

PATIENT
Jamar Little

DOB 06/13/1986
AGE 37 yrs
SEX Male
PRN JL520832

FACILITY
PEF CLINIC II, LTD/ JPH
T (773) 947-7746
F (773) 947-7751
 7531 S. Stony Island
 Room 176
 Chicago, IL 60649

Patient identifying details and demographics

FIRST NAME	Jamar	SEX	Male	RACE	Black or African American
MIDDLE NAME	-	DATE OF BIRTH	06/13/1986	ETHNICITY	-
LAST NAME	Little	DATE OF DEATH	-	PREF. LANGUAGE	English
SSN	-	PRN	JL520832	STATUS	Active patient

CONTACT INFORMATION

ADDRESS LINE 1	7920 S Manistee	CONTACT BY	-
ADDRESS LINE 2	-	EMAIL	jlittle2216@gmail.com
CITY	Chicago	HOME PHONE	(773) 573-7951
STATE	IL	MOBILE PHONE	Does not have mobile
ZIP CODE	60617	OFFICE PHONE	-
		OFFICE EXTENSION	-

FAMILY INFORMATION

NEXT OF KIN	-	PATIENT'S MOTHER'S MAIDEN NAME	-
RELATION TO PATIENT	-		
PHONE	-		
ADDRESS	-		

Active insurance**PRIMARY PAYER**

PAYER	Blue Cross Blue Shield Illinois	INSURED ID NUMBER	PAS823919118
PRIORITY	Primary	GROUP NUMBER	193252
TYPE	PPO	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	12/01/2018	PAYMENT TYPE	Fixed
END DATE	-	COPAY AMOUNT	0
		STATUS	Active

Inactive insurance**PRIMARY PAYER**

PAYER	Blue Cross Blue Shield Illinois	INSURED ID NUMBER	2546607700
PRIORITY	Primary	GROUP NUMBER	-
TYPE	PPO	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	01/01/2013	PAYMENT TYPE	Fixed
END DATE	12/31/9999	COPAY AMOUNT	0
		STATUS	Inactive

PRIMARY PAYER

PAYER	Medicaid - Illinois	INSURED ID NUMBER	061369088
PRIORITY	Primary	GROUP NUMBER	-
TYPE	Other	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	10/01/2014	PAYMENT TYPE	Fixed
END DATE	-	COPAY AMOUNT	3.9
		STATUS	Inactive

PRIMARY PAYER

PAYER	SELF PAY	INSURED ID NUMBER	8500
PRIORITY	Primary	GROUP NUMBER	8500
TYPE	Other	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	12/01/2018	PAYMENT TYPE	Fixed
END DATE	-	COPAY AMOUNT	85
		STATUS	Inactive

Payment information

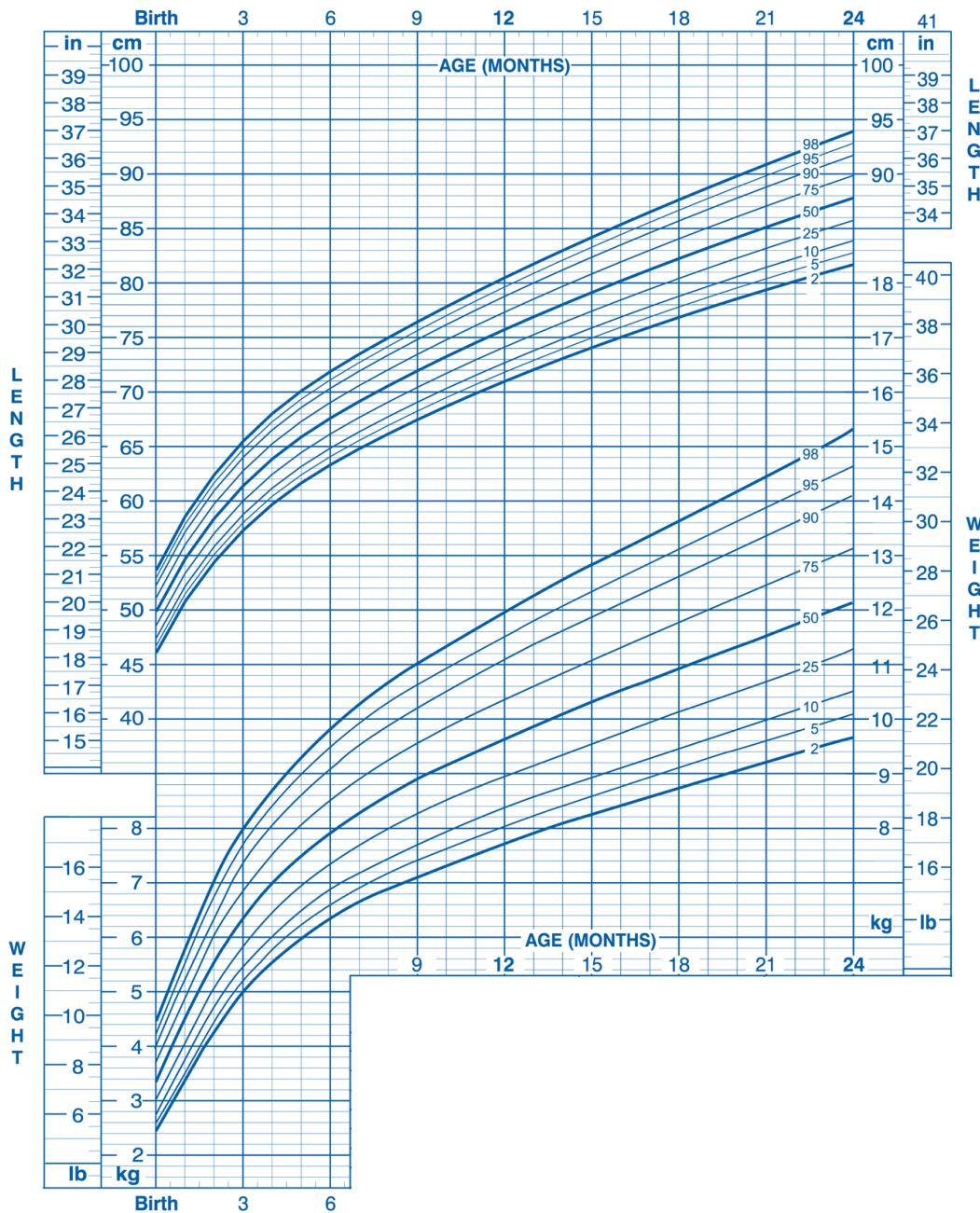
PAYMENT PREFERENCE	Primary Insurance	DATE OF BIRTH	06/13/1986
PATIENT'S RELATIONSHIP TO GUARANTOR	Self	SEX	Male
GUARANTOR NAME	Jamar Little	SOCIAL SECURITY NUMBER	-
GUARANTOR ADDRESS	7920 S Manistee Chicago, IL 60617	PRIMARY PHONE NUMBER	-
		SECONDARY PHONE NUMBER	(773) 573-7951

Vitals flowsheet - Jamar Little

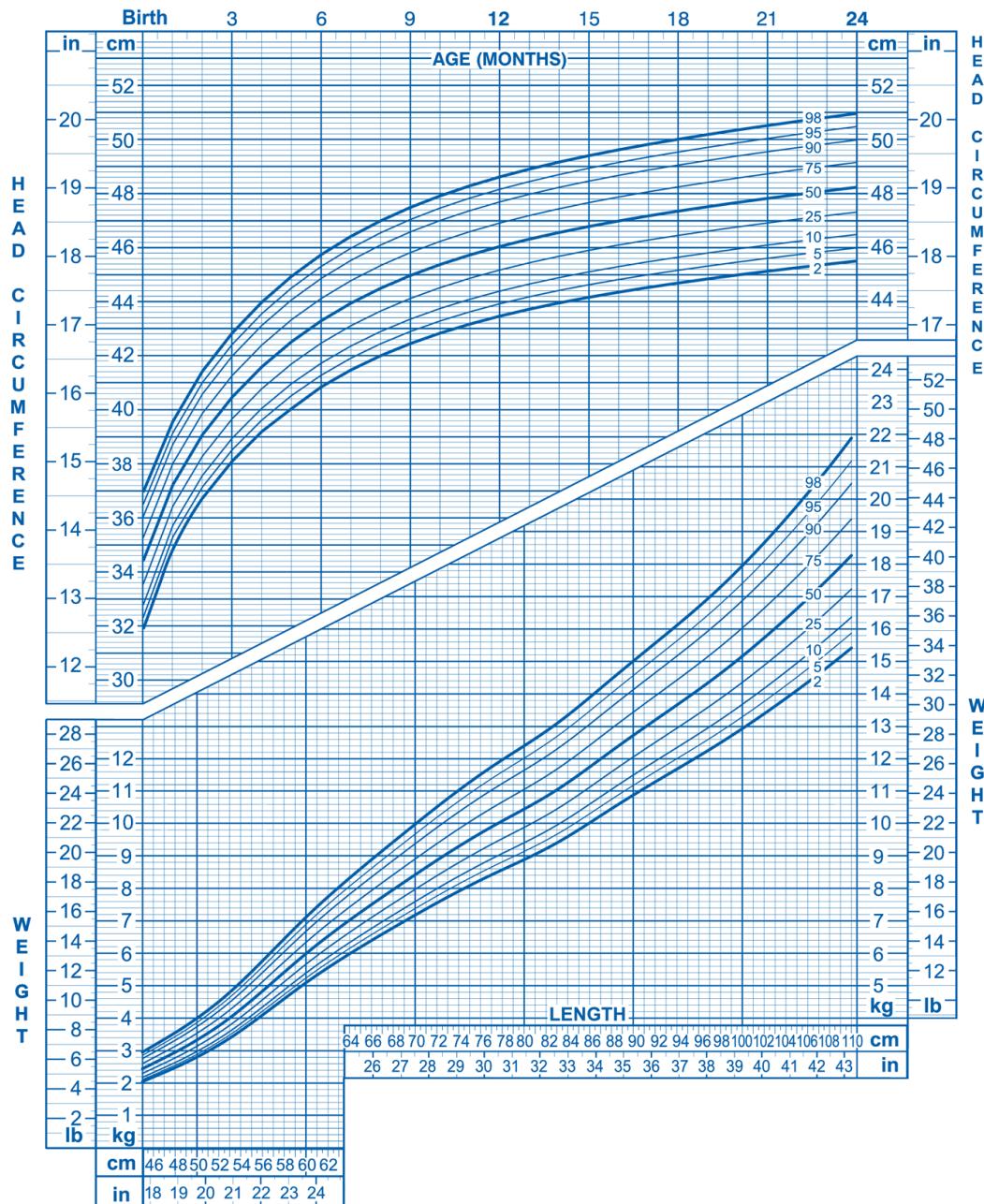
	05/20/19 10:49 AM
Vitals	
Height	68 in
Weight	262 lb
BMI	39.84
BMI Percentile	
BP	101/67 mmHg
Temperature	98.7 °F
Pulse	84 bpm
Respiratory rate	20 bpm
O2 Saturation	
Pain	6
Head Circumference	

Growth charts

Birth to 24 months: Boys Length-for-age and Weight-for-age percentiles

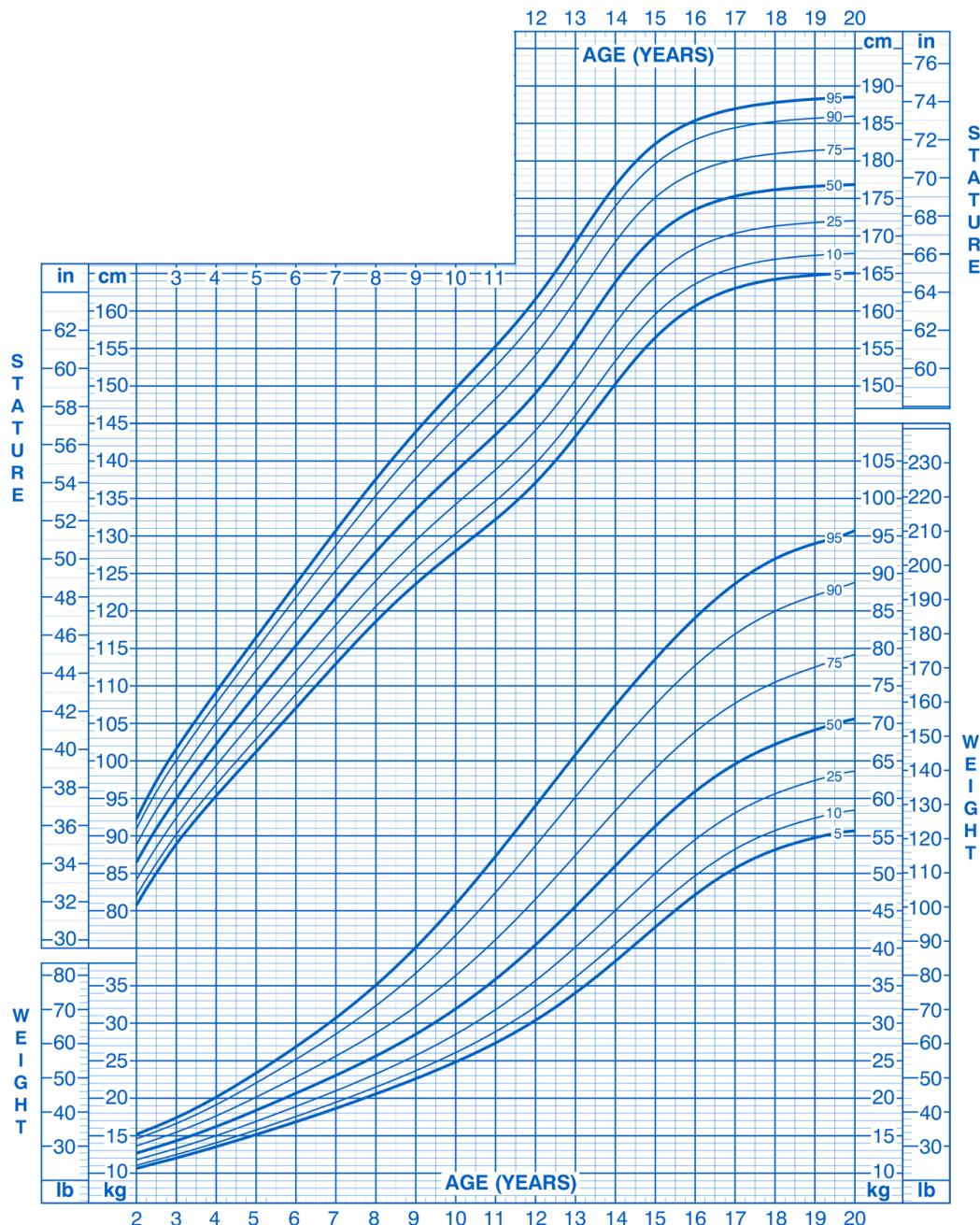


Birth to 24 months: Boys
Head circumference-for-age and
Weight-for-length percentiles

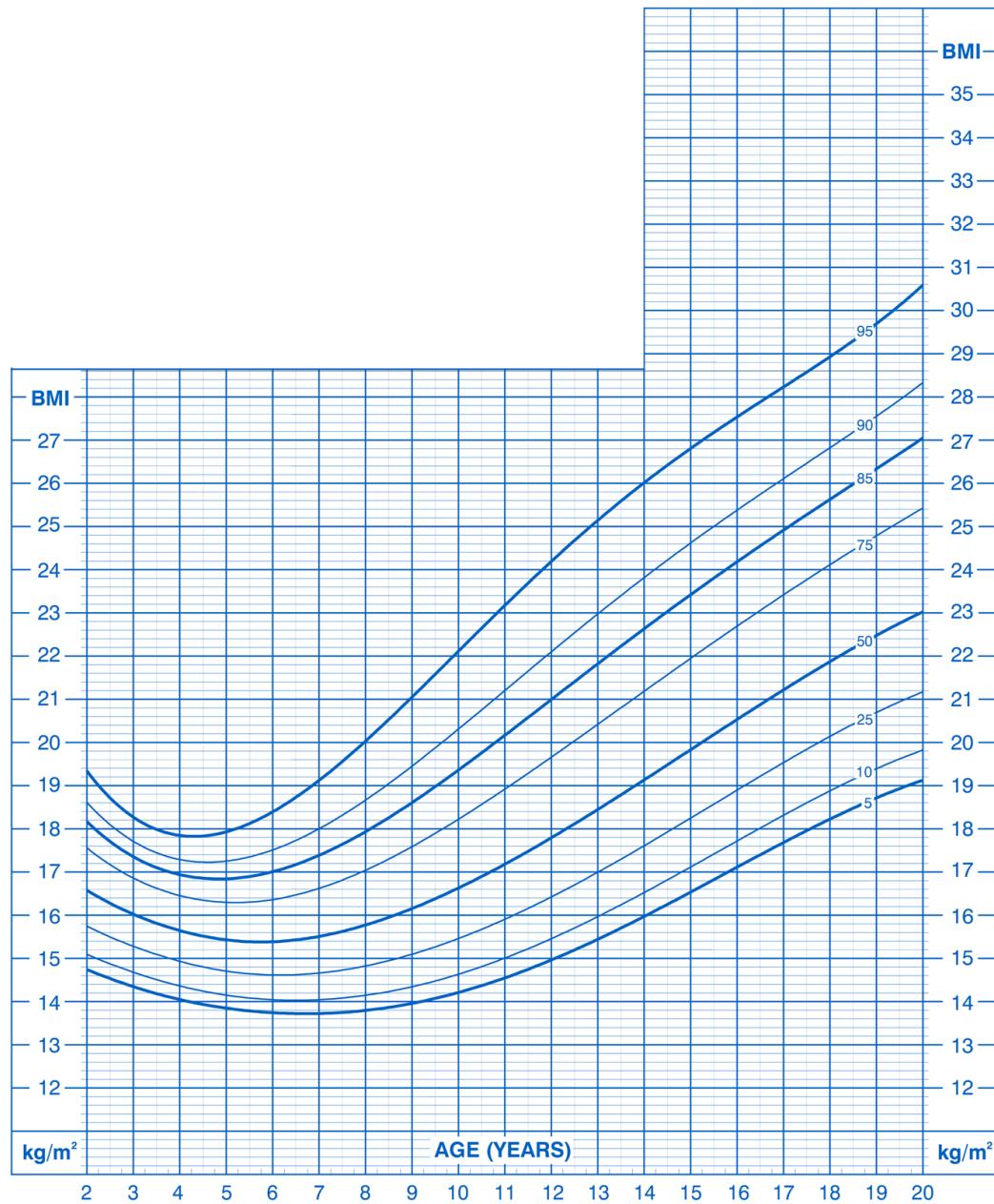


2 to 20 years: Boys

Stature-for-age and Weight-for-age percentiles



2 to 20 years: Boys
Body mass index-for-age percentiles



Diagnoses

Current	ACUITY	START	STOP
Routine general medical examination at a health care facility	Chronic	10/02/2014	
Contact with or exposure to venereal diseases	Chronic	10/02/2014	
Obesity, unspecified	Chronic	10/02/2014	
Migraine, unspecified	Acute	01/17/2013	
Vitamin d deficiency	Chronic	01/16/2013	

Medication Vitamin D3 Start: 01/17/13 Stop: 04/18/13

Historical	ACUITY	START	STOP
No historical diagnoses			

Drug Allergies

Active	SEVERITY/REACTIONS	ONSET
Patient has no known drug allergies		

Food Allergies

Active	SEVERITY/REACTIONS	ONSET
No food allergies recorded		

Environmental Allergies

Active	SEVERITY/REACTIONS	ONSET
No environmental allergies recorded		

Medications

Active	SIG	START/STOP	ASSOCIATED DX
Amoxicillin & Pot Clavulanate (Amoxicillin-Pot Clavulanate) 875-125 MG Oral Tablet	Take 1 tablet (875 mg) by mouth every 12 hours for 7 days	05/08/18 -	-
- EScript (verified): 05/08/18 Prescriber: Naveed Muhammad MD SIG: Take 1 tablet (875 mg) by mouth every 12 hours for 7 days Refills: 0 Quantity: 14			
Aspirin 81 MG Oral Tablet Delayed Release	Take 1 tablet (81 mg) by mouth daily	01/07/20 -	-
- EScript (verified): 01/07/20 Prescriber: Naveed Muhammad MD SIG: Take 1 tablet (81 mg) by mouth daily Refills: 2 Quantity: 90			
- EScript (verified): 12/04/18 Prescriber: Naveed Muhammad MD SIG: Take 1 tablet (81 mg) by mouth daily Refills: 2 Quantity: 90			
Azithromycin 500 MG Oral Tablet	Take 2 tablets (1,000 mg) by mouth one time	09/25/18 -	-
- EScript (verified): 09/25/18 Prescriber: Naveed Muhammad MD SIG: Take 2 tablets (1,000 mg) by mouth one time Refills: 0 Quantity: 2			
Ergocalciferol (Vitamin D (Ergocalciferol)) 50000 UNIT Oral Capsule	Take 1 capsule (50,000 units) by mouth once a week for 12 weeks.	06/20/16 -	-
- EScript (verified): 06/20/16 Prescriber: Naveed Muhammad MD SIG: Take 1 capsule (50,000 units) by mouth once a week for 12 weeks. Refills: 2 Quantity: 4			
Ibuprofen 600 MG Oral Tablet	Take 1 tablet (600 mg) by mouth 3 times per day with food or milk as needed	05/08/18 -	-
- EScript (verified): 11/09/19 Prescriber: Naveed Muhammad MD SIG: TAKE 1 TABLET(600 MG) BY MOUTH THREE TIMES DAILY WITH FOOD OR MILK AS NEEDED Refills: 1 Quantity: 60			
- EScript (verified): 06/20/19 Prescriber: Naveed Muhammad MD Refills: 1 Quantity: 60			
- EScript (verified): 05/29/19 Prescriber: Naveed Muhammad MD Refills: 1 Quantity: 60			
- EScript (verified): 05/08/18 Prescriber: Naveed Muhammad MD SIG: Take 1 tablet (600 mg) by mouth 3 times per day with food or milk as needed Refills: 0 Quantity: 60			

Historical**SIG****START/STOP****ASSOCIATED DX**

azithromycin (Zithromax) 500 mg oral tablet	TAKE 4 TABLETS (2000 MG) BY MOUTH X 1 DOSE.	10/02/14 - 09/25/18	-
- EScript (verified): 10/02/14 Prescriber: Naveed Muhammad MD Refills: 0 Quantity: 4			
cholecalciferol (Vitamin D3) 50,000 intl units oral capsule	TAKE ONE CAPSULE PO ONCE A WEEK FOR 12 WEEKS.	01/17/13 - 04/18/13	Vitamin d deficiency
- Script (unknown): 01/17/13 Prescriber: Naveed Muhammad MD Refills: 2 Quantity: 4			

Immunizations

DATE	VACCINE	SOURCE	LOT NUMBER	EXPIRES	COMMENT
Unknown					
12/18/2015	ppd	Administered by provider	wprivat ec4584a a	11/05/2016	given ppd 12/18/2015 read 12/21/2015 zero mm ind negative tj

Social history

TOBACCO USE	RECORDED
Current tobacco use 0 cigarettes per day (non-smoker or less than 100 in lifetime)	01/16/2013
Past entries Non-smoker	05/20/2019
ALCOHOL USE	RECORDED
No alcohol use history available for this patient	
SOCIAL HISTORY (FREE-TEXT)	
No social history (free-text) recorded for this patient	
FINANCIAL RESOURCES	RECORDED
No financial resources recorded for this patient	
EDUCATION	RECORDED
No education recorded for this patient	
PHYSICAL ACTIVITY	RECORDED
No physical activity available for this patient	
NUTRITION HISTORY	RECORDED
No nutrition history available for this patient	
STRESS	RECORDED
No stress available for this patient	
SOCIAL ISOLATION AND CONNECTION	RECORDED
No social isolation and connection available for this patient	
EXPOSURE TO VIOLENCE	RECORDED
No exposure to violence history available for this patient	
GENDER IDENTITY	
No gender identity recorded for this patient	
SEXUAL ORIENTATION	
No sexual orientation recorded for this patient	

Past medical history

No past medical history available for this patient.

Family health history

DIAGNOSIS	ONSET DATE
No Family health history recorded	
FAMILY HEALTH HISTORY (FREE TEXT)	
No family health history (free text) available for this patient.	

Advance Directive**DIRECTIVE****RECORDED**

No advance directives recorded for this patient.

Implantable devices

No implantable devices recorded

Active health concerns**DESCRIPTION****EFFECTIVE DATE**

No active health concerns recorded

Inactive health concerns**DESCRIPTION****EFFECTIVE DATE**

No inactive health concerns recorded

Active Goals**DESCRIPTION****EFFECTIVE DATE**

No active goals recorded

Inactive Goals**DESCRIPTION****EFFECTIVE DATE**

No inactive goals recorded

PATIENT	FACILITY	ENCOUNTER	
Jamar Little	Wabash	Office Visit	
DOB 06/13/1986	T (312) 808-0621	NOTE TYPE	SOAP Note
AGE 37 yrs	F (312) 808-0655	SEEN BY	Naveed Muhammad
SEX Male	2850 S. WABASH AVENUE	MD	
PRN JL520832	SUITE 203	DATE	05/20/2019
	Chicago, IL 60616-2412	AGE AT DOS	32 yrs
		Electronically signed by Naveed	
		Muhammad MD at 05/20/2019 11:58 am	

Chief complaint

(Appt time: 11:00 AM) (Arrival time: 10:44 AM)

Vitals for this encounter	
	05/20/19 10:49 AM
Height	68 in
Weight	262 lb
Temperature	98.70 °F
Pulse	84 bpm
Respiratory rate	20 bpm
Pain	6
BMI	39.84
Blood pressure	101/67 mmHg

SUBJECTIVE

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is no significant alcohol use.

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient does not get regular exercise.

Audit_C

How often do you have a drink containing alcohol? Never

How many drinks containing alcohol do you have on a typical day of drinking? one or two

How often do you have six or more drinks on one occasion? Never

Audit_C result is normal. The score is 0

Opiate Pre-screen is negative :

Here for follow up post Cardiology visit at Northwestern Hospital and also had a negative tilt table test at Northwestern Hospital on 5/9/19.

No further episode of syncope for the last 5 weeks.

Northwestern Cardiologist also suggested consultation with Dr. Bruce A. Cohen, a Neurologist and an Endocrinologist.

Dr. Gulati suggests Psychiatry evaluation which patient agrees with.

Patient still complains of Daily Headaches despite taking the medication prescribed by Dr. Gulati.

OBJECTIVE

General: Normotensive, in no acute distress.
Head: Normocephalic, no lesions.
Eyes: PERRLA, EOM's full, conjunctivae clear..
Ears: EAC's clear, TM's normal.
Nose: Mucosa normal, no obstruction.
Throat: Clear, no exudates, no lesions.
Neck: Supple, no masses, no thyromegaly, no Carotid bruits bilaterally. Mild Acanthosis Nigricans on the neck..
Chest: Lungs clear, no rales, no rhonchi, no wheezes.
Heart: RR, no murmurs, no rubs, no gallops.
Abdomen: Soft, no tenderness, no masses, BS normal.
Back: Normal curvature, no tenderness.
Extremities: FROM, no deformities, no edema, no erythema.
Neuro: Physiological, no localizing findings.
Sensory and motor grossly intact.. No neuro deficits noticed..

ASSESSMENT

Well Exam.
History of Recurrent syncope.
History of Migraine headaches..
History of Marijuana use.

PLAN

Neurology, Psychiatry as well as Endocrinology referrals given.
Advised to stop Alcohol use..
Advised to lose weight..
Advised to eat healthy, exercise regularly and to avoid violence.
Testicular self exam advised.
Safe sex education advised.
99213..
Follow up in 1 month.

PATIENT	FACILITY	ENCOUNTER
Jamar Little	Wabash	Office Visit
DOB 06/13/1986	T (312) 808-0621	NOTE TYPE SOAP Note
AGE 37 yrs	F (312) 808-0655	SEEN BY Naveed Muhammad
SEX Male	2850 S. WABASH AVENUE	MD
PRN JL520832	SUITE 203	DATE 12/10/2018
	Chicago, IL 60616-2412	AGE AT DOS 32 yrs
		Electronically signed by Naveed
		Muhammad MD at 12/10/2018 10:28 am

Chief complaint

(Appt time: 9:30 AM) (Arrival time: 9:37 AM)

Vitals for this encounter	
	12/10/18 9:42 AM
Height	68 in
Weight	260 lb
Temperature	99.20 °F
Pulse	80 bpm
Respiratory rate	20 bpm
Pain	6
BMI	39.53
Blood pressure	99/60 mmHg

SUBJECTIVE

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient does not get regular exercise.

Here for follow up.

States he had another spell yesterday at home while playing video game between 1200 and 1300 hours where he could not move for a little while and does not remember what happened but states the controllers he had in his hands were on the ground when he came to his senses and people were trying to ask him whether he was ok on the headsets he was wearing. Again he had blurred vision in his Right eye and had a Headache behind his Right eye and in the temporal area. States he did not have the Carotid Doppler nor the EEG yet as he did not get the referrals. Also did not do the blood draw as requested.

I have not recd. any reports from Rush as a Release was initiated last week.

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear..

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction.

Throat: Clear, no exudates, no lesions.

Neck: Supple, no masses, no thyromegaly, no Carotid bruits bilaterally. Mild Acanthosis Nigricans on the neck..

Chest: Lungs clear, no rales, no rhonchi, no wheezes.
 Heart: RR, no murmurs, no rubs, no gallops.
 Abdomen: Soft, no tenderness, no masses, BS normal.
 Back: Normal curvature, no tenderness.
 Extremities: FROM, no deformities, no edema, no erythema.
 Neuro: Physiological, no localizing findings.
 Sensory and motor grossly intact.. No neuro deficits noticed..

ASSESSMENT

Well Exam.
 Near syncope ? (TIA ? Doubt it).
 History of Migraine headaches..
 History of Marijuana use.

PLAN

Carotid Doppler bilateral stat.. Reordered.
 EEG ordered.. Reordered.
 Advised to stop Alcohol use..
 Advised to lose weight..
 Advised to eat healthy, exercise regularly and to avoid violence. Testicular self exam advised. Safe sex education advised.
 ESR,CRP,ANA, Vitamin B12 levels, folate levels, Magnesium levels Today.
 99213.
 Neurology Consult.
 Follow up in 10 days.

Addenda

ADDENDUM	STATUS	SOURCE	DATE/TIME
2D Echo, Cardiology consult and MRI of the Brain without contrast ordered.	Accepted by Naveed Muhammad MD	Doctor	02/14/2019 10:01 am
PLEASE AUTHORIZE TILT TABLE TEST (SYNCOPES).	Accepted by Naveed Muhammad MD	Doctor	04/08/2019 12:24 am

PATIENT	FACILITY	ENCOUNTER
Jamar Little	Wabash	Office Visit
DOB 06/13/1986	T (312) 808-0621	NOTE TYPE SOAP Note
AGE 37 yrs	F (312) 808-0655	SEEN BY Naveed Muhammad
SEX Male	2850 S. WABASH AVENUE	MD
PRN JL520832	SUITE 203	DATE 12/04/2018
	Chicago, IL 60616-2412	AGE AT DOS 32 yrs
		Electronically signed by Naveed
		Muhammad MD at 12/04/2018 11:27 am

Chief complaint

(Appt time: 9:30 AM) (Arrival time: 9:32 AM)

Vitals for this encounter	
	12/04/18 10:26 AM
Height	68 in
Weight	254 lb
Temperature	97.80 °F
Pulse	68 bpm
Respiratory rate	20 bpm
Pain	0
BMI	38.62
Blood pressure	119/75 mmHg

SUBJECTIVE

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient exercises regularly. Details:

On November 27, 2018, while at work patient apparently passed out but states his eyes were open and he was unresponsive. Was taken to the ER at Rush Hospital where he was hospitalized and work up was done including CT scan of the Brain and Chest and serial EKG'S were done. Neurology consult was done as well and EEG is recommended to be done as an outpatient. Midlower sternal Chest pains as well which are still ongoing. Dull and aching type of pain. Worsened by sitting up straight. Also having off and on numbness and tingling type of pain in his Right hand fingers (2/3 rd of them). Was discharged on 11/28/18 with the dx of Syncope and Angina.Denies Cocaine use.

Denies any kind of heavy exertion. States he had an episode of Shoulder pain which radiated to the top of the Head followed by pain behind the Right eye following which he could not remember what happened. States also could not see anything from the Right eye for 2-3 minutes following the episode. Was also told that he had some Abnormal Rhythm of the heart. No medication was prescribed upon discharge from the hospital. History of Marijuana use with last dose prior to the episode was about a month or longer.

Patient also states that his manager and one of the coworker stated that he was shaking when he was trying to punch out of work.

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear.

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction.

Throat: Clear, no exudates, no lesions.

Neck: Supple, no masses, no thyromegaly, no Carotid bruits bilaterally. Mild Acanthosis Nigricans on the neck.

Chest: Lungs clear, no rales, no rhonchi, no wheezes.

Heart: RR, no murmurs, no rubs, no gallops.

Abdomen: Soft, no tenderness, no masses, BS normal.

Back: Normal curvature, no tenderness.

Extremities: FROM, no deformities, no edema, no erythema.

Neuro: Physiological, no localizing findings.

Sensory and motor grossly intact.

No neuro deficits noticed.

Skin: Normal, no rashes, no lesions noted.

ASSESSMENT

Near syncope ? (TIA ? Doubt it).

History of Migraine headaches..

History of Marijuana use.

PLAN

Carotid Doppler bilateral stat.

EEG ordered.

Advised to stop Alcohol use..

Advised to lose weight..

Consent for release of medical information.. Advised to eat healthy, exercise regularly and to avoid violence. Testicular self exam advised. Safe sex education advised.

Follow up in 2 weeks.

99214.

Aspirin 81 mg po daily.

Off work x 2 weeks.

ESR,CRP,ANA, Vitamin B12 levels, folate levels, Magnesium levels Today.

PATIENT

Jamar Little

DOB 06/13/1986

AGE 37 yrs

SEX Male

PRN JL520832

FACILITY

Wabash

T (312) 808-0621

F (312) 808-0655

2850 S. WABASH AVENUE

SUITE 203

Chicago, IL 60616-2412

ENCOUNTER

Orders Only

NOTE TYPE Cancelled

SEEN BY Naveed Muhammad

MD

DATE 11/30/2018

AGE AT DOS 32 yrs

Not signed

Chief complaint

No chief complaint recorded

Vitals for this encounter

No vitals recorded

CANCELLED

No proof of ins

PATIENT	FACILITY	ENCOUNTER
Jamar Little	Wabash	Office Visit
DOB 06/13/1986	T (312) 808-0621	NOTE TYPE SOAP Note
AGE 37 yrs	F (312) 808-0655	SEEN BY Naveed Muhammad
SEX Male	2850 S. WABASH AVENUE	MD
PRN JL520832	SUITE 203	DATE 09/25/2018
	Chicago, IL 60616-2412	AGE AT DOS 32 yrs
		Electronically signed by Naveed Muhammad MD at 09/25/2018 09:47 am

Chief complaint

(Appt time: 9:00 AM) (Arrival time: 8:59 AM)

Vitals for this encounter	
	09/25/18 9:19 AM
Height	68 in
Weight	242 lb
Temperature	98.50 °F
Pulse	72 bpm
Respiratory rate	20 bpm
Pain	0
BMI	36.80
Blood pressure	105/76 mmHg

SUBJECTIVE

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient exercises regularly. Details:

Audit_C

How often do you have a drink containing alcohol? 2-4 times per month

How many drinks containing alcohol do you have on a typical day of drinking? one or two

How often do you have six or more drinks on one occasion? Never

Audit_C result is normal. The score is 2

Opiate Pre-screen is negative

Here for Treatment of Ginorrhea as his Girl friend was trsted Positive last week.

Denies any issues except for some Abdominal aches. Denies Vomiting or constipation or diarrhea. No fever.

Denies Penile discharge.

Denies any medical problems.

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear.

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction.

Throat: Clear, no exudates, no lesions.

Neck: Supple, no masses, no thyromegaly, no bruits.

Chest: Lungs clear, no rales, no rhonchi, no wheezes.

Heart: RR, no murmurs, no rubs, no gallops.

Abdomen: Soft, no tenderness, no masses, BS normal.

Back: Normal curvature, no tenderness.

Extremities: FROM, no deformities, no edema, no erythema.

Neuro: Physiological, no localizing findings.

Skin: Normal, no rashes, no lesions noted.

Genitalia : Uncircumcised Penis. No Discharge. Testes Bilaterally normal. No masses felt.

ASSESSMENT

Well Exam.

History of exposure to Gonorrhea.

History of Migraine headaches..

PLAN

URINE FOR GONORRHEA AND CHLAMYDIA C/S ORDERED TODAY..

HIV TEST,RPR,HEPATITIS B SURFACE ANTIGEN AND ANTIBODY AND HEPATITIS C ANTIBODY ORDERED TODAY..

Rocephin 250 mg IM x 1 today.

Zithromax 1 gram po x 1 today.

Follow up in 1 month.

99213.

Advised to eat healthy,exercise regularly and to avoid violence. Testicular self exam advised. Safe sex education advised.

PATIENT	FACILITY	ENCOUNTER
Jamar Little	Wabash	Office Visit
DOB 06/13/1986	T (312) 808-0621	NOTE TYPE SOAP Note
AGE 37 yrs	F (312) 808-0655	SEEN BY Naveed Muhammad
SEX Male	2850 S. WABASH AVENUE	MD
PRN JL520832	SUITE 203	DATE 05/08/2018
	Chicago, IL 60616-2412	AGE AT DOS 31 yrs
		Electronically signed by Naveed
		Muhammad MD at 05/08/2018 02:15 pm

Chief complaint

(Appt time: 2:00 PM) (Arrival time: 1:06 PM)

Vitals for this encounter	
	05/08/18 1:18 PM
Height	68 in
Weight	239 lb
Temperature	97.7 °F
Pulse	70 bpm
Respiratory rate	20 bpm
Pain	0
BMI	36.34
Blood pressure	116/79 mmHg

SUBJECTIVE

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been an ER visit since the last office visit. Details:

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

TheAudit_C

How often do you have a drink containing alcohol? 2-4 times per month

How many drinks containing alcohol do you have on a typical day of drinking? one or two

How often do you have six or more drinks on one occasion? Never

Audit_C result is normal. The score is 2

Opiate Pre-screen is negative

re is no exposure to second hand smoke.

Right Middle finger pain x 2 days. Getting worse. Denies h/o trauma or injury. Denies cutting his nails recently.

History of Paronychia 15 years ago.

Went to the Trinity ER this am where told everything was ok.

OBJECTIVE

On exam, Right Middle finger radial aspect of the tip with tenderness on palpation. No pus seen.+ Mild swelling.No Discoloration.

ASSESSMENT

Early Paronychia ?

History of Elevated Blood sugar in 2016.

PLAN

Will try Augmentin 875 mg po bid x 7 days.

Ibuprofen 600 mg po q 8 hours prn pain with food.

Advised to eat healthy, exercise regularly and to avoid violence. Testicular self exam advised. Safe sex education advised. Follow up in 1 week.

99213.

CBC,CMP,LIPID,UA, VITAMIN D LEVELS.

Accu Check 110 today.

PATIENT
Jamar Little

DOB 06/13/1986
AGE 37 yrs
SEX Male
PRN JL520832

FACILITY
Wabash
T (312) 808-0621
F (312) 808-0655
2850 S. WABASH AVENUE
SUITE 203
Chicago, IL 60616-2412

ENCOUNTER
Office Visit
NOTE TYPE SOAP Note
SEEN BY Naveed Muhammad MD
DATE 06/01/2016
AGE AT DOS 29 yrs
Electronically signed by Naveed Muhammad MD at 06/01/2016 04:33 pm

Chief complaint

No chief complaint recorded

Vitals for this encounter	
	06/01/16 2:33 PM
Height	68 in
Temperature	98.60 °F
Respiratory rate	20 bpm
Pulse	76 bpm
Weight	212 lb
Pain	0
BMI	32.23
Blood pressure	109/67 mmHg

SUBJECTIVE

New information collected during intake:

(Q) Medications:

(A) Taking: Zithromax 500 mg oral tablet

Not taking: Vitamin D3 (cholecalciferol) oral capsule

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is no significant alcohol use.

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient does not get regular exercise.

Scheduled for CPD skills testing on Saturday and needs Clearance.

No complaints. Feels well.

Has been training for the test for the last 3 months.

!@#\$

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear.

Ears: EAC's clear, TM's normal.
Nose: Mucosa normal, no obstruction.
Throat: Clear, no exudates, no lesions.
Neck: Supple, no masses, no thyromegaly, no bruits.
Chest: Lungs clear, no rales, no rhonchi, no wheezes.
Heart: RR, no murmurs, no rubs, no gallops.
Abdomen: Soft, no tenderness, no masses, BS normal.
Back: Normal curvature, no tenderness.
Extremities: FROM, no deformities, no edema, no erythema.
Neuro: Physiological, no localizing findings.
Skin: Normal, no rashes, no lesions noted.

ASSESSMENT

Well Exam.
Physical for job..

PLAN

CBC,CMP,LIPID,UA , Vitamin D levels TODAY.
Urine for GONORRHEA AND CHLAMYDIA C/S ORDERED TODAY.
Advised to eat healthy,exercise regularly and to avoid violence.
Testicular self exam advised.
Safe sex education advised.
Follow up in 6 months .
99395 Well Care Est 18-39.

Screenings/ Interventions/ Assessments

CATEGORY	NAME	STATUS
Communication	Patient registration form used (finding)	Documented

PATIENT	FACILITY	ENCOUNTER
Jamar Little	PEF CLINIC II, LTD/ JPH	NOTE TYPE
DOB	T (773) 947-7746	SEEN BY
AGE	F (773) 947-7751	Naveed Muhammad
SEX	7531 S. Stony Island	MD
PRN	Room 176	DATE
JL520832	Chicago, IL 60649	10/02/2014
		AGE AT DOS
		28 yrs
		Electronically signed by Naveed
		Muhammad MD at 10/09/2014 10:34 pm

Chief complaint

Spoke w/-er. (Appt time: 3:00 PM) (Arrival time: 2:42 PM) check up

Vitals for this encounter	
	10/02/14
Weight	231 lb
Respiratory rate	20 bpm
Temperature	98.80 °F
Height	68 in
Pulse	76 bpm
BMI	35.12
Blood pressure	118/74 mmHg

SUBJECTIVE

Pain Scale = 0

Audit_C

How often do you have a drink containing alcohol? 2-4 times per month

How many drinks containing alcohol do you have on a typical day of drinking? one or two

How often do you have six or more drinks on one occasion? Never

Audit_C result is normal. The score is 2

Opiate Pre-screen is negative

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been an ER visit since the last office visit. Details:

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient exercises regularly. Details:

Needs physical for CPD POWER TEST.

Also girl friend has some std and patient wants to be checked and treated.

Testicles feels tender to touch but denies penile discharge.

No complaints otherwise. !@#\$

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear.

Ears: EAC's clear, TM's normal.

Nose: Mucosa normal, no obstruction.

Throat: Clear, no exudates, no lesions.

Neck: Supple, no masses, no thyromegaly, no bruits.
 Chest: Lungs clear, no rales, no rhonchi, no wheezes.
 Heart: RR, no murmurs, no rubs, no gallops.
 Abdomen: Soft, no tenderness, no masses, BS normal.
 Back: Normal curvature, no tenderness.
 Extremities: FROM, no deformities, no edema, no erythema.
 Neuro: Physiological, no localizing findings.
 Skin: Normal, no rashes, no lesions noted.
 GU: Normal, no lesions, no discharge, no hernias noted. Bilaterally descended testicles are normal in size and consistency.

ASSESSMENT

Physical for job.
 Exposure to std.

PLAN

Zithromax prescribed.
 CBC,CMP,LIPID,UA ORDERED TODAY.
 Advised to lose weight.
 GONORRHEA AND CHLAMYDIA C/S ORDERED TODAY.
 Advised to eat healthy, exercise regularly and to avoid violence.
 Safe sex education advised. Testicular self exam advised.
 Follow up in 1 month.
 99395 Well Care Est 18-39.
 Advised to stop Alcohol use.

PATIENT**Jamar Little**

DOB 06/13/1986
AGE 37 yrs
SEX Male
PRN JL520832

FACILITY

PEF CLINIC II, LTD/ JPH
 T (773) 947-7746
 F (773) 947-7751
 7531 S. Stony Island
 Room 176
 Chicago, IL 60649

ENCOUNTER

NOTE TYPE	No Show Notes
SEEN BY	Julia Dotson MA
DATE	09/22/2014
AGE AT DOS	28 yrs
Electronically signed by Naveed Muhammad MD at 10/02/2014 03:35 pm	

Chief complaint

No show

Vitals for this encounter

No vitals recorded

NO SHOW NOTES

PATIENT**Jamar Little**

DOB 06/13/1986
AGE 37 yrs
SEX Male
PRN JL520832

FACILITY

PEF CLINIC II, LTD/ JPH
T (773) 947-7746
F (773) 947-7751
7531 S. Stony Island
Room 176
Chicago, IL 60649

ENCOUNTER

NOTE TYPE No Show Notes
SEEN BY Julia Dotson MA
DATE 01/30/2013
AGE AT DOS 26 yrs
Electronically signed by Naveed
Muhammad MD at 10/02/2014 03:35 pm

Chief complaint

No show

Vitals for this encounter

No vitals recorded

NO SHOW NOTES

PATIENT	FACILITY	ENCOUNTER
Jamar Little	PEF CLINIC II, LTD/ JPH	NOTE TYPE
DOB	T (773) 947-7746	SEEN BY
AGE	F (773) 947-7751	Naveed Muhammad
SEX	7531 S. Stony Island	MD
PRN	Room 176	DATE
JL520832	Chicago, IL 60649	01/16/2013
		AGE AT DOS
		26 yrs
		Electronically signed by Naveed
		Muhammad MD at 01/16/2013 04:31 pm

Chief complaint

Spoke w/-er. (Appt time: 2:30 PM) (Arrival time: 2:20 PM) check up

Vitals for this encounter	
	01/16/13
Respiratory rate	20 bpm
Weight	202 lb
Temperature	97.80 °F
Height	68 in
Pulse	76 bpm
BMI	30.71
Blood pressure	124/72 mmHg

SUBJECTIVE

Pain Scale = 0

Audit_C

How often do you have a drink containing alcohol? Monthly or less

How many drinks containing alcohol do you have on a typical day of drinking? three or four

How often do you have six or more drinks on one occasion? Never

Audit_C result is normal. The score is 2

Opiate Pre-screen is negative

ASK EVERY VISIT:

There has been no loss of interest or pleasure in the last two weeks.

There has been no depressed mood in the last two weeks.

There has been no ER visit since the last office visit.

There is significant alcohol use (see alcohol screen).

There is no current use of tobacco.

There is no exposure to second hand smoke.

The patient exercises regularly. Details:

Headaches for past 3-4 weeks. Almost daily. Behind the left peri orbital area. Throbbing type. No prior history of similar headaches. Sensitivity to light. Progressively builds up. No aura. No h/o Migraines in the family. No nausea. Lasts sometimes all day. Helped by Advil which usually puts him to sleep. Phonosensitivity and photosensitivity. Dark room helps. Scale 5-6/10 at present. Feels stressed and anxious because of these headaches. Going through divorce process after being married for 3 years.

Mid lower back pains x 1-2 weeks. Works as a Cable Technician and carries heavy loads. No radiation. Scale 5/10. Unsure what started these back pains.

2-3 weeks ago noticed blood in his stools and then once in his vomitus. Has not happened since. Blood was bright red and in the toilet. Also had bright red blood in his vomitus once and was bright red in color. No episode since. denies Abdominal pains.!@#\$

OBJECTIVE

General: Normotensive, in no acute distress.

Head: Normocephalic, no lesions.

Eyes: PERRLA, EOM's full, conjunctivae clear, fundi grossly normal.

Ears: EAC's clear, TM's normal. Nose: Mucosa normal, no obstruction.

Throat: Clear, no exudates, no lesions.

Neck: Supple, no masses, no thyromegaly, no bruits.

Chest: Lungs clear, no rales, no rhonchi, no wheezes.

Heart: RR, no murmurs, no rubs, no gallops.

Abdomen: Soft, no tenderness, no masses, BS normal.

Rectal: No lesions, no hemorrhoids, stool heme negative.

Back: Normal curvature, no tenderness.

Neuro: Physiological, no localizing findings. Visual field normal.

Skin: Normal, no rashes, no lesions noted.

Prostate: Smooth, symmetrical, non-tender, sulci clearly palpable, Hemoccult Negative.

Extremities: Warm, well perfused, no edema.

ASSESSMENT

Migraine headaches.

Blood per rectum and per oral once.

Back pain.

PLAN

Imitrex 100 mg po at headache onset. Can repeat once more after 2 hours if no relief. Max 2 tabs per day.

CBC,CMP,LIPID,UA,TSH,VITAMIN D LEVELS ORDERED TODAY. ESR.

Advised to stop Alcohol use. Advised to lose weight.

Stool occult x 3 slides given.

Influenza vaccine given.

Surgical Consult for BLOOD IN STOOLS AND PER ORAL.

Advised to eat healthy, exercise regularly and to avoid violence. Advised to lose wt.

Safe sex education advised. Testicular self exam advised.

99214 Office Visit Established Level IV.

Follow up in 2 weeks.

CT SCAN OF THE BRAIN.

Screenings/ Interventions/ Assessments

No active screening/interventions/assessments recorded.

Page 1 of 3

NICL LABORATORIES

Ordering Facility
 Acct #: 334972
 PEF CLINIC II - RT264
 2850 S WABASH SUITE 203 CHICAGO, IL
 60616
 Phone: 312-808-0621

306 Era Drive
 Northbrook, Illinois 60062
 (847) 509-9779

Patient Information

LITTLE, JAMAR
 PID: PTM347947 Rm #:
 DOB: 06/13/1986 Age: 26 Sex: M
 Home Phone #: 773-397-6335
 Physician: MUHAMMAD M.D. NAVEED

Requisition#	Collected	Reported	Status
130023598	01/16/2013 04:35	01/17/2013 09:11	Complete Report

HEMATOLOGY

Test	Within Range	Out of Range	Ref Range	Units
SED RATE, ESR	2		0 - 15	mm/HR

URINALYSIS

Test	Within Range	Out of Range	Ref Range	Units
COLOR	YELLOW		STRAW - AMBER	

TURBIDITY

SPECIFIC GRAVITY	1.021	SL-CLOUDY	H	CLEAR
PH	7.0			1.005 - 1.030
PROTEIN, SEMI-QUANT	NEGATIVE			4.0 - 8.0
GLUCOSE, SEMI-QUANT	NEGATIVE			NEGATIVE
KETONES, SEMI-QUANT	NEGATIVE			mg/dl
BILIRUBIN, SEMI-QUANT	NEGATIVE			NEGATIVE
BLOOD, SEMI-QUANT.	NEGATIVE			mg/dl
NITRITE	NEGATIVE			NEGATIVE
UROBILINOGEN, SEMI-QT	0.2			0.2 - 1.0
LEUKOCYTES, SEMI-QT	NEGATIVE			EU/DL

URINALYSIS MICROSCOPIC

Test	Within Range	Out of Range	Ref Range	Units
WHITE BLOOD CELLS	0-2/HPF		None - 2-5/HPF	
RED BLOOD CELLS	0-2/HPF		None - 0-5/HPF	
EPITHELIAL CELLS	None seen		None seen - Few	
AMORPHOUS SEDIMENT		ModerateH	None - Few	
BACTERIA		ModerateH	None	

25-OH VITAMIN D

Test	Within Range	Out of Range	Ref Range	Units
25-OH VITAMIN D		12.4 L	30.0 - 100.0	ng/ml

When considering treatment, the following reference ranges

are generally followed:

Vitamin D deficiency < 10 ng/mL

Vitamin D insufficiency 10-30 ng/mL

Vitamin D sufficiency 30-100 ng/mL

Observed range for 95 percent of our winter population
of apparently healthy individuals 19.1-57.6 ng/mL

H - High, L - Low, A* - Alert, C* - Critical

Gradimir B. Vuckovic, M.D., Medical Director

Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062 unless otherwise indicated.

Autolims Version 3.02 On 01/17/2013



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2365814-
14747876

(W)

1/17/13

VIT D 50000IU once a week
for 12 weeks. 4Cap (2) Refill.

Page 2 of 3

Ordering Facility

Acct #: 334972
 PEF CLINIC II - RT264
 2850 S WABASH SUITE 203 CHICAGO, IL
 60616
 Phone: 312-808-0621

NICL LABORATORIES

306 Era Drive
 Northbrook, Illinois 60062
 (847) 509-9779

Patient Information

LITTLE, JAMAR
 PID: PTM347947 Rm #:
 DOB: 06/13/1986 Age: 26 Sex: M
 Home Phone #: 773-397-6335
 Physician: MUHAMMAD M.D. NAVEED

Requisition#	Collected	Reported	Status
130023598	01/16/2013 04:35	01/17/2013 09:11	Complete Report

HEMATOLOGY

CBC W/O DIFFERENTIAL

	01/16/13 04:35	11/16/10 15:20	Reference Range	Units
WHITE BLOOD CELLS	6.51	6.57	4.80 - 10.80	THO/mm3
RED BLOOD CELLS	5.60	5.30	4.70 - 6.10	MIL/mm3
HEMOGLOBIN	15.1	14.3	14.0 - 18.0	gm/dl
HEMATOCRIT	46.4	42.5	42.0 - 52.0	%
MCV	82.9	80.2	80.0 - 94.0	um3
MCH	27.0	27.0	27.0 - 33.0	uug
MCHC	32.5	33.6	32.0 - 36.0	gm/dl
PLATELET COUNT	261	266	150 - 400	THO/mm3
MPV	10.3	10.3	9.5 - 13.1	um3

CHEMISTRY

LIPID PANEL W/HDL

	01/16/13 04:35	11/16/10 15:20	Reference Range	Units
CHOLESTEROL	149	144	110 - 200	mg/dl
TRIGLYCERIDES	61	98	10 - 150	mg/dl
HDL CHOLESTEROL	42 L	41 L	50 - 72	mg/dl
LDL	95	84	50 - 130	mg/dl
CHOLESTEROL/HDL RATIO	3.55	3.53		
LDL/HDL RISK RATIO	2.26	2.05		
RISK RATIOS		LDL/HDL CHOL/HDL		
	Women Men	Women Men		
1/2 Average	1.00 1.47	3.43 3.27		
Average	3.55 3.22	4.97 4.44		
2X Average	6.25 5.03	9.55 7.05		
3X Average	7.99 6.14	23.39 11.04		

COMPREHENSIVE METABOLIC

	01/16/13 04:35	11/16/10 15:20	Reference Range	Units
GLUCOSE	94	99	70 - 110	mg/dl
BUN	12	10	5 - 20	mg/dl
CREATININE	1.11	1.08	0.40 - 1.60	mg/dl
BILIRUBIN, TOTAL	0.8	0.7	0.2 - 1.3	mg/dl
PROTEIN, TOTAL	7.6	7.3	6.0 - 8.2	gm/dl
ALBUMIN	4.7	4.5	3.2 - 5.0	gm/dl
SODIUM	139	137	136 - 147	mEq/L
POTASSIUM	4.7	3.9	3.7 - 5.1	mEq/L
CHLORIDE	101	103	93 - 110	mEq/L
CARBON DIOXIDE	29	30	19.51 - 30.49	mM/L

H - High, L - Low, A* - Alert, C* - Critical

Gradimir B. Vuckovic, M.D., Medical Director

Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062 unless otherwise indicated.



Page 3 of 3

NICL LABORATORIES**Ordering Facility**

Acct #: 334972
 PEF CLINIC II - RT264
 2850 S WABASH SUITE 203 CHICAGO, IL
 60616
 Phone: 312-808-0621

306 Era Drive
 Northbrook, Illinois 60062
 (847) 509-9779

Patient Information

LITTLE, JAMAR
 PID: PTM347947 Rm #:
 DOB: 06/13/1986 Age: 26 Sex: M
 Home Phone #: 773-397-6335
 Physician: MUHAMMAD M.D. NAVEED

Requisition#	Collected	Reported	Status
130023598	01/16/2013 04:35	01/17/2013 09:11	Complete Report

COMPREHENSIVE METABOLIC

	01/16/13 04:35	11/16/10 15:20	Reference Range	Units
SGPT(ALT)	19	20	0 - 35	U/L
SGOT(AST)	17	19	9 - 35	U/L
ALK. PHOSPHATASE	78	89	29 - 130	U/L
CALCIUM	10.5 H	9.7	8.2 - 10.2	mg/dl
eGFR	> 60	> 60	greater than 60	ml/m/1.73m ²

According to the National Kidney Foundation, estimated GFR values above 60 mL/min/1.73m² should be interpreted as 'above 60 mL/min/1.73m²' not as an exact number.

> INDICATES GREATER THAN

eGFR reference range is Greater than or equal to 60 mL/min/1.73m²

The eGFR result has been calculated assuming the patient is Caucasian. If the patient is African American please multiply the result by 1.21.

If you have not provided a Date of Birth for this patient, the eGFR may or may not be properly represented on this report.

THYROIDS

	01/16/13 04:35	Reference Range	Units
TSH, ULTRA SENSITIVE 3RD GEN	0.427 L	0.550 - 4.780	uIU/ml

This TSH was measured using a 3rd generation Ultrasensitive assay.

Requisition Comments

H - High, L - Low, A* - Alert, C* - Critical

Gradimir B. Vuckovic, M.D., Medical Director

Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062 unless otherwise indicated.

Autolims Version 3.02 On 01/17/2013



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2365814-
14747876

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 12/10/2018 10:35 am
 Order #: 181926808
 Accession #: 938495

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

SED RATE, ESR

Observations	Result	Reference / UoM	Date/Status
SED RATE, ESR	3	0 - 15 mm/h	12/10/2018 11:49 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
SED RATE, ESR	3	0 - 15 mm/h	12/10/2018 11:49 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

C-REACTIVE PROTEIN, CRP

Observations	Result	Reference / UoM	Date/Status
C-REACTIVE PROTEIN, CRP	● 2.4	0.0 - 1.0 mg/L Above high normal	12/10/2018 10:30 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
C-REACTIVE PROTEIN, CRP	● 2.4	0.0 - 1.0 mg/L Above high normal	12/10/2018 10:30 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

MAGNESIUM

Observations	Result	Reference / UoM	Date/Status
MAGNESIUM	1.9	1.6 - 2.4 mg/dL	12/10/2018 10:17 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
MAGNESIUM	1.9	1.6 - 2.4 mg/dL	12/10/2018 10:17 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

FOLATE AND VITAMIN B12

Observations	Result	Reference / UoM	Date/Status
VITAMIN B12	487	211 - 911 pg/mL	12/10/2018 10:27 pm
VITAMIN B12	487	211 - 911 pg/mL	12/10/2018 10:27 pm
FOLATE, SERUM	9.64	3.37 - 24.00 ng/mL	12/10/2018 10:27 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: Folate deficient 0.35 - 3.37 ng/mL Indeterminate 3.38 - 5.38 ng/mL . Siemens Healthcare Diagnostics has confirmed through internal investigation that this Folate assay is susceptible to biotin interference when present in patient samples. Serum levels of biotin at 50 ng/ml will cause a less than 10% bias. Normal dietary intake is unlikely to cause interference, but dietary biotin supplements may cause falsely elevated values of Folate. Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			
FOLATE, SERUM	9.64	3.37 - 24.00 ng/mL	12/10/2018 10:27 pm

Performing Laboratory

Performing lab details not present

04/10/2019 11:02
4/9/2019

3129292338

SCNA

PAGE 02/05

Encounter - Office Visit Date of service: 04/03/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

PATIENT**Jamar Little**

DOB 06/13/1986
AGE 32 yrs
SEX Male
PRN LJ415710

FACILITY
Anil Gulati SCNA
T (312) 496-3488
F (312) 929-2338
2850 S Wabash
Suite 102
Chicago, IL 60616-2491

ENCOUNTER

NOTE TYPE SOAP Note
SEEN BY Anil Gulati MD
DATE 04/03/2019
AGE AT DOS 32 yrs
Electronically signed by Anil Gulati MD at
04/09/2019 12:29 pm

Patient identifying details and demographics

FIRST NAME	Jamar	SEX	Male	ETHNICITY	Provider did not ask
MIDDLE NAME	-	DATE OF BIRTH	06/13/1986	PREF. LANGUAGE	-
LAST NAME	Little	DATE OF DEATH	-	RACE	Provider did not ask
SSN	-	PRN	LJ415710	STATUS	Active patient

CONTACT INFORMATION

ADDRESS LINE 1	7920 S Manistee	CONTACT BY	-
ADDRESS LINE 2	-	EMAIL	-
CITY	Chicago	HOME PHONE	-
STATE	IL	MOBILE PHONE	(773) 573-7951
ZIP CODE	60617	OFFICE PHONE	-
		OFFICE EXTENSION	-

FAMILY INFORMATION

NEXT OF KIN	-	PATIENT'S MOTHER'S MAIDEN NAME	-
RELATION TO PATIENT	-		
PHONE	-		
ADDRESS	-		

PATIENT NOTES

BCBS PAS823919118 Dr. Naveed Muhammad

Active Insurance**PRIMARY PAYER**

PAYER	ILLINOIS BLUE CROSS AND BLUE SHIELD	INSURED ID NUMBER	PAS823919118
PRIORITY	Primary	GROUP NUMBER	-
TYPE	Other	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	01/01/2018	PAYMENT TYPE	Fixed
END DATE	-	COPAY AMOUNT	-
		STATUS	Active

Inactive insurance

(W)

Payment information

PAYMENT PREFERENCE	Primary Insurance	DATE OF BIRTH	-
PATIENT'S RELATIONSHIP TO GUARANTOR	-	SEX	-
GUARANTOR NAME	-	SOCIAL SECURITY NUMBER	-
GUARANTOR ADDRESS	-	PRIMARY PHONE NUMBER	-
		SECONDARY PHONE NUMBER	-

4/9/2019

Encounter - Office Visit Date of service: 04/03/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

Subjective

32-year-old gentleman was seen in the office for the evaluation of recurrent episodes of passing out.

April 3, 2019

Mr. Little return to the office today for the evaluation of recurrent episodes of passing out. He was last seen in office about a week ago. He reports that he is concerned about returning to work and have an episode of passing out.

He was recently hospitalized at Northwestern University and remained hospitalized there for a few days. I have not reviewed any of the diagnostic workup done there.

He denies any headache. He is compliant with the prescribed medications.

Today the patient does complain of localized low back pain which has been present for many months if not longer duration . He denies any history of trauma. He denies any leg weakness though had does have some trouble walking due to the pain. The back pain is persistent and present all the time.

He reports that he has been advised to receive physical therapy for the back pain.

March 27, 2019

Patient return to the office today for the evaluation of recurrent episodes of passing out.

Patient was not accompanied by his girlfriend today who is currently at work.

He continues to experience headaches and sleep disturbance.

He had another episode of passing out when he was at the department store shopping. He was taken to Northwestern University where he remained hospitalized for a few days. I do not have access to the records. He reports that he had extensive neuro diagnostic workup done there.

His EEG done at Jackson Park Hospital was negative. MRI brain also is negative or normal.

January 14, 2019

He is accompanied by his girlfriend who has known him for the last several months.

He was apparently in his usual state of health on November 27, 2018 when he was at work and was found to be unresponsive at his desk by his coworker. It is unclear for how long he had passed out though. He does recall waking up with a headache. The paramedics were not called and he was not taken to the emergency room as he essentially felt well. Though subsequently he decided to drive to the rest Presbyterian emergency room. He was hospitalized overnight. He had a CT of the head done which was reviewed to be unremarkable. He had several EKGs which was reported to be abnormal. But he was discharged home the next day in a stable condition.

He has not returned to work since though..

Since then he has had at least 4 spells.

(W)

The last spell was on January 9, 2019 when he passed out at home. He was home alone at that time. When his girlfriend came home she does her, he was taken to Mercy Hospital emergency room and was noted to have bradycardia. She is advised to follow-up with a neurologist as well as a cardiologist.

He has had daily headaches for the last few months. He does have background history of headaches for a long time though currently is having daily headaches with a variable degree of severity. She also complains of generalized body pain and fatigue. He has gained about 40 pounds in the last few months.

He denies any chest pain or shortness of breath. There is no history of seizure disorder.

The past history significant for frequent headaches for a long time. Currently takes baby aspirin every day.

4/9/2019

Encounter - Office Visit Date of service: 04/03/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

He has no drug allergies.

He drinks alcohol only on the weekends. She has not had any drink for the last few months. He does not smoke and there is no history of drug abuse.

The comprehensive review of all systems is essentially unremarkable and or negative except for the above presenting symptom complex..

Objective

The blood pressure 143/94 . Pulse 97 Weight 268 pounds

The patient looks comfortable and in no significant distress. The patient appears well groomed and makes appropriate eye contact.

The general physical examination appears normal.

There is no facial asymmetry present. Ocular motility is normal. There is no nystagmus present. Visual field examination by confrontation method is normal. The fundus examination reveals normal-looking optic disc.

There is no pronator sign present.

The sensory motor system examination is normal. The muscle tone is normal.

The reflexes are symmetrical and normal bilaterally. There is no Babinski sign present.

No abnormal movements are present.

The casual gait is normal. There is no carotid artery bruit present..

Assessment

32-year-old gentleman with history of recurrent episodes of passing out over the last 4 months with associated daily headaches. He has been noted to have bradycardia.

Neurological examination appears to be essentially nonfocal and normal.

The etiology of the recurrent episodes is concerning.

The differential diagnostic possibilities include

Seizure disorder

Syncopal episode

Cardiac arrhythmia/bradycardia arrhythmia

I do remain concerned about the daily headaches that he has experienced which may or may not be related to the episodes of passing out.

I have not reviewed any of the diagnostic workup that has been performed in the past.

Hypothyroidism and Brugada syndrome may be the possible culprits.

Seizure is less likely but does remain in the differential diagnosis.

W

March 27, 2019

Young gentleman with recurrent episodes of passing out with a normal neurological examination.

Etiology is unclear.

I understand he was hospitalized at Northwestern University for a few days and had extensive diagnostic workup done. The results are not available to me at this time.

4/8/2019 Encounter - Office Visit Date of service: 04/03/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

The EEG done at excellent Park Hospital is normal.

I suspect his episodes are likely of cardiac etiology.

April 3, 2019

The patient has experienced recurrent episodes of passing out with a normal neurological examination of unclear etiology. The neuro diagnostic workup has been unremarkable. I understand he is scheduled to see a cardiologist in couple of weeks. He complains of back pain which has been present for the last several months if not longer duration.

The neurological examination remains essentially nonfocal and normal. Straight leg raising sign is not present. Reflexes are symmetrical.

The etiology of the episodes is unclear. The neurological workup has been unremarkable. I believe the episode may be of cardiac etiology. He is scheduled to see a cardiologist in next few weeks.

I understand he was hospitalized at Northwestern University couple of weeks ago. I have not received any of the diagnostic workup done at the Northwestern University.

Diagnoses attached to this encounter:

- Headache [ICD-10: R51], [ICD-9: 784.0], [SNOMED: 25064002]
- Loss of consciousness [ICD-10: R55], [ICD-9: 780.09], [SNOMED: 419045004]
- Pain in back [ICD-10: M54.9], [ICD-9: 724.5], [SNOMED: 161891005]

Plan

I discussed my evaluation with the patient and the following recommendations are being made at this time:

#1 headache diary

#2 I would like to review the diagnostic workup done at the Northwestern University

#3 cardiology workup

#4 I advised him to continue taking nortriptyline 50 mg nightly to be taken no later than 9 PM. Side effects discussed

#6 I advised him to take gabapentin 300 mg capsule 3 times a day. Side effects discussed

#7 I recommend MRI lumbar spine without contrast

#8 he may not return to work until next 3-4 weeks until he has been cleared by cardiology.

#9 patient is appropriately concerned about driving as he had had some frequent episodes of passing out.

I spent 35 minutes with the patient and greater than 50 % of time was spent in counseling and coordinating the patient care.

This note was generated using voice recognition software. If you require clarification or have any questions, please feel free to contact my office.

(w)

PEF II CLINIC / DOCTORS OFFICE

PATIENT Last Name

First Name

□ PCP
□ SPECIALIST

10

Address

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REFERRING MET

DATE OF VISIT

Change Information

CPT CODE	DESCRIPTION	OFFICE NEW	ESTABLISHED
CPT CODE	DESCRIPTION	LAB/THERAPEUTIC SERVICES	
99201	LEVEL I	99211	LEVEL I
99202	LEVEL II	99212	LEVEL II
99203	LEVEL III	99213	LEVEL III
99204	LEVEL IV	99214	LEVEL IV
99205	LEVEL V	99215	LEVEL V
PHYSICAL EXAM NEW	PHYSICAL EXAM EST	82948	GLUCOSE BLOOD, ^{URINE} _{URINE}

CPT CODE	DESCRIPTION
INJECTIONS/VACCINES	
90633	HEPATITIS A
90645	HIB
90649	HPV GARDASIL
90657	FLU SPLIT 6-35 MONTHS
90658	FLU 3 YEARS & OLDER
VO4.81	VO4.81

03/22/2019 - ED in Northwestern Memorial Emergency Department

Reason for Visit

Chief Complaint

- Near Syncope

Visit Diagnosis

Name	Code	Is ED?
Syncope (primary)	R55	Yes

Visit Information

Admission Information

Arrival Date/Time:	03/22/2019 1540	Admit Date/Time:	03/22/2019 1628	IP Adm. Date/Time:
Admission Type:	Emergency	Point of Origin:	From Home/work	Admit Category:
Means of Arrival:	Walked In	Primary Service:	Emergency Medicine	Secondary Service: N/A
Transfer Source:		Service Area:	NORTHWESTERN MEDICINE	Unit: Northwestern Memorial Emergency Department
Admit Provider:		Attending Provider:	Baran, Emily A., MD	Referring Provider: Baran, Emily A., MD

Discharge Information

Discharge Date/Time	Discharge Disposition	Discharge Destination	Discharge Provider	Unit
03/23/2019 1332	Home Or Self Care	None	None	Northwestern Memorial Emergency Department

Follow-up Information

Follow-up With	Details	Why	Contact Info
PCP cardiology			

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary**

Discharge Summary by Pruitt, Peter B., MD at 3/23/2019 1:13 PM

Emergency Department Observation Discharge Summary

Please see the ED Admit H&P Note for HPI, ROS, PFSH, and physical exam. Below is a discharge summary along with any progress notes for the stay. Patient was admitted to the EDOU for: syncope

Jamar Little
6/13/1986

Discharge Information
Admit Date: 03/22/2019

Discharge Date: 03/23/2019

Discharge Diagnoses:**1. Syncope**

Attending Physician at Discharge: Dr. Pruitt

HPI

CC:

Chief Complaint

Patient presents with

- Near Syncope

SUMMARY OF HOSPITAL COURSE

32yo M with history of chronic migraines presents to the ED for evaluation of syncopal event. Pt had an episode on 3/22 while seated that was witnessed by his girlfriend. He was casually eating breakfast and talking and girlfriend noticed he nodded off with his eyes initially twitching and then closed for about 5-10 mins. He denies falling or hitting his head. Denies confusion after he awoke, tingling, visual changes, tongue biting. He reports that since November of last year he has been having intermittent syncopal episodes, about 20 events so far. He describes a shooting pain in his neck as a prodrome to the syncopal event which also occurred yesterday. Denies shaking, incontinence. He does notice he is a lot more tired than usual. Patient states that he has seen a Neurologist and had some outpatient testing including an MRI and EEG at RUSH which he does not know the results of. In addition, he has an appointment to see a Cardiologist on 4/4. He came to the ED because of the recurrence in events. In the ED, he had labs WNL, normal CT brain and normal exam. EKG showed inferolateral TWI which is not new as per care everywhere. There was a noteable systolic murmur on exam in the ED which pt states he has had when he was a child. He was then sent to EDOU for further management. Overnight, he had no acute events. He had a 2D echo done which was normal. Cardiology was called and recommended an outpatient work up. There were no telemetry events overnight. He was discharged with recommendations on follow up with cardiologist and PCP as well as holter monitor. He was also advised to get an outpatient sleep study for possible sleep apnea causing his sx as girlfriend notices he snores a lot while sleeping and pt only getting 4 hours of sleep per night.

DISCHARGE PHYSICAL EXAM (KEY FINDINGS)

Vitals:

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)**

	03/22/19 1830	03/22/19 2100	03/23/19 0116	03/23/19 0522
BP:		132/83	142/80	143/63
Pulse:		95	92	88
Resp:		18	18	18
Temp:	98.3 °F (36.8 °C)	97.7 °F (36.5 °C)	97.8 °F (36.6 °C)	97.2 °F (36.2 °C)
SpO2:		95%	97%	98%
	03/23/19 1111			
BP:	124/70			
Pulse:	83			
Resp:	18			
Temp:	97.5 °F (36.4 °C)			
SpO2:	97%			

Vital signs reviewed as above

Constitutional/General: No apparent distress, resting comfortably in bed

Eyes: EOM grossly intact, no scleral icterus, pupils equal and round

HENT: MMM, No nodes or masses, lips on inspection normal, voice clear and audible

CV: equal bilat extremity pulses 2+, no peripheral edema, nl s1s2

Resp: unlabored equal respirations, CTAB

Abd: NT / NG / No rebound tenderness

Ext: MAES, digits and nails w/o cyanosis

Skin: No Rash, no bullae

Neuro: AOx3, CN II-XII grossly intact, speech nl

Psych: Appropriate affect and mood for situation, normal insight

Patient Condition at Discharge:

Improved

Patient Disposition (home,nursing facility,e.g.):

Home

(W)

LABS AND IMAGING THIS VISIT

Results for orders placed or performed during the hospital encounter of 03/22/19

Basic Metabolic Panel

Result	Value	Ref Range
Sodium	142	133 - 146 mEq/L
Potassium	4.5	3.5 - 5.1 mEq/L
Chloride	106	98 - 109 mEq/L
CO2	29	21 - 31 mEq/L
Calcium	9.6	8.3 - 10.5 mg/dL
Urea Nitrogen	13	2 - 25 mg/dL
Creatinine	1.06	0.60 - 1.30 mg/dL
Glucose	104 (H)	65 - 100 mg/dL
Anion Gap	7	5 - 16
GFR(African American)	>60	>=60 mL/min/1.73m2

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)
Discharge Summary (continued)

GFR(Others)	>60	>=60 mL/min/1.73m2
Troponin		
Result	Value	Ref Range
Troponin I	0.00	0.00 - 0.04 ng/mL
Magnesium Level		
Result	Value	Ref Range
Magnesium	1.9	1.5 - 2.7 mg/dL
.CBC		
Result	Value	Ref Range
White Cell Count	7.9	3.5 - 10.5 K/UL
Red Cell Count	5.28	4.30 - 5.80 M/UL
Hemoglobin	14.2	13.0 - 17.5 g/dL
Hematocrit	44.4	38.0 - 50.0 %
MCV	84	80 - 99 fL
MCH	26.9 (L)	27.0 - 34.0 pg
MCHC	32.0	32.0 - 35.5 %
RDW	14.2	11.0 - 15.0 %
Platelet Count	389	140 - 390 K/UL
MPV	10.7	8.8 - 12.1 fL
Differential Type	Auto	
Reflex Morphology	No	
.Auto Diff		
Result	Value	Ref Range
Neutrophils	55	%
Lymphocytes	30	%
Monocytes	11	%
Eosinophils	3	%
Basophils	1	%
Immature Granulocytes	0	%
Absolute Neutrophils	4.3	1.5 - 8.0 K/UL
Absolute Lymphocytes	2.4	1.0 - 4.0 K/UL
Absolute Monocytes	0.9	0.2 - 1.0 K/UL
Absolute Eosinophils	0.2	0.0 - 0.6 K/UL
Absolute Basophils	0.1	0.0 - 0.2 K/UL
A Im Gran Absolute	0.00	0.00 - 0.10 K/UL
Extra Lt. Green(Li Heparin) Top Tube		
Result	Value	Ref Range
Extra Lt Grn	2	
Extra Lavender Top Tube		
Result	Value	Ref Range
Extra Lav		
Extra lavender tube received. Held for add-on testing.		
Troponin		
Result	Value	Ref Range
Troponin I	0.00	0.00 - 0.04 ng/mL

Imaging Results
Echo 2D Only Adult (Final result)

 Result time: 03/23/19
 12:23:03

Final result by Allison R. Zielinski, MD (03/23/19 12:23:03)

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)****Narrative:**

Northwestern Medicine
Bluhm Cardiovascular Institute
675 N. St. Clair
Chicago, IL 60611

Echocardiography Report: ECHO 2D ONLY ADULT

Date of service: 3/23/2019 8:22:01 AM

Accession #: N19US4648648

Ordering physician: 1386914075 IBADETE SULEJMANI

Reason for Study: syncope

Sonographer: Tina Smith

Interpreting Physician: 1467771378 Allison Zielinski

Referring Physician:

PATIENT:

Name: JAMAR LITTLE

MRN: 111012202087

Date of Birth: 6/13/1986 Age: 32 years

Gender: M

Admission status: Inpatient

Height: 172.00 cm BSA: 2.39 m²

Weight: 119.29 kg BMI: 40.3 kg/m²

Cardiac History:

History of syncope.

Heart rate 81 bpm

Blood pressure 143/63 mmHg

Study quality: good.

MEASUREMENTS:

	Value	Indexed Value
Sinus of Valsalva	3.2 cm	
Left atrium diameter	3.7 cm (2D)	
Left atrial volume		16.6 ml/m ²
Left atrial volume	40.3 ml.	16.9 ml/m ²
Left atrial volume	42.3 ml.	17.73 ml/m ²
LV ID (diastole)	4.8 cm (2D)	2.0 cm/m ²
LV ID (systole)	2.9 cm (2D)	1.2 cm/m ²
IVS, leaflet tips	1.1 cm (2D)	
Posterior wall thickness	1.1 cm (2D)	
LV stroke volume	31 ml (2D biplane)	
LVOT diam	2.4 cm	
LV end diastolic volume	47 ml (2D biplane)	19.5 ml/m ²
LV end systolic volume	15 ml (2D biplane)	6.3 ml/m ²
Ejection Fraction	67 % (2D biplane)	
RV basal diameter	3.4 cm	
TAPSE	21.0 mm	

(W)

FINDINGS:

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)****LEFT VENTRICLE:**

The left ventricle is normal in size.

There is no left ventricular hypertrophy.

Left ventricular systolic function is normal. **EF = 67% (2D biplane)**

Left ventricular diastolic function was not evaluated.

LV Wall Motion:

All scored segments are normal.

RIGHT VENTRICLE:

The right ventricle is normal in size. Right ventricular systolic function is normal.

The right atrial pressure is 3 mmHg. RV free wall is not well seen.

LEFT ATRIUM:

The left atrial size is normal. The LA volume is 40.3 ml, 16.9 ml/m² when indexed.

RIGHT ATRIUM:

The right atrial cavity is normal in size.

MITRAL VALVE:

The mitral valve leaflets are structurally normal. There is mild mitral valve leaflet thickening.

TRICUSPID VALVE:

The tricuspid valve leaflets are structurally normal.

AORTIC VALVE:

The aortic valve leaflets are structurally normal. The aortic valve is tricuspid.

PULMONIC VALVE

The pulmonic valve cusps are structurally normal.

AORTA:

The visualized aorta is normal in size.

Measurements - Sinus 3.2 cm. Sinotubular junction 2.4 cm. Proximal ascending aorta 2.6 cm.

PULMONARY ARTERIES:

The pulmonary arteries are normal.

PERICARDIUM:

There is trivial pericardial effusion.

(W)

CONCLUSIONS:

-Study quality: good.

-Two-dimensional transthoracic echocardiography was performed using standard views & projections.

-The left ventricle is normal in size. There is no left ventricular hypertrophy. Left ventricular systolic function is normal. EF = 67% (2D biplane) All scored segments are normal.

-The right ventricle is normal in size. Right ventricular systolic function is normal. The right atrial pressure is 3 mmHg.

-No significant valvular abnormalities. Non-doppler study.

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)**

- Normal atria and aorta.
- No prior echocardiographic exam available for comparison.

Electronically signed by Dr.Allison Zielinski on 3/23/2019 at 12:23:02 PM.

**** Final ****

CT Brain without Contrast (Final result)

Result time: **03/23/19
09:06:17**

Final result by Tarek A. Hijaz, MD (03/23/19 09:06:17)

Narrative:

NONCONTRAST CT BRAIN

HISTORY: 32-year-old man presenting following a syncopal event. The patient also has a history of migraine headaches.

TECHNIQUE: Noncontrast helical images of the brain were obtained from the foramen magnum to the vertex. Coronal reformatted images were generated.

COMPARISON: None.

FINDINGS:

The ventricles and sulci are within normal limits for the patient's age. There is no midline shift or mass effect. The basal cisterns are intact.

No acute intracranial hemorrhage or extra axial fluid collection is identified. There are no areas of abnormal parenchymal attenuation. The gray-white differentiation is maintained.

The extracranial soft tissues and orbital contents are unremarkable. An osteoma in the medial aspect of the left frontal sinus measures approximately 10 mm AP by 17 mm TV. There is a 3.5 mm left ethmoid osteoma. Small retention cysts are identified in the right anterior ethmoid air cell and in the left maxillary sinus. The mastoid air cells and middle ear cavities are clear.

IMPRESSION:

1. No acute intracranial abnormality. Further evaluation with a brain MRI may be performed if clinically indicated.
2. Osteoma in the medial aspect of the left frontal sinus measures approximately 10 mm AP by 17 mm TV. Additionally, there is a 3.5 mm left ethmoid osteoma.

FINAL REPORT

THE ATTENDING RADIOLOGIST INTERPRETED THIS STUDY WITH THE RESIDENT WHOSE NAME APPEARS BELOW, AND FULLY AGREES WITH THE REPORT AND HAS AMENDED THE REPORT WHEN NECESSARY:

Attending Radiologist: Hijaz, Tarek MD

Radiology Resident: Mackey, Rosewell MD

Date Signed Off: 03/23/2019 09:06

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)**

Additional Instructions(diet, activity, e.g.): Gen diet, activity as tolerated.

I saw and evaluated the patient. I have discussed the case with the resident or advanced practice provider and reviewed their documentation. I agree with the findings and plan of care by the resident or advanced practice provider with any additions and corrections above and/or below if necessary.

Peter Pruitt, MD

Electronically signed by Pruitt, Peter B., MD at 3/23/2019 2:22 PM



03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**ED Provider Note**

ED Provider Notes by Baran, Emily A., MD at 3/22/2019 5:03 PM

Treatment Team: Attending Provider: Emily A. Baran, MD; Registered Nurse: Fiona Duggan, RN; Medical Student: Madeleine Alder
Arrived Via: Walked In
PCP: No primary care provider on file.

SUBJECTIVE**Chief Complaint**

Patient presents with

- Near Syncope

HPI

32 y.o. male w/ h/o migraines presenting recurrent syncopal-like events. Pt states that he had twenty syncopal events since November. He has already been to multiple physicians for this issue including a neurologist and a cardiologist. Pt presents today after an episode witnessed by his girlfriend. They were eating brunch together and his eye fluttered and he was not responsive to her saying his name. He did not slump forward and did not hit his head. He says that his warning for these episodes is sharp pain in his neck. The neurologist has done an MRI and an EEG, pt does not know the results of either. Cardiologist kept him overnight, but has not done a holter monitor Girlfriend says that he snores.

ROS

Constitutional: Negative except as documented in HPI or above or below.

Skin: Negative except as documented in HPI or above or below.

Eye: Negative except as documented in HPI or above or below.

ENT: Negative except as documented in HPI or above or below.

Respiratory: Negative except as documented in HPI or above or below.

Cardiovascular: Negative except as documented in HPI or above or below.

Gastrointestinal: Negative except as documented in HPI or above or below.

Genitourinary: Negative except as documented in HPI or above or below.

Musculoskeletal: Negative except as documented in HPI or above or below.

Neurologic: Negative except as documented in HPI or above or below.

Psychiatric: Negative except as documented in HPI or above or below.

Endocrine: Negative except as documented in HPI or above or below.

Hematologic/Lymphatic: Negative except as documented in HPI or above or below.

Allergy/immunologic: Negative except as documented in HPI or above or below.

Additional ROS: All other systems reviewed and otherwise negative or above or below.

(W)

PAST MEDICAL HISTORY

No past medical history on file.

No past surgical history on file.

MEDICATIONS

No current facility-administered medications on file prior to encounter.

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**ED Provider Note (continued)**

No current outpatient prescriptions on file prior to encounter.

ALLERGIES

No Known Allergies

SOCIAL HISTORY**Social History****Substance Use Topics**

- Smoking status: Not on file
- Smokeless tobacco: Not on file
- Alcohol use Not on file

Tobacco - denies

Alcohol - denies

Recreational Drug use - occasional marijuana use

FAMILY HISTORY

No family history on file.

Past medical, family, and social histories as documented in the EMR reviewed and verified.

OBJECTIVE**Vitals:**

03/22/19 1641

BP: 149/66
Pulse: (1) 105
Resp: 18
SpO2: 100%

Vital Signs Reviewed As Above

Constitutional/General: No apparent distress

Eyes: EOM grossly intact, no scleral icterus, pupils equal and round

HENT: MMM, lips on inspection normal, voice clear and audible

CV: 2/6 systolic murmur with S4

Resp: unlabored equal respirations, CTAB

Abd: NT / NG / No rebound tenderness

Ext: MAES, digits and nails w/o cyanosis

Skin: No Rash, no bullae

Neuro: A0x3, no facial asymmetry or droop, moving all extremities, speech nl

Psych: Appropriate affect and mood for situation, normal judgement and insight

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**ED Provider Note (continued)****Labs and Imaging**

No results found for this visit on 03/22/19.

Imaging Results

None

PROCEDURES**ASSESSMENT & PLAN**

32 y.o. male With recurrent syncope representing with a heart murmur and abnormal EKGs.

DX: No diagnosis found.

ATTENDING ATTESTATION

I have seen, personally examined and evaluated the patient. I have reviewed the student's documentation and discussed the case with the student. I agree with the student's findings and plan of care with any additions and corrections noted above and/or below. Healthy 32-year-old male obese who since November of last year been having intermittent syncopal episodes. Some weird shooting pain in his neck as a prodrome also has a history of migraines then brief episodes of nodding off or falling down without postictal. Shaking incontinence or tongue biting. His seen a cardiologist and neurologist with some outpatient testing including an MRI and EEG which ~~she~~ does not know the results. Today had a brief syncopal episode while seated his head knotted down was witnessed by his girlfriend when he awoke he seemed not confused. His only complaint now is some musculoskeletal complaints including shoulder and back pain which also are new since November as well as generalized fatigue. Reports That He Does Snore Has Never Been Tested for Sleep Apnea. On My Exam He Is Well-Appearing He Does Have a 2 out of 6 Systolic Diastolic Murmur As Well As an S4. States he may have had a murmur a a child but has never had an ECHO, EKG with twi inferior and laterally. Admit observation for arrhythmia/telemetry monitoring, echocardiogram in the morning as well as cardiology evaluation. Needs outpatient sleep study. If cannot find MRI imaging as outpatient will need CT brain here.

1. Syncope

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)

ED Provider Note (continued)

Critical Care time: 0

Emily Baran, MD
Attending Physician
Pager 5-7232
Cell 6-7298

REASSESSMENT/UPDATES

ED Course

Electronically signed by Baran, Emily A., MD at 3/22/2019 5:59 PM

(W)

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**H&P**

H&P by Pruitt, Peter B., MD at 3/22/2019 10:14 PM

Clinical Decision Unit H&P**HPI:**

32yo M pmhx chronic migraines presents to the ED for evaluation of syncopal event. Pt had an episode today while seated that was witnessed by his girlfriend. He did not slump forward and denies hitting his head. Denies confusion after he awoke.

He reports that since November of last year who has been having intermittent syncopal episodes. He describes a shooting pain in his neck as a prodrome to the syncopal event. Denies shaking, incontinence or tongue biting.

Patient states that he has seen a Neurologist and had some outpatient testing including an MRI and EEG at RUSH which he does not know the results. In addition, he has an appointment to see a Cardiologist on 4/4.

ED Workup:

Troponin negative X2

EKG with sinus tachycardia @102bpm with twi inferior and laterally

CT brain without acute intracranial abnormality

CBC, BMP WNL

Patient was transferred to the CDU for continued observation and Cardiology consult in the AM.

Upon my assessment, pt is well appearing, A&O x3, afebrile, and hemodynamically stable. He reports some musculoskeletal complaints including shoulder and back pain with generalized feeling of fatigue. Denies CP/SOB/Lightheadedness/Dizziness/Abdominal Pain/Nausea/Vomiting

PMHx:

Migraines

Medications:

Nortriptyline 50mg daily

Vitals:

03/23/19 0522

BP: 143/63

Pulse: 88

Resp: 18

Temp: 97.2 °F (36.2 °C)

(W)

Physical Exam:**General:** nontoxic and NAD.**Skin:** Warm, pink, no rash or lesion**Head:** Atraumatic, NCAT**Eye:** EOMI, sclera white**ENT:** dry mucous membranes**Respiratory:** Respirations non-labored, lungs CTAB, no wheeze, no rhonchi, no rales**Cardiovascular:** Regular rate and rhythm, 2/6 systolic murmur with S4**Gastrointestinal:** NT/ND/ No rebound tenderness

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**H&P (continued)****Ext:** no LE edema, wwp**Psychiatric:** Cooperative and appropriate mood & affect.**Neurologic:** Alert and oriented x3.

II: vision grossly intact

III, IV, VI: PERRL, EOMI, no gaze deviation

V: sensation in face intact

VII: No facial weakness, symmetry in face, nasolabial fold flattening

VIII: hearing grossly intact

IX, X: midline uvula and palate elevation

XI: 5/5 b/l trapezius

XII: normal tongue appearance, non-lateralizing protrusion

Motor: 5/5 strength RUE and RLEs. 5/5 on left**Sensory:** intact to light touch b/l LE and UE**Cerebellar:** no pronator drift**Psych:** Appropriate affect and mood for situation, normal insight**Assessment/Plan**

32yo M pmhx chronic migraines presents to the ED for evaluation of syncopal event.

--1L IVF

--Telemetry monitoring

--2D ECHO

--Cardiology consult in AM, possible outpatient Ziopatch

Signed: Ibadete Sulejmani, PA-C in the service of Dr. Pruitt

I saw and evaluated the patient. I have discussed the case with the resident or advanced practice provider and reviewed their documentation. I agree with the findings and plan of care by the resident or advanced practice provider with any additions and corrections above and/or below if necessary.

Peter Pruitt, MD

Electronically signed by Pruitt, Peter B., MD at 3/23/2019 11:06 AM

Labs**Troponin [1235597490] (Completed)****Specimen Information**

ID	Type	Source	Collected By
1-19-081-08812	Blood	—	Pagador, Andrea, RN 03/22/19 2225

Troponin [1235597490]

Resulted: 03/22/19 2301, Result status: Final result

Ordering provider: Sulejmani, Ibadete, PA-C 03/22/19 2053

Order status: Completed

Filed by: Edi, Nm Pathnet Orders-Results In (963303) 03/22/19

Collected by: Pagador, Andrea, RN 03/22/19 2225

2301

Resulting lab: NORTHWESTERN MEMORIAL HOSPITAL LAB

Narrative:

ORDERING DEPARTMENT:NMH EMERGENCY DEPARTMENT

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)****Preliminary result by Rosewell Valentino Mackey, MD (03/22/19 19:00:47)**

Narrative:

NONCONTRAST CT BRAIN

HISTORY: Migraine and syncope.

TECHNIQUE: Noncontrast helical images of the brain were obtained from the foramen magnum to the vertex. Coronal reformatted images were generated and reviewed

COMPARISON: None.

FINDINGS:

The ventricles and sulci are within normal limits for the patient's age. There is no midline shift or mass effect. The basal cisterns are intact.

No acute intracranial hemorrhage or extra axial fluid collection is identified. There are no areas of abnormal parenchymal attenuation. The gray-white differentiation is maintained.

The calvarium is intact. There is a contour irregularity involving the nasal arch, which may represent an age indeterminant nasal bone fracture. There is a small retention cyst within the left maxillary sinus. The visualized paranasal sinuses are well-aerated. The mastoid air cells are clear.

IMPRESSION:

1. No acute intracranial abnormality. A follow-up brain MRI could be performed if there persistent clinical concern for acute intracranial process, as clinically directed.
2. Mild contour irregularity involving the nasal arch, which may represent an age-indeterminate nasal bone fracture. Clinical correlation is recommended.

PRELIMINARY REPORT

THIS DOCUMENT HAS NOT BEEN APPROVED
BY AN ATTENDING RADIOLOGIST

Dictated by: Mackey, Rosewell MD 03/22/2019 18:49

Xray Chest PA Lateral (Final result)Result time: 03/23/19
13:01:12**Final result by Imran M. Omar, MD (03/23/19 13:01:12)**

Narrative:

PROCEDURE: XR CHEST PA LAT. 3/22/2019 5:29 PM.

TECHNIQUE: 2 views (PA and Lateral) of the chest were performed.

HISTORY: Syncope.

COMPARISON: None.

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)****FINDINGS:**

Support Devices: None.

Cardiac Silhouette/Mediastinum/Hila: The cardiac, mediastinal, and hilar contours are within normal limits for age.

Lungs/Pleural Spaces: The lungs and pleural spaces are clear.

Chest Wall/Diaphragm/Upper Abdomen: The thoracic musculoskeletal structures and the upper abdomen are age-appropriate in appearance.

CONCLUSION(S):

1. There is no acute cardiopulmonary process.

FINAL REPORT

THE ATTENDING RADIOLOGIST INTERPRETED THIS STUDY WITH THE RESIDENT WHOSE NAME APPEARS BELOW, AND FULLY AGREES WITH THE REPORT AND HAS AMENDED THE REPORT WHEN NECESSARY:

Attending Radiologist: Omar, Imran MD

Radiology Resident: Hirano, Miki MD

Date Signed Off: 03/23/2019 13:01

Preliminary result by Miki Hirano, MD (03/23/19 08:51:28)

Narrative:

PROCEDURE: XR CHEST PA LAT. 3/22/2019 5:29 PM.

TECHNIQUE: 2 views (PA and Lateral) of the chest were performed.

HISTORY: Syncope.

COMPARISON: None.

FINDINGS:

Support Devices: None.

Cardiac Silhouette/Mediastinum/Hila: The cardiac, mediastinal, and hilar contours are within normal limits for age.

Lungs/Pleural Spaces: The lungs and pleural spaces are clear.

Chest Wall/Diaphragm/Upper Abdomen: The thoracic musculoskeletal structures and the upper abdomen are age-appropriate in appearance.

CONCLUSION(S):

1. There is no acute cardiopulmonary process.

PRELIMINARY REPORT

THIS DOCUMENT HAS NOT BEEN APPROVED
BY AN ATTENDING RADIOLOGIST

Dictated by: Hirano, Miki MD 03/22/2019 17:51

**Preliminary result by Miki Hirano, MD (03/22/19 17:51:28)**

03/22/2019 - ED in Northwestern Memorial Emergency Department (continued)**Discharge Summary (continued)****Narrative:**

PROCEDURE: XR CHEST PA LAT. 3/22/2019 5:29 PM.

TECHNIQUE: 2 views (PA and Lateral) of the chest were performed.

HISTORY: Syncope.

COMPARISON: None.

FINDINGS:

Support Devices: None.

Cardiac Silhouette/Mediastinum/Hila: The cardiac, mediastinal, and hilar contours are within normal limits for age.

Lungs/Pleural Spaces: The lungs and pleural spaces are clear.

Chest Wall/Diaphragm/Upper Abdomen: The thoracic musculoskeletal structures and the upper abdomen are age-appropriate in appearance.

CONCLUSION(S):

1. There is no acute cardiopulmonary process.

PRELIMINARY REPORT

THIS DOCUMENT HAS NOT BEEN APPROVED
BY AN ATTENDING RADIOLOGIST

Dictated by: Hirano, Miki MD 03/22/2019 17:51

PROCEDURES PERFORMED THIS VISIT

None

Complete Discharge Medication List Incorporating Changes: Home Medications:

MEDICATIONS (FACILITY AND HOME MEDS)**Previous Medications**

No medications on file

Scheduled Meds:

Continuous Infusions:

PRN Meds:

No current facility-administered medications for this encounter.

No current outpatient prescriptions on file.

Relevant changes to Home Medications: None

Follow up Plan: With PMD and cardiologist



CHICAGO POLICE DEPARTMENT
HUMAN RESOURCES DIVISION
Investigations Section

Medical Release for Testing
POWER TEST

Date: OCT 02, 2014

To: Rose Sprinkle
Deputy Director
Human Resources Division

From: Doctor NAVEED MUHAMMAD MD
(Doctor, Please PRINT your full name)

I hereby certify that the following individual:

JAMAR

(First Name)

D

(MI)

LITTLE

(Last Name)

was examined by me on OCTOBER 02, 2014.
(Month) (Day)

I also certify that this individual is able to participate in vigorous physical exercise, with NO RESTRICTIONS, including running one and one half (1-1/2) miles, completing up to thirty-seven (37) sit-ups, having to reach (while sitting) a maximum of eighteen (18) inches, and having to bench press a maximum of ninety-eight (98%) percent of their body weight.

Naveed Muhammad

(Signature)

2850 S. WABASH AVE # 203
(Address - Please Print)

CHICAGO, IL 60616
(City, State and Zip Code)

312 808 0621
(Telephone Number)

MERCY HOSPITAL AND MEDICAL CTR
(Name of Hospital Affiliation)
2525 S. MICHIGAN AVE,
CHICAGO, IL 60616.

ATT: CLINTON LEE
2850 S. WABASH AVE., SUITE
CHICAGO, IL 60616
Ph: 312-603-0321
FAX: 312-603-0635

4/29/2019

Encounter - Office Visit Date of service: 04/29/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

PATIENT	FACILITY	ENCOUNTER
Jamar Little	Anil Gulati SCNA	NOTE TYPE SOAP Note
DOB 06/13/1986	T (312) 496-3488	SEEN BY Anil Gulati MD
AGE 32 yrs	F (312) 929-2338	DATE 04/29/2019
SEX Male	2850 S Wabash	AGE AT DOS 32 yrs
PRN LJ415710	Suite 102	Electronically signed by Anil Gulati MD at
	Chicago, IL 60616-2491	04/29/2019 02:55 pm

Chief complaint

(Appt time: 2:00 PM) (Arrival time: 2:09 PM) follow up

Subjective

32-year-old gentleman was seen in the office for the evaluation of recurrent episodes of passing out.

April 29, 2019

Mr. Little returns to the office today for evaluation of recurrent episodes of passing out. He was last seen about a month ago. He has not had any further episodes of passing out. He does complain of localized low back pain due to the recent MRI of the lumbar spine was negative.

He has not returned to work yet. He denies any headaches. He is reportedly compliant with the prescribed medications.

I have not reviewed any of the prior neurodiagnostic work-up done at Northwestern University. I understand he is scheduled to see cardiologist early next week.

April 3, 2019

Mr. Little return to the office today for the evaluation of recurrent episodes of passing out. He was last seen in office about a week ago. He reports that he is concerned about returning to work and have an episode of passing out.

He was recently hospitalized at Northwestern University and remained hospitalized there for a few days. I have not reviewed any of the diagnostic workup done there.

He denies any headache. He is compliant with the prescribed medications.

Today the patient does complain of localized low back pain which has been present for many months if not of longer duration . He denies any history of trauma. He denies any leg weakness though had does have some trouble walking due to the pain. The back pain is persistent and present all the time.

He reports that he has been advised to receive physical therapy for the back pain.

**March 27, 2019**

Patient return to the office today for the evaluation of recurrent episodes of passing out.

Patient was not accompanied by his girlfriend today who is currently at work.

He continues to experience headaches and sleep disturbance.

He had another episode of passing out when he was at the department store shopping. He was taken to Northwestern University where he remained hospitalized for a few days. I do not have access to the records. He reports that he had extensive neuro diagnostic workup done there.

His EEG done at Jackson Park Hospital was negative. MRI brain also is negative or normal.

January 14, 2019

He is accompanied by his girlfriend who has known him for the last several months.

4/29/2019

Encounter - Office Visit Date of service: 04/29/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

He was apparently in his usual state of health on November 27, 2018 when he was at work and was found to be unresponsive at his desk by his coworker. It is unclear for how long he had passed out though. He does recall waking up with a headache. The paramedics were not called and he was not taken to the emergency room as he essentially felt well. Though subsequently he decided to drive to the rest Presbyterian emergency room. He was hospitalized overnight. He had a CT of the head done which was reviewed to be unremarkable. He had several EKGs which was reported to be abnormal. But he was discharged home the next day in a stable condition.

He has not returned to work since though..

Since then he has had at least 4 spells.

The last spell was on January 9, 2019 when he passed out at home. He was home alone at that time. When his girlfriend came home she does her, he was taken to Mercy Hospital emergency room and was noted to have bradycardia. She is advised to follow-up with a neurologist as well as a cardiologist.

He has had daily headaches for the last few months. He does have background history of headaches for a long time though currently is having daily headaches with a variable degree of severity. She also complains of generalized body pain and fatigue. He has gained about 40 pounds in the last few months.

He denies any chest pain or shortness of breath. There is no history of seizure disorder.

The past history significant for frequent headaches for a long time. Currently takes baby aspirin every day.

He has no drug allergies.

He drinks alcohol only on the weekends. She has not had any drink for the last few months. He does not smoke and there is no history of drug abuse.

The comprehensive review of all systems is essentially unremarkable and or negative except for the above presenting symptom complex..

Objective

The blood pressure 117/81 . Pulse 102 Weight 263 pounds

The patient looks comfortable and in no significant distress. The patient appears well groomed and makes appropriate eye contact.

The general physical examination appears normal.

There is no facial asymmetry present. Ocular motility is normal. . There is no nystagmus present. Visual field examination by confrontation method is normal. The fundus examination reveals normal-looking optic disc.

There is no pronator sign present.

The sensory motor system examination is normal. The muscle tone is normal.



The reflexes are symmetrical and normal bilaterally. There is no Babinski sign present.

No abnormal movements are present.

The casual gait is normal. There is no carotid artery bruit present.

Assessment

32-year-old gentleman with history of recurrent episodes of passing out over the last 4 months with associated daily headaches. He has been noted to have bradycardia.

Neurological examination appears to be essentially nonfocal and normal.

The etiology of the recurrent episodes is concerning.

4/29/2019

Encounter - Office Visit Date of service: 04/29/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

The differential diagnostic possibilities include

Seizure disorder

Syncopal episode

Cardiac arrhythmia/bradycardia arrhythmia

I do remain concerned about the daily headaches that he has experienced which may or may not be related to the episodes of passing out.

I have not reviewed any of the diagnostic workup that has been performed is done in the past.

Hypothyroidism and Brugada syndrome may be the possible culprits.

Seizure is less likely but does remain in the differential diagnosis.

March 27, 2019

Young gentleman with recurrent episodes of passing out with a normal neurological examination.

Etiology is unclear.

I understand he was hospitalized at Northwestern University for a few days and had extensive diagnostic workup done. The results are not available to me at this time.

The EEG done at excellent Park Hospital is normal.

I suspect his episodes are likely of cardiac etiology.

(W)

April 3, 2019

The patient has experienced recurrent episodes of passing out with a normal neurological examination of unclear etiology. The neuro diagnostic workup has been unremarkable. I understand he is scheduled to see a cardiologist in couple of weeks. He complains of back pain which has been present for the last several months if not longer duration.

The neurological examination remains essentially nonfocal and normal. Straight leg raising sign is not present. Reflexes are symmetrical.

The etiology of the episodes is unclear. The neurological workup has been unremarkable. I believe the episode may be of cardiac etiology. He is scheduled to see a cardiologist in next few weeks.

I understand he was hospitalized at Northwestern University couple of weeks ago. I have not received any of the diagnostic workup done at the Northwestern University.

April 29, 2019

The patient has experienced recurrent episodes of passing out with a normal neurological examination of unclear etiology. The neuro diagnostic workup has been unremarkable.

The neurological examination remains essentially nonfocal and normal. Straight leg raising sign is not present. Reflexes are symmetrical.

He has not had any further episodes passing out. Last episode was about a month ago.

He does have history of alcohol abuse on a daily basis and excessive amount though he apparently stopped drinking in November 2018. He has had only very few drinks since. Last alcoholic drink being about 2 days ago.

He does admit to feeling depressed. He has not returned to work yet.

MRI lumbar spine is unremarkable.

4/29/2019

Encounter - Office Visit Date of service: 04/29/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

Plan

I discussed my evaluation with the patient and the following recommendations are being made at this time:

- #1 I advised him to continue taking nortriptyline 50 mg nightly to be taken no later than 9 PM. Side effects discussed
- #2 I advised him to continue taking gabapentin 300 mg capsule 3 times a day. Side effects discussed
- #3 I would like to review the prior neurodiagnostic work-up done at Northwestern University
- #4 I encouraged him to see the cardiologist next week
- #5 he has been advised to minimize his use of alcohol or quit if possible
- #6 psychiatry consultation would be of great help
- #7 return visit in 3 to 4 weeks

I spent 35 minutes with the patient and greater than 50 % of time was spent in counseling and coordinating the patient care.

This note was generated using voice recognition software. If you require clarification or have any questions, please feel free to contact my office.

practicefusion

2020-03-28

Encounter - Office Visit Date of service: 03/27/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

PATIENT

Jamar Little
DOB 06/13/1986
AGE 32 yrs
SEX M
PRN LJ415710

FACILITY
Anil Gulati SCNA
T (312) 496-3488
F (312) 929-2338
2850 S Wabash
Suite 102
Chicago, IL 60616-2491

ENCOUNTER

NOTE TYPE SOAP Note
SEEN BY Anil Gulati MD
DATE 03/27/2019
AGE AT DOS 32 yrs
Electronically signed by Anil Gulati MD at 03/27/2019 10:12 pm

Active insurance**PRIMARY PAYER**

PAYER	ILLINOIS BLUE CROSS AND BLUE SHIELD	INSURED ID NUMBER	PAS823919118
PRIORITY	Primary	GROUP NUMBER	-
TYPE	Other	EMPLOYER NAME	-
RELATIONSHIP TO INSURED	Self	INSURANCE PAYMENT TYPE	Copay
START DATE	01/01/2018	PAYMENT TYPE	Fixed
END DATE	-	COPAY AMOUNT	-
		STATUS	Active

Inactive insurance**Payment information**

PAYMENT PREFERENCE	Primary Insurance	DATE OF BIRTH	-
PATIENT'S RELATIONSHIP TO GUARANTOR	-	SEX	-
GUARANTOR NAME	-	SOCIAL SECURITY NUMBER	-
GUARANTOR ADDRESS	-	PRIMARY PHONE NUMBER	-
		SECONDARY PHONE NUMBER	-

Subjective

32-year-old gentleman was seen in the office for the evaluation of recurrent episodes of passing out.

March 27, 2019

Patient return to the office today for the evaluation of recurrent episodes of passing out.

Patient was not accompanied by his girlfriend today who is currently at work.

He continues to experience headaches and sleep disturbance.

He had another episode of passing out when he was at the department store shopping. He was taken to Northwestern University where he remained hospitalized for a few days. I do not have access to the records. He reports that he had extensive neuro diagnostic workup done there.

His EEG done at Jackson Park Hospital was negative. MRI brain also is negative or normal.

January 14, 2019

He is accompanied by his girlfriend who has known him for the last several months.

He was apparently in his usual state of health on November 27, 2018 when he was at work and was found to be unresponsive at his desk by his coworker. It is unclear for how long he had passed out though. He does recall waking up with a headache. The paramedics were not called and he was not taken to the emergency room as he essentially felt well. Though subsequently he

4-1-19
 Please ask pt to sign
 Release for Medical
 Records from
 NW Hospital

(w) 4-1-19
 Cardiology consult
 for recurrent
 syncope

Naveed Mohamed

03/28/2019
 decided to drive to the rest Presbyterian emergency room. He was hospitalized overnight. He had a CT of the head done which was reviewed to be unremarkable. He had several EKGs which was reported to be abnormal. But he was discharged home the next day in a stable condition.

He has not returned to work since though..

Since then he has had at least 4 spells.

The last spell was on January 9, 2019 when he passed out at home. He was home alone at that time. When his girlfriend came home she does her, he was taken to Mercy Hospital emergency room and was noted to have bradycardia. She is advised to follow-up with a neurologist as well as a cardiologist.

He has had daily headaches for the last few months. He does have background history of headaches for a long time though currently is having daily headaches with a variable degree of severity. She also complains of generalized body pain and fatigue. He has gained about 40 pounds in the last few months.

He denies any chest pain or shortness of breath. There is no history of seizure disorder.

The past history significant for frequent headaches for a long time. Currently takes baby aspirin every day.

He has no drug allergies.

He drinks alcohol only on the weekends. She has not had any drink for the last few months. He does not smoke and there is no history of drug abuse.

The comprehensive review of all systems is essentially unremarkable and or negative except for the above presenting symptom complex..

Objective

The blood pressure 134/95 . Pulse 99 Weight 263

The patient looks comfortable and in no significant distress. The patient appears well groomed and makes appropriate eye contact.

The general physical examination appears normal.

There is no facial asymmetry present. Ocular motility is normal. There is no nystagmus present. Visual field examination by confrontation method is normal. The fundus examination reveals normal-looking optic disc.

There is no pronator sign present.

The sensory motor system examination is normal. The muscle tone is normal.

The reflexes are symmetrical and normal bilaterally. There is no Babinski sign present.

No abnormal movements are present.



The casual gait is normal. There is no carotid artery bruit present..

Assessment

32-year-old gentleman with history of recurrent episodes of passing out over the last 4 months with associated daily headaches. He has been noted to have bradycardia.

Neurological examination appears to be essentially nonfocal and normal.

The etiology of the recurrent episodes is concerning.

The differential diagnostic possibilities include
Seizure disorder

~~Syncopal episode~~~~Cardiac arrhythmia/bradycardia arrhythmia~~

Encounter - Office Visit Date of service: 03/27/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

I do remain concerned about the daily headaches that he has experienced which may or may not be related to the episodes of passing out.

I have not reviewed any of the diagnostic workup that has been performed is done in the past.

Hypothyroidism and Brugada syndrome may be the possible culprits.

Seizure is less likely but does remain in the differential diagnosis.

March 27, 2019

Young gentleman with recurrent episodes of passing out with a normal neurological examination.
Etiology is unclear.

I understand he was hospitalized at Northwestern University for a few days and had extensive diagnostic workup done. The results are not available to me at this time.

The EEG done at excellent Park Hospital is normal.

I suspect his episodes are likely of cardiac etiology.

Plan:

I discussed my evaluation with the patient and the following recommendations are being made at this time:

#1 headache diary

#2 I would like to review the diagnostic workup done at the Northwestern University

#3 cardiology workup

#4 blood workup including B12, TSH and ESR

#5 I recommend nortriptyline 50 mg nightly to be taken no later than 9 PM. Side effects discussed

#6 I advised him to take gabapentin 300 mg capsule 3 times a day. Side effects discussed

#7 return visit 3-4 weeks

I spent 35 minutes with the patient and greater than 50 % of time was spent in counseling and coordinating the patient care.

This note was generated using voice recognition software. If you require clarification or have any questions, please feel free to contact my office.

2/12/2019

Encounter - Office Visit Date of service: 01/14/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

PATIENT
Jamar Little
 DOB 06/13/1986
 AGE 32 yrs
 SEX Male
 PRN LJ415710

FACILITY
Anil Gulati SCNA
 T (312) 496-3488
 F (312) 929-2338
 2850 S Wabash
 Suite 102
 Chicago, IL 60616-2491

ENCOUNTER
 NOTE TYPE SOAP Note
 SEEN BY Anil Gulati MD
 DATE 01/14/2019
 AGE AT DOS 32 yrs
 Electronically signed by Anil Gulati MD at
 01/19/2019 02:57 pm

Chief complaint

severe headaches, pain on the right side from the shoulder to the lower back, pt has stated that he's passed out 5x's since Nov. 27, 2018- K Haywood, RMA (Appt time: 2:30 PM) (Arrival time: 2:42 PM)

Vitals for this encounter

	01/14/19
	2:42 PM
Height	68 in
Weight	257 lb
Pulse	99 bpm
BMI	39.08
Blood pressure	129/70 mmHg

Current Diagnoses

No current diagnoses

ACUITY	START	STOP
--------	-------	------

Historical Diagnoses

No historical diagnoses

ACUITY	START	STOP
--------	-------	------

Subjective

32-year-old gentleman was seen in the office for the evaluation of recurrent episodes of passing out.

He is accompanied by his girlfriend who has known him for the last several months.

He was apparently in his usual state of health on November 27, 2018 when he was at work and was found to be unresponsive at his desk by his coworker. It is unclear for how long he had passed out though. He does recall waking up with a headache. Though subsequently he paramedics were not called and he was not taken to the emergency room as he essentially felt well. Though subsequently he decided to drive to the ~~Presbyterian~~ Mercy Hospital emergency room. He was hospitalized overnight. He had a CT of the head done which was reviewed to be unremarkable. He had several EKGs which was reported to be abnormal. But he was discharged home the next day in a stable condition.

He has not returned to work since though..

Since then he has had at least 4 spells.

The last spell was on January 9, 2019 when he passed out at home. He was home alone at that time. When his girlfriend came home she does her, he was taken to Mercy Hospital emergency room and was noted to have bradycardia. She is advised to follow-up with a neurologist as well as a cardiologist.

2/12/2019

Encounter - Office Visit Date of service: 01/14/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

He has had daily headaches for the last few months. He does have background history of headaches for a long time though currently is having daily headaches with a variable degree of severity. She also complains of generalized body pain and fatigue. He has gained about 40 pounds in the last few months.

He denies any chest pain or shortness of breath. There is no history of seizure disorder.

The past history significant for frequent headaches for a long time. Currently takes baby aspirin every day.

He has no drug allergies.

He drinks alcohol only on the weekends. She has not had any drink for the last few months. He does not smoke and there is no history of drug abuse.

The comprehensive review of all systems is essentially unremarkable and or negative except for the above presenting symptom complex..

Objective

The blood pressure 129/70 . Pulse 99 Weight 257

The patient looks comfortable and in no significant distress. The patient appears well groomed and makes appropriate eye contact.

The general physical examination appears normal.

The examination of the head reveals no tenderness or asymmetry. The neck is supple. The examination of the chest reveals clear lung fields. The cardiac examination reveals normal heart sounds S1 and S2 without any murmurs. The abdominal examination reveals soft nontender abdomen without any organomegaly with normal bowel sounds. The skin looks normal.

The speech and language function is normal.

There is no facial asymmetry present. The vision is 20/20 bilaterally. The pupil examination is normal. Eye movements are full. There is no nystagmus present. Visual field examination by confrontation method is normal. The fundus examination reveals normal-looking optic disc.

There is no pronator sign present.

The sensory motor system examination is normal. The muscle tone is normal.

The reflexes are symmetrical and normal bilaterally. There is no Babinski sign present.

No abnormal movements are present.

The casual gait is normal. There is no carotid artery bruit present..

Assessment

32-year-old gentleman with history of recurrent episodes of passing out over the last 4 months with associated daily headaches. He has been noted to have bradycardia.

Neurological examination appears to be essentially nonfocal and normal.

The etiology of the recurrent episodes is concerning.

The differential diagnostic possibilities include

Seizure disorder ✓

Syncopal episode ✓

Cardiac arrhythmia/bradycardia arrhythmia ✓

I do remain concerned about the daily headaches that he has experienced which may or may not be related to the episodes of passing out.

2/12/2019 Encounter - Office Visit Date of service: 01/14/19 Patient: Jamar Little DOB: 06/13/1986 PRN: LJ415710

I have not reviewed any of the diagnostic workup that has been performed is done in the past.

Hypothyroidism and Brugada syndrome may be the possible culprits. ✓

Seizure is less likely but does remain in the differential diagnosis.

Plan

I discussed my evaluation with the patient and the following recommendations are being made at this time:

#1 headache diary

#2 MRI brain without contrast

#3 EEG

#4 cardiology workup ✓

#5 blood workup including B12, TSH and ESR

#6 I recommend nortriptyline 50 mg nightly to be taken no later than 9 PM. Side effects discussed

#7 further recommendations to follow after the diagnostic workup has been reviewed

8 return visit 3-4 weeks

I spent 60 minutes with the patient and greater than 50 % of time was spent in counseling and coordinating the patient care.

This note was generated using voice recognition software. If you require clarification or have any questions, please feel free to contact my office.

Medications attached to this encounter:

— Aspirin EC Low Dose 81 MG Oral Tablet Delayed Release take 1 tab po qd

— Acetaminophen ER 650 MG Oral Tablet Extended Release take 1 tab prn

 practice fusion



PEFClinic, Ltd.

PROGRESS NOTES

Last Name <u>Dittico</u>	First Name <u>JAMAL</u>	Attending Physician <u>Madhani</u>	Room No. <u>232</u>	Hosp. No.
Date <u>4/4/19</u>	Notes Should Be Signed By Physician			
Age: <u>32</u>	PAIN ASSESSMENT <u>#</u>	DURATION: <u>constant</u>		
Temp: <u>98.4</u>	LOCATION: <u>low back</u>	PAIN SCALE: <u>7</u>		
Pulse: <u>82</u>	CHARACTER: <u>st. arm</u>	EXACERBATING FACTORS: <u>upon movement</u>		
Resp: <u>18</u>	RADIATION: <u>low</u>			
B/P: <u>120/70</u>	RELIEVING FACTORS: <u>Gas pain</u>			
HT: <u>5'7"</u>				

WT: 266 4/4/19 Patient here to see Doctor
1/20 pain to lower back & rt. arm
and neck area. Patient stated, "passing
out x 24 times since November".
Visited E.R. x 3, all Gated CT

Do you smoke cigarettes?
Y N
If so, how much?
X

DEPRESSION:
1. Loss of interest / pleasure > 2 wks.
Y N

2. Depressed mood > 2 wks.
Y N

3. ER VISIT since last OV
Y N

If, YES Date: _____

Physical Activities
Walking

Do you drink alcohol?
Y N
If so, how much?

Completed required ETOH screening?
Y N

4/7/19 Please Anterior tilt table test for syncope evaluation will follow
New evaluation

It had syncopal episode
It has heart monitor - 14 days
Given by Northwestern University
- no cardiac arrhythmia noted
It was seen by Neurologist - Dr. Culati
Echo was done at Northwestern
reported negative Pt as on
It work at cell center
IE - amiodarone - Newardin
- VT
(2) Tilt
hyp - J, PS at the ✓ tilt ten.
Heart - normal
Abd - normal
Ext - good
NCV - ATR x 3
(1) Syncope - work up in progress
will consider tilt table test -
Please Anterior tilt table test for syncope evaluation will follow
New evaluation

From:

04/04/2019 12:12 #362 P.002/002

M. Mohammad,
312-608-0621
312-608-0655
312

J331595

JACKSON PARK HOSPITAL
7531 Stony Island Avenue
Chicago, Illinois 60649-3993
Phone: (773) 947-7500

NAME Little Jamar DATE 4/4/19
ADDRESS R

1-24
 25-49
 50-74
 75-100
 101-150
 151 and over

MAY SUBSTITUTE _____
 MAY NOT SUBSTITUTE _____

Refill NR 1 2 3 4 5 Void After _____ DEA NO. _____

Prescription is void if more than one (1) controlled substance is written per blank.

223414

PE FClinic, Ltd.

PROGRESS NOTES

Last Name Little JAMAN	First Name	Attending Physician Madhans	Room No. 232	Hosp. No.
Date 4/4/19	Notes Should Be Signed By Physician			
Age: 32	PAIN ASSESSMENT #	DURATION: constant		
Temp: 98.4	LOCATION: Lower back & rt. arm	PAIN SCALE: 7		
Pulse: 82	CHARACTER: sharp	EXACERBATING FACTORS: upon movement		
Resp: 18	RADIATION: Gas pain			
B/P: 120/70	RELIEVING FACTORS: Gas pain relief			
HT: 5'7"				
WT: 266	4/4/19 Patient here to see Doctor			
BMI: 2	1/20 pain to lower back & rt. arm			
LMP: Male	and neck area. Patient stated, "passing out x 24 times since November after division E.R. x 3. M.G. history			
PAIN <input checked="" type="radio"/> N				
AC - CK <input checked="" type="radio"/>				
PK - FL <input checked="" type="radio"/>				
Do you smoke cigarettes? <input checked="" type="radio"/> N	It has syncopal episode			
If so, how much? <input checked="" type="radio"/>	It has heart monitor - 14 days			
DEPRESSION:				
1. Loss of interest / pleasure > 2 wks. <input checked="" type="radio"/> N	Given by Northwestern University			
2. Depressed mood > 2 wks. <input checked="" type="radio"/>	- no cardiac arrhythmia noted			
3. ER VISIT since 2 mo. ov <input checked="" type="radio"/> N	It was seen by Neurology - Dr. Levitan			
If, YES Date: _____	Echo was done at Northwestern			
Physical Activities				
<u>WALKING</u>	reported negative Pt 2 m			
Do you drink alcohol? <input checked="" type="radio"/> N	Neurology			
If so, how much? <input checked="" type="radio"/>	Amyotrophilic			
Completed required ETOH screening? <input checked="" type="radio"/> N				
<p>(1) Syncpe - Workup in progress will consider tilt table test - with carotid</p> <p>(2) NCx - ATE x 3</p> <p>(3) Tilt table test - with carotid</p>				

ANIL GULATI, M.D.
SOUTHEAST CHICAGO NEUROLOGY ASSOCIATES, S.C.
PRACTICE LIMITED TO NEUROLOGY
2850 SOUTH WABASH
SUITE 102
CHICAGO, IL 60616

TELEPHONE (312) 496-3488
FAX (312) 929-2338

DEA REG. NO. BG2661836

NAME

Tamar Lille

1/14/19

AGE

ADDRESS

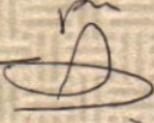
DATE

R

TSH

1:20

B₁₂



spells

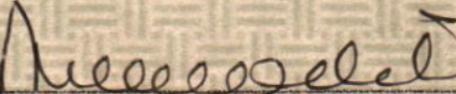
ESR

LABEL

REFILL ____ TIMES

MAY SUBSTITUTE

MAY NOT SUBSTITUTE



, M.D.



NMG 675 N ST CLAIR ST AMB
NM CARDIOLOGY
675 N St Clair St, Ste 19-100
Chicago IL 60611-5975
312-695-4965
312-695-5774

May 7, 2019

Anil Gulati
2820 S Wabash Ave
#102
Chicago IL 60616
VIA Facsimile: 312-929-2338

Re: Jamar Little
DOB: 6/13/1986
MRN: 111012202087

Dear Dr. Gulati,

It was a pleasure to see Jamar Little in my office at the Northwestern Medicine Department of Cardiology on 5/2/2019. A summary of the visit is attached.

Thank you for allowing me to participate in Mr. Little's care. Please do not hesitate to contact me directly at 312-695-4965 with any questions.

Sincerely,

Benjamin H Freed, MD

Freed/Fellow
675 N St Clair St, Ste 19-100
Chicago IL 60611-5975
312-695-4965

A handwritten red signature, likely belonging to Benjamin H Freed, is placed here.

A handwritten blue signature, likely belonging to Anil Gulati, is placed here.

Cardiology Progress Note

Patient: Jamar Little DOB: 6/13/1986 MRN: 111012202087

Encounter Date: 05/02/2019

Authorizing Provider: Freed/Fellow

Anil Gulati

Naveed Muhammad

New Patient Visit

Referred by: Emergency Department

Reason for visit: Syncope

HPI:

Jamar Little is a 32 y.o. male with a h/o peptic ulcer disease who presents for evaluation for recurrent syncope. The pt reports that since 11/2018, he has passed out 24 separate times. He states that episodes are similar in initiation, feels a sharp pain in the R side of his neck that radiates to his occiput, then after 1-2 minutes loses consciousness. Many of these episodes have been witnessed by his girlfriend who states he does not exhibit shaking, tongue biting, bowel/bladder incontinence during these episodes. Does not have any confusion once he comes to, usually 5-7 minutes later. He does not remember anything from the episodes themselves. Denies LH prior to syncopal events, but states he feels "disoriented" and "overwhelmed" prior. Despite all of these episodes of reported syncope, he denies any significant head injury or major lacerations, broken bones, or ecchymoses. He does state that one episode occurred on 1/25/2019 while he was driving with his girlfriend as a passenger. States he was traveling on the highway and crashed into the median. States car "wasn't totaled" and he received a bump on his head and his girlfriend did not sustain any injuries so they did not seek immediate medical attention at the time.

Initial admission for syncope was at Rush on 11/27/2018 for a similar episode. Since then, he has seen a neurologist (Dr. Gulati) and a cardiologist (Dr. Mahati) at Advocate. Neurology work up has included MRI and CTA head and neck which have been unremarkable. Per report he also has completed an EEG which was unrevealing (but there are no results for this in CareEverywhere). He states the cardiologist "just did an ECG". On 3/22/2019 he had an ED visit at NMH for a similar episode at work, though per ED note he was having brunch with his girlfriend when his eyes started fluttering and he became unresponsive, but did not slump over in his chair. He was admitted overnight for observation with echo which was unremarkable, then discharged the following day with a 14 day Ziopatch and outpt cardiology follow up.

Mr. Little states he has had an **unintentional 50lb weight gain since November**, despite not changing his eating habits. In November after his first syncopal episode also stopped drinking (previously at least 2-3 drinks per day per report). His activity level has decreased significantly which he states is related to significant pain all along the R side of his body and lower back pain for which his neurologist has prescribed gabapentin and nortriptyline. His PCP has also prescribed ASA 81mg daily for unclear reasons.

He endorses new significant DOE since November as well, states even getting up to use the bathroom will feel exhausted with chest pain described as a "feeling of getting punched in the chest" under his R breast which lasts for 2-3 minutes. Occasionally will also have chest discomfort at night which wakes him from sleep. He was SOB walking from Uber to clinic today and also notes a feeling of his heart racing with exertion. Also feels palpitations prior to syncopal episodes.

ROS also significant for increased thirst (without increased urination) and easy bruising).

Neurologist - Dr. Gulati at Advocate

Cardiologist - Dr. Mahati at Advocate at Jackson Park

PCP - Dr. Navid Mohammad at Advocate, saw him 2 months ago

PMH:

Peptic Ulcer Disease

Recurrent Syncope

Meds:

Gabapentin 300mg TID

Nortriptyline 50mg daily

ASA 81mg daily

Ibuprofen 500mg prn, no more than 5 per day

Allergies:

No Known Allergies

FAMILY HISTORY:

MGM with "heart disease" - 70 when she died

MUncle - Died at 46 of an overdose, also had heart problems

SOCIAL HISTORY:

Never cigarettes

Recently started smoking marijuana - smokes a few puffs occasionally or uses edibles

Quit drinking in November, previously every day drinker 2-3 drinks per day

Works at a call center, not married but has a girlfriend

ROS:

10 systems reviewed and are negative except as mentioned in the HPI.

Vitals:

Vitals:

05/02/19 0925

BP: 122/78

Pulse: 80

Weight: 117.9 kg (260 lb)

Height: 1.702 m (5' 7")

(W)

BP Readings from Last 3 Encounters:

05/02/19 122/78
03/23/19 124/70

Body mass index is 40.72 kg/m².

Wt Readings from Last 5 Encounters:

05/02/19 117.9 kg (260 lb)
03/22/19 119.5 kg (263 lb 7.2 oz)

Physical Exam:

General: Obese, NAD.

Skin: Warm, moist. No rashes, petechiae. No significant ecchymoses.

HEENT: NCAT. Sclera white, conjunctiva pink. MMM. Neck supple. Trachea midline.

Chest and Lungs: CTAB. No wheezes or crackles. Thorax symmetric with good expansion.

Normal WOB.

Cardiovascular: RRR, No MRG. Normal S1, S2. No palpable thrills or heaves. No JVD.

Abdomen: Normoactive BS. NT/ND. No HSM.

Extremities: Warm, well perfused. No LEE.

Neurologic: A&OX4. Conversant and appropriate.

Labs/Studies:

Lab Results

Component	Value	Date
WBC	7.9	03/22/2019
RBC	5.28	03/22/2019
HGB	14.2	03/22/2019
HCT	44.4	03/22/2019
MCV	84	03/22/2019
MCH	26.9 (L)	03/22/2019
MCHC	32.0	03/22/2019
PLT	389	03/22/2019
RDW	14.2	03/22/2019
EOSPCT	3	03/22/2019
BASOPCT	1	03/22/2019
NEUTROABS	4.3	03/22/2019
LYMPHSABS	2.4	03/22/2019
EOSABS	0.2	03/22/2019
BASOSABS	0.1	03/22/2019

Chemistry

(W)

Component	Value	Date/Time	Component	Value	Date/Time
NA	142	03/22/2019 1725	CALCIUM	9.6	03/22/2019 1725
K	4.5	03/22/2019 1725			
CL	106	03/22/2019 1725			
CO2	29	03/22/2019 1725			
BUN	13	03/22/2019 1725			
CREATININE	1.06	03/22/2019			
NE		1725			

Last GFR:

GFR(Others)

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	>60	>=60 mL/min/1.73m ²	Final

CBC

White Cell Count

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	7.9	3.5 - 10.5 K/UL	Final

Hemoglobin

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	14.2	13.0 - 17.5 g/dL	Final

Platelet Count

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	389	140 - 390 K/UL	Final

LAST CHEMISTRY PANEL

Sodium

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	142	133 - 146 mEq/L	Final

Potassium

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	4.5	3.5 - 5.1 mEq/L	Final

Comment:

Hemolyzed Specimen

(W)

Urea Nitrogen

Date/Time	Value	Ref Range	Status
03/22/2019 05:25 PM	13	2 - 25 mg/dL	Final

EKG:

Sinus tach, non-specific ST-T wave abnormalities

Echo 3/23/2019:

- The left ventricle is normal in size. There is no left ventricular hypertrophy. Left ventricular systolic function is normal. EF = 67% (2D biplane) All scored segments are normal.
- The right ventricle is normal in size. Right ventricular systolic function is normal. The right atrial pressure is 3 mmHg.
- No significant valvular abnormalities. Non-doppler study.
- Normal atria and aorta.
- No prior echocardiographic exam available for comparison.

ZioPatch 14 days 4/1/2019:

Patient had a min HR of 61 bpm, max HR of 179 bpm, and avg HR of 98 bpm. Predominant underlying rhythm was Sinus Rhythm. 1 run of Supraventricular Tachycardia occurred lasting 6 beats with a max rate of 179 bpm (avg 156 bpm). Isolated SVEs were rare (<1.0%), SVE Couples were rare (<1.0%), and no SVE Triplets were present. Isolated VEs were rare (<1.0%), and no VE Couples or VE Triplets were present.

CTb 3/22/2019:

1. No acute intracranial abnormality. Further evaluation with a brain MRI may be performed if clinically indicated.
2. Osteoma in the medial aspect of the left frontal sinus measures approximately 10 mm AP by 17 mm TV. Additionally, there is a 3.5 mm left ethmoid osteoma.

CTA Head and Neck Rush 11/27/2018:

Unremarkable CT angiogram of the head and neck. No dissection. No aneurysms. No large vessel occlusion.

MRib 2/25/2019:

1. Mild volume loss.

No evidence of acute intracranial pathologic process.

Assessment:

32 y.o. male with a h/o peptic ulcer disease who presents for evaluation for recurrent syncope.

Problems:

#Recurrent syncope/loss of consciousness: Reports 24 episodes since 11/2018, but no significant injury. One episode occurring while driving leading to minor accident but pt reports he was on highway and car struck median with minimal injury to himself and passenger. Unclear etiology, but episodes are extremely atypical for true syncope (preceded by severe R neck pain radiating to occiput). Differential includes complex migraines, seizure disorder, vasovagal episodes, and psychogenic pseudo-syncope/pseudo-seizure. He has had extensive w/u already including MRI, CTA head and neck, and EEG which reportedly have been unremarkable. Though he has no evidence of structural heart disease on his echocardiogram, 14-day Zio curiously showed elevated resting HR (average 96) and resting ECG exhibits non-specific ST-T changes. In the context of exertional symptoms as below, further evaluation for cardiogenic source of loss of consciousness is reasonable. Given elevated HR, will pursue tilt table testing to definitively rule out POTS as well as evaluate for alternative diagnoses (e.g. vasovagal syncope). Additionally, will pursue exercise stress echo. Given report of daytime fatigue and girlfriends report of snoring, would also recommend sleep study to be arranged through PCP. If above workup is unrevealing would reassure pt that symptoms are very unlikely to be cardiac in nature and encourage continued f/u with PCP and neurologist.

#Chest pain, dyspnea on exertion: Symptoms somewhat atypical (occurring at rest at night occasionally) but for the most part are exertional. Suspect likely 2/2 deconditioning in setting of significant weight gain, but will pursue non-invasive evaluation with exercise stress echo (needs imaging given baseline ECG abnormalities).

#Weight gain: Reports unintentional 50 lb wt gain over 5 months. States eating habits have not changed but does admit he is less active due to body pain. Given reports of easy bruising and increased thirst it is reasonable to rule out Cushing's and diabetes. May benefit from endocrinology referral for further evaluation.

#Primary prevention: It appears that his PCP has prescribed ASA 81mg for primary prevention in the context of syncopal episodes. Especially given pt's reported history of peptic ulcer disease, would strongly recommend against continuation of ASA in the absence of known ASCVD equivalent. Lipid panel for risk stratification would be beneficial, however.

Plan:

- Order tilt table testing
- Order stress echo
- Order lipids, HbA1c, 24 hour urinary cortisol
- Discontinue ASA
- Recommend sleep study and consideration of endocrinology referral with PCP

Patient was seen and discussed with Dr. Freed. Please see attending addendum below for final recommendations.

Ramsey Wehbe
Cardiology Fellow, PGY-5
Pager 312-921-9437

(W)

Patient interviewed and examined personally. I reviewed with Dr. Wehbe during the patient's visit, the patient's history, exam, diagnosis, and the plan of treatment. It is noted that the patient has a history of peptic ulcer disease who presents for evaluation for recurrent syncope.

Has had over 25 episodes of syncope since November. Many witnessed and no seizure like activity noted. Has similar vague prodrome prior to each event. Also notes worsening DOE and atypical chest discomfort. Seen by neuro and cards at OSH and has had extensive workup with no clear findings. Patient looking for a second opinion.

My exam confirms that patient:

Blood pressure 122/78, pulse 80, height 1.702 m (5' 7"), weight 117.9 kg (260 lb).

Body surface area is 2.26 meters squared.

Body mass index is 40.72 kg/m².

Physical Exam

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.

HENT:

Head: Normocephalic and atraumatic.

Eyes: Pupils are equal, round, and reactive to light.

Neck: Normal range of motion. No JVD present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Exam reveals no gallop and no friction rub.

No murmur heard.

Pulmonary/Chest: Effort normal and breath sounds normal.

Abdominal: Soft. Bowel sounds are normal. There is no tenderness.

Musculoskeletal: He exhibits no edema.

Neurological: He is alert and oriented to person, place, and time.

Skin: Skin is warm and dry.

Psychiatric: He has a normal mood and affect.

I agree with Dr. Wehbe's plan of care as follows:

Patient will undergo stress echo to evaluate his baseline EKG abnormalities and new onset DOE.

Will also undergo tilt table testing to evaluate for POTs and try to determine if cardiogenic syncope. In the meantime, agree with the recommendations by his neurologist not to drive and this was reiterated to patient.

I spent 60 minutes with the patient and over 50% was counseling and/or coordination of care. We discussed at length the possible causes of his syncope and reasons for pursuing further testing.

Benjamin H Freed, MD, FACC, FASE

Assistant Professor of Medicine
Bluhm Cardiovascular Institute

Cc:

Dr. Gulati at Advocate
Dr. Navid Mohammad at Advocate



LITTLE, JAMAR
7920 S MANISTEE AVE APT 1
CHICAGO IL 60617-1326

THE FOLLOWING PERSONS ARE COVERED:

JAMAR LITTLE

ID #: 061369088 DOB: 06-13-86

TOTAL NUMBER OF COVERED PERSONS: 1

To check your eligibility using the 24 hour automated system, call:
Para comprobar su elegibilidad usando el sistema automatizado de 24 horas,
llama al: 1-855-828-4995

THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.

Medical providers must verify identity and eligibility when you need care.

ESTA TARJETA NO GARANTIZA LA ELEGIBILIDAD O PAGO. Los proveedores médicos deben verificar la identidad y elegibilidad cuando necesite atención médica.

OT-052914



Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Patient information

Patient ID: JL520832

Home: (773) 573-7951

Address: 7920 S Manistee
Chicago, IL 60617

Collection: 05/08/2018 02:24 pm

Order #: 181622440

Accession #: 333820

Requesting Provider

Name: Naveed Muhammad

GLYCOHEMOGLOBIN/A1C

Observations	Result	Reference / UoM	Date/Status
HEMOGLOBIN A1C	6.0	4.4 - 6.3 %	05/08/2018 11:58 pm
Vendor note: Hemoglobin A1c results between 5.7% and 6.4% are associated with an increased risk for diabetes.			
Hemoglobin A1c <7.0% represents optimal control in nonpregnant diabetic patients. Different metrics may apply to specific patient populations. Standards of Medical Care in Diabetes-2016. Diabetes Care. 2013;36:s11-s66			
REFERENCE VALUES		HEMOGLOBIN A1C	
DIABETICS		>6.3%	
GOOD CONTROL		<7.2%	
FAIR CONTROL		7.2-9.2%	
POOR CONTROL		>9.2%	
Estimated Average Glucose eAG			
A1C %	eAG mg/dl (95% Confidence interval)		
6%	126 (100-152)		
7%	154 (123-185)		
8%	183 (147-217)		
9%	212 (170-249)		
10%	240 (193-282)		
11%	269 (217-314)		
12%	298 (240-347)		
Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

CBC W/O DIFFERENTIAL

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELLS	5.95	4.80 - 10.80 THO/mm3	05/08/2018 11:12 pm
RED BLOOD CELLS	5.48	4.70 - 6.10 MIL/mm3	05/08/2018 11:12 pm
HEMOGLOBIN	15.0	14.0 - 18.0 gm/dl	05/08/2018 11:12 pm
HEMATOCRIT	46.3	42.0 - 52.0 %	05/08/2018 11:12 pm
MCV	84.5	80.0 - 94.0 um3	05/08/2018 11:12 pm
MCH	27.4	27.0 - 33.0 uug	05/08/2018 11:12 pm
MCHC	32.4	32.0 - 36.0 gm/dl	05/08/2018 11:12 pm
RDW-CV	13.5	11.5 - 15.2 %	05/08/2018 11:12 pm
PLATELET COUNT	312	150 - 400 THO/mm3	05/08/2018 11:12 pm
MPV	10.4	9.5 - 13.1 um3	05/08/2018 11:12 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

LIPID PANEL W/HDL

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL	159	120 - 200 mg/dl	05/08/2018 11:27 pm
TRIGLYCERIDES	71	10 - 150 mg/dl	05/08/2018 11:27 pm
HDL CHOLESTEROL	● 46	50 - 72 mg/dl Below low normal	05/08/2018 11:27 pm
LDL	99	50 - 130 mg/dl	05/08/2018 11:27 pm
CHOLESTEROL/HDL RATIO	3.46	Ratio	05/08/2018 11:27 pm
LDL/HDL RISK RATIO	2.15	Ratio	05/08/2018 11:27 pm
Vendor note: RISK RATIOS			
.	Women	Men	Women
1/2 Average	1.00	1.47	3.43
Average	3.55	3.22	4.97
2X Average	6.25	5.03	9.55
3X Average	7.99	6.14	23.39
Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

COMPREHENSIVE METABOLIC

Observations	Result	Reference / UoM	Date/Status
GLUCOSE	90	70 - 110 mg/dl	05/08/2018 11:22 pm
BUN	13	5 - 20 mg/dl	05/08/2018 11:22 pm
CREATININE	1.01	0.40 - 1.60 mg/dl	05/08/2018 11:22 pm
BILIRUBIN, TOTAL	0.64	0.20 - 1.30 mg/dl	05/08/2018 11:22 pm
PROTEIN, TOTAL	7.5	6.0 - 8.2 gm/dl	05/08/2018 11:22 pm
ALBUMIN	4.6	3.2 - 5.0 gm/dl	05/08/2018 11:22 pm
SODIUM	140	136 - 147 mEq/L	05/08/2018 11:22 pm
POTASSIUM	4.6	3.7 - 5.1 mEq/L	05/08/2018 11:22 pm
CHLORIDE	102	97 - 108 mEq/L	05/08/2018 11:22 pm
CARBON DIOXIDE	28	20 - 30 mM/L	05/08/2018 11:22 pm
SGPT(ALT)	21	0 - 35 U/L	05/08/2018 11:22 pm
SGOT(AST)	17	10 - 22 U/L	05/08/2018 11:22 pm
ALK. PHOSPHATASE	77	29 - 130 U/L	05/08/2018 11:22 pm
CALCIUM	9.8	8.2 - 10.2 mg/dl	05/08/2018 11:22 pm
eGFR If African American	> 60	greater than 60 ml/m/1.73m ²	05/08/2018 11:22 pm
eGFR If Non-African American	> 60	greater than 60 ml/m/1.73m ²	05/08/2018 11:22 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: > INDICATES GREATER THAN eGFR reference range is Greater than or equal to 60 mL/min/1.73m² According to the National Kidney Foundation, estimated GFR values above 60 mL/min/1.73m² should be interpreted as 'above 60 mL/min/1.73m²' not as an exact number.</p> <p>If you have not provided a Date of Birth for this patient, the eGFR may or may not be properly represented on this report.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

URINALYSIS

Observations	Result	Reference / UoM	Date/Status
COLOR	YELLOW	STRAW - AMBER	05/08/2018 11:14 pm
TURBIDITY	CLEAR	CLEAR - CLEAR	05/08/2018 11:14 pm
SPECIFIC GRAVITY	1.024	1.005 - 1.030	05/08/2018 11:14 pm
PH	6.5	4.0 - 8.0	05/08/2018 11:14 pm
PROTEIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dl	05/08/2018 11:14 pm
GLUCOSE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dl	05/08/2018 11:14 pm
KETONES, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dl	05/08/2018 11:14 pm
BILIRUBIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	05/08/2018 11:14 pm
BLOOD, SEMI-QUANT.	NEGATIVE	NEGATIVE - NEGATIVE	05/08/2018 11:14 pm
NITRITE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	05/08/2018 11:14 pm
UROBILINOGEN, SEMI-QT	0.2	0.2 - 1.0 EU/DL	05/08/2018 11:14 pm
LEUKOCYTES, SEMI-QT	TRACE	NEGATIVE - TRACE	05/08/2018 11:14 pm
<p>Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

MICROSCOPIC

Observations	Result	Reference / UoM	Date/Status
RED BLOOD CELLS/HPF	2	NONE - 5 /HPF	05/08/2018 11:14 pm
WHITE BLOOD CELLS/HPF	● 7	NONE - 5 /HPF Above high normal	05/08/2018 11:14 pm
EPITHELIAL CELLS	FEW	NONE - FEW /HPF	05/08/2018 11:14 pm
BACTERIA	NONE	NONE - NONE	05/08/2018 11:14 pm
HYALINE CASTS	● 6	NONE - 3 /LPF Above high normal	05/08/2018 11:14 pm
<p>Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

25-OH VITAMIN D

Observations	Result	Reference / UoM	Date/Status
25-OH VITAMIN D	● 12.1	30.0 - 100.0 ng/ml Below low normal	05/08/2018 11:31 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: When considering treatment, the following reference ranges are generally followed:</p> <p>Vitamin D deficiency < 10 ng/mL Vitamin D insufficiency 10-30 ng/mL Vitamin D sufficiency 30-100 ng/mL</p> <p>Observed range for 95 percent of our winter population of apparently healthy individuals 19.1-57.6 ng/mL</p> <p>The method used to perform this Vitamin D has been standardized by the Ghent University reference measurement procedures, a reference method for the Vitamin D standardization program based on isotope-dilution liquid chromatography-tandem mass spectrometry, and in 2014 was certified by the Centers for Disease Control.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

Performing Laboratory

Performing lab details not present

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 01/23/2019 01:20 pm
 Order #: 190032636
 Accession #: 388011

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

VITAMIN B12

Observations	Result	Reference / UoM	Date/Status
VITAMIN B12	586	211 - 911 pg/mL	01/23/2019 10:18 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

SED RATE, ESR

Observations	Result	Reference / UoM	Date/Status
SED RATE, ESR	3	0 - 15 mm/h	01/23/2019 11:42 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

TSH, ULTRA SENSITIVE 3RD GEN

Observations	Result	Reference / UoM	Date/Status
TSH, ULTRA SENSITIVE 3RD GEN	0.853	0.550 - 4.780 uIU/mL	01/23/2019 10:18 pm
Vendor note: This TSH was measured using a 3rd generation Ultrasensitive assay. Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

Performing Laboratory

Performing lab details not present

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 10/02/2014 03:57 pm
 Order #: 140524554
 Accession #: 740781

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

CBC W/O DIFFERENTIAL

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELLS	5.05	4.80 - 10.80 THO/mm3	10/02/2014 11:32 pm
WHITE BLOOD CELLS	5.05	4.80 - 10.80 THO/mm3	10/02/2014 11:32 pm
RED BLOOD CELLS	5.32	4.70 - 6.10 mil/mm3	10/02/2014 11:32 pm
RED BLOOD CELLS	5.32	4.70 - 6.10 mil/mm3	10/02/2014 11:32 pm
HEMOGLOBIN	14.3	14.0 - 18.0 gm/dL	10/02/2014 11:32 pm
HEMOGLOBIN	14.3	14.0 - 18.0 gm/dL	10/02/2014 11:32 pm
HEMATOCRIT	43.3	42.0 - 52.0 %	10/02/2014 11:32 pm
HEMATOCRIT	43.3	42.0 - 52.0 %	10/02/2014 11:32 pm
MCV	81.4	80.0 - 94.0 um3	10/02/2014 11:32 pm
MCV	81.4	80.0 - 94.0 um3	10/02/2014 11:32 pm
MCH	● 26.9	27.0 - 33.0 UUG Below low normal	10/02/2014 11:32 pm
MCH	● 26.9	27.0 - 33.0 UUG Below low normal	10/02/2014 11:32 pm
MCHC	33.0	32.0 - 36.0 gm/dL	10/02/2014 11:32 pm
MCHC	33.0	32.0 - 36.0 gm/dL	10/02/2014 11:32 pm
RDW-CV	13.6	11.5 - 15.2 %	10/02/2014 11:32 pm
RDW-CV	13.6	11.5 - 15.2 %	10/02/2014 11:32 pm
PLATELET COUNT	283	150 - 400 THO/mm3	10/02/2014 11:32 pm
PLATELET COUNT	283	150 - 400 THO/mm3	10/02/2014 11:32 pm
MPV	9.9	9.5 - 13.1 um3	10/02/2014 11:32 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
MPV	9.9	9.5 - 13.1 um3	10/02/2014 11:32 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

LIPID PANEL W/HDL

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL	143	110 - 200 mg/dL	10/02/2014 11:41 pm
CHOLESTEROL	143	110 - 200 mg/dL	10/02/2014 11:41 pm
TRIGLYCERIDES	55	10 - 150 mg/dL	10/02/2014 11:41 pm
TRIGLYCERIDES	55	10 - 150 mg/dL	10/02/2014 11:41 pm
HDL CHOLESTEROL	● 43	50 - 72 mg/dL Below low normal	10/02/2014 11:41 pm

Observations	Result	Reference / UoM		Date/Status
HDL CHOLESTEROL	● 43	50 - 72 mg/dL Below low normal		10/02/2014 11:41 pm
LDL	89	50 - 130 mg/dL		10/02/2014 11:41 pm
LDL	89	50 - 130 mg/dL		10/02/2014 11:41 pm
CHOLESTEROL/HDL RATIO	3.33	Ratio		10/02/2014 11:41 pm
CHOLESTEROL/HDL RATIO	3.33	Ratio		10/02/2014 11:41 pm
LDL/HDL RISK RATIO	2.07	Ratio		10/02/2014 11:41 pm
Vendor note: RISK RATIOS . Women Men Women Men 1/2 Average 1.00 1.47 3.43 3.27 Average 3.55 3.22 4.97 4.44 2X Average 6.25 5.03 9.55 7.05 3X Average 7.99 6.14 23.39 11.04 Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920				
LDL/HDL RISK RATIO	2.07	Ratio		10/02/2014 11:41 pm
Vendor note: RISK RATIOS . Women Men Women Men 1/2 Average 1.00 1.47 3.43 3.27 Average 3.55 3.22 4.97 4.44 2X Average 6.25 5.03 9.55 7.05 3X Average 7.99 6.14 23.39 11.04 Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920				

GC and CHLAMY-AMP DNA PROBE

Observations	Result	Reference / UoM	Date/Status
Result	FINAL		10/06/2014 09:29 am

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: 740780 GC and CHLAMY-AMP DNA PROBE - Not specified site/source</p> <p>GC, AMP DNA PROBE NOT DETECTED</p> <p>CHLAMYDIA, AMP DNA PROBE NOT DETECTED</p> <p>Methodology: Roche Amplicor - Polymerase Chain Reaction.</p> <p>Results are interpreted as follows:</p> <ul style="list-style-type: none"> 'DNA NOT DETECTED' - the specimen is presumptive negative. 'INHIBITORS' - DNA, if present, would not be detectable due to inhibitors in the specimen. A new specimen must be collected. 'DNA DETECTED' - Organism viability/infectivity cannot be inferred since target DNA may persist in the absence of viable organisms. 'EQUIVOCAL' - Results are inconclusive for DNA, and additional patient testing is necessary. Repeat testing on a new specimen from the patient or additional testing by an alternate methodology is recommended. <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

BASIC METABOLIC

Observations	Result	Reference / UoM	Date/Status
CREATININE	1.07	0.40 - 1.60 mg/dL	10/02/2014 11:41 pm
CREATININE	1.07	0.40 - 1.60 mg/dL	10/02/2014 11:41 pm
BUN	9	5 - 20 mg/dL	10/02/2014 11:41 pm
BUN	9	5 - 20 mg/dL	10/02/2014 11:41 pm
GLUCOSE	92	70 - 110 mg/dL	10/02/2014 11:41 pm
GLUCOSE	92	70 - 110 mg/dL	10/02/2014 11:41 pm
CALCIUM	10.1	8.2 - 10.2 mg/dL	10/02/2014 11:41 pm
CALCIUM	10.1	8.2 - 10.2 mg/dL	10/02/2014 11:41 pm
SODIUM	● 135	136 - 147 MEQ/L Below low normal	10/02/2014 11:41 pm
SODIUM	● 135	136 - 147 MEQ/L Below low normal	10/02/2014 11:41 pm
POTASSIUM	4.6	3.7 - 5.1 MEQ/L	10/02/2014 11:41 pm
POTASSIUM	4.6	3.7 - 5.1 MEQ/L	10/02/2014 11:41 pm
CHLORIDE	100	93 - 110 MEQ/L	10/02/2014 11:41 pm
CHLORIDE	100	93 - 110 MEQ/L	10/02/2014 11:41 pm
CARBON DIOXIDE	27	19.51 - 30.49 mM/L	10/02/2014 11:41 pm
CARBON DIOXIDE	27	19.51 - 30.49 mM/L	10/02/2014 11:41 pm
eGFR If African American	> 60	greater than 60 ml/m/1.73m ²	10/02/2014 11:41 pm
eGFR If African American	> 60	greater than 60 ml/m/1.73m ²	10/02/2014 11:41 pm
eGFR If Non-African American	> 60	greater than 60 ml/m/1.73m ²	10/02/2014 11:41 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: According to the National Kidney Foundation, estimated GFR values above 60 mL/min/1.73m² should be interpreted as 'above 60 mL/min/1.73m²' not as an exact number.</p> <p>If you have not provided a Date of Birth for this patient, the eGFR may or may not be properly represented on this report.</p> <p>> INDICATES GREATER THAN</p> <p>eGFR reference range is Greater than or equal to 60 mL/min/1.73m²</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			
eGFR If Non-African American	> 60	greater than 60 ml/m/1.73m2	10/02/2014 11:41 pm

URINALYSIS

Observations	Result	Reference / UoM	Date/Status
COLOR	YELLOW	STRAW - AMBER	10/02/2014 11:52 pm
COLOR	YELLOW	STRAW - AMBER	10/02/2014 11:52 pm
TURBIDITY	CLEAR	CLEAR - CLEAR	10/02/2014 11:52 pm
TURBIDITY	CLEAR	CLEAR - CLEAR	10/02/2014 11:52 pm
SPECIFIC GRAVITY	1.008	1.005 - 1.030	10/02/2014 11:52 pm
SPECIFIC GRAVITY	1.008	1.005 - 1.030	10/02/2014 11:52 pm
PH	7.5	4.0 - 8.0	10/02/2014 11:52 pm
PH	7.5	4.0 - 8.0	10/02/2014 11:52 pm
PROTEIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
PROTEIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
GLUCOSE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
GLUCOSE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
KETONES, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
KETONES, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE mg/dL	10/02/2014 11:52 pm
BILIRUBIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
BILIRUBIN, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
BLOOD, SEMI-QUANT.	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
BLOOD, SEMI-QUANT.	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
NITRITE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
NITRITE, SEMI-QUANT	NEGATIVE	NEGATIVE - NEGATIVE	10/02/2014 11:52 pm
UROBILINOGEN, SEMI-QT	0.2	0.2 - 1.0 EU/dL	10/02/2014 11:52 pm
UROBILINOGEN, SEMI-QT	0.2	0.2 - 1.0 EU/dL	10/02/2014 11:52 pm
LEUKOCYTES, SEMI-QT	● SMALL	NEGATIVE - TRACE Above high normal	10/02/2014 11:52 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
LEUKOCYTES, SEMI-QT	● SMALL	NEGATIVE - TRACE Above high normal	10/02/2014 11:52 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

MICROSCOPIC

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELLS	● 5-10/HPF	None - 2-5/HPF Above high normal	10/02/2014 11:52 pm
WHITE BLOOD CELLS	● 5-10/HPF	None - 2-5/HPF Above high normal	10/02/2014 11:52 pm
RED BLOOD CELLS	0-2/HPF	None - 0-5/HPF	10/02/2014 11:52 pm
RED BLOOD CELLS	0-2/HPF	None - 0-5/HPF	10/02/2014 11:52 pm
EPITHELIAL CELLS	Trace	None seen - Few	10/02/2014 11:52 pm
EPITHELIAL CELLS	Trace	None seen - Few	10/02/2014 11:52 pm
AMORPHOUS SEDIMENT	Few	None - Few	10/02/2014 11:52 pm
AMORPHOUS SEDIMENT	Few	None - Few	10/02/2014 11:52 pm
BACTERIA	● Few	None - None Above high normal	10/02/2014 11:52 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
BACTERIA	● Few	None - None Above high normal	10/02/2014 11:52 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

Performing Laboratory

Performing lab details not present

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 09/25/2018 01:00 pm
 Order #: 181821505
 Accession #: 725939

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

HIV 1/0/2 Ag/Ab COMBO, 4th GEN

Observations	Result	Reference / UoM	Date/Status
HIV 1/0/2 Ag/Ab COMBO, 4th GEN	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:31 pm
Vendor note: The HIV Ag/Ab Combo assay is an in vitro diagnostic immunoassay for the simultaneous qualitative detection of human immunodeficiency virus p24 antigen and antibodies to human immunodeficiency viruses type 1 (including group O) and type 2, in serum using the ADVIA Centaur XP systems. The assay is intended to be used as an aid in the diagnosis of HIV infection in pediatric and adult populations, including pregnant women.			
A reactive result using the ADVIA Centaur CHIV assay does not distinguish HIV-1 p24 antigen, HIV-1 antibody, HIV-2 antibody, and HIV-1 group O antibody. Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

RPR

Observations	Result	Reference / UoM	Date/Status
RPR	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:44 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

HEPATITIS BsAg, ANTIGEN

Observations	Result	Reference / UoM	Date/Status
HEPATITIS BsAg, ANTIGEN	NONREACTIVE	NONREACTIVE - See Note	09/25/2018 10:42 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

HEPATITIS C Ab, ANTIBODY

Observations	Result	Reference / UoM	Date/Status
HEPATITIS C Ab, ANTIBODY	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:11 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

Performing Laboratory

Performing lab details not present

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 09/25/2018 01:00 pm
 Order #: 181821505
 Accession #: 725944

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

GC and CHLAMY-AMP DNA PROBE

Observations	Result	Reference / UoM	Date/Status
Result	FINAL		09/29/2018 12:14 am
Vendor note: 725944 GC and CHLAMY-AMP DNA PROBE - Urine			
GC, AMP DNA PROBE NOT DETECTED			
CHLAMYDIA, AMP DNA PROBE NOT DETECTED			
<p>Methodology: Roche Amplicor - Polymerase Chain Reaction. Results are interpreted as follows: 'DNA NOT DETECTED' - the specimen is presumptive negative. 'INHIBITORS' - DNA, if present, would not be detectable due to inhibitors in the specimen. A new specimen must be collected. 'DNA DETECTED' - Organism viability/infectivity cannot be inferred since target DNA may persist in the absence of viable organisms. 'EQUIVOCAL' - Results are inconclusive for DNA, and additional patient testing is necessary. Repeat testing on a new specimen from the patient or additional testing by an alternate methodology is recommended.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

HIV 1/0/2 Ag/Ab COMBO, 4th GEN

Observations	Result	Reference / UoM	Date/Status
HIV 1/0/2 Ag/Ab COMBO, 4th GEN	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:31 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: The HIV Ag/Ab Combo assay is an in vitro diagnostic immunoassay for the simultaneous qualitative detection of human immunodeficiency virus p24 antigen and antibodies to human immunodeficiency viruses type 1 (including group O) and type 2, in serum using the ADVIA Centaur XP systems. The assay is intended to be used as an aid in the diagnosis of HIV infection in pediatric and adult populations, including pregnant women.</p> <p>A reactive result using the ADVIA Centaur CHIV assay does not distinguish HIV-1 p24 antigen, HIV-1 antibody, HIV-2 antibody, and HIV-1 group O antibody.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

RPR

Observations	Result	Reference / UoM	Date/Status
RPR	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:44 pm

Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920

HEPATITIS BsAg, ANTIGEN

Observations	Result	Reference / UoM	Date/Status
HEPATITIS BsAg, ANTIGEN	NONREACTIVE	NONREACTIVE - See Note	09/25/2018 10:42 pm

Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920

HEPATITIS C Ab, ANTIBODY

Observations	Result	Reference / UoM	Date/Status
HEPATITIS C Ab, ANTIBODY	NONREACTIVE	NONREACTIVE - NONREACTIVE	09/25/2018 11:11 pm

Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920

Performing Laboratory
Performing lab details not present

Lab Results for Little, Jamar (Male, 06/13/1986)**Laboratory**

Name: NICL Laboratories

Collection: 06/01/2016 04:50 am
 Order #: 163630531
 Accession #: 561107

Patient information

Patient ID: JL520832
 Home: (773) 573-7951
 Address: 7920 S Manistee
 Chicago, IL 60617

Requesting Provider

Name: Naveed Muhammad

CBC W/O DIFFERENTIAL

Observations	Result	Reference / UoM	Date/Status
WHITE BLOOD CELLS	5.31	4.80 - 10.80 THO/mm3	06/01/2016 10:25 pm
WHITE BLOOD CELLS	5.31	4.80 - 10.80 THO/mm3	06/01/2016 10:25 pm
RED BLOOD CELLS	5.43	4.70 - 6.10 MIL/mm3	06/01/2016 10:25 pm
RED BLOOD CELLS	5.43	4.70 - 6.10 MIL/mm3	06/01/2016 10:25 pm
HEMOGLOBIN	14.5	14.0 - 18.0 gm/dl	06/01/2016 10:25 pm
HEMOGLOBIN	14.5	14.0 - 18.0 gm/dl	06/01/2016 10:25 pm
HEMATOCRIT	45.5	42.0 - 52.0 %	06/01/2016 10:25 pm
HEMATOCRIT	45.5	42.0 - 52.0 %	06/01/2016 10:25 pm
MCV	83.8	80.0 - 94.0 um3	06/01/2016 10:25 pm
MCV	83.8	80.0 - 94.0 um3	06/01/2016 10:25 pm
MCH	● 26.7	27.0 - 33.0 uug Below low normal	06/01/2016 10:25 pm
MCH	● 26.7	27.0 - 33.0 uug Below low normal	06/01/2016 10:25 pm
MCHC	● 31.9	32.0 - 36.0 gm/dl Below low normal	06/01/2016 10:25 pm
MCHC	● 31.9	32.0 - 36.0 gm/dl Below low normal	06/01/2016 10:25 pm
RDW-CV	13.9	11.5 - 15.2 %	06/01/2016 10:25 pm
RDW-CV	13.9	11.5 - 15.2 %	06/01/2016 10:25 pm
PLATELET COUNT	286	150 - 400 THO/mm3	06/01/2016 10:25 pm
PLATELET COUNT	286	150 - 400 THO/mm3	06/01/2016 10:25 pm
MPV	10.1	9.5 - 13.1 um3	06/01/2016 10:25 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
MPV	10.1	9.5 - 13.1 um3	06/01/2016 10:25 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

LIPID PANEL W/HDL

Observations	Result	Reference / UoM	Date/Status
CHOLESTEROL	149	120 - 200 mg/dl	06/01/2016 10:39 pm
CHOLESTEROL	149	120 - 200 mg/dl	06/01/2016 10:39 pm
TRIGLYCERIDES	106	10 - 150 mg/dl	06/01/2016 10:39 pm
TRIGLYCERIDES	106	10 - 150 mg/dl	06/01/2016 10:39 pm

Observations	Result	Reference / UoM		Date/Status
HDL CHOLESTEROL	● 44	50 - 72 mg/dl Below low normal		06/01/2016 10:39 pm
HDL CHOLESTEROL	● 44	50 - 72 mg/dl Below low normal		06/01/2016 10:39 pm
LDL	84	50 - 130 mg/dl		06/01/2016 10:39 pm
LDL	84	50 - 130 mg/dl		06/01/2016 10:39 pm
CHOLESTEROL/HDL RATIO	3.39	Ratio		06/01/2016 10:39 pm
CHOLESTEROL/HDL RATIO	3.39	Ratio		06/01/2016 10:39 pm
LDL/HDL RISK RATIO	1.90	Ratio		06/01/2016 10:39 pm
Vendor note: RISK RATIOS . Women Men Women Men 1/2 Average 1.00 1.47 3.43 3.27 Average 3.55 3.22 4.97 4.44 2X Average 6.25 5.03 9.55 7.05 3X Average 7.99 6.14 23.39 11.04 Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920				
LDL/HDL RISK RATIO	1.90	Ratio		06/01/2016 10:39 pm
Vendor note: RISK RATIOS . Women Men Women Men 1/2 Average 1.00 1.47 3.43 3.27 Average 3.55 3.22 4.97 4.44 2X Average 6.25 5.03 9.55 7.05 3X Average 7.99 6.14 23.39 11.04 Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920				

GC and CHLAMY-AMP DNA PROBE

Observations	Result	Reference / UoM	Date/Status
Result	FINAL		06/03/2016 05:20 pm

Observations	Result	Reference / UoM	Date/Status
Vendor note: 561111 GC and CHLAMY-AMP DNA PROBE - Urine			
GC, AMP DNA PROBE NOT DETECTED			
CHLAMYDIA, AMP DNA PROBE NOT DETECTED			
<p>Methodology: Roche Amplicor - Polymerase Chain Reaction.</p> <p>Results are interpreted as follows:</p> <p>'DNA NOT DETECTED' - the specimen is presumptive negative.</p> <p>'INHIBITORS' - DNA, if present, would not be detectable due to inhibitors in the specimen. A new specimen must be collected.</p> <p>'DNA DETECTED' - Organism viability/infectivity cannot be inferred since target DNA may persist in the absence of viable organisms.</p> <p>'EQUIVOCAL' - Results are inconclusive for DNA, and additional patient testing is necessary. Repeat testing on a new specimen from the patient or additional testing by an alternate methodology is recommended.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

COMPREHENSIVE METABOLIC

Observations	Result	Reference / UoM	Date/Status
GLUCOSE	● 135	70 - 110 mg/dl Above high normal	06/01/2016 10:12 pm
GLUCOSE	● 135	70 - 110 mg/dl Above high normal	06/01/2016 10:12 pm
BUN	11	5 - 20 mg/dl	06/01/2016 10:12 pm
BUN	11	5 - 20 mg/dl	06/01/2016 10:12 pm
CREATININE	1.08	0.40 - 1.60 mg/dl	06/01/2016 10:12 pm
CREATININE	1.08	0.40 - 1.60 mg/dl	06/01/2016 10:12 pm
BILIRUBIN, TOTAL	0.70	0.20 - 1.30 mg/dl	06/01/2016 10:12 pm
BILIRUBIN, TOTAL	0.70	0.20 - 1.30 mg/dl	06/01/2016 10:12 pm
PROTEIN, TOTAL	7.4	6.0 - 8.2 gm/dl	06/01/2016 10:12 pm
PROTEIN, TOTAL	7.4	6.0 - 8.2 gm/dl	06/01/2016 10:12 pm
ALBUMIN	4.5	3.2 - 5.0 gm/dl	06/01/2016 10:12 pm
ALBUMIN	4.5	3.2 - 5.0 gm/dl	06/01/2016 10:12 pm
SODIUM	139	136 - 147 mEq/L	06/01/2016 10:12 pm
SODIUM	139	136 - 147 mEq/L	06/01/2016 10:12 pm
POTASSIUM	4.8	3.7 - 5.1 mEq/L	06/01/2016 10:12 pm
POTASSIUM	4.8	3.7 - 5.1 mEq/L	06/01/2016 10:12 pm
CHLORIDE	106	97 - 108 mEq/L	06/01/2016 10:12 pm
CHLORIDE	106	97 - 108 mEq/L	06/01/2016 10:12 pm
CARBON DIOXIDE	27	20 - 30 mM/L	06/01/2016 10:12 pm
CARBON DIOXIDE	27	20 - 30 mM/L	06/01/2016 10:12 pm
SGPT(ALT)	22	0 - 35 U/L	06/01/2016 10:12 pm
SGPT(ALT)	22	0 - 35 U/L	06/01/2016 10:12 pm
SGOT(AST)	18	10 - 22 U/L	06/01/2016 10:12 pm

Observations	Result	Reference / UoM	Date/Status
SGOT(AST)	18	10 - 22 U/L	06/01/2016 10:12 pm
ALK. PHOSPHATASE	89	29 - 130 U/L	06/01/2016 10:12 pm
ALK. PHOSPHATASE	89	29 - 130 U/L	06/01/2016 10:12 pm
CALCIUM	10.2	8.2 - 10.2 mg/dl	06/01/2016 10:12 pm
CALCIUM	10.2	8.2 - 10.2 mg/dl	06/01/2016 10:12 pm
eGFR If African American	> 60	greater than 60 ml/m/1.73m ²	06/01/2016 10:12 pm
eGFR If African American	> 60	greater than 60 ml/m/1.73m ²	06/01/2016 10:12 pm
eGFR If Non-African American	> 60	greater than 60 ml/m/1.73m ²	06/01/2016 10:12 pm
<p>Vendor note: According to the National Kidney Foundation, estimated GFR values above 60 mL/min/1.73m² should be interpreted as 'above 60 mL/min/1.73m²' not as an exact number.</p> <p>If you have not provided a Date of Birth for this patient, the eGFR may or may not be properly represented on this report.</p> <p>> INDICATES GREATER THAN</p> <p>eGFR reference range is Greater than or equal to 60 mL/min/1.73m²</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			
eGFR If Non-African American	> 60	greater than 60 ml/m/1.73m ²	06/01/2016 10:12 pm
<p>Vendor note: According to the National Kidney Foundation, estimated GFR values above 60 mL/min/1.73m² should be interpreted as 'above 60 mL/min/1.73m²' not as an exact number.</p> <p>If you have not provided a Date of Birth for this patient, the eGFR may or may not be properly represented on this report.</p> <p>> INDICATES GREATER THAN</p> <p>eGFR reference range is Greater than or equal to 60 mL/min/1.73m²</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			

URINALYSIS

Observations	Result	Reference / UoM	Date/Status
COLOR	YELLOW	STRAW - AMBER	06/01/2016 10:15 pm
COLOR	YELLOW	STRAW - AMBER	06/01/2016 10:15 pm
TURBIDITY	CLEAR	CLEAR	06/01/2016 10:15 pm
TURBIDITY	CLEAR	CLEAR	06/01/2016 10:15 pm
SPECIFIC GRAVITY	1.026	1.005 - 1.030	06/01/2016 10:15 pm
SPECIFIC GRAVITY	1.026	1.005 - 1.030	06/01/2016 10:15 pm
PH	6.0	4.0 - 8.0	06/01/2016 10:15 pm
PH	6.0	4.0 - 8.0	06/01/2016 10:15 pm
PROTEIN, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
PROTEIN, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
GLUCOSE, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
GLUCOSE, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
KETONES, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
KETONES, SEMI-QUANT	NEGATIVE	NEGATIVE mg/dl	06/01/2016 10:15 pm
BILIRUBIN, SEMI-QUANT	NEGATIVE	NEGATIVE	06/01/2016 10:15 pm
BILIRUBIN, SEMI-QUANT	NEGATIVE	NEGATIVE	06/01/2016 10:15 pm

Observations	Result	Reference / UoM	Date/Status
BLOOD, SEMI-QUANT.	● TRACE	NEGATIVE Above high normal	06/01/2016 10:15 pm
BLOOD, SEMI-QUANT.	● TRACE	NEGATIVE Above high normal	06/01/2016 10:15 pm
NITRITE, SEMI-QUANT	NEGATIVE	NEGATIVE	06/01/2016 10:15 pm
NITRITE, SEMI-QUANT	NEGATIVE	NEGATIVE	06/01/2016 10:15 pm
UROBILINOGEN, SEMI-QT	1.0	0.2 - 1.0 EU/DL	06/01/2016 10:15 pm
UROBILINOGEN, SEMI-QT	1.0	0.2 - 1.0 EU/DL	06/01/2016 10:15 pm
LEUKOCYTES, SEMI-QT	NEGATIVE	NEGATIVE - TRACE	06/01/2016 10:15 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
LEUKOCYTES, SEMI-QT	NEGATIVE	NEGATIVE - TRACE	06/01/2016 10:15 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

MICROSCOPIC

Observations	Result	Reference / UoM	Date/Status
RED BLOOD CELLS/HPF	3	NONE - 5 /HPF	06/01/2016 10:15 pm
RED BLOOD CELLS/HPF	3	NONE - 5 /HPF	06/01/2016 10:15 pm
WHITE BLOOD CELLS/HPF	3	NONE - 5 /HPF	06/01/2016 10:15 pm
WHITE BLOOD CELLS/HPF	3	NONE - 5 /HPF	06/01/2016 10:15 pm
EPITHELIAL CELLS	FEW	NONE - FEW /HPF	06/01/2016 10:15 pm
EPITHELIAL CELLS	FEW	NONE - FEW /HPF	06/01/2016 10:15 pm
BACTERIA	NONE	NONE	06/01/2016 10:15 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			
BACTERIA	NONE	NONE	06/01/2016 10:15 pm
Vendor note: Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920			

25-OH VITAMIN D

Observations	Result	Reference / UoM	Date/Status
25-OH VITAMIN D	● 12.1	30.0 - 100.0 ng/ml Below low normal	06/01/2016 10:31 pm

Observations	Result	Reference / UoM	Date/Status
<p>Vendor note: When considering treatment, the following reference ranges are generally followed:</p> <p>Vitamin D deficiency < 10 ng/mL Vitamin D insufficiency 10-30 ng/mL Vitamin D sufficiency 30-100 ng/mL</p> <p>Observed range for 95 percent of our winter population of apparently healthy individuals 19.1-57.6 ng/mL</p> <p>The method used to perform this Vitamin D has been standardized by the Ghent University reference measurement procedures, a reference method for the Vitamin D standardization program based on isotope-dilution liquid chromatography-tandem mass spectrometry, and in 2014 was certified by the Centers for Disease Control.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p> <p>OFFICE CLOSED, FAXED RESULTS @ 17:20 BY MP ON 06/03/2016</p> <p>Reported to: FRIEDELL PRIMARY CARE- RT264 at 06/03/16 17:27</p>			
<p>25-OH VITAMIN D • 12.1 30.0 - 100.0 ng/ml Below low normal 06/01/2016 10:31 pm</p>			
<p>Vendor note: When considering treatment, the following reference ranges are generally followed:</p> <p>Vitamin D deficiency < 10 ng/mL Vitamin D insufficiency 10-30 ng/mL Vitamin D sufficiency 30-100 ng/mL</p> <p>Observed range for 95 percent of our winter population of apparently healthy individuals 19.1-57.6 ng/mL</p> <p>The method used to perform this Vitamin D has been standardized by the Ghent University reference measurement procedures, a reference method for the Vitamin D standardization program based on isotope-dilution liquid chromatography-tandem mass spectrometry, and in 2014 was certified by the Centers for Disease Control.</p> <p>Test performed at NICL Laboratories, 306 Era Drive, Northbrook, IL 60062, Gradimir B. Vuckovic, M.D., Medical Director, CLIA 14D0427920</p>			
<p>Performing Laboratory</p> <p>Performing lab details not present</p>			