**Medical Report for User: 68d7b5cacbe6485b12e35c42**

**1. Present Illness**

The patient is a 68-year-old right-handed male presenting for evaluation of a progressively worsening tremor. He reports an insidious onset of a right-sided resting tremor approximately 18 months ago, which has become more pronounced over the past 6 months. The tremor is described as a "pill-rolling" motion, is most prominent when his hand is at rest, improves with intentional movement, and resolves with sleep. Concurrently, he has developed generalized bradykinesia, manifesting as difficulty with fine motor tasks such as buttoning his shirt, micrographia, and a reduced arm swing on the right while walking. He also endorses a feeling of axial and limb rigidity, a softer voice (hypophonia), and a shuffling gait with subjective postural instability, though he denies any falls. Associated non-motor symptoms include chronic constipation and hyposmia, which he notes predated the onset of motor symptoms by several years. He denies any cognitive decline, diplopia, vertigo, focal weakness, or sensory deficits. The symptoms are now causing functional impairment with activities of daily living and social embarrassment.

**2. Analysis and Plan**

Assessment
This 68-year-old gentleman presents with a constellation of signs and symptoms that are pathognomonic for idiopathic Parkinson's Disease. The diagnosis is made on clinical grounds, supported by the classic triad of an asymmetric, pill-rolling resting tremor, generalized bradykinesia, and rigidity. The insidious onset, progressive course, and presence of supportive features such as micrographia, hypophonia, and a shuffling gait further solidify this impression. Critically, his history of premotor symptoms, including chronic constipation and hyposmia predating the motor deficits by several years, is highly characteristic of an underlying alpha-synucleinopathy. The absence of atypical features, such as early falls, significant cognitive impairment, or prominent autonomic failure, makes alternative parkinsonian syndromes less likely at this time. His symptoms are now causing functional impairment, warranting the initiation of symptomatic therapy.
Plan
The immediate plan is to confirm the diagnosis clinically, establish a baseline for monitoring, and initiate treatment to improve his quality of life. We will proceed with a non-contrast MRI of the brain to rule out any structural mimics of parkinsonism, such as normal pressure hydrocephalus or evidence of significant vascular disease. To address his functionally limiting motor symptoms, we will initiate dopaminergic therapy with carbidopa/levodopa 25/100 mg three times daily. I have educated him on the rationale for this medication, its profound expected benefit on his bradykinesia and rigidity, and potential side effects such as nausea or lightheadedness. A robust positive response to this therapy will also serve to further confirm our diagnosis.
In conjunction with pharmacotherapy, we will pursue a comprehensive multidisciplinary approach. I am placing referrals for physical therapy to focus on gait training, balance, and large-amplitude movements, as well as occupational therapy to develop strategies for managing fine motor tasks and activities of daily living. A referral to speech therapy will also be made to address his hypophonia, ideally with a provider trained in the Lee Silverman Voice Treatment (LSVT LOUD) protocol. We will schedule a follow-up visit in six weeks to meticulously assess his response to levodopa, titrate the dose for optimal efficacy, and review the progress made with his rehabilitation therapies.