CONFIDENTIAL PATIENT MASTER RECORD

PATIENT ID: 221 | MRN: MRN-221-2025

I. REGISTRATION FACE SHEET

PATIENT IDENTITY	
Name:	Max Black
DOB:	1986-06-13
Gender:	female
Race:	Caucasian
Height:	5 ft 6 in
Weight:	145 lbs
Telecom:	917-555-1234
Address:	30 Broke Street, Williamsburg, Brooklyn, NY 11211
Marital Status:	Single
Multiple Birth:	No (Order: 1)

COMMUNICATION	
Language:	English
Preferred:	Yes

EMERGENCY CONTACT	
Relationship:	Emergency Contact
Name:	Caroline Channing
Telecom:	917-555-5678
Address:	30 Broke Street, Williamsburg, Brooklyn, NY 11211
Gender:	female
Organization:	N/A
Period Start:	2011-09-19
Period End:	ongoing

PRIMARY PROVIDER	
General Practitioner:	Dr. Eleanor Abernathy, MD
Managing Organization:	Brooklyn General Hospital

INSURANCE / PAYER	
Payer ID:	J1113
Payer Name:	Empire Health
Plan Name:	Empire Blue PPO 25

Plan Type:	PPO
Group ID:	MAXCUP789
Group Name:	Max's Homemade Cupcakes
Member ID:	EMP345876123
Policy Number:	EMP-POL-987654321
Effective Date:	2024-01-01
Termination Date:	ongoing
Copay:	$40
Deductible:	$1500
SUBSCRIBER	
Subscriber ID:	EMP345876123
Subscriber Name:	Max Black
Relationship:	Self
Subscriber DOB:	1986-06-13
Subscriber Address:	30 Broke Street, Williamsburg, Brooklyn, NY 11211

II. MEDICAL BIOGRAPHY & HISTORY

Max Black is a 37-year-old female resident of Brooklyn, NY, where she works as a waitress and co-owner of a small cupcake business. Her lifestyle is admittedly stressful, characterized by long hours, financial pressures, and a long-standing smoking habit. She has a history of managed hypertension and generalized anxiety. She initially presented to her primary care physician, Dr. Eleanor Abernathy, with new-onset, intermittent, sharp chest pains that were atypical for cardiac angina. Due to her risk factors, including smoking and hypertension, she was referred to a cardiologist, Dr. Preston Burke, for a comprehensive workup. The initial evaluation included a normal resting EKG and bloodwork that revealed mild dyslipidemia. A subsequent exercise stress echocardiogram was performed to assess for inducible ischemia. While she reached a good exercise tolerance without EKG changes, the imaging portion of the test was equivocal, suggesting possible but undefined wall motion abnormalities due to suboptimal image quality. Given the inconclusive nature of the stress echo and her persistent, albeit atypical, symptoms, Dr. Burke has recommended a Myocardial Perfusion Imaging (MPI) scan to definitively rule out myocardial ischemia as the cause of her chest pain. The current request for prior authorization is for this medically necessary diagnostic procedure to clarify the equivocal findings and guide further management.

III. CLINICAL REPORTS & IMAGING

■ *PCP VISIT NOTE 20251115*

Report Text:
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Patient: Max Black (MRN: MRN-221)
DOB: 1986-06-13
Date of Service: 2025-11-15
Attending Provider: Dr. Eleanor Abernathy, MD

SUBJECTIVE:
Chief Complaint: "I keep getting this weird, sharp pain in my chest."

History of Present Illness:
Ms. Max Black is a 37-year-old female who presents to the clinic today for evaluation of intermittent chest pain. The patient reports that for the last week, she has experienced episodes of sharp, stabbing pain located in the left central chest. The pain is non-radiating. Each episode lasts for approximately 30 seconds to a minute and resolves spontaneously. She cannot identify any specific triggers. The pain occurs at rest and is not associated with exertion, eating, or specific body positions. She denies any associated shortness of breath, diaphoresis, nausea, vomiting, or dizziness during these episodes. She rates the pain as a 5/10 on the pain scale. She is concerned because of the location of the pain, though she notes her high-stress lifestyle might be a contributing factor. She has not tried any treatments for these episodes.

Review of Systems:
- CONSTITUTIONAL: Denies fever, chills, or recent weight changes. Reports generalized fatigue, attributed to work.
- EYES: Denies vision changes or eye pain.
- ENT: Denies sore throat, rhinorrhea, or ear pain.
- CARDIOVASCULAR: Admits to intermittent chest pain as per HPI. Denies palpitations, orthopnea, or lower extremity edema.
- RESPIRATORY: Denies cough, wheezing, or dyspnea. History of mild, infrequent asthma.
- GASTROINTESTINAL: Denies nausea, vomiting, diarrhea, constipation, or abdominal pain. Denies heartburn or reflux symptoms.
- MUSCULOSKELETAL: Denies myalgias, arthralgias, or back pain. No recent trauma to the chest wall.
- NEUROLOGICAL: Denies headaches, dizziness, syncope, or focal weakness.
- PSYCHIATRIC: Reports ongoing stress related to her small business and financial pressures. Denies new or worsening anxiet...

■ *CARDIOLOGY CONSULT 20251122*

Report Text:
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Patient: Max Black (MRN: MRN-221)
DOB: 1986-06-13
Date of Consultation: 2025-11-22
Referring Provider: Dr. Eleanor Abernathy, MD
Consulting Provider: Dr. Preston Burke, MD, FACC

REASON FOR CONSULTATION:
Evaluation of atypical chest pain in a 37-year-old female.

HISTORY OF PRESENT ILLNESS:
I had the pleasure of evaluating Ms. Black today. She was referred by her PCP, Dr. Abernathy, for intermittent chest pain. She confirms the history as documented by her PCP. Over the past two weeks, she has had several episodes of sharp, stabbing left-sided chest pain, lasting less than a minute. The pain does not radiate and is not associated with physical activity, meals, or changes in position. She has not identified any clear triggers but notes it seems to occur during periods of rest, often in the evening. She denies associated dyspnea, diaphoresis, palpitations, or presyncope. She is concerned about a possible cardiac cause. The patient states her lifestyle is very stressful, and she smokes a

half-pack of cigarettes daily.

PAST MEDICAL HISTORY:
- Hypertension, managed with Lisinopril and Amlodipine.
- Generalized Anxiety Disorder, managed with Sertraline.
- Smoker (15-pack-year history).

MEDICATIONS:
- Lisinopril 10 mg daily
- Amlodipine 5 mg daily
- Sertraline 50 mg daily
- Aspirin 81 mg daily (she reports starting this herself a few days ago out of concern)

ALLERGIES:
- No known drug allergies.

SOCIAL HISTORY:
As per PCP note, notable for significant occupational stress and active tobacco use. Patient reiterated the pressures of running a small business.

FAMILY HISTORY:
No known family history of coronary artery disease, sudden cardiac death, or inheritable cardiac conditions. Father with HTN.

REVIEW OF SYSTEMS:
Focused on the cardiovascular system. Patient denies orthopnea, PND, and lower extremity edema. She affirms the intermittent chest pain as described above. She den...

■ *LAB REPORT 20251116*

Report Text:
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Patient: Black, Max
MRN: MRN-221
DOB: 1986-06-13
Ordering Provider: Dr. Eleanor Abernathy, MD
Accession #: ACC-2025-78199

Collection Date: 2025-11-16 08:30 EST
Report Date: 2025-11-16 15:00 EST

LIPID PANEL ---
TEST NAME RESULT FLAG REFERENCE RANGE
CHOLESTEROL, TOTAL 215 mg/dL High <200 mg/dL
TRIGLYCERIDES 130 mg/dL <150 mg/dL
HDL CHOLESTEROL 50 mg/dL >39 mg/dL
LDL CHOLESTEROL, CALC 140 mg/dL High <100 mg/dL (Optimal)
CHOL/HDLC RATIO 4.3 <5.0

NON-HDL CHOLESTEROL 165 mg/dL High <130 mg/dL

COMPREHENSIVE METABOLIC PANEL ---
TEST NAME RESULT FLAG REFERENCE RANGE
SODIUM 140 mmol/L 136-145 mmol/L
POTASSIUM 4.1 mmol/L 3.5-5.1 mmol/L
CHLORIDE 102 mmol/L 98-107 mmol/L
CARBON DIOXIDE 25 mmol/L 23-29 mmol/L
GLUCOSE 92 mg/dL 74-106 mg/dL
BUN 15 mg/dL 6-20 mg/dL
CREATININE 0.8 mg/dL 0.6-1.2 mg/dL
BUN/CREATININE RATIO 19 8-27
CALCIUM 9.5 mg/dL 8.5-10.2 mg/dL
PROTEIN, TOTAL 7.1 g/dL 6.0-8.2 g/dL
ALBUMIN 4.2 g/dL 3.5-5.5 g/dL
GLOBULIN, TOTAL 2.9 g/dL 1.5-4.5 g/dL
A/G RATIO 1.4 1.1-2.5
BILIRUBIN, TOTAL 0.6 mg/dL 0.0-1.2 mg/dL
ALKALINE PHOSPHATASE 78 U/L 39-117 U/L
AST (SGOT) 25 U/L 0-35 U/L
ALT (SGPT) 28 U/L 0-35 U/L

CBC WITH DIFFERENTIAL ---
TEST NAME ...

■ *EKG REPORT 20251122*

Report Text:
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Patient: Max Black
MRN: MRN-221
DOB: 1986-06-13
Date of Study: 2025-11-22 10:30 EST
Ordering Physician: Dr. Preston Burke, MD

Procedure: 12-Lead Electrocardiogram
Reason for EKG: Atypical chest pain

TECHNICAL DETAILS:
A standard 12-lead electrocardiogram was performed with the patient in the supine position. The recording is of good quality with minimal artifact.

INTERPRETATION:
- **Rhythm:** Normal Sinus Rhythm
- **Heart Rate:** 84 bpm
- **PR Interval:** 160 ms
- **QRS Duration:** 88 ms

- **QT/QTc Interval:** 400/430 ms (Bazett)
- **Axis:** Normal frontal plane axis at approximately +60 degrees.

FINDINGS:
- **P waves:** Normal morphology and axis.
- **QRS complexes:** Normal morphology. No pathological Q waves. R wave progression in the precordial leads is normal.
- **ST segments:** Isoelectric in all leads. There is no evidence of ST-segment elevation or depression to suggest acute injury or ischemia.
- **T waves:** Upright in leads I, II, aVF, and V2-V6. Normal morphology. No evidence of hyperacute T waves or inversions.
- **Comparison to prior EKG:** No prior EKG available for comparison.

IMPRESSION:
1. Normal Sinus Rhythm.
2. No electrocardiographic evidence of acute myocardial ischemia, injury, or infarction.
3. Normal intervals and axis.

This is a normal resting electrocardiogram.

Electronically Signed,
Preston Burke, MD, FACC
Cardiology
Williamsburg Cardiology Associates
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■ *STRESS ECHO REPORT 20251205*

Report Text:
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Patient: Max Black
MRN: MRN-221
DOB: 1986-06-13
Date of Study: 2025-12-05
Referring Physician: Dr. Preston Burke, MD

Procedure: Exercise Stress Echocardiogram (CPT 93350)
Indication: Atypical chest pain. Rule out coronary artery disease.

Protocol: Standard Bruce protocol exercise treadmill test with concurrent 2D echocardiographic imaging at rest and immediately post-exercise.

STRESS TEST DETAILS:
- **Baseline HR:** 80 bpm
- **Baseline BP:** 128/84 mmHg
- **Resting EKG:** Normal sinus rhythm, no significant ST-T wave abnormalities.
- **Exercise Duration:** 8 minutes and 45 seconds (Completed Stage 3).

- **Peak Heart Rate:** 168 bpm (92% of age-predicted maximum of 183 bpm).
- **Peak Blood Pressure:** 180/88 mmHg.
- **Symptoms during test:** Patient reported mild fatigue but denied any chest pain, significant shortness of breath, or dizziness during exercise.
- **EKG response to stress:** No significant ST-segment depression or elevation. Occasional isolated PVCs noted at peak exercise.
- **Reason for Termination:** Fatigue.

ECHOCARDIOGRAPHIC FINDINGS:
Image Quality: Suboptimal. Acoustic windows were limited due to patient body habitus.

1. Resting Echocardiogram:
- **Left Ventricle:** Normal left ventricular size and wall thickness. Estimated ejection fraction is 60-65%. No regional wall motion abnormalities are noted at rest. Normal diastolic function (Grade 1).
- **Right Ventricle:** Normal size and systolic function.
- **Atria:** Biatrial enlargement is not present.
- **Valves:** All valves (mitral, aortic, tricuspid, pulmonic) appear structurally normal with no evidence of significant stenosis or regurgitation.
- **Pericardium:** No pericardial effusion.

2. Post-Exercise Echocardiogram:
- **Regional Wall Motion:** At immediate post-exercise imaging, there is new possible mild hypokinesis of the mid-anterior and mid-ante...
