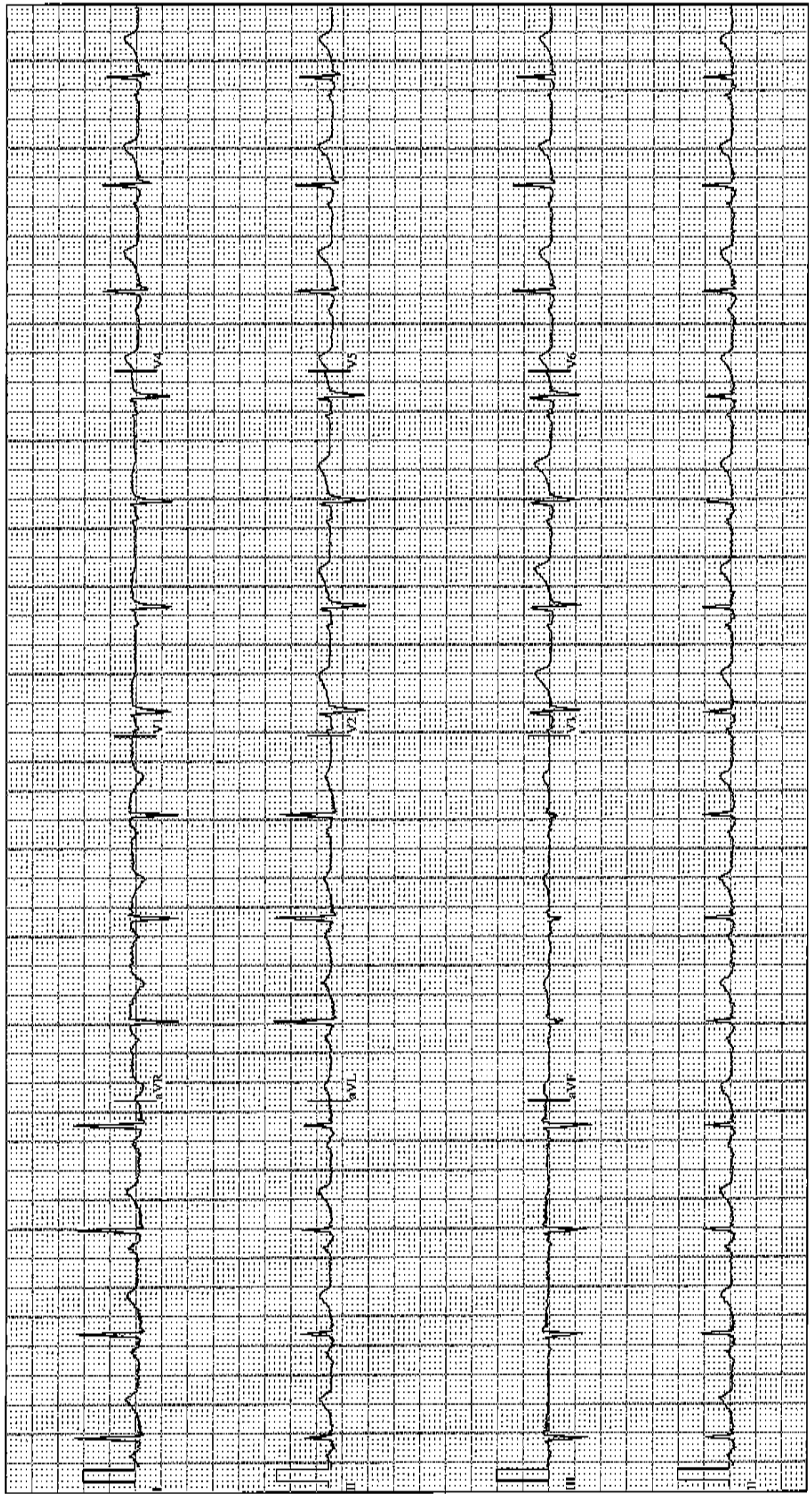
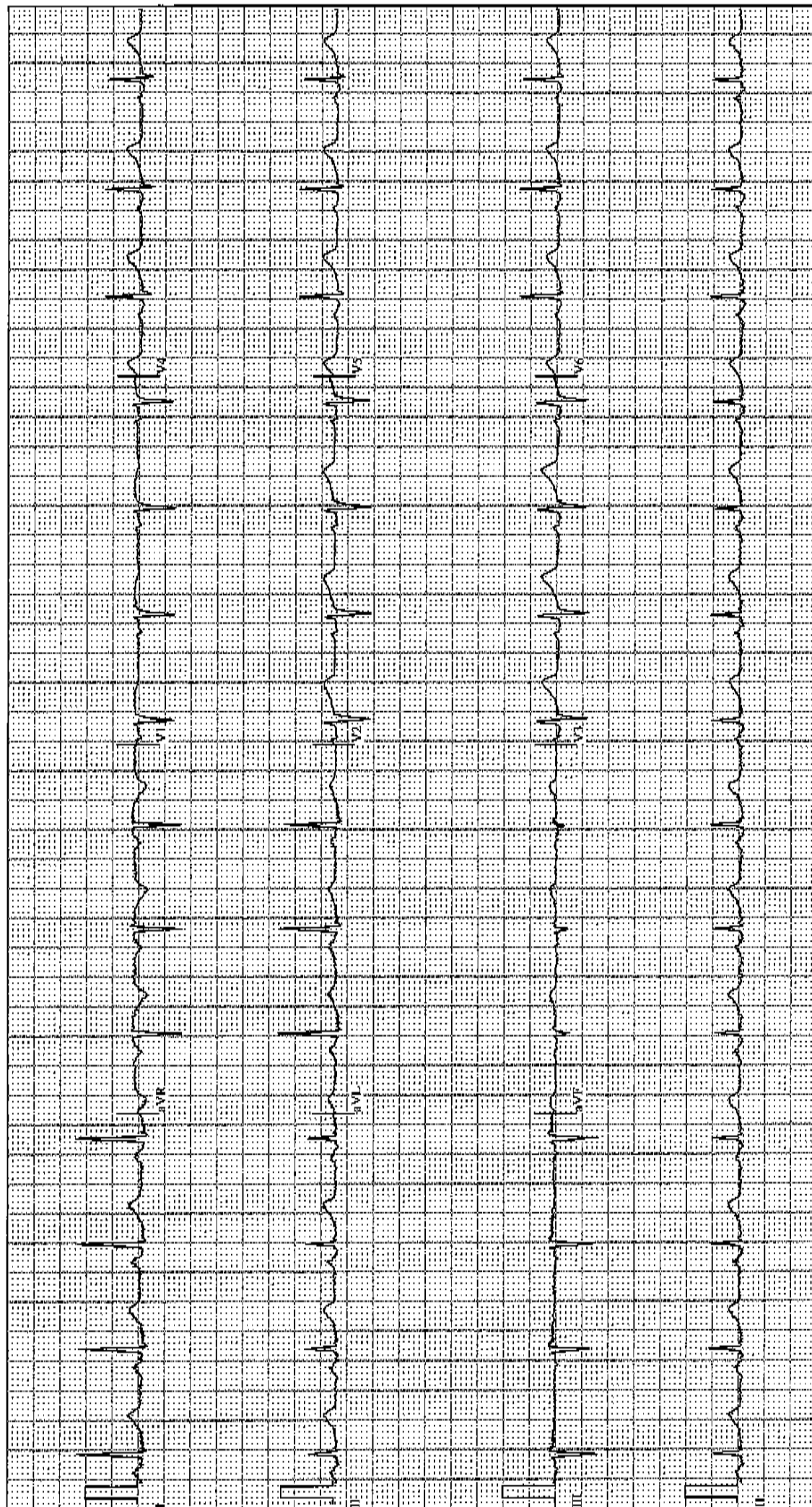


Name: Kim Decker		Midmark Diagnostics Group		Rate: 83		BPM		Interpretation:	
ID: 35384		Req. Physician: Doti MD, Sandy W		PR: 140	msec	Sinus Rhythm			
Sex: Female		Technician: Karen Emerizy MA		QT: 380	msec	Low voltage in precordial leads.			
BP:		History:		QTaB: 446	msec	ABNORMAL			
Weight: lbs		Medication:		QRSD: 86	msec				
Height: inches		Date of Report: 01/24/20	14:24:34	P-QRS-T: 21/-4/20	degree				
DOB: 10/06/1964 (55 Years)		Reviewed By: Sobolev MD, Maria							
Comments:		Review Date: 01/24/20	21:48:59						



Name: Kim Decker		Midmark Diagnostics Group		Rate: 83		BPM		Interpretation:	
ID: 35384	Req. Physician: Doti MD, Sandy W	Technician: Karen Emeritz MA		PR: 140	msec		Sinus Rhythm		
Sex: Female	History:	Medication:		QT: 380	msec		Low voltage in precordial leads.		
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Weight: lbs	Review Date: 01/24/20 21:48:59			QRS-D: 86	msec				
Height: inches				P-QRS-T: 21/-4/20	degree				
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Comments:									





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Middletown, NY 10941

845-703-6999
www.crystalrunhealthcare.com

PATIENT: Kim Decker
DATE OF BIRTH: 10/06/1964
DATE: 01/24/2020 01:30 PM
VISIT TYPE: Preventive Medicine

This 55 year old female presents for Preventive exam.

History of Present Illness:

1. Preventive exam

Gravida: 4. Parity: 4. The patient states her exercise level is average. The patient no longer uses tobacco. Tobacco cessation has been discussed. She has not been exposed to passive smoke. She does not drink alcohol. Additional information: Here for well exam and now has insurance and had labs that were normal. BP controlled. No CP or DOE.

Screening Tools

Drug Abuse Screening Test:

The Drug Abuse Screening Test score is 0 which equals none reported.

Other Screenings:

Encounter Date	Documented Date	Instrument	Score	Severity/Interpretation	MDD Classification
01/24/2020	01/24/2020	Patient Health Questionnaire (PHQ-2)	0	Further testing is not required	
01/24/2020	01/24/2020	Drug Abuse Screening Test (DAST)	0	None reported	
01/24/2020	01/24/2020	AUDIT-C Screening Instrument	2		

DRUG ABUSE SCREENING TEST

1. Have you used drugs other than those required for medical reasons? No

Score: 0

Severity: None reported

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

NOT AT ALL SEVERAL DAYS MORE THAN HALF THE DAYS NEARLY EVERY DAY

Feb. 26, 2020 1:07PM
1. Little interest or pleasure in doing things X
2. Feeling down, depressed or hopeless X

No. 1015 P. 4

PROBLEM LIST: Problem List reviewed.

Problem Description	Onset Date	Chronic	Clinical Status	Notes
Hyperlipidemia	05/23/2007	Y		

Problem List (not yet mapped to SNOMED-CT®):

Problem Description	Onset Date	Notes
Renal Cell CA	05/23/2007	
Pericarditis, Acute Idiopathic	05/23/2007	

Social History: (Reviewed, updated)

Tobacco use reviewed.

Preferred language is English.

MARITAL STATUS/FAMILY/SOCIAL SUPPORT

Currently married.

Smoking status: Former smoker.

SMOKING STATUS

Type	Smoking Status	Usage Per Day	Years Used	Total Pack Years
	Former smoker			

TOBACCO/VAPING EXPOSURE

No passive smoke exposure.

ALCOHOL

There is no history of alcohol use.

CAFFEINE

The patient does not use caffeine.

LIFESTYLE

average activity level.

Medications (active prior to today)

Medication Name	Sig Description	Start Date	Stop Date	Refilled	Rx Elsewhere
Tylenol Extra Strength 500 mg Tab	Use as directed	//			Y
hydrochlorothiazide 25 mg tablet	take one tablet by mouth once daily	06/18/2019		06/18/2019	N
lisinopril 40 mg tablet	TAKE ONE TABLET BY MOUTH ONCE DAILY	06/18/2019		06/18/2019	N
phentermine 37.5 mg capsule	take 1 capsule by oral route every day before breakfast	10/14/2019		10/14/2019	N
Tamiflu 75 mg capsule	take 1 capsule by oral route 2 times every day	01/17/2020	01/24/2020		N

Medication Reconciliation

Medications reconciled today.

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Allergies

(allergies)Reviewed, no changes.

Review of Systems

System	Neg/Pos	Details
Constitutional	Negative	Chills, Fatigue and Fever.
ENMT	Negative	Nasal drainage and Sinus pressure.
Respiratory	Negative	Cough and Dyspnea.
Cardio	Negative	Chest pain and Edema.
GI	Negative	Abdominal pain and Change in stool pattern.
GU	Negative	Dysuria and Hematuria.
Endocrine	Negative	Cold intolerance and Heat intolerance.
Neuro	Negative	Dizziness and Headache.
Psych	Negative	Anxiety and Depression.
MS	Positive	Joint pain.
Hema/Lymph	Negative	Easy bleeding and Easy bruising.

Vital Signs

Time	BP	Pulse	Resp	Temp F	Ht ft	Ht in	Ht cm	Wt lb	Wt kg	BMI	BSA m2	O2
	mm/Hg	/min	/min							kg/m2		Sat%
1:46 PM	116/80	72			5.0	7.00	170.18	275.00	124.738	43.07		

Measured By

Time	Measured by
1:46 PM	Karen Emerizy MA

Screening Summary:

Pain is described as 0/10. Evaluated pain score with Numeric Pain Intensity Scale.

The following were reviewed: tobacco use, date of last pap and date of last mammogram

Physical Exam

Exam	Findings	Details
Constitutional	Normal	Well developed.
Eyes	Normal	Pupil - Right: Normal, Left: Normal.
Ears	Normal	TM - Right: Normal, Left: Normal.
Neck Exam	Normal	Thyroid gland - Normal.
Respiratory	Normal	Inspection - Normal. Auscultation - Normal.
Cardiovascular	Normal	Regular rate and rhythm. No murmurs, gallops, or rubs.
Abdomen	Comments	Lower abdominal hernia noted
Abdomen	Normal	Inspection - Normal. Auscultation - Normal. No abdominal tenderness.
Musculoskeletal	Normal	Visual overview of all four extremities is normal.
Extremity	Normal	No edema.
Neurological	Normal	Memory - Normal.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation. Appropriate mood and affect.

Completed Orders (this encounter)

Order	Details	Reason	Side	Interpretation	Result	Initial Treatment Date	Region
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Patient Health
Questionnaire
(PHQ-2)

Further testing 0
is not required

Drug Abuse
Screening Test
(DAST)

None reported 0

AUDIT-C
Screening
Instrument

2

Assessment/Plan

#	Detail Type	Description
1.	Assessment	Encntr for general adult medical exam w/o abnormal findings (Z00.00).
	Patient Plan	Labs reviewed. Continue regimen. Mammogram ordered. Podiatry consult. Surgery consult for hernia repair. Weight loss and continue Phentermine
	Plan Orders	She is to schedule a follow-up visit with new ortho consult, She is to schedule a follow-up visit with new podiatry consult and She is to schedule a follow-up visit with Sandy Doti MD.
2.	Assessment	Other specified abdominal hernia without obstruction or gangrene (K45.8).
	Plan Orders	She is to schedule a follow-up visit with Guillermo Uy MD.

Pain Management Plan

Pain Scale: 0/10.

Method: Numeric Pain Intensity Scale.

Medications *(Added, Continued or Stopped today)*

Started	Medication	Directions	Instruction	Stopped
06/18/2019	hydrochlorothiazid e 25 mg tablet	take one tablet by mouth once daily.		
06/18/2019	lisinopril 40 mg tablet	TAKE ONE TABLET BY MOUTH ONCE DAILY		
10/14/2019	phentermine 37.5 mg capsule	take 1 capsule by oral route every day before breakfast	MDD 1 capsule. IStop 112582501	
	Tylenol Extra Strength 500 mg Tab	Use as directed		

Counseling / Educational Factors:

Counseling / educational factors reviewed.

Provider:

Doti MD, Sandy W 01/28/2020 6:00 PM

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Crystal Run Healthcare, LLP