2.7		x10E3/uL	0.7 - 3.1	01
Monocytes(Absolute)	0.4		x10E3/uL	0.1 - 0.9	01
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	01
Baso (Absolute)	0.0		x10E3/uL	0.0 - 0.2	01
Immature Granulocytes	0		%	Not Estab.	01
Immature Grans (Abs)	0.0		x10E3/uL	0.0 - 0.1	01
Comp. Metabolic Panel (14)					
Glucose	72		mg/dL	65 - 99	01
BUN	9		mg/dL	8 - 27	01
Creatinine	0.63		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	95		mL/min/1.73	>59	
eGFR If Africn Am	110		mL/min/1.73	>59	
BUN/Creatinine Ratio	14			12 - 28	
Sodium	144		mmol/L	134 - 144	01

Date Issued: 10/16/19 1308 ET **FINAL REPORT**

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 863364
Specimen ID: 288-229-6261-0
Date collected: 10/15/2019 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Potassium	3.9		mmol/L	3.5 - 5.2	01
Chloride	105		mmol/L	96 - 106	01
Carbon Dioxide, Total	26		mmol/L	20 - 29	01
Calcium	9.8		mg/dL	8.7 - 10.3	01
Protein, Total	6.6		g/dL	6.0 - 8.5	01
Albumin	4.3		g/dL	3.6 - 4.8	01
Globulin, Total	2.3		g/dL	1.5 - 4.5	
A/G Ratio	1.9			1.2 - 2.2	
Bilirubin, Total	0.5		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase	83		IU/L	39 - 117	01
AST (SGOT)	10		IU/L	0 - 40	01
ALT (SGPT)	6		IU/L	0 - 32	01

Ambig Abbrev CMP14 Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA
92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

LabCorp

Patient Report

Specimen ID: 304-229-4977-0
Control ID: 972884

Acct #: 04267185 Phone: (323) 732-0100 Rte: 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/08/20
Gender: F SSN:
Patient ID: 50469

Specimen Details
Date collected: 10/31/2019 0000 Local
Date received: 11/01/2019
Date entered: 11/01/2019
Date reported: 11/01/2019 1906 ET

Physician Details
Ordering: D GHODS
Referring:
ID:
NPI: 1992234199

General Comments & Additional Information
Total Volume: Not Provided

Fasting: No

Ordered Items
Comp. Metabolic Panel (14); Urinalysis, Routine; Lipid Panel; Hemoglobin A1c; Ambig Abbrev LP Default; Ambig Abbrev CMP14 Default; Urine Culture, Routine; Request Problem; Request Problem

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Comp. Metabolic Panel (14)					
Glucose	81		mg/dL	65 - 99	01
BUN	7	Low	mg/dL	8 - 27	01
Creatinine	0.62		mg/dL	0.57 - 1.00	01
eGFR If NonAfricn Am	96		mL/min/1.73	>59	
eGFR If Africn Am	110		mL/min/1.73	>59	
BUN/Creatinine Ratio	11	Low		12 - 28	
Sodium	142		mmol/L	134 - 144	01
Potassium	3.8		mmol/L	3.5 - 5.2	01
Chloride	105		mmol/L	96 - 106	01
Carbon Dioxide, Total	21		mmol/L	20 - 29	01
Calcium	10.2		mg/dL	8.7 - 10.3	01
Protein, Total	6.9		g/dL	6.0 - 8.5	01
Albumin	4.3		g/dL	3.6 - 4.8	01
Globulin, Total	2.6		g/dL	1.5 - 4.5	
A/G Ratio	1.7			1.2 - 2.2	
Bilirubin, Total	0.6		mg/dL	0.0 - 1.2	01
Alkaline Phosphatase	87		IU/L	39 - 117	01
AST (SGOT)	12		IU/L	0 - 40	01
ALT (SGPT)	<5		IU/L	0 - 32	01
Verified by repeat analysis					
Urinalysis, Routine					
Specific Gravity					
No urine specimen received. 11/01/2019-Cordova					01
Lipid Panel					
Cholesterol, Total	191		mg/dL	100 - 199	01
Triglycerides	108		mg/dL	0 - 149	01
HDL Cholesterol	44		mg/dL	>39	01

LabCorp

Patient Report

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 972884

Specimen ID: 304-229-4977-0
Date collected: 10/31/2019 0000 Local

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
VLDL Cholesterol Cal	22		mg/dL	5 - 40	
LDL Cholesterol Calc	125	High	mg/dL	0 - 99	
Hemoglobin A1c					
Hemoglobin A1c	5.2		%	4.8 - 5.6	01
Please Note:					01

Prediabetes: 5.7 - 6.4
Diabetes: >6.4
Glycemic control for adults with diabetes: <7.0

Ambig Abbrev LP Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Lipid Panel, Test Code #303756 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Ambig Abbrev CMP14 Default 01

A hand-written panel/profile was received from your office. In accordance with the LabCorp Ambiguous Test Code Policy dated July 2003, we have completed your order by using the closest currently or formerly recognized AMA panel. We have assigned Comprehensive Metabolic Panel (14), Test Code #322000 to this request. If this is not the testing you wished to receive on this specimen, please contact the LabCorp Client Inquiry/Technical Services Department to clarify the test order. We appreciate your business.

Urine Culture, Routine

No urine specimen received. **Abnormal** 01
11/01/2019-Pimentel

Request Problem

No urine specimen received. 01
TEST: 003038 Urinalysis, Routine
11/01/2019-Cordova

Request Problem

No urine specimen received. 01
TEST: 008847 Urine Culture, Routine
11/01/2019-Pimentel

01 SO LabCorp San Diego
13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108
Dir: Jenny Galloway, MD

For inquiries, the physician may contact Branch: 800-859-6046 Lab: 858-668-3700

Date Issued: 11/01/19 1906 ET **FINAL REPORT** Page 2 of 2

LabCorp **Patient Report**

Specimen ID: 315-229-4458-0
Control ID: 984998

Acct #: 04267185 **Phone:** (323) 732-0100 **Rte:** 00

ROQUEMORE, SANDRA
1763 EXPOSITION BLVD
LOS ANGELES CA 90018
(323) 643-4539

Omid Nassium MD
3631 Crenshaw Blvd Ste 109/110
LOS ANGELES CA 90016

Patient Details
DOB: 02/11/1955
Age(y/m/d): 064/09/00
Gender: F **SSN:**
Patient ID: 50469

Specimen Details
Date collected: 11/11/2019 0000 Local
Date received: 11/12/2019
Date entered: 11/12/2019
Date reported: 11/14/2019 0505 ET

Physician Details
Ordering: D GHODS
Referring:
ID:
NPI: 1992234199

General Comments & Additional Information
Total Volume: Not Provided **Fasting:** No

Ordered Items
Urinalysis, Complete; Urine Culture, Routine

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Urinalysis, Complete					
Urinalysis Gross Exam					01
Specific Gravity	1.001	Low		1.005 - 1.030	01
pH	5.5			5.0 - 7.5	01
Urine-Color	Yellow			Yellow	01
Appearance	Clear			Clear	01
WBC Esterase	Negative			Negative	01
Protein	Negative			Negative/Trace	01
Glucose	Negative			Negative	01
Ketones	Negative			Negative	01
Occult Blood	Negative			Negative	01
Bilirubin	Negative			Negative	01
Urobilinogen,Semi-Qn	0.2		mg/dL	0.2 - 1.0	01
Nitrite, Urine	Negative			Negative	01
Microscopic Examination					
Microscopic follows if indicated.					01
Microscopic Examination					
	See below:				01
WBC	0-5		/hpf	0 - 5	01
RBC	0-2		/hpf	0 - 2	01
Epithelial Cells (non renal)					
	None seen		/hpf	0 - 10	01
Bacteria	None seen			None seen/Few	01
Urine Culture, Routine					
Urine Culture, Routine					
Final report					01
Result 1					
Mixed urogenital flora					01
10,000-25,000 colony forming units per mL					

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID: 50469 Control ID: 984998
Specimen ID: 315-229-4458-0
Date collected: 11/11/2019 0000 Local

01	SO	LabCorp San Diego 13112 Evening Creek Dr So Ste 200, San Diego, CA 92128-4108	Dir: Jenny Galloway, MD

For inquiries, the physician may contact **Branch: 800-859-6046 Lab: 858-668-3700**

LabCorp

Patient Report

Specimen ID: 355-P75-0029-0
Control ID: AGL04224920

Acct #: 04224920 Phone: (310) 385-7747 Rm: 00
Beverly Tower Women's Center
Ludmila Bojman
465 N Roxbury Dr Ste 101
BEVERLY HILLS CA 90210

ROQUEMORE, SANDRA
1763 EXPOSITION
LOS ANGELES CA 90018
(323) 643-4539

Patient Details
DOB: 02/11/1955
Age(y/m/d): 061/10/09
Gender: F SSN:
Patient ID:

Specimen Details
Date collected: 12/19/2016 0040 Local
Date entered: 12/20/2016
Date reported: 00/00/0000 0000 ET

Physician Details
Ordering: L. BOJMAN
Referring:
ID:
NPI: 1922043413

Additional Information:
Clinical Info: CO-LWS201636719
UPIN: D33723

Tests Ordered:
Pathology Report

Material Submitted: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY

Diagnosis: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY:
- BENIGN BREAST TISSUE SHOWING STROMAL FIBROSIS.
- MICROCALCIFICATIONS IDENTIFIED.
- No evidence of malignancy.

COMMENT:
This case was reviewed by Dr. Yong who concurs with the above diagnosis. (HL:jv)
cc/Fax: NASSIM M.D., O.
BXR/12/20/2016

Pathologist Provided ICD Code(s): (01)
N60.21

CPT Codes: (01)
88305I

Clinician Provided ICD Code(s) & Clinical History:

Gross Description: (01)
1 Container, formalin-filled, labeled with patient identification. RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY: Multiple cores of firm tan-yellow tissue measuring from 4.3 x 0.2 to 0.2 x 0.1 cm. The specimen is filtered and submitted in 4 cassettes.
/QJA

File POST Review by Dr Nassim

(01) LCMON LabCorp Monrovia 605 East Huntington Drive Ste 209 Monrovia CA 91016-6353 Labz: 626-471-3600 Dir: Praveena Yetur, MD

For inquiries, the physician may contact the lab using the numbers indicated above.

Date Issued: 12/20/16 21:58 ET **DUPLICATE FINAL REPORT** Page 1 of 2

Patient: ROQUEMORE, SANDRA
DOB: 02/11/1955 Patient ID:
Control ID: AGL04234920
Specimen ID: 355-P75-0029-0
Date collected: 12/19/2016 0040 Local

Electronically signed by (01)
Heng Li, MD, Pathologist

LabCorp Laboratory Corporation of America

Patient Report

Specimen ID: 353-P75-0029-0
Control ID: AGL04224920

Acct #: 04224920 **Phone:** (310) 385-7747 **Rte:** 00
Beverly Tower Women's Center
Ludmila Bojman
465 N Roxbury Dr Ste 101
BEVERLY HILLS CA 90210

ROQUEMORE, SANDRA
1763 EXPOSITION
LOS ANGELES CA 90018
(323) 643-4539

Patient Details	Specimen Details	Physician Details
DOB: 02/11/1955	**Date collected:** 12/19/2016 0040 Local	**Ordering:** L BOJMAN
Age(y/m/d): 061/10/08	**Date entered:** 12/20/2016	**Referring:**
Gender: F **SSN:**	**Date reported:** 12/21/2016 0921 ET	**ID:**
Patient ID:		**NPI:** 1922043413

Additional Information:
Clinical info: CO-LWS201636719
UPIN: D33723

Tests Ordered:
Pathology Report

Clinician Provided ICD Code(s) & Clinical History:

Material Submitted: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY

Diagnosis: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY:
- BENIGN BREAST TISSUE SHOWING STROMAL FIBROSIS.
- MICROCALCIFICATIONS IDENTIFIED.
- No evidence of malignancy.

COMMENT:
This case was reviewed by Dr. Yong who concurs with the above diagnosis. (HL:jv)
cc/Fax: NASSIM M.D., O.
BXR/12/20/2016

Pathologist Provided ICD Code(s): (01)
N60.21

CPT Codes: (01)
883051

Gross Description: (01)
1 Container, formalin-filled, labeled with patient identification.
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY: Multiple cores of firm tan-yellow tissue measuring from 4.3 x 0.2 to 0.2 x 0.1 cm. The specimen is filtered and submitted in 4 cassettes.
/QJA

File - After Reffer By Dr. Nassim
A. [signature]

(01) LCMON LabCorp Monrovia	605 East Huntington Drive Ste 209	Monrovia CA 91016-6353	Lab: 626-471-3500	Dir: Praveena Yatur, MD

For inquiries, the physician may contact the lab using the numbers indicated above.

Benevolence Health Center Progress Note

Date: 03/15/17 Patient Name: Roquemore, Sandra DOB: 02/11/55

Vital Signs: BP: 112/70 P: 70 RR: 18 Temp: 98.3 HT: 64.12" WT: 125 LMP:

Chief Complaint: ① cough and congestion x 1 week. worse at night ; ② physical therapy Ref per Pain Management Allergies: NKDA O2 98% SH

CDSS:

HISTORY OF PRESENT ILLNESS:

REVIEW OF SYSTEMS (Cicle all the negatives)

NEG
- € Const: Fever chills w/ loss fatigue
- € Eyes: Pain discharge redness visual changes foreign body
- € ENT: Pain bleeding congestion sore throat dysphagia discharge
- € Resp: SOB cough sputum wheezing pain
- € CV: chest pain palpitation DOE PND Edema
- € GI: ↓ appetite pain nausea vomiting diarrhea blood constipation
- € GU: dysuria hematuria flank pain discharge bleeding
- € Gyne: LMP: ☐ NLP Normal ______ Date

NEG
- € Musc: bone/joint back pain restricted ROM
- € Integ: rash skin illness lesions erythema laceration bruising
- € Neuro: HA dizziness syncope seizure local-wealness
- € Endo: polyuria polydipsia dry-skin temp-intelorence
- € Lymp: edenopathy render nodes lymphedema
- € Psych: hallucinations depression anxiety suicidal ideation
- € Immun: urticaria rhiniria pruritus immunodeficiency
- € Others

Medications

PHYSICAL EXAMINATION

	Normal	Abnormal
Const		–
Head		–
Eyes		
ENMT		–
Neck		–
Resp		Amch [illegible]
CV		
Breast	–	mammogram was done 2 mos ago
GI	–	
GU	–	Pap smear [illegible] ☐ Pap Done
Neuro	✓	
Psych	–	
Skin	–	
Ext		
Others		lumbalgia, neck pain

LABS/TESTS: N

☐ Colonoscopy
☐ Mammogram
☐ Pap Smear

DIAGNOSIS: Asthma vs Bronchitis

- Zithromax 250 pack as directed
- ℞ Ventolin inhaler 2 Puff TID

PLAN: Pain on lower back & Neck
Physical therapy for 2 mos

Follow up: ☐ 4wks ☑ 8 wks ☐ 3 month ☐ Other

EDUCATION
- € Diet Modification: Diabetes heart dz, weight control cholesterol
- € Exercise
- € Accident prevention: Seat belt, helmet, DUI, guns
- € Guidance: Smoking Alcohol, marijuana, cocaine, sex education, goals on life

Chest X-ray 2 View

Provider Signature: [signature] Date:

Augusto A. Zablan, M.D., F.A.C.S.
DIPLOMATE AMERICAN BOARD OF SURGERY
GENERAL SURGERY

FAX# (213)413-1860

FAX COVER LETTER

Please deliver the following pages to:

ATTN:
DR. D. NASSIM
FAX#:
323)734-1666
Total # of pages including cover letter: 5
Date: 1/9/17 From: MAIRA
RE: ROQUEMORE, SANDRA
DOB: 02/11/1955

SEE ATTACHED:

- CONSULTATION REPORT FOR YOUR RECORDS

NOTE: 6 MONTH FOLLOW-UP BREAST MAMMOGRAM
OFFICE FOLLOW-UP ONLY PRN

THANK YOU.
If you have any questions or problems regarding this transmission,
Please call us as soon as possible.
Tel# (213)413-1752

AUGUSTO A. ZABLAN, M.D., F.A.C.S.

DIPLOMATE AMERICAN BOARD OF SURGERY
2105 Beverly Blvd., Suite 213
Los Angeles, CA 90057-2216
(213) 413-1752 phone
(213) 413-1860 fax

Date 1-9-2016

RE: Sandra ROQUEMORE Age (6)
Date of Examination 1-9-2016

Dear Dr. OMID Nassim MD,

Thank you for referring your patient. The following is a summary of essential findings:

History 61 year old (F) is followed up - she has indeterminate calcifications in her (R) breast upper outer quadrant. there are also benign calcifications in her (R) breast inner lower quadrant -

Physical Findings Stereotactic needle core biopsy of (R) breast of calcifications was done on 12-14-16 at beverly tower.

Diagnosis Womens center with benign findings - of stromal fibrosis, micro calcifications identified no evidence of malignancy -

Treatment or Disposition Imp: (R) breast microcalcifications benign stromal fibrosis

recommend: 6 month follow up breast mammogram bilateral consider excision

- ☐ Remarks:
- ☐ More Complete Letter to Follow
- ☐ See Attached Diagram, X-ray, Blood Test, Etc.

Signed
AUGUSTO A. ZABLAN, M.D., F.A.C.S.

LabCorp

Patient Report

Specimen ID: 355-P75-0029-0
Control ID: AGL04224920

ROQUEMORE, SANDRA
1763 EXPOSITION
LOS ANGELES CA 90018
(323) 643-4539

Acct #: 04224920 Phone: (310) 385-7747 Rte: 00
Beverly Tower Women's Center
Ludmila Bojman
465 N Roxbury Dr Ste 101
BEVERLY HILLS CA 90210

Patient Details
DOB: 02/11/1955
Age(y/m/d): 061/10/08
Gender: F SSN:
Patient ID:

Specimen Details
Date collected: 12/19/2016 0040 Loca
Date entered: 12/20/2016
Date reported: 12/21/2016 0921 ET

Physician Details
Ordering: L BOJMAN
Referring:
ID:
NPI: 1922043413

Additional Information:
Clinical Info: CO-LWS201636719
UPIN: D33723

Tests Ordered:
Pathology Report

Clinician Provided ICD Code(s) & Clinical History:

Material Submitted: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY

Gross Description: (01)
1 Container, formalin-filled, labeled with patient identification. RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY: Multiple cores of firm tan-yellow tissue measuring from 4.3 x 0.2 to 0.2 x 0.1 cm. The specimen is filtered and submitted in 4 cassettes
/GAA

Diagnosis: (01)
RIGHT BREAST WITH CALCIFICATIONS, STEREOTACTIC BIOPSY:
- BENIGN BREAST TISSUE SHOWING STROMAL FIBROSIS.
- MICROCALCIFICATIONS IDENTIFIED.
- No evidence of malignancy.

COMMENT:
This case was reviewed by Dr. Yong who concurs with the above diagnosis. (HL;jv)
cc/Fax: NASSIM M.D., O.
BXR/12/20/2016

Pathologist Provided ICD Code(s): (01)
N60.21

CPT Codes: (01)
88305-1

1/11/17

(01) LQMON LabCorp Monrovia 605 East Huntington Drive Ste 209 Monrovia CA 91016-6353 Lab: 626-471-9500 Dr. Praveena Yalla, MD

For inquiries, the physician may contact the lab using the numbers indicated above.

Date Issued: 12/21/16 0921 ET **FINAL REPORT** Page 1 of 2

Beverly Tower
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Fax: (310) 385-9144

ROQUEMORE, SANDRA
MRN: 1355036BR1
DOB: 02-11-1955 Sex: F
Phone:(323) 643-4539

Date of Service: 12-19-2016

Ordered By

OMID NASSIM, MD
3533 W PICO BLVD
LOS ANGELES CA, 90019

FAX: (562) 491-1200

Addendum 1

ADDENDUM

The results of the biopsy demonstrate presence of benign breast tissue with the associated calcifications. There is no evidence of malignancy.

End of addendum for accession: 8668377
Dictated: 12-21-2016 10:13:25 AM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 12-21-2016 10:13:25 AM

Original Report

EXAM: MAMMOGRAPHY RIGHT STEREOTACTIC BIOPSY, 1 LOCATION

HISTORY: Right breast calcifications

PROCEDURE: The risks and complications of the procedure, including infection, bleeding, organ injury and nondiagnostic biopsy were explained to the patient. She understood the risks and complications and signed an informed consent form.

The skin was then cleaned and prepped in a sterile manner and 1% lidocaine was used for local anesthetic. A vacuum-assisted 9-gauge Eviva needle was used. 10 core biopsies were obtained without immediate complications. A specimen radiograph was obtained and demonstrated adequate sampling of the calcifications. The specimens were then sent to the laboratory for further analysis. The patient was given appropriate post-biopsy instructions and left the department in the same stable condition.

A clip was deployed following the biopsy.

A radiograph of the specimen demonstrates presence of calcifications within many of the cores.

IMPRESSION:

Successful biopsy of right breast calcifications.

End of diagnostic report for accession: 8668377
Dictated: 12-19-2016 2:04:25 PM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 12-19-2016 2:04:25 PM

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MRN: 1355036BR1
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Phone:(323) 643-4539

Date of Service: 12-19-2016

Ordered By

OMID NASSIM, MD
3533 W PICO BLVD
LOS ANGELES CA, 90019

FAX: (562) 491-1200

EXAM: POST PROCEDURAL RIGHT MAMMOGRAM FOR MARKER PLACEMENT

HISTORY: Postbiopsy of right breast calcifications and clip placement

TECHNIQUE: Mediolateral and craniocaudal views were obtained using low dose digital mammography.

FINDINGS:

2 views of the right breast demonstrate presence of a clip in the upper outer right breast in the area of few remaining calcifications.

IMPRESSION: Clip in appropriate location

End of diagnostic report for accession: 8668376
Dictated: 12-19-2016 10:19:47 AM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 12-19-2016 10:19:47 AM

Confidential

1/4/17

DATE OF EXAM: 12/19/2017
REFERRED BY: Norma Salceda MD
DOB: 02/11/1955
PATIENT NO.: UM2044790

Sandra Roquemore
1763 Exposition Blvd
Los Angeles, CA 90018

Dear Sandra Roquemore,

The ROUTINE DIGITAL SCREENING MAMMOGRAPHY that you recently had with us here at United Medical Imaging Healthcare, demonstrates a finding in your breast which requires further assessment. Please do not be alarmed by this notification, this does not necessarily mean that there are positive (malignant/cancerous) findings.

This information about the results of your mammogram is given to you to raise awareness and to inform your conversations with your doctor. Together, you can decide which screening options are right for you.

The final report regarding these findings is being sent to your referring physician. Your referring physician will discuss these findings, recommendations and further evaluations with you.

By the time you receive this letter you may have already discussed your recent ROUTINE DIGITAL SCREENING MAMMOGRAPHY findings with your referring physician or our radiologist. If you have any other questions regarding your ROUTINE DIGITAL SCREENING MAMMOGRAPHY, please contact our office with reference to this letter.

Most findings that require further evaluation are one of many benign (non-cancerous) changes that develop in the breast. This recommended follow-up is necessary to complete your breast evaluation, and to establish a definitive baseline evaluation.

Thank you for choosing United Medical Imaging Healthcare for your health care needs.

Priscilla Wong, M.D.

8540 South Sepulveda Blvd., Suite 111
Los Angeles, California 90045
Phone: (310) 645-9050
Fax: (310) 216-2683

Magnetic Resonance Imaging
Computed Tomography
Ultrasound

Digital Mammography
X-ra
Fluo. opy

PATIENT: ROQUEMORE, SANDRA NUMBER: 160775
DOB: 02/11/55 50Y SEX - F

DOCTOR: JAY THOMPSON, M.D.

CT OF THE CERVICAL SPINE: 11/09/05

Reason for Exam: Right-sided neck pain and numbness

Helical scanning of the cervical spine was performed at 2 mm collimation. Axial images were reconstructed at 2.4 mm intervals. Sagittal reconstructions were performed. Images were filmed at bone and soft tissue windows.

FINDINGS:

Overview of the spine shows loss of normal lordosis with sclerotic changes at C4-5 and C5-6 with anterior spurring. The discs are also narrowed at C4-5 and C5-6.

C2-3: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C3-4: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C4-5: A 3 mm central irregular osteophytic ridge encroaches on the anterior cord, causing mild central stenosis. The cord is otherwise normal. Uncinate spurring is causing moderate bilateral foraminal narrowing.

C5-6: There is a calcified left posterolateral 2 mm protrusion. There is no evidence for central bulge or herniation. Uncinate spurring is causing moderate bilateral foraminal narrowing.

C6-7: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

C7-T1: There is no disc protrusion. There is no spinal canal or neural foraminal stenosis.

IMPRESSION:

Loss of lordosis.

Sclerotic vertebral bodies at C4-5 and C5-6 with anterior spurring and disc space narrowing at these levels.

(CONTINUED)

CHESTER ADVANCED IMAGING MEDICAL GROUP

South Sepulveda Blvd., Suite 111
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Phone: (310) 645-9050
Fax: (310) 216-2683

Magnetic Resonance Imaging
Computed Tomography
Ultrasound

Dig Mammography
X-ray
Fluoroscopy

PATIENT: ROQUEMORE, SANDRA NUMBER: 160775
DOB: 02/11/55 50Y SEX - F

DOCTOR: JAY THOMPSON, M.D.

CT OF THE CERVICAL SPINE: 11/09/05

(CONTINUED - PAGE 2)

IMPRESSION CONTINUED.....

C4-5 central 3 mm osteophytic ridge with mild central stenosis and moderate bilateral foraminal narrowing.

C5-6 calcified left posterolateral 2 mm protrusion; uncinate spurring with moderate bilateral foraminal narrowing.

Thank you for referring this patient.

kg
d: 11/10/05
t: 11/10/05
Tech: Leticia Orozco, RHT#66547

WILLIAM AULL, M.D.

ROQSA001

UNITED MEDICAL IMAGING
of LOS ANGELES - WILSHIRE

PATIENT: Sandra Roquemore
REFERRED BY: Gilda Ngo MD
PATIENT NO: UM2044790

DATE OF EXAM: 05/21/2014
DOB: 02/11/1955
FAX: (213) 743-9160

X-RAY OF THE CERVICAL SPINE - FOUR VIEWS

FINDINGS:
The examination is somewhat limited and the oblique projections have not been appropriately positioned.

There is a post-operative status at C4,C5 and C6. Corpectomy and discectomy has been performed. There is metallic plate in the anterior aspect of the above vertebrae and this has been fixed to C4 and C6 by four metallic screws. There is obliteration of C4-5 and C5-6.

There is no evidence of a fracture. The vertebral bodies are well aligned. The metallic hardware is intact.

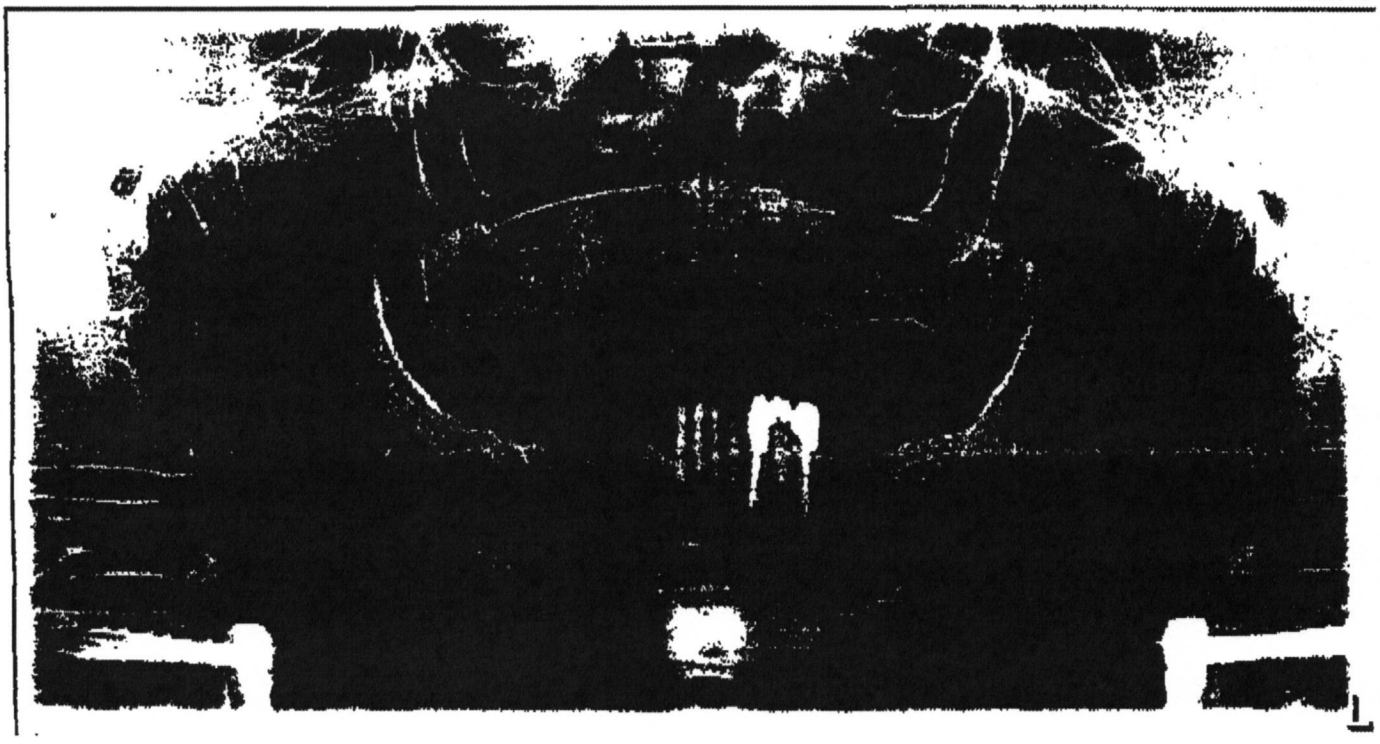
IMPRESSION:
SPINAL FUSION AS DISCUSSED ABOVE.

6/4/14

Electronically Signed by Manouchehr Koukhab, M.D., D.A.B.R.
RADIOLOGIST

D: 05/22/2014 \ T: 05/22/2014 by Candyce Henderson

6/17/14 Ms. Aragon



Beverly Tower
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Fax: (310) 385-9144

ROQUEMORE, SANDRA
MRN: 1355036BR1
DOB: 02-11-1955 Sex: F
Phone:(323) 843-4539

Date of Service: 08-31-2016

Ordered By

OMID NASSIM, MD
3533 W PICO BLVD
LOS ANGELES CA, 90019

FAX: (562) 491-1200

EXAM: DIGITAL SCREENING BILATERAL MAMMOGRAPHY WITH CAD

HISTORY: Screening.

RISK FACTORS: None.

TECHNIQUE: Mediolateral oblique and craniocaudal views of both breasts were obtained using low dose digital mammography unit. Computer-Aided Detection (CAD) was utilized.

COMPARISON: None available.

FINDINGS:

Tissue Density: The breasts are heterogeneously dense, which may obscure small masses.

There are indeterminate amorphous calcification seen in the right upper breast corresponding to 12 o'clock and outer breast location on the craniocaudal view. Additionally, a small cluster of calcifications is seen in the left lower inner breast at posterior depth.

There are no suspicious masses or areas of unexplained architectural distortion.

The skin, nipples and bilateral axilla are unremarkable.

IMPRESSION: Bilateral breast calcifications

RECOMMENDATION: Comparison with prior studies.
Comparison with patient's prior mammograms is recommended. If these become available, an addendum report will be issued. If not available, the patient will be recalled for bilateral diagnostic mammograms and, if needed, at the discretion of the radiologist, breast ultrasound.

call pt for old Mammo from records

ASSESSMENT: BI-RADS Category 0: Incomplete. Need additional imaging evaluation and/or prior mammograms for comparison.

A letter regarding the results of this study has been sent to the patient.

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Fax: (310) 38[illegible]9144

Your patient has been entered into our reminder system. We will notify the patient when their next breast imaging exam is due.

End of diagnostic report for accession: 7454249
Dictated: 08-31-2016 4:10:00 PM
Dictated By: Krane, Rita, MD
Signed By: Krane, Rita, MD 08-31-2016 4:10:00 PM

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FAX: (562) 491-1200

ROQUEMORE, SANDRA
MRN: 1355036BR1
DOB: 02-11-1955 Sex: F
Phone:(323) 643-4539

Date of Service: 10-07-2016

EXAM: DIGITAL DIAGNOSTIC BILATERAL MAMMOGRAPHY CALLBACK WITH BREAST ULTRASOUND

HISTORY: Patient is recalled for bilateral calcifications noted on the screening study

TECHNIQUE: Utilizing digital technique, mammographic views were obtained. Realtime upper outer right breast ultrasound was also performed.

COMPARISON: 8/31/2016

FINDINGS:

Tissue Density: The breasts are heterogeneously dense, which may obscure small masses.

Multiple additional views of each breast were obtained. In the left breast there is a benign-appearing group of calcifications in the inner lower breast. No other masses or abnormalities are noted. In the right breast there are vague appearing calcifications associated with tissue density in the upper outer breast. Other calcifications are also noted at around 12 o'clock on the right side. Calcifications do not appear to be suspicious.

Ultrasound examination of the upper outer right breast does not demonstrate any masses. There is a vague dense tissue but no calcifications were identified.

IMPRESSION: Indeterminate calcifications in the upper outer right breast for which biopsy is recommended. The calcifications in the left breast appear benign

RECOMMENDATION: Biopsy should be considered.
Stereotactic biopsy of right breast calcifications is recommended. Patient will also attempt to provide her prior study for comparison

ASSESSMENT: BI-RADS Category 4: Suspicious.

A letter regarding the results of this study has been sent to the patient.

Your patient has been entered into our reminder system. We will notify the patient when their next breast imaging exam is due.

End of diagnostic report for accession: 7811519

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pls call pt [illegible]

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Fax: (310) 38[illegible]144

Dictated: 10-07-2016 9:44:30 AM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 10-07-2016 9:44:30 AM

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Ordered By

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FAX: (562) 491-1200

ROQUEMORE, SANDRA
MRN: 1355036BR1
DOB: 02-11-1955 Sex: F
Phone:(323) 643-4539

Date of Service: 12-19-2016

Addendum 1

ADDENDUM

The results of the biopsy demonstrate presence of benign breast tissue with the associated calcifications. There is no evidence of malignancy.

End of addendum for accession: 8668377
Dictated: 12-21-2016 10:13:25 AM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 12-21-2016 10:13:25 AM

Original Report

EXAM: MAMMOGRAPHY RIGHT STEREOTACTIC BIOPSY, 1 LOCATION

HISTORY: Right breast calcifications

PROCEDURE: The risks and complications of the procedure, including infection, bleeding, organ injury and nondiagnostic biopsy were explained to the patient. She understood the risks and complications and signed an informed consent form.

The skin was then cleaned and prepped in a sterile manner and 1% lidocaine was used for local anesthetic. A vacuum-assisted 9-gauge Eviva needle was used. 10 core biopsies were obtained without immediate complications. A specimen radiograph was obtained and demonstrated adequate sampling of the calcifications. The specimens were then sent to the laboratory for further analysis. The patient was given appropriate post-biopsy instructions and left the department in the same stable condition.

A clip was deployed following the biopsy.

A radiograph of the specimen demonstrates presence of calcifications within many of the cores.

IMPRESSION:

Successful biopsy of right breast calcifications.

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End of diagnostic report for accession: 8668377
Dictated: 12-19-2016 2:04:25 PM
Dictated By: Bojman, Ludmila, MD
Signed By: Bojman, Ludmila, MD 12-19-2016 2:04:25 PM

File
16

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