CONFIDENTIAL PATIENT MASTER RECORD

PATIENT ID: 211 | MRN: MRN-211-2025

I. REGISTRATION FACE SHEET

PATIENT IDENTITY	
Name:	Gregory House
DOB:	1959-06-11
Gender:	male
Race:	Caucasian
Height:	6 ft 2 in
Weight:	185 lbs
Telecom:	609-555-1959
Address:	221B Baker Street, Princeton, NJ 08540
Marital Status:	Divorced
Multiple Birth:	No (Order: 1)

COMMUNICATION	
Language:	English
Preferred:	Yes

EMERGENCY CONTACT	
Relationship:	Emergency Contact
Name:	Dr. James Wilson
Telecom:	609-555-1960
Address:	100 Plainsboro Road, Princeton, NJ 08540
Gender:	male
Organization:	Princeton-Plainsboro Teaching Hospital
Period Start:	2004-11-16
Period End:	ongoing

PRIMARY PROVIDER	
General Practitioner:	Dr. Lisa Cuddy, MD
Managing Organization:	Princeton-Plainsboro Teaching Hospital

INSURANCE / PAYER	
Payer ID:	J1113
Payer Name:	Aetna
Plan Name:	Aetna Choice POS II

Plan Type:	POS
Group ID:	PPTH-789
Group Name:	Princeton-Plainsboro Teaching Hospital
Member ID:	AETNA-GH-19590611
Policy Number:	POL-PPTH-998877
Effective Date:	2004-01-01
Termination Date:	ongoing
Copay:	$40
Deductible:	$1000
SUBSCRIBER	
Subscriber ID:	MEM-19590611
Subscriber Name:	Gregory House
Relationship:	Self
Subscriber DOB:	1959-06-11
Subscriber Address:	221B Baker Street, Princeton,NJ 08540

II. MEDICAL BIOGRAPHY & HISTORY

Dr. Gregory House is a highly intelligent, cynical, and iconoclastic medical genius who heads the Department of Diagnostic Medicine at Princeton-Plainsboro Teaching Hospital. His life and career are defined by an infarction in his right quadriceps muscle that occurred approximately two decades ago. Misdiagnosis and a stubborn refusal to accept the severity of the situation led to muscle death, leaving him with chronic, debilitating pain and a permanent limp, for which he uses a cane. This event is the cornerstone of his physical and psychological state, leading to a long-term, high-dose dependency on the opioid painkiller Vicodin.

Socially, Dr. House is isolated, his abrasive personality and intellectual arrogance alienating most of his colleagues, with the notable exception of his long-suffering best friend, Dr. James Wilson. He is divorced and lives alone. His habits include a fondness for whiskey and a general disregard for his own health, aside from that which is required to continue solving medical puzzles. He is a former smoker.

Clinically, his case is dominated by the sequelae of his leg injury and his subsequent opioid dependence. He also has managed hypertension and hyperlipidemia, both common for his age and exacerbated by his lifestyle. The current presentation of new-onset, exertional chest pain is a significant deviation from his baseline of musculoskeletal pain. It represents a new clinical problem that, despite his own dismissiveness, requires a thorough cardiac investigation due to his significant risk factor profile.

III. CLINICAL REPORTS & IMAGING

■ *GP PROGRESS NOTE 20240625*

Report Text:
Clinic Note

Patient: HOUSE, GREGORY (MRN: 211)
DOB: 1959-06-11

Date of Service: 2024-06-25
Attending Physician: Dr. Lisa Cuddy, MD

Subjective:
Chief Complaint: "I have chest pain, and no, it's not a ploy to get more Vicodin."

History of Present Illness: Dr. Gregory House is a 65-year-old male with a notoriously complex past medical history who presents to my clinic today with a new complaint of intermittent chest pain. The patient is a highly unreliable historian, but reports that over the last 2-3 weeks, he has experienced several episodes of left-sided chest discomfort. He describes the sensation as a "dull ache" or "pressure". He reluctantly admits the pain is primarily precipitated by exertion, such as walking quickly up a flight of stairs or during his physical therapy sessions. He denies any clear radiation to the arm or jaw. Episodes last for 5-10 minutes and resolve with rest. He denies associated diaphoresis, frank dyspnea, or palpitations, though he does feel "annoyed" by it. He has not tried any new medications for this. He denies any similar pain in the past.

His baseline is chronic, severe right leg pain managed with high doses of hydrocodone, which he has taken for over two decades. He is adamant the current chest pain is distinct from his usual suffering.

Review of Systems:
- Constitutional: Denies fever, chills. Reports baseline fatigue.
- Cardiovascular: As per HPI. Denies palpitations, orthopnea, PND, or lower extremity edema.
- Respiratory: Denies cough, wheezing, or shortness of breath at rest.
- GI: Denies nausea, vomiting, heartburn. States his usual baseline of intermittent dyspepsia.
- Musculoskeletal: Complains of his chronic 10/10 right leg pain. Denies other joint pain or swelling.
- All other systems reviewed and are negative or as per baseline.

Past Medical History:
1. Chronic right thigh pain secondary to quadriceps infarction (~20 years ago).
2. Opioid Dependence (Hyd...

■ *ECG REPORT 20240625*

Report Text:
12-Lead ECG Interpretation Report

Patient: HOUSE, GREGORY (MRN: 211)
DOB: 1959-06-11
Date of Study: 2024-06-25, 09:32
Referring Physician: Dr. Lisa Cuddy, MD
Interpreting Physician: Dr. Lisa Cuddy, MD

Reason for ECG: New onset exertional chest pain. Rule out ischemia.

Technical Details:
- Ventricular Rate: 87 bpm
- Atrial Rate: 87 bpm
- PR Interval: 168 ms

- QRS Duration: 94 ms
- QT Interval: 402 ms
- QTc (Bazett): 431 ms
- P-R-T Axes: 75, 5, 60 degrees

Interpretation:
- **Rhythm:** Normal sinus rhythm.
- **Conduction:** Normal PR and QRS intervals. No evidence of AV block or bundle branch block.
- **Axis:** Normal frontal plane QRS axis.
- **Hypertrophy:** Voltage criteria for left ventricular hypertrophy are not met.
- **Ischemia/Infarction:**
- No pathological Q waves.
- ST segments show minor (less than 1mm) ST depression in leads V5, V6, and aVL.
- T waves are flattened in the lateral leads (I, aVL, V5-V6).
- No significant ST elevation is present.

Comparison: No prior ECG available for comparison.

Impression:
1. Normal sinus rhythm at 87 bpm.
2. Non-specific ST-T wave abnormalities, specifically minor ST depression and T-wave flattening in the lateral leads.
3. Findings are non-diagnostic for acute ischemia but, in the context of exertional chest pain, are suspicious and warrant further investigation. Correlation with cardiac enzymes and further functional testing (e.g., stress test) is recommended.

Electronically Signed,
Lisa Cuddy, MD
Chief of Medicine
Princeton-Plainsboro Teaching Hospital

■ *LAB REPORT COMPREHENSIVE 20240625*

Report Text:
Laboratory Report

Patient: HOUSE, GREGORY (MRN: 211)
DOB: 1959-06-11
Date Collected: 2024-06-25, 09:20
Date Reported: 2024-06-25, 10:30
Ordering Physician: Dr. Lisa Cuddy, MD

Test Name Result Flag Reference Range & Units

Comprehensive Metabolic Panel (CMP)
Sodium 139 136-145 mmol/L

Potassium 4.2 3.5-5.1 mmol/L
Chloride 101 98-107 mmol/L
Carbon Dioxide (CO2) 25 23-29 mmol/L
Anion Gap 13 5-17
Glucose 98 65-99 mg/dL
Blood Urea Nitrogen (BUN) 24 H 6-20 mg/dL
Creatinine 1.3 H 0.7-1.2 mg/dL
eGFR 58 L >60 mL/min/1.73m2
Calcium 9.5 8.5-10.2 mg/dL
Protein, Total 7.1 6.0-8.3 g/dL
Albumin 4.0 3.5-5.5 g/dL
Bilirubin, Total 0.8 0.3-1.2 mg/dL
Alkaline Phosphatase 70 44-147 IU/L
AST (SGOT) 25 0-40 IU/L
ALT (SGPT) 30 0-44 IU/L

Complete Blood Count (CBC) with Differential
White Blood Cell Count 7.8 4.5-11.0 K/uL
Red Blood Cell Count 4.9 4.7-6.1 M/uL
Hemoglobin 15.2 14.0-18.0 g/dL
Hematocrit 45.1 42-52 %
MCV 92 80-99 fL
MCH 31 27-31 pg
MCHC 33.7 31.5-35.7 g/dL
RDW 12.9 11.5-14.5 %
Platelet Count 250 150-450 K/uL

Cardiac & Lipid Panel
Troponin-I, High Sensitivity <0.04

■ *CARDIOLOGY CONSULT NOTE 20240701*

Report Text:
Cardiology Consultation Note

Patient: HOUSE, GREGORY (MRN: 211)
DOB: 1959-06-11
Date of Consultation: 2024-07-01
Consulting Physician: Dr. Robert Chase, MD
Referring Physician: Dr. Lisa Cuddy, MD

Reason for Consultation: Evaluation of new onset exertional chest pain in a patient with multiple cardiovascular risk factors.

History of Present Illness: I had the pleasure of evaluating Dr. House today. The patient is a 65-year-old male, referred from primary care for exertional chest discomfort. He provides the history with his usual candor. The pain began approximately one month ago. It is a left-sided, substernal pressure, brought on by significant exertion (e.g.,

hurrying, stairs) and consistently resolves within minutes of rest. He quantifies the pain as 4/10. He denies radiation, diaphoresis, or palpitations. He has multiple risk factors for CAD including age, male sex, history of smoking, hypertension, and hyperlipidemia (as seen on recent labs).

An initial workup by Dr. Cuddy included an ECG which showed non-specific ST-T wave abnormalities in the lateral leads. A high-sensitivity troponin was negative.

Review of Systems: Consistent with Dr. Cuddy's note. The patient's primary focus remains his chronic leg pain, but he admits the chest pain is a new and different sensation.

Past Medical/Surgical History: As noted in the chart. Notably, chronic pain from thigh infarction, long-term opioid use, HTN, CKD stage 2.

Objective:
Vitals: T: 98.7 F, HR: 82 bpm, RR: 16, BP: 138/85 mmHg, SpO2: 98% on room air.
Physical Exam:
- General: Alert and oriented x3, cynical but cooperative. Walks with a limp, uses a cane.
- Neck: No JVD. Carotid upstrokes are brisk and without bruits.
- Lungs: Clear bilaterally.
- Cardiovascular: Regular rhythm. No murmurs, gallops or rubs. PMI is non-displaced. No peripheral edema.
- Extremities: Warm with good capillary refill, except for coolness in the dist...

■ *STRESS TEST REPORT 20240708*

Report Text:
Exercise Treadmill Stress Test Report

Patient: HOUSE, GREGORY (MRN: 211)
DOB: 1959-06-11
Date of Study: 2024-07-08
Referring Physician: Dr. Lisa Cuddy, MD
Supervising Physician: Dr. Robert Chase, MD

Indication: Chest pain on exertion. Rule out myocardial ischemia.

Procedure: The patient underwent a symptom-limited exercise tolerance test using the standard Bruce protocol. Continuous 12-lead ECG and blood pressure were monitored throughout.

Baseline Data (Resting):
- Heart Rate: 85 bpm
- Blood Pressure: 140/88 mmHg
- ECG: Normal sinus rhythm, non-specific lateral ST-T changes as noted previously.

Exercise Data:
- **Protocol:** Standard Bruce Protocol
- **Total Exercise Duration:** 5 minutes and 30 seconds (Stage 2)
- **Reason for Termination:** Patient stopped due to severe right leg pain. He also reported mild (3/10) chest discomfort in the final minute of exercise, similar to his presenting symptom.

- **Peak Heart Rate:** 132 bpm (85% of age-predicted maximum of 155 bpm). This is considered an adequate heart rate response.
- **Peak Blood Pressure:** 178/95 mmHg. Normal hypertensive response to exercise.
- **METs Achieved:** Approximately 7 METs.

ECG Findings During Exercise:
- No significant arrhythmias were observed.
- At peak exercise, there was 1mm of horizontal ST-segment depression in leads V5 and V6. These changes resolved within 2 minutes of recovery.
- No ST elevation was noted.

Post-Exercise Data (Recovery):
- Heart rate returned to baseline within 5 minutes.
- Blood pressure normalized.
- ST segments returned to baseline.
- Patient's chest discomfort resolved within 1 minute of stopping.

Impression:
1. **Equivocal / Non-Diagnostic Study:** The patient achieved an adequate target heart rate (85%). However, the test was limited by non-cardiac symptoms (right leg pain). The patient experienced chest discomfort similar to his chief complaint.
2. ...
