



lead and innovate

Case #: I842189  
Worked By: Lena Joslin  
Method Received: FTP  
Number of Pages: 24  
Date: 10/1/2018

## Records Request

Name: [REDACTED]  
SSN: [REDACTED]  
DOB: [REDACTED]  
State: [REDACTED]  
Policy #: [REDACTED]

Company: Ameriprise  
Account#: [REDACTED]  
Requester: [REDACTED]  
U/W Team: [REDACTED]  
Doc Type(s): [REDACTED]

Facility: BAPTIST PRIMARY CARE  
Address: 8614 BAYMEADOWS WAY SUITE 100  
City, St: JACKSONVILLE, FL 32256  
Phone/Fax: 904-396-0450 / 904-346-0212

33983825 AP  
UNKNOWN

**Special Instructions:**

**Dr. DR RICHARD GLOCK**

**PLEASE PROVIDE ALL**

**MEDICAL RECORDS FOR THE PAST FIVE YEARS**

**CHIEF COMPLAINT:**

Followup of Gastro-esophageal reflux disease with esophagitis  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine with aura, intractable, with status migrainosus  
Followup of Superior glenoid labrum lesion of right shoulder, initial encounter

**HISTORY OF PRESENT ILLNESS:**

On 03/26/2018, [REDACTED], a 47 year old female presented with:

-- Problem:annual exam.

-- Migraine with aura, intractable, with status migrainosus (followup visit), which began years ago. Severity after meds was described as Continues to have migraines with menses and when under significant stress but resolves with maxalt within 1-2 hours. Medication side effects reported were fatigue for about an hour. Patient compliance: takes medications as prescribed. An associated sign and symptom is Mostly left sided aura, nausea.

-- Gastro-esophageal reflux disease with esophagitis (followup visit), which began years ago. Severity after meds was described as Stable with medication, prilosec prn and worse when under stress and with certain foods. Patient compliance: takes medications as prescribed. The patient denied the following: dysphagia.

-- Superior glenoid labrum lesion of right shoulder, initial encounter (followup visit), which began about a year ago. Severity was described as mild. Severity after meds was described as Improved following injection and with physical therapy. Medication side effects reported were none. Patient compliance: Following up with Dr. Kaplan.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Controlled with medication, wellbutrin. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

**ALLERGIES:** NKDA**MEDICATIONS HISTORY:****Current Medications:**

1. Protonix 40 mg Tab, 1 PO once daily
2. Maxalt 10 mg tablet, 1 po daily as needed
3. Wellbutrin XL 300 mg 24 hr tablet, extended release, 1 by mouth once a day

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.  
Chronic Illnesses - GERD and migraine headaches.  
Accidents - Fracture.  
Operations - LASIK  
Transfusions- no.  
Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction  
: Congestive heart failure  
: CVA  
: Hypertension  
**Father:** Father alive and well at 63 in 2010  
: Hypertension  
**Mother:** Mother alive and well at 63 in 2010  
: Hypercholesterolemia  
: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician;; Sexual Activity - married to [REDACTED] Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - Progressive hearing loss and Sinus congestion with current pollen allergy season  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - See HPI  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence  
MUSCULOSKELETAL - See HPI  
NEUROLOGICAL - See HPI and Had meningioma seen 8 years ago.  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS:

B/P - 114/75 Retaken by MD

Pulse - 67

Temperature - 97.7 degrees

Weight - 131.00000 lbs.

Height - 63 inches

BMI: 23.20

Weight Change: 1.00 lbs. gained since Mar 23 2017

repeat BP 112/74 :Retaken by MD

**AUDIOMETRY:**

Twenty-five (25) decibels, and below, are considered normal hearing levels with the most acute hearing being the lowest figure. Thirty (30) decibels, and above, are considered to constitute hearing impairment with sixty (60) decibels being serious hearing loss and ninety (90) decibels being severe hearing loss.

Performed by: KATHY MCLAIN, LPN/RMA/BMO

LEFT 250 HZ: 20 Decibels

LEFT 500 HZ: 10

LEFT 1000 HZ: 10

LEFT 2000 HZ: 15

LEFT 3000 HZ: 60

LEFT 4000 HZ: 60

LEFT 6000 HZ: 90

LEFT 8000 HZ: 70

RIGHT 250 HZ: 15

RIGHT 500 HZ: 10

RIGHT 1000 HZ: 0

RIGHT 2000 HZ: 15  
RIGHT 3000 HZ: 45  
RIGHT 4000 HZ: 50  
RIGHT 6000 HZ: 70  
RIGHT 8000 HZ: 65

Interpretation: severe hearing impairment both ears high frequency

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry. and small granuloma above the right ankle

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

EXTREMITIES - Symmetrical without deformities, no edema. and 2+ pulses

NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BREAST - Fibrocystic changes at 10 o'clock in the periphery on the right and 2 o'clock on the left

BACK - Full forward flexion

#### ASSESSMENT:

1. Benign neoplasm of cerebral meninges - Stable
2. Major depressive disorder, recurrent, unspecified - Stable
3. Migraine with aura, intractable, with status migrainosus - Stable
4. Mixed conductive and sensorineural hearing loss, bilateral - Worsening
5. Gastro-esophageal reflux disease with esophagitis - Stable
6. Superior glenoid labrum lesion of right shoulder, initial encounter - Improving
7. Examination routine adult W/ abnormal findings - New
8. BMI 23.0-23.9 - Unchanged

Headaches occur several times monthly. Worse pre-menstrual. Depression better since she is working again. No menopausal signs. GERD better controlled.

#### PLAN:

1. Request Clinical Summary -
2. Physical Exam 1 year -
3. CT Head with and without contrast - Benign neoplasm of cerebral meninges
4. Audiometry Diagnostic Done today - Mixed conductive and sensorineural hearing loss, bilateral
5. ENT GREEN, DOUGLAS [GEE836PR000001] Org: JACKSONVILLE HEARING AND BALANCE INST Ph: 904/399-0350 Fax: 904/399-5914 10475 CENTURION PARKWAY N. 303 JACKSONVILLE, FL 32256 - Mixed conductive and sensorineural hearing loss, bilateral
6. \*CBC with Auto Diff 3/26/18 Coll by (GSANC) - Examination routine adult W/ abnormal findings
7. \*CMP - Examination routine adult W/ abnormal findings
8. \*TSH - Examination routine adult W/ abnormal findings
9. \*Lipid Panel - Examination routine adult W/ abnormal findings
10. \*Urinalysis, With Reflex to Culture - Examination routine adult W/ abnormal findings

Same meds. Hearing test shows severe hearing loss bilaterally at higher frequencies. Will refer to Dr Riegler but she is a candidate for hearing aides.

**DRUG RX:**

1. Maxalt 10 mg tablet, 30, 1 po daily as needed, Refills: 6
2. Wellbutrin XL 300 mg 24 hr tablet, extended release, 30, 1 by mouth once a day, Refills: 6

Ordered REFERRAL to:

1. ENT, GREEN, DOUGLAS [GREE836PR000001] Org:JACKSONVILLE HEARING AND BALANCE INST Ph:904/399-0350 Fax:904/399-5914 10475 CENTURION PARKWAY N. 303 JACKSONVILLE, FL 32256, H90.6

This document was created in whole or in part using scribe: Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 03/26/2018 21:59:00

**CHIEF COMPLAINT:**

Followup of Gastro-esophageal reflux disease with esophagitis  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine

**HISTORY OF PRESENT ILLNESS:**

On 03/23/2017, [REDACTED] a 46 year old female presented with:

-- Problem:annual exam.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Improving with increasing wellbutrin to 300mg. Medication side effects reported were none. Patient compliance: takes medications as prescribed. Depressed after leaving job.

-- Migraine (followup visit), which began years ago. Severity was described as Increased frequency with higher stress. Severity after meds was described as Gets relief with maxalt. Medication side effects reported were none. Patient compliance: takes medications as prescribed and average 3 monthly.

-- Gastro-esophageal reflux disease with esophagitis (followup visit), which began years ago. Severity after meds was described as Stable with medication, otc nexium. Medication side effects reported were none. Patient compliance: Takes medication prn.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:****Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Maxalt 10 mg tablet, 1 po daily as needed
4. Wellbutrin XL 150 mg 24 hr tablet, extended release, 1 by mouth once a day

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction

: Congestive heart failure

: CVA

: Hypertension

**Father:** Father alive and well at 63 in 2010

: Hypertension

**Mother:** Mother alive and well at 63 in 2010

: Hypercholesterolemia

: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician;; Sexual Activity - married to [REDACTED]; Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills, Strength stable and energy down  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence, menstrual cycle slightly irregular and headaches  
MUSCULOSKELETAL - Bilateral knee stiffness. Right hip stable following surgery, occasional discomfort with standing for extended periods of time  
NEUROLOGICAL - See HPI  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS: B/P - 112/72, Pulse - 62 , Temperature - 97.3 degrees , Weight - 130.00 lbs., Height - 63 inches

BMI: 23.03

Weight Change: 4.20 lbs. gained since Mar 17 2016

repeat BP 106/70 :Retaken by MD

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3  
SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.  
HEAD - Normocephalic. No trauma.  
EYE - EOM intact, conjugate eye movement, PERL.  
ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.  
NECK - No masses, lymphadenopathy or thyroid abnormality. and no carotid bruit  
CHEST - Clear to auscultation. No labored breathing.  
CARDIAC - Regular sinus rhythm, no murmur or gallop  
ABDOMEN - BS(+), soft, mild epigastric tenderness, nondistended. No masses or organomegaly.  
EXTREMITIES - Symmetrical without deformities, no edema., 2+ pulses and mild right hip discomfort with abduction  
NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot  
PSYCHIATRIC - Normal mood and affect.  
IMMUNOLOGIC - No lymphadenopathy.  
BREAST - normal breasts, no dominant mass  
BACK - Negative SLR and Full forward flexion

**ASSESSMENT:**

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere -  
Stable

- 2. Major depressive disorder, recurrent, unspecified - Stable
- 3. Migraine with aura, intractable, with status migrainosus - Stable
- 4. Gastro-esophageal reflux disease with esophagitis - Stable
- 5. Pain in right hip - Stable
- 6. Examination routine adult W/ abnormal findings - New
- 7. Encounter for immunization - New

Depression controlled on Wellbutrin 300 mg . Headaches generally better. Maxalt effective. Some tension headaches respond to Ibuprofen. Stomach better after treating H. Pylori.

**PLAN:**

- 1. Request Clinical Summary -
- 2. Comp Exam 1 year -
- 3. H.Pylori Stool Antigen - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
- 4. \*CBC with Auto Diff 03/23/17 coll by GSANC (ADORS) - Examination routine adult W/ abnormal findings
- 5. \*Lipid Panel - Examination routine adult W/ abnormal findings
- 6. \*CMP - Examination routine adult W/ abnormal findings
- 7. \*TSH - Examination routine adult W/ abnormal findings
- 8. \*Urinalysis,With Reflex to Culture - Examination routine adult W/ abnormal findings
- 9. \*Td Vaccine done today - Encounter for immunization

Pt needs to be working. Same meds. Increase physical and mental activity.

**DRUG RX:**

- 1. Wellbutrin XL 300 mg 24 hr tablet, extended release, 30, 1 by mouth once a day,  
Refills: 6

**The following drugs were stopped:**

- 1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
- 2. Wellbutrin XL 150 mg 24 hr tablet, extended release, 1 by mouth once a day

This document was created in whole or in part using scribe: Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 03/23/2017 21:20:08

**CHIEF COMPLAINT:**

Followup of Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine  
Followup of Pain in right hip  
physical exam

**HISTORY OF PRESENT ILLNESS:**

On 03/17/2016, [REDACTED] a 45 year old female presented with:

-- Problem:annual exam.

-- Migraine (followup visit), which began years ago. Severity was described as 1-2 monthly. Patient compliance: takes medications as prescribed. Associated with stress and premenstrual.

-- Gastro-esophageal reflux disease with esophagitis and Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere (followup visit), which began months ago. Severity after meds was described as Stable with medication, pantoprazole. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Stable with medication, wellbutrin. Medication side effects reported were decreased libido with higher dose. Patient compliance: takes medications as prescribed and Following up with therapist. An associated sign and symptom is Difficulty sleeping, abdominal pain.

-- Pain in right hip (followup visit), which began over a year ago. Severity was described as Improved following surgical repair.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:****Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY
3. Maxalt 10 mg Tab, 1 po daily as needed
4. Protonix 40 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction

: Congestive heart failure

: CVA

: Hypertension

**Father:** Father alive and well at 63 in 2010

: Hypertension

**Mother:** Mother alive and well at 63 in 2010

: Hypercholesterolemia

: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Tobacco Status - non- user; Caffeine intake - Coffee 3 cups per day;

Patient: GUZMAN, NILMARIE MRNO: 1006323 DOB: 12/23/1970 - Continued  
Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation -  
Physician, University of Florida; Sexual Activity - married to [REDACTED]  
[REDACTED]; Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - See HPI  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence  
MUSCULOSKELETAL - See HPI  
NEUROLOGICAL - See HPI  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Difficulty sleeping

**EXAMINATION:**

VITAL SIGNS: B/P - 107/67, Pulse - 68 , Temperature - 98.5 degrees , Weight - 125.80000 lbs., Height - 63.00 inches

BMI: 22.32

Weight Change: -4.20 lbs. lost since Mar 12 2015

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3  
SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.  
HEAD - Normocephalic. No trauma.  
EYE - EOM intact, conjugate eye movement, PERL.  
ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.  
NECK - No masses, lymphadenopathy or thyroid abnormality.  
CHEST - Clear to auscultation. No labored breathing.  
CARDIAC - Regular sinus rhythm, no murmur or gallop  
ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.  
EXTREMITIES - Symmetrical without deformities, no edema. and 2+ pulses  
NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot  
PSYCHIATRIC - Normal mood and affect.  
IMMUNOLOGIC - No lymphadenopathy.  
BACK - Full forward flexion

**ASSESSMENT:**

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere - Stable
2. Major depressive disorder, recurrent, unspecified - Improving
3. Gastro-esophageal reflux disease with esophagitis - Stable
4. Pain in right hip - Improving
5. Examination routine adult W/O abnormal findings - New
6. Migraine - Stable

Pt with minor sx of depression and stress. Stopped Lexapro due to sexual side effects.

**Continued**

**PLAN:**

1. Request Clinical Summary -
2. Schedule Physical Exam -
3. Return in 1 year -
4. \*CBC with Auto Diff 03/25/16 - Examination routine adult W/O abnormal findings
5. \*CMP - Examination routine adult W/O abnormal findings
6. \*TSH - Examination routine adult W/O abnormal findings
7. \*Urinalysis,With Reflex to Culture - Examination routine adult W/O abnormal findings
8. \*Lipid Panel - Examination routine adult W/O abnormal findings

Leave Shands if she wishes. OK to take a sabatical On Wellbutrinin and depresuin is doing better,

**DRUG RX:**

1. Maxalt 10 mg tablet, 14, 1 po daily as needed, Refills: 6
2. Wellbutrin XL 150 mg 24 hr tablet, extended release, 30, 1 by mouth once a day, Refills: 6

**The following drugs were stopped:**

1. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY

This document was created in whole or in part using scribe: - Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 03/17/2016 23:27:09

**CHIEF COMPLAINT:**

Followup of Migraine  
Hip pain  
Pre-op exam

**HISTORY OF PRESENT ILLNESS:**

On 03/12/2015, [REDACTED] a 44 year old female presented with:

-- Problem: Hip pain. Onset: 18 months ago. Antecedents: Running. Location: R hip. Severity: Labral tear. Relieving factors: Nothing, has tried injections, meloxicam, diclofenac and physical therapy. Surgery with Dr. Kaplan 4/7/15.

-- Migraine (followup visit), which began years ago. Severity after meds was described as Stable with medication, maxalt prn. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

**Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY
3. Maxalt 10 mg Tab, 1 po daily as needed
4. Protonix 40 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.  
Chronic Illnesses - GERD and migraine headaches.  
Accidents - Fracture.  
Operations - LASIK  
Transfusions- no.  
Wears Glasses - No.

**Smoking Status:**

Never smoker/Recode: 4 03/12/15

Tobacco Status: non- user.

**SOCIAL HISTORY:** Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke;  
Tobacco Status - non- user; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician, University of Florida; Sexual Activity - married to [REDACTED]  
Comments- Husband in a lawsuit;

**FAMILY HISTORY:**

Father -

Father alive and well, at 63 in 2010 and Hypertension;

Mother - Mother alive and well, at 63 in 2010, Hypercholesterolemia and Hypertension;

**HEALTH MAINTENANCE HISTORY:**

Breast Exam: 03/12/15

DRE - Digital Rectal Exam: 03/12/15

EKG: 04/28/10

FOBT-Stool Occult blood test: 08/08/12

Mammogram: 01/01/06

Pap Smear: 11/25/09

TMST: 05/14/10

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.

GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia

GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence

MUSCULOSKELETAL - See HPI

NEUROLOGICAL - See HPI

PSYCHIATRIC - Depressed. On Wellbutrin

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS:

B/P - 115/74

Pulse - 60

Temperature - 98.7 degrees

Weight - 130.00000 lbs. Height - 63 inches Weight Change: 2.00 lbs. gained since 04/13/12

BMI 23.03

CONSTITUTIONAL - In no distress.

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

RECTAL - not indicated

EXTREMITIES - Symmetrical without deformities, no edema. and Pain adduction R hip.

NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BREAST - normal breasts, no dominant mass

**ECG TEST:**

Test Date: 03/12/15

Findings: Normal sinus rhythm and Normal EKG

**ASSESSMENT:**

1. Migraine - New
2. Pre-op EKG - New

At low risk for surgery. Infrequent headaches.

**PLAN:**

1. Request Clinical Summary -
2. \*CMP 3/12/15 collected by GSANC - Pre-op EKG
3. \*CBC with Auto Diff - Pre-op EKG
4. EKG done today - Pre-op EKG
5. Return in 1 year - Pre-op EKG
6. Schedule Physical Exam - Pre-op EKG

Proceed with surgery R hip next month. Labs drawn

This document was created in whole or in part using scribe: - Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 03/12/2015 23:55:29

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Followup of Fatigue and malaise  
Followup of GERD  
Followup of Screening cholesterol/ lipid disorders

**HISTORY OF PRESENT ILLNESS:**

On 04/13/2012, [REDACTED] a 41 year old female presented with:

-- Problem: Irregular periods, night sweats. Onset: 6 months. Will see Dr Baird.

-- Migraines (followup visit), which began years ago and recently worse. Severity was described as worsening. Severity after meds was described as Improved with Maxalt. Patient compliance: Ran out of meds. An associated sign and symptom is Visual aura.. The patient denied the following: No neuro sx..

-- Chest pain unspec and GERD (followup visit), which began 2 years ago. It is located on the Lower esophagus. Severity was described as improving. Severity after meds was described as improving. Patient compliance: exercising regularly, does not follow diet plan and takes medications as prescribed. No reflux.

**ALLERGIES: NKDA**

**MEDICATIONS HISTORY:**

**Current medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Lexapro 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:** Multiple family members - CHF, CVA, unknown type, Hypertension and MI. Family - CHF, CVA, unknown type, Hypertension and MI. Mother - Alive at 63 in 2010, Hypercholesterolemia and Hypertension; Father - Alive at 63 in 2010 and Hypertension.

**SOCIAL HISTORY:** Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician, University of Florida; Sexual Activity - married to [REDACTED] Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies. No sore throat or hoarseness.

**RESPIRATORY** - No cough, wheezing or dyspnea.  
**CARDIOVASCULAR** - No chest pain, palpitations or edema. No orthopnea or PND.  
**GASTROINTESTINAL** - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia  
**GENITOURINARY** - Denies dysuria, hematuria, urgency, incontinence and Nocturia x 1  
**MUSCULOSKELETAL** - back pain  
**NEUROLOGICAL** - headache(s) and No neurological complaints or focal deficits  
**PSYCHIATRIC** - Denies depression or anxiety.  
**ENDOCRINE** - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
**HEMATOLOGIC/ONCOLOGIC** - No bruising or unusual bleeding. No lymphadenopathy.  
**SLEEP** - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 116/76

Pulse - 57

Temperature - 97.0 degrees

Weight - 128.00 lbs. Height - 63 inches BMI - 22.67

Weight Change: .00 lbs. lost since 09/29/11

**CONSTITUTIONAL** - Anxious, In no distress and well nourished

**SKIN** - No rash or lesions. Normal texture and Turgor, skin warm and dry.

**HEAD** - Normocephalic. No trauma.

**EYE** - EOM intact, conjugate eye movement, PERL.

**ENT** - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

**NECK** - No masses, lymphadenopathy or thyroid abnormality.

**CHEST** - Clear to auscultation. No labored breathing.

**CARDIAC** - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

**ABDOMEN** - BS(+), soft, nontender, nondistended. No masses or organomegaly.

**RECTAL** - not indicated

**EXTREMITIES** - Symmetrical without deformities, no edema.

**NEUROLOGICAL** - Alert, active without obvious motor or sensory deficits.

**PSYCHIATRIC** - Normal mood and affect.

**IMMUNOLOGIC** - No lymphadenopathy.

**BREAST** - normal breasts, no dominant mass

**ASSESSMENT:**

1. Chest pain unspec - Controlled
2. Fatigue and malaise - Controlled
3. GERD - Controlled
4. Screening cholesterol/ lipid disorders - Controlled

Migraines worse since more recent stress.

**PLAN:**

1. Return in 1 year -
2. \*FOBT Kit - Fatigue and malaise
3. \*CBC with Auto Diff - Chest pain unspec
4. \*CMP - Chest pain unspec
5. \*Lipid Panel - Chest pain unspec
6. \*TSH - Chest pain unspec
7. \*T4 - Chest pain unspec

Stay on same meds. Renew rx,

**DRUG RX:**

1. Lexapro 10 mg, Oral Tab, 30, TAKE 1 TABLET BY MOUTH ONCE DAILY, Refills: 11
2. Maxalt 10 mg, Oral Tab, #14(Fourteen), 1 po daily as needed, Refills: 6
3. Protonix 40 mg, Oral TbEC, 30, 1 PO once daily, Refills: 11

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 04/13/2012 09:30:34

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Followup of GERD

**HISTORY OF PRESENT ILLNESS:**

On 09/29/2011, [REDACTED] a 40 year old female presented with:

-- Problem: Fatigue. Onset: 2 months ago.. Associated signs and symptoms: Cold intolerance, hair loss, weight gain menorrhagia.. Concerned with thyroid..

-- GERD (followup visit), which began several years ago. Severity was described as improving.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

**Current medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Lexapro 10 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills and Energy down.

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies. No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - Palpitations at times. No chest pain.

GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia

GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence, irregular menses and menorrhagia

MUSCULOSKELETAL - Low back pain.

NEUROLOGICAL - No seizures or syncope. No paresthesias, tremor or weakness. No headache or confusion.

PSYCHIATRIC - Denies depression or anxiety.

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 101/68

Pulse - 48

Temperature - 97.8 degrees

Weight - 128.00 lbs. Height - 62.9 inches BMI - 22.74

Weight Change: 5.00 lbs. gained since 09/03/10

CONSTITUTIONAL - well nourished and Attractive

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

RECTAL - not indicated

EXTREMITIES - Symmetrical without deformities, no edema.

NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BACK - Minor tenderness low back.

**ASSESSMENT:**

1. Fatigue and malaise - New
2. GERD - Controlled

Chest pain resolved. GERD doing better. Fatigue and S of hypothyroidism.

**PLAN:**

1. \*TSH - Fatigue and malaise
2. \*T4 - Fatigue and malaise
3. \*CMP - Fatigue and malaise
4. \*CBC with Auto Diff - Fatigue and malaise
5. \*Vitamin D, 25-Hydroxy - Fatigue and malaise
6. Schedule Physical Exam - Fatigue and malaise
7. Return Visit in 6 Months - Fatigue and malaise

Check TFT's. PPI only as needed.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 09/29/2011 12:21:58

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Headaches.

**HISTORY OF PRESENT ILLNESS:**

On 09/03/2010, Nilmarie Guzman MD, a 39 year old female presented with:

-- Chest pain unspec (followup visit), which began several years ago. Severity was described as improving. Medication side effects reported were none. Associated signs and symptoms are bloating and heartburn. The patient denied the following: dysphagia.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

Current medications:

1. Lexapro 10 mg, Oral Tab, 1 PO once daily
2. Fioricet 50-325-40 mg, Oral Tab, Take as Directed, prn
3. Protonix 40 mg, Oral TbEC, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.

GASTROINTESTINAL - bloating and heartburn

MUSCULOSKELETAL - No joint swelling or pain. No myalgia.

NEUROLOGICAL - No seizures or syncope. No paresthesias, tremor or weakness. No headache or confusion.

PSYCHIATRIC - Denies depression or anxiety.

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 113/69

Pulse - 59

Temperature - 97.0 degrees

Weight - 123.00 lbs.

Weight Change: -4.00 lbs. lost since 05/14/10

CONSTITUTIONAL - In no distress.

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.  
HEAD - Normocephalic. No trauma.  
EYE - EOM intact, conjugate eye movement, PERL.  
ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.  
NECK - No masses, lymphadenopathy or thyroid abnormality.  
CHEST - Clear to auscultation. No labored breathing.  
CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.  
ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly. and Tender epigastrium  
RECTAL - FOBT collected, No rectal masses noted. and not indicated  
EXTREMITIES - Symmetrical without deformities, no edema.  
NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.  
PSYCHIATRIC - Normal mood and affect.  
IMMUNOLOGIC - No lymphadenopathy.

**ASSESSMENT:**

1. GERD - Controlled
2. Screening cholesterol/ lipid disorders - New

GERD. not well controlled with Prilosec.

**PLAN:**

1. Return Visit in 6 Months -
2. \*FOBT Kit - GERD

Will try protonix, Aciphex. Hemoccult

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 09/03/2010 09:25:59

**UF Health Radiology  
SHANDS JACKSONVILLE  
Imaging Result Report**

PCP: Glock, Richard D      Alt Prov:  
Auth Prov: Baird, Tim  
Phone: 904-296-2441  
Fax: 904-821-3113  
6879 Southpoint Drive North  
North Florida Obstetrics & Gynecology Associates  
Jacksonville FL 32216

**Final Report**

**MAM Screening**

**Exam Date & Time:** Tue Oct 25, 2016 9:29 AM

**Reason For Exam:** None Specified

**Ordering Diagnosis:** Visit for screening mammogram

Bilateral Digital Screening Mammogram

Comparison: 2013, 2015

History: 45-year-old female with no current complaints.

Routine digital cranial caudal and MLO views were obtained.

Findings: Scattered fibroglandular densities are seen. Nodular asymmetry within the right retroareolar breast CC view only. There are no abnormal clustered microcalcifications. No evidence of architectural distortion or skin thickening identified. No suspicious mammographic findings on the left.

CAD was also utilized.

**IMPRESSION:**

Impression: BIRADS:0, assessment is incomplete.

Recommend right breast diagnostic mammogram with spot tomosynthesis and right breast ultrasound for further evaluation of nodular asymmetry within the right retroareolar breast CC view only.

**NOTE:**

An x-ray report which is negative for cancer should not delay biopsy if a dominant or clinically suspicious mass is present. 4 to 8% of cancers are not identified by x-ray.

A negative report may reinforce clinical impression.

Adenosis or fibrocystic disease ( mammary dysplasia )may obscure an underlying neoplasm.

False positive reports average 6 to 10%.

Written notification of the findings and follow-up recommendations were mailed to the patient.

Read By - Cassandra Aboy M.D.

Electronically Verified By - Cassandra Aboy M.D.

Released Date Time - 10/25/2016 10:02 AM

Resident -

Read By:Fernandez, Cassandra, MD

Electronically Verified and Signed by: Cassandra Fernandez on 10/25/2016 10:02 AM

SHANDS JACKSONVILLE

This study was personally reviewed by me and I agree with the report.

CC: RICHARD D GLOCK, MD - FAX



Akumin Orange Park  
2020 Professional Center Dr  
Orange Park, FL 32073

Toll-Free Phone: 1-800-730-0050  
Toll-Free Fax: 1-855-855-0050  
Website: akumin.com



**Exam requested by:**

RICHARD GLOCK

8614 BAYMEADOWS WAY, SUITE 100  
JACKSONVILLE FL 32256

Fax: 9043460212

CT HEAD WITH AND WITHOUT CONTRAST (with AEC) [70470] -  
Neuro



**EXAM: CT HEAD WITH AND WITHOUT CONTRAST (WITH AEC)**

**CLINICAL HISTORY:** 47-year-old female with chronic headaches. History of meningioma.

**COMPARISON:** None

**TECHNIQUE:** Axial CT scan images of the cranium were obtained without and with IV administration of 100 cc Isovue 300 contrast agent.

**FINDINGS:**

There is 1.1 x 0.7 cm extra-axial ossification in the right parasagittal anterior frontal region at the vertex which may represent osteoma versus a calcified meningioma regarding the patient's history.

The ventricles and sulci are normal in size and configuration. There is no mass, mass effect or midline shift. No intra or extra-axial acute hemorrhage. No abnormal extra-axial fluid collection is noted. Gray-white matter differentiation is intact.

After IV contrast injection, there is no abnormal parenchymal or meningeal contrast enhancement throughout the brain.

The calvarium is intact.

The visualized orbits, paranasal sinuses and mastoid air cells are grossly unremarkable.

**IMPRESSION:**

Unremarkable Cranial CT without and with contrast except for 1.1 x 0.7 cm extra-axial ossification in the right parasagittal anterior frontal region at the vertex which may represent osteoma versus a calcified meningioma regarding the patient's history.

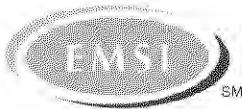
*Thank you for referring your patient to Akumin Orange Park*

Uzuner, Ovsev, MD

Electronically Signed: 04/25/2018

Duval

The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named as recipient. If the reader is not the intended recipient, be hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.



lead and innovate

Case #: I842189  
Worked By: Lena Joslin  
Method Received: FTP  
Number of Pages: 24  
Date: 10/1/2018

## Records Request

**Facility:** BAPTIST PRIMARY CARE  
**Address:** 8614 BAYMEADOWS WAY SUITE 100  
**City, St:** JACKSONVILLE, FL 32256  
**Phone/Fax:** 904-396-0450 / 904-346-0212

33983825 AP  
UNKNOWN

**Special Instructions:**

**Dr. DR RICHARD GLOCK** PLEASE PROVIDE ALL  
MEDICAL RECORDS FOR THE PAST FIVE YEARS

**CHIEF COMPLAINT:**

Followup of Gastro-esophageal reflux disease with esophagitis  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine with aura, intractable, with status migrainosus  
Followup of Superior glenoid labrum lesion of right shoulder, initial encounter

**HISTORY OF PRESENT ILLNESS:**

On 03/26/2018, Nilmarie Guzman, a 47 year old female presented with:

-- Problem:annual exam.

-- Migraine with aura, intractable, with status migrainosus (followup visit), which began years ago. Severity after meds was described as Continues to have migraines with menses and when under significant stress but resolves with maxalt within 1-2 hours. Medication side effects reported were fatigue for about an hour. Patient compliance: takes medications as prescribed. An associated sign and symptom is Mostly left sided aura, nausea.

-- Gastro-esophageal reflux disease with esophagitis (followup visit), which began years ago. Severity after meds was described as Stable with medication, prilosec prn and worse when under stress and with certain foods. Patient compliance: takes medications as prescribed. The patient denied the following: dysphagia.

-- Superior glenoid labrum lesion of right shoulder, initial encounter (followup visit), which began about a year ago. Severity was described as mild. Severity after meds was described as Improved following injection and with physical therapy. Medication side effects reported were none. Patient compliance: Following up with Dr. Kaplan.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Controlled with medication, wellbutrin. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

**ALLERGIES:** NKDA**MEDICATIONS HISTORY:****Current Medications:**

1. Protonix 40 mg Tab, 1 PO once daily
2. Maxalt 10 mg tablet, 1 po daily as needed
3. Wellbutrin XL 300 mg 24 hr tablet, extended release, 1 by mouth once a day

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.  
Chronic Illnesses - GERD and migraine headaches.  
Accidents - Fracture.  
Operations - LASIK  
Transfusions- no.  
Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction  
: Congestive heart failure  
: CVA  
: Hypertension  
**Father:** Father alive and well at 63 in 2010  
: Hypertension  
**Mother:** Mother alive and well at 63 in 2010  
: Hypercholesterolemia  
: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician;; Sexual Activity - married to [REDACTED] Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - Progressive hearing loss and Sinus congestion with current pollen allergy season  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - See HPI  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence  
MUSCULOSKELETAL - See HPI  
NEUROLOGICAL - See HPI and Had meningioma seen 8 years ago.  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS:

B/P - 114/75 Retaken by MD  
Pulse - 67  
Temperature - 97.7 degrees  
Weight - 131.00000 lbs.  
Height - 63 inches  
BMI: 23.20

Weight Change: 1.00 lbs. gained since Mar 23 2017

repeat BP 112/74 :Retaken by MD

**AUDIOMETRY:**

Twenty-five (25) decibels, and below, are considered normal hearing levels with the most acute hearing being the lowest figure. Thirty (30) decibels, and above, are considered to constitute hearing impairment with sixty (60) decibels being serious hearing loss and ninety (90) decibels being severe hearing loss.

Performed by: KATHY MCLAIN, LPN/RMA/BMO

LEFT 250 HZ: 20 Decibels

LEFT 500 HZ: 10

LEFT 1000 HZ: 10

LEFT 2000 HZ: 15

LEFT 3000 HZ: 60

LEFT 4000 HZ: 60

LEFT 6000 HZ: 90

LEFT 8000 HZ: 70

RIGHT 250 HZ: 15

RIGHT 500 HZ: 10

RIGHT 1000 HZ: 0

RIGHT 2000 HZ: 15  
RIGHT 3000 HZ: 45  
RIGHT 4000 HZ: 50  
RIGHT 6000 HZ: 70  
RIGHT 8000 HZ: 65

Interpretation: severe hearing impairment both ears high frequency

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry. and small granuloma above the right ankle

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

EXTREMITIES - Symmetrical without deformities, no edema. and 2+ pulses

NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BREAST - Fibrocystic changes at 10 o'clock in the periphery on the right and 2 o'clock on the left

BACK - Full forward flexion

#### ASSESSMENT:

1. Benign neoplasm of cerebral meninges - Stable
2. Major depressive disorder, recurrent, unspecified - Stable
3. Migraine with aura, intractable, with status migrainosus - Stable
4. Mixed conductive and sensorineural hearing loss, bilateral - Worsening
5. Gastro-esophageal reflux disease with esophagitis - Stable
6. Superior glenoid labrum lesion of right shoulder, initial encounter - Improving
7. Examination routine adult W/ abnormal findings - New
8. BMI 23.0-23.9 - Unchanged

Headaches occur several times monthly. Worse pre-menstrual. Depression better since she is working again. No menopausal signs. GERD better controlled.

#### PLAN:

1. Request Clinical Summary -
2. Physical Exam 1 year -
3. CT Head with and without contrast - Benign neoplasm of cerebral meninges
4. Audiometry Diagnostic Done today - Mixed conductive and sensorineural hearing loss, bilateral
5. ENT GREEN, DOUGLAS [GEE836PR000001] Org: JACKSONVILLE HEARING AND BALANCE INST Ph: 904/399-0350 Fax: 904/399-5914 10475 CENTURION PARKWAY N. 303 JACKSONVILLE, FL 32256 - Mixed conductive and sensorineural hearing loss, bilateral
6. \*CBC with Auto Diff 3/26/18 Coll by (GSANC) - Examination routine adult W/ abnormal findings
7. \*CMP - Examination routine adult W/ abnormal findings
8. \*TSH - Examination routine adult W/ abnormal findings
9. \*Lipid Panel - Examination routine adult W/ abnormal findings
10. \*Urinalysis, With Reflex to Culture - Examination routine adult W/ abnormal findings

Same meds. Hearing test shows severe hearing loss bilaterally at higher frequencies. Will refer to Dr Riegler but she is a candidate for hearing aides.

**DRUG RX:**

1. Maxalt 10 mg tablet, 30, 1 po daily as needed, Refills: 6
2. Wellbutrin XL 300 mg 24 hr tablet, extended release, 30, 1 by mouth once a day, Refills: 6

Ordered REFERRAL to:

1. ENT, GREEN, DOUGLAS [GREE836PR000001] Org:JACKSONVILLE HEARING AND BALANCE INST Ph:904/399-0350 Fax:904/399-5914 10475 CENTURION PARKWAY N. 303 JACKSONVILLE, FL 32256, H90.6

This document was created in whole or in part using scribe: Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 03/26/2018 21:59:00

**CHIEF COMPLAINT:**

Followup of Gastro-esophageal reflux disease with esophagitis  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine

**HISTORY OF PRESENT ILLNESS:**

On 03/23/2017, [REDACTED], a 46 year old female presented with:

-- Problem:annual exam.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Improving with increasing wellbutrin to 300mg. Medication side effects reported were none. Patient compliance: takes medications as prescribed. Depressed after leaving job.

-- Migraine (followup visit), which began years ago. Severity was described as Increased frequency with higher stress. Severity after meds was described as Gets relief with maxalt. Medication side effects reported were none. Patient compliance: takes medications as prescribed and average 3 monthly.

-- Gastro-esophageal reflux disease with esophagitis (followup visit), which began years ago. Severity after meds was described as Stable with medication, otc nexium. Medication side effects reported were none. Patient compliance: Takes medication prn.

**ALLERGIES:** NKDA**MEDICATIONS HISTORY:****Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Maxalt 10 mg tablet, 1 po daily as needed
4. Wellbutrin XL 150 mg 24 hr tablet, extended release, 1 by mouth once a day

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction

: Congestive heart failure

: CVA

: Hypertension

**Father:** Father alive and well at 63 in 2010

: Hypertension

**Mother:** Mother alive and well at 63 in 2010

: Hypercholesterolemia

: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician;; Sexual Activity - married to [REDACTED] : Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills, Strength stable and energy down  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence, menstrual cycle slightly irregular and headaches  
MUSCULOSKELETAL - Bilateral knee stiffness. Right hip stable following surgery, occasional discomfort with standing for extended periods of time  
NEUROLOGICAL - See HPI  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS: B/P - 112/72, Pulse - 62 , Temperature - 97.3 degrees , Weight - 130.00 lbs., Height - 63 inches

BMI: 23.03

Weight Change: 4.20 lbs. gained since Mar 17 2016

repeat BP 106/70 :Retaken by MD

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3  
SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.  
HEAD - Normocephalic. No trauma.  
EYE - EOM intact, conjugate eye movement, PERL.  
ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.  
NECK - No masses, lymphadenopathy or thyroid abnormality. and no carotid bruit  
CHEST - Clear to auscultation. No labored breathing.  
CARDIAC - Regular sinus rhythm, no murmur or gallop  
ABDOMEN - BS(+), soft, mild epigastric tenderness, nondistended. No masses or organomegaly.  
EXTREMITIES - Symmetrical without deformities, no edema., 2+ pulses and mild right hip discomfort with abduction  
NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot  
PSYCHIATRIC - Normal mood and affect.  
IMMUNOLOGIC - No lymphadenopathy.  
BREAST - normal breasts, no dominant mass  
BACK - Negative SLR and Full forward flexion

**ASSESSMENT:**

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere -  
Stable

2. Major depressive disorder, recurrent, unspecified - Stable
3. Migraine with aura, intractable, with status migrainosus - Stable
4. Gastro-esophageal reflux disease with esophagitis - Stable
5. Pain in right hip - Stable
6. Examination routine adult W/ abnormal findings - New
7. Encounter for immunization - New

Depression controlled on Wellbutrin 300 mg . Headaches generally better. Maxalt effective. Some tension headaches respond to Ibuprofen. Stomach better after treating H. Pylori.

**PLAN:**

1. Request Clinical Summary -
2. Comp Exam 1 year -
3. H.Pylori Stool Antigen - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
4. \*CBC with Auto Diff 03/23/17 coll by GSANC (ADORS) - Examination routine adult W/ abnormal findings
5. \*Lipid Panel - Examination routine adult W/ abnormal findings
6. \*CMP - Examination routine adult W/ abnormal findings
7. \*TSH - Examination routine adult W/ abnormal findings
8. \*Urinalysis,With Reflex to Culture - Examination routine adult W/ abnormal findings
9. \*Td Vaccine done today - Encounter for immunization

Pt needs to be working. Same meds. Increase physical and mental activity.

**DRUG RX:**

1. Wellbutrin XL 300 mg 24 hr tablet, extended release, 30, 1 by mouth once a day, Refills: 6

**The following drugs were stopped:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Wellbutrin XL 150 mg 24 hr tablet, extended release, 1 by mouth once a day

This document was created in whole or in part using scribe: Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 03/23/2017 21:20:08

**CHIEF COMPLAINT:**

Followup of Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere  
Followup of Major depressive disorder, recurrent, unspecified  
Followup of Migraine  
Followup of Pain in right hip  
physical exam

**HISTORY OF PRESENT ILLNESS:**

On 03/17/2016, [REDACTED] a 45 year old female presented with:

-- Problem:annual exam.

-- Migraine (followup visit), which began years ago. Severity was described as 1-2 monthly. Patient compliance: takes medications as prescribed. Associated with stress and premenstrual.

-- Gastro-esophageal reflux disease with esophagitis and Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere (followup visit), which began months ago. Severity after meds was described as Stable with medication, pantoprazole. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

-- Major depressive disorder, recurrent, unspecified (followup visit), which began years ago. Severity after meds was described as Stable with medication, wellbutrin. Medication side effects reported were decreased libido with higher dose. Patient compliance: takes medications as prescribed and Following up with therapist. An associated sign and symptom is Difficulty sleeping, abdominal pain.

-- Pain in right hip (followup visit), which began over a year ago. Severity was described as Improved following surgical repair.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:****Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY
3. Maxalt 10 mg Tab, 1 po daily as needed
4. Protonix 40 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:**

**Family:** Myocardial infarction

: Congestive heart failure

: CVA

: Hypertension

**Father:** Father alive and well at 63 in 2010

: Hypertension

**Mother:** Mother alive and well at 63 in 2010

: Hypercholesterolemia

: Hypertension

**SOCIAL HISTORY:** - Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Tobacco Status - non- user; Caffeine intake - Coffee 3 cups per day;

Patient: [REDACTED]  
Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation -  
Physician, University of Florida; Sexual Activity - married to [REDACTED]  
Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal  
SKIN - Denies rash, new skin lesions, or change in moles  
EYES - No changes in vision. Denies glaucoma or cataracts  
ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.  
RESPIRATORY - No cough, wheezing or dyspnea.  
CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.  
GASTROINTESTINAL - See HPI  
GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence  
MUSCULOSKELETAL - See HPI  
NEUROLOGICAL - See HPI  
PSYCHIATRIC - See HPI  
ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.  
SLEEP - Difficulty sleeping

**EXAMINATION:**

VITAL SIGNS: B/P - 107/67, Pulse - 68 , Temperature - 98.5 degrees , Weight - 125.80000 lbs., Height - 63.00 inches

BMI: 22.32

Weight Change: -4.20 lbs, lost since Mar 12 2015

CONSTITUTIONAL - In no distress., well developed, well nourished and alert and oriented x 3  
SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.  
HEAD - Normocephalic. No trauma.  
EYE - EOM intact, conjugate eye movement, PERL.  
ENT - TM's normal color with distinct landmarks, Dentition in good repair and No oral or pharyngeal lesions.  
NECK - No masses, lymphadenopathy or thyroid abnormality.  
CHEST - Clear to auscultation. No labored breathing.  
CARDIAC - Regular sinus rhythm, no murmur or gallop  
ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.  
EXTREMITIES - Symmetrical without deformities, no edema. and 2+ pulses  
NEUROLOGICAL - Alert and oriented to time, place and person., Romberg negative, finger to nose test normal and able to tandem walk and stand on one foot  
PSYCHIATRIC - Normal mood and affect.  
IMMUNOLOGIC - No lymphadenopathy.  
BACK - Full forward flexion

**ASSESSMENT:**

1. Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere - Stable
2. Major depressive disorder, recurrent, unspecified - Improving
3. Gastro-esophageal reflux disease with esophagitis - Stable
4. Pain in right hip - Improving
5. Examination routine adult W/O abnormal findings - New
6. Migraine - Stable

Pt with minor sx of depression and stress. Stopped Lexapro due to sexual side effects.

**Continued**

**PLAN:**

1. Request Clinical Summary -
2. Schedule Physical Exam -
3. Return in 1 year -
4. \*CBC with Auto Diff 03/25/16 - Examination routine adult W/O abnormal findings
5. \*CMP - Examination routine adult W/O abnormal findings
6. \*TSH - Examination routine adult W/O abnormal findings
7. \*Urinalysis,With Reflex to Culture - Examination routine adult W/O abnormal findings
8. \*Lipid Panel - Examination routine adult W/O abnormal findings

Leave Shands if she wishes. OK to take a sabatical On Wellbutrinin and depresuin is doing better,

**DRUG RX:**

1. Maxalt 10 mg tablet, 14, 1 po daily as needed, Refills: 6
2. Wellbutrin XL 150 mg 24 hr tablet, extended release, 30, 1 by mouth once a day, Refills: 6

**The following drugs were stopped:**

1. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY

This document was created in whole or in part using scribe: - Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 03/17/2016 23:27:09

**CHIEF COMPLAINT:**

Followup of Migraine  
Hip pain  
Pre-op exam

**HISTORY OF PRESENT ILLNESS:**

On 03/12/2015, [REDACTED] a 44 year old female presented with:

-- Problem: Hip pain. Onset: 18 months ago. Antecedents: Running. Location: R hip. Severity: Labral tear. Relieving factors: Nothing, has tried injections, meloxicam, diclofenac and physical therapy. Surgery with Dr. Kaplan 4/7/15.

-- Migraine (followup visit), which began years ago. Severity after meds was described as Stable with medication, maxalt prn. Medication side effects reported were none. Patient compliance: takes medications as prescribed.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

**Current Medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. escitalopram 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY
3. Maxalt 10 mg Tab, 1 po daily as needed
4. Protonix 40 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.  
Chronic Illnesses - GERD and migraine headaches.  
Accidents - Fracture.  
Operations - LASIK  
Transfusions- no.  
Wears Glasses - No.

**Smoking Status:**

Never smoker/Recode: 4 03/12/15

Tobacco Status: non- user.

**SOCIAL HISTORY:** Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke;  
Tobacco Status - non- user; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician.  
University of Florida; Sexual Activity - married to [REDACTED]  
Comments- Husband in a lawsuit;

**FAMILY HISTORY:**

Father -

Father alive and well, at 63 in 2010 and Hypertension;

Mother - Mother alive and well, at 63 in 2010, Hypercholesterolemia and Hypertension;

**HEALTH MAINTENANCE HISTORY:**

Breast Exam: 03/12/15

DRE - Digital Rectal Exam: 03/12/15

EKG: 04/28/10

FOBT-Stool Occult blood test: 08/08/12

Mammogram: 01/01/06

Pap Smear: 11/25/09

TMST: 05/14/10

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.

GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia

GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence

MUSCULOSKELETAL - See HPI

NEUROLOGICAL - See HPI

PSYCHIATRIC - Depressed. On Wellbutrin

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

VITAL SIGNS:

B/P - 115/74

Pulse - 60

Temperature - 98.7 degrees

Weight - 130.00000 lbs. Height - 63 inches Weight Change: 2.00 lbs. gained since 04/13/12

BMI 23.03

CONSTITUTIONAL - In no distress.

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

RECTAL - not indicated

EXTREMITIES - Symmetrical without deformities, no edema. and Pain adduction R hip.

NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BREAST - normal breasts, no dominant mass

**ECG TEST:**

Test Date: 03/12/15

Findings: Normal sinus rhythm and Normal EKG

**ASSESSMENT:**

1. Migraine - New
2. Pre-op EKG - New

At low risk for surgery. Infrequent headaches.

**PLAN:**

1. Request Clinical Summary -
2. \*CMP 3/12/15 collected by GSANC - Pre-op EKG
3. \*CBC with Auto Diff - Pre-op EKG
4. EKG done today - Pre-op EKG
5. Return in 1 year - Pre-op EKG
6. Schedule Physical Exam - Pre-op EKG

Proceed with surgery R hip next month. Labs drawn

This document was created in whole or in part using scribe: - Mary Harper, NCMA.

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 03/12/2015 23:55:29

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Followup of Fatigue and malaise  
Followup of GERD  
Followup of Screening cholesterol/ lipid disorders

**HISTORY OF PRESENT ILLNESS:**

On 04/13/2012, [REDACTED] a 41 year old female presented with:

-- Problem: Irregular periods, night sweats. Onset: 6 months. Will see Dr Baird.

-- Migraines (followup visit), which began years ago and recently worse. Severity was described as worsening. Severity after meds was described as Improved with Maxalt. Patient compliance: Ran out of meds. An associated sign and symptom is Visual aura.. The patient denied the following: No neuro sx..

-- Chest pain unspec and GERD (followup visit), which began 2 years ago. It is located on the Lower esophagus. Severity was described as improving. Severity after meds was described as improving. Patient compliance: exercising regularly, does not follow diet plan and takes medications as prescribed. No reflux.

**ALLERGIES: NKDA**

**MEDICATIONS HISTORY:**

**Current medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Lexapro 10 mg Tab, TAKE 1 TABLET BY MOUTH ONCE DAILY

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**FAMILY HISTORY:** Multiple family members - CHF, CVA, unknown type, Hypertension and MI. Family - CHF, CVA, unknown type, Hypertension and MI. Mother - Alive at 63 in 2010, Hypercholesterolemia and Hypertension; Father - Alive at 63 in 2010 and Hypertension.

**SOCIAL HISTORY:** Alcohol Use - Wine, 1 glass on weekends; Smoking - Does not smoke; Caffeine intake - Coffee 3 cups per day; Exercise - exercises more than 3 x weekly; Seat Belt Use - Yes; Occupation - Physician, University of Florida; Sexual Activity - married to [REDACTED] Comments- Husband in a lawsuit;

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies. No sore throat or hoarseness.

**RESPIRATORY** - No cough, wheezing or dyspnea.  
**CARDIOVASCULAR** - No chest pain, palpitations or edema. No orthopnea or PND.  
**GASTROINTESTINAL** - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia  
**GENITOURINARY** - Denies dysuria, hematuria, urgency, incontinence and Nocturia x 1  
**MUSCULOSKELETAL** - back pain  
**NEUROLOGICAL** - headache(s) and No neurological complaints or focal deficits  
**PSYCHIATRIC** - Denies depression or anxiety.  
**ENDOCRINE** - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.  
**HEMATOLOGIC/ONCOLOGIC** - No bruising or unusual bleeding. No lymphadenopathy.  
**SLEEP** - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 116/76

Pulse - 57

Temperature - 97.0 degrees

Weight - 128.00 lbs. Height - 63 inches BMI - 22.67

Weight Change: .00 lbs. lost since 09/29/11

**CONSTITUTIONAL** - Anxious, In no distress and well nourished

**SKIN** - No rash or lesions. Normal texture and Turgor, skin warm and dry.

**HEAD** - Normocephalic. No trauma.

**EYE** - EOM intact, conjugate eye movement, PERL.

**ENT** - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

**NECK** - No masses, lymphadenopathy or thyroid abnormality.

**CHEST** - Clear to auscultation. No labored breathing.

**CARDIAC** - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

**ABDOMEN** - BS(+), soft, nontender, nondistended. No masses or organomegaly.

**RECTAL** - not indicated

**EXTREMITIES** - Symmetrical without deformities, no edema.

**NEUROLOGICAL** - Alert, active without obvious motor or sensory deficits.

**PSYCHIATRIC** - Normal mood and affect.

**IMMUNOLOGIC** - No lymphadenopathy.

**BREAST** - normal breasts, no dominant mass

**ASSESSMENT:**

1. Chest pain unspec - Controlled
2. Fatigue and malaise - Controlled
3. GERD - Controlled
4. Screening cholesterol/ lipid disorders - Controlled

Migraines worse since more recent stress.

**PLAN:**

1. Return in 1 year -
2. \*FOBT Kit - Fatigue and malaise
3. \*CBC with Auto Diff - Chest pain unspec
4. \*CMP - Chest pain unspec
5. \*Lipid Panel - Chest pain unspec
6. \*TSH - Chest pain unspec
7. \*T4 - Chest pain unspec

Stay on same meds. Renew rx,

**DRUG RX:**

1. Lexapro 10 mg, Oral Tab, 30, TAKE 1 TABLET BY MOUTH ONCE DAILY, Refills: 11
2. Maxalt 10 mg, Oral Tab, #14(Fourteen), 1 po daily as needed, Refills: 6
3. Protonix 40 mg, Oral TbEC, 30, 1 PO once daily, Refills: 11

Entered by: RICHARD D GLOCK MD

---

Electronically signed by RICHARD D GLOCK MD 04/13/2012 09:30:34

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Followup of GERD

**HISTORY OF PRESENT ILLNESS:**

On 09/29/2011, [REDACTED] a 40 year old female presented with:

-- Problem: Fatigue. Onset: 2 months ago.. Associated signs and symptoms: Cold intolerance, hair loss, weight gain menorrhagia.. Concerned with thyroid..

-- GERD (followup visit), which began several years ago. Severity was described as improving.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

**Current medications:**

1. Fioricet 50 mg-325 mg-40 mg Tab, Take as Directed, prn
2. Protonix 40 mg Tab, 1 PO once daily
3. Lexapro 10 mg Tab, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills and Energy down.

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies. No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - Palpitations at times. No chest pain.

GASTROINTESTINAL - No nausea, vomiting or changes in bowel patterns. No hematochezia or melena. No GERD or dysphagia

GENITOURINARY - Denies dysuria, hematuria, urgency, incontinence, irregular menses and menorrhagia

MUSCULOSKELETAL - Low back pain.

NEUROLOGICAL - No seizures or syncope. No paresthesias, tremor or weakness. No headache or confusion.

PSYCHIATRIC - Denies depression or anxiety.

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 101/68

Pulse - 48

Temperature - 97.8 degrees

Weight - 128.00 lbs. Height - 62.9 inches BMI - 22.74

Weight Change: 5.00 lbs. gained since 09/03/10

CONSTITUTIONAL - well nourished and Attractive

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly.

RECTAL - not indicated

EXTREMITIES - Symmetrical without deformities, no edema.

NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

BACK - Minor tenderness low back.

**ASSESSMENT:**

1. Fatigue and malaise - New
2. GERD - Controlled

Chest pain resolved. GERD doing better. Fatigue and S of hypothyroidism.

**PLAN:**

1. \*TSH - Fatigue and malaise
2. \*T4 - Fatigue and malaise
3. \*CMP - Fatigue and malaise
4. \*CBC with Auto Diff - Fatigue and malaise
5. \*Vitamin D, 25-Hydroxy - Fatigue and malaise
6. Schedule Physical Exam - Fatigue and malaise
7. Return Visit in 6 Months - Fatigue and malaise

Check TFT's. PPI only as needed.

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 09/29/2011 12:21:58

**CHIEF COMPLAINT:**

Followup of Chest pain unspec  
Headaches.

**HISTORY OF PRESENT ILLNESS:**

On 09/03/2010, [REDACTED] a 39 year old female presented with:

-- Chest pain unspec (followup visit), which began several years ago. Severity was described as improving. Medication side effects reported were none. Associated signs and symptoms are bloating and heartburn. The patient denied the following: dysphagia.

**ALLERGIES:** NKDA

**MEDICATIONS HISTORY:**

Current medications:

1. Lexapro 10 mg, Oral Tab, 1 PO once daily
2. Fioricet 50-325-40 mg, Oral Tab, Take as Directed, prn
3. Protonix 40 mg, Oral TbEC, 1 PO once daily

**PAST HISTORY:**

Childhood Illnesses -Chicken Pox.

Chronic Illnesses - GERD and migraine headaches.

Accidents - Fracture.

Operations - LASIK

Transfusions- no.

Wears Glasses - No.

**REVIEW OF SYSTEMS:**

GENERAL - Denies fever or chills. Strength and energy normal

SKIN - Denies rash, new skin lesions, or change in moles

EYES - No changes in vision. Denies glaucoma or cataracts

ENT - No changes in hearing. and No nasal drainage or congestion. No inhalant allergies.  
No sore throat or hoarseness.

RESPIRATORY - No cough, wheezing or dyspnea.

CARDIOVASCULAR - No chest pain, palpitations or edema. No orthopnea or PND.

GASTROINTESTINAL - bloating and heartburn

MUSCULOSKELETAL - No joint swelling or pain. No myalgia.

NEUROLOGICAL - No seizures or syncope. No paresthesias, tremor or weakness. No headache or confusion.

PSYCHIATRIC - Denies depression or anxiety.

ENDOCRINE - No polydipsia or polyuria. Weight and appetite stable. No cold or heat intolerance.

HEMATOLOGIC/ONCOLOGIC - No bruising or unusual bleeding. No lymphadenopathy.

SLEEP - Denies insomnia or signs of sleep apnea

**EXAMINATION:**

**VITAL SIGNS:**

B/P - 113/69

Pulse - 59

Temperature - 97.0 degrees

Weight - 123.00 lbs.

Weight Change: -4.00 lbs. lost since 05/14/10

CONSTITUTIONAL - In no distress.

SKIN - No rash or lesions. Normal texture and Turgor, skin warm and dry.

HEAD - Normocephalic. No trauma.

EYE - EOM intact, conjugate eye movement, PERL.

ENT - TM's normal color with distinct landmarks, Nasal membranes normal, Dentition in good repair and No oral or pharyngeal lesions.

NECK - No masses, lymphadenopathy or thyroid abnormality.

CHEST - Clear to auscultation. No labored breathing.

CARDIAC - Regular rate and rhythm. No murmur, gallop, rub or click., No JVD, carotid or abdominal bruits. and Peripheral pulses normal and symmetric.

ABDOMEN - BS(+), soft, nontender, nondistended. No masses or organomegaly. and Tender epigastrium

RECTAL - FOBT collected, No rectal masses noted. and not indicated

EXTREMITIES - Symmetrical without deformities, no edema.

NEUROLOGICAL - Alert, active without obvious motor or sensory deficits.

PSYCHIATRIC - Normal mood and affect.

IMMUNOLOGIC - No lymphadenopathy.

**ASSESSMENT:**

1. GERD - Controlled
2. Screening cholesterol/ lipid disorders - New

GERD. not well controlled with Prilosec.

**PLAN:**

1. Return Visit in 6 Months -
2. \*FOBT Kit - GERD

Will try protonix, Aciphex. Hemoccult

Entered by: RICHARD D GLOCK MD

Electronically signed by RICHARD D GLOCK MD 09/03/2010 09:25:59

**UF Health Radiology  
SHANDS JACKSONVILLE  
Imaging Result Report**

PCP: Glock, Richard D                          Alt Prov:  
Auth Prov: Baird, Tim  
Phone:904-296-2441  
Fax:904-821-3113  
6879 Southpoint Drive North  
North Florida Obstetrics & Gynecology Associates  
Jacksonville FL 32216

**Final Report**

**MAM Screening**

**Exam Date & Time:** Tue Oct 25, 2016 9:29 AM

**Reason For Exam:** None Specified

**Ordering Diagnosis:** Visit for screening mammogram

Bilateral Digital Screening Mammogram

Comparison: 2013, 2015

History: 45-year-old female with no current complaints.

Routine digital cranial caudal and MLO views were obtained.

**Findings:** Scattered fibroglandular densities are seen. Nodular asymmetry within the right retroareolar breast CC view only. There are no abnormal clustered microcalcifications. No evidence of architectural distortion or skin thickening identified. No suspicious mammographic findings on the left.

CAD was also utilized.

**IMPRESSION:**

Impression: BIRADS:0, assessment is incomplete.

Recommend right breast diagnostic mammogram with spot tomosynthesis and right breast ultrasound for further evaluation of nodular asymmetry within the right retroareolar breast CC view only.

**NOTE:**

An x-ray report which is negative for cancer should not delay biopsy if a dominant or clinically suspicious mass is present. 4 to 8% of cancers are not identified by x-ray.

A negative report may reinforce clinical impression.

Adenosis or fibrocystic disease ( mammary dysplasia )may obscure an underlying neoplasm.

False positive reports average 6 to 10%.

Written notification of the findings and follow-up recommendations were mailed to the patient.

Read By - Cassandra Aboy M.D.

Electronically Verified By - Cassandra Aboy M.D.

Released Date Time - 10/25/2016 10:02 AM

Resident -

Read By:Fernandez, Cassandra, MD

Electronically Verified and Signed by: Cassandra Fernandez on 10/25/2016 10:02 AM

SHANDS JACKSONVILLE

This study was personally reviewed by me and I agree with the report.

CC: RICHARD D GLOCK, MD - FAX



Akumin Orange Park  
2020 Professional Center Dr  
Orange Park, FL 32073

Toll-Free Phone: 1-800-730-0050  
Toll-Free Fax: 1-855-855-0050  
Website: akumin.com



Exam requested by:  
**RICHARD GLOCK**  
8614 BAYMEADOWS WAY, SUITE 100  
JACKSONVILLE FL 32256  
Fax: 9043460212  
CT HEAD WITH AND WITHOUT CONTRAST (with AEC) [70470] -  
Neuro

**EXAM: CT HEAD WITH AND WITHOUT CONTRAST (WITH AEC)**

**CLINICAL HISTORY:** 47-year-old female with chronic headaches. History of meningioma.

**COMPARISON:** None

**TECHNIQUE:** Axial CT scan images of the cranium were obtained without and with IV administration of 100 cc Isovue 300 contrast agent.

**FINDINGS:**

There is 1.1 x 0.7 cm extra-axial ossification in the right parasagittal anterior frontal region at the vertex which may represent osteoma versus a calcified meningioma regarding the patient's history.

The ventricles and sulci are normal in size and configuration. There is no mass, mass effect or midline shift. No intra or extra-axial acute hemorrhage. No abnormal extra-axial fluid collection is noted. Gray-white matter differentiation is intact.

After IV contrast injection, there is no abnormal parenchymal or meningeal contrast enhancement throughout the brain.

The calvarium is intact.

The visualized orbits, paranasal sinuses and mastoid air cells are grossly unremarkable.

**IMPRESSION:**

Unremarkable Cranial CT without and with contrast except for 1.1 x 0.7 cm extra-axial ossification in the right parasagittal anterior frontal region at the vertex which may represent osteoma versus a calcified meningioma regarding the patient's history.

*Thank you for referring your patient to Akumin Orange Park*

Uzuner, Ovsev, MD  
Electronically Signed: 04/25/2018

Duval

The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named as recipient. If the reader is not the intended recipient, be hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address via the U.S. Postal Service. Thank you.