CONFIDENTIAL PATIENT MASTER RECORD

PATIENT ID: 228 | MRN: MRN-228-2025

I. REGISTRATION FACE SHEET

PATIENT IDENTITY	
Name:	Perry Cox
DOB:	1965-06-15
Gender:	male
Race:	Caucasian
Height:	6 ft 1 in
Weight:	185 lbs
Telecom:	310-555-2001
Address:	456 Sacred Heart Way, San DiFrangeles, CA 90210
Marital Status:	Divorced
Multiple Birth:	No (Order: 1)

COMMUNICATION	
Language:	English
Preferred:	Yes

EMERGENCY CONTACT	
Relationship:	Ex-wife
Name:	Jordan Sullivan
Telecom:	310-555-2002
Address:	789 Malibu Point, Malibu, CA 90265
Gender:	female
Organization:	N/A
Period Start:	2001-05-10
Period End:	ongoing

PRIMARY PROVIDER	
General Practitioner:	Dr. John Dorian, MD
Managing Organization:	Sacred Heart Hospital

INSURANCE / PAYER	
Payer ID:	J1113
Payer Name:	Aethem BlueCross
Plan Name:	Gold PPO Plan

Plan Type:	PPO
Group ID:	SHH-EMP-456
Group Name:	Sacred Heart Hospital Employee Group
Member ID:	AETBC-899123456
Policy Number:	PPO-SHH-77810
Effective Date:	2010-01-01
Termination Date:	ongoing
Copay:	$40
Deductible:	$1000
SUBSCRIBER	
Subscriber ID:	MEM-899123456
Subscriber Name:	Perry Cox
Relationship:	Self
Subscriber DOB:	1965-06-15
Subscriber Address:	456 Sacred Heart Way, San DiFrangeles, CA 90210

II. MEDICAL BIOGRAPHY & HISTORY

Perry Cox is a 59-year-old physician presenting with a complex and frustrating medical issue, amplified by his own abrasive and cynical personality. As a seasoned attending physician at Sacred Heart Hospital, he has a deep-seated distrust of the medical system, which paradoxically makes him a difficult patient. His chief complaint is a chronic, non-specific abdominal pain that has persisted for months, causing him significant irritation and anxiety, though he would never admit to the latter.

Socially, Mr. Cox is divorced from Jordan Sullivan, with whom he has a complicated but enduring relationship. He lives alone and channels most of his energy into his work and his elaborate, sarcastic rants directed at his colleagues, particularly his primary physician, Dr. John Dorian. His lifestyle is high-stress, with long hours at the hospital, a diet heavy in caffeine and cafeteria food, and regular evening consumption of scotch to 'unwind.' This lifestyle, combined with his underlying anxiety, is a significant confounding factor in his clinical presentation.

Clinically, the patient's presentation is a classic case where subjective complaints do not align with objective findings. Despite his insistence on the severity of his pain, a comprehensive workup including a full blood panel and a recent gastroenterology consultation have been entirely unremarkable. The GI specialist has explicitly advised against further invasive testing, suggesting a functional (stress-related) etiology. However, Mr. Cox's personality and medical knowledge make him resistant to a psychosomatic explanation, leading him to demand more aggressive, definitive testing, believing something has been missed. This has resulted in the reluctant request for a CT-guided procedure, primarily to appease the patient rather than due to clinical indication.

III. CLINICAL REPORTS & IMAGING

INITIAL CONSULT NOTE

Report Text:
'''

FACILITY: Sacred Heart Hospital - Clinic A

PATIENT NAME: Cox, Perry
DOB: 1965-06-15
MRN: MRN-228
DATE OF SERVICE: 2024-05-15

CHIEF COMPLAINT: "My gut has been trying to kill me for six months, and I want you, Newbie, to figure out why before it succeeds."

HISTORY OF PRESENT ILLNESS:
Mr. Perry Cox is a 59-year-old male presenting as a new patient to the practice for evaluation of chronic abdominal pain. The patient provides the history with a great deal of sarcasm and impatience, but the core details have been extracted. He reports a vague, intermittent, generalized abdominal pain that began approximately 6 months ago. He is unable to localize the pain to a specific quadrant, describing it as "a dull, annoying ache that wanders around like it's looking for a place to rent." The pain has no clear relationship to meals, bowel movements, or time of day. He denies any associated nausea, vomiting, diarrhea, constipation, fever, or chills. He has not experienced any significant weight loss.

The patient states he has tried over-the-counter antacids and Ibuprofen with minimal to no relief. He describes the pain as a 3/10 on average but can flare to a 5/10, which is more of an irritant than a debilitating symptom. He appears frustrated that there is no clear trigger or relieving factor. He expresses extreme skepticism towards the medical field but is here at the insistence of his ex-wife. He is a poor historian regarding specifics, often digressing into lengthy, critical monologues about modern medicine.

REVIEW OF SYSTEMS:
- CONSTITUTIONAL: Denies fever, chills, weight loss. Reports generalized fatigue, which he attributes to "being surrounded by incompetence."
- GI: As per HPI. No dysphagia, odynophagia, hematemesis, or melena. Normal bowel habits.
- CARDIOVASCULAR: Denies chest pain, palpitations, or shortness of breath. History of hypertension.
- RESPIRATORY: Denies cough or wheezing.
- ALL OTHER SYSTEMS: Rev...

■ *LAB REPORT CBC CMP*

Report Text:
'''
FACILITY: Sacred Heart Lab
PATIENT NAME: Cox, Perry
DOB: 1965-06-15
MRN: MRN-228
DATE COLLECTED: 2024-05-16
DATE REPORTED: 2024-05-16

TEST: COMPREHENSIVE METABOLIC PANEL (CMP)
- **SODIUM:** 140 mEq/L (Ref: 136-145) - NORMAL
- **POTASSIUM:** 4.1 mEq/L (Ref: 3.5-5.1) - NORMAL
- **CHLORIDE:** 102 mEq/L (Ref: 98-107) - NORMAL
- **CO2:** 25 mEq/L (Ref: 23-29) - NORMAL

- **GLUCOSE:** 92 mg/dL (Ref: 74-106) - NORMAL
- **BUN:** 15 mg/dL (Ref: 6-24) - NORMAL
- **CREATININE:** 0.9 mg/dL (Ref: 0.7-1.3) - NORMAL
- **CALCIUM:** 9.5 mg/dL (Ref: 8.5-10.2) - NORMAL
- **PROTEIN, TOTAL:** 7.1 g/dL (Ref: 6.0-8.3) - NORMAL
- **ALBUMIN:** 4.2 g/dL (Ref: 3.5-5.2) - NORMAL
- **GLOBULIN:** 2.9 g/dL (Ref: 2.3-3.4) - NORMAL
- **BILIRUBIN, TOTAL:** 0.6 mg/dL (Ref: 0.3-1.2) - NORMAL
- **ALKALINE PHOSPHATASE:** 65 U/L (Ref: 44-147) - NORMAL
- **AST (SGOT):** 22 U/L (Ref: 8-48) - NORMAL
- **ALT (SGPT):** 25 U/L (Ref: 7-56) - NORMAL

TEST: COMPLETE BLOOD COUNT (CBC) WITH DIFFERENTIAL
- **WHITE BLOOD CELL COUNT (WBC):** 6.8 x10E3/uL (Ref: 4.5-11.0) - NORMAL
- **RED BLOOD CELL COUNT (RBC):** 5.10 M/uL (Ref: 4.70-6.10) - NORMAL
- **HEMOGLOBIN:** 15.5 g/dL (Ref: 13.5-17.5) - NORMAL
- **HEMATOCRIT:** 46.2 % (Ref: 42.0-52.0) - NORMAL
- **MCV:** 90.6 fL (Ref: 80.0-99.0) - NORMAL
- **MCH:** 30.4 pg (Ref: 27.0-31.0) - NORMAL
- **MCHC:** 33.6 g/dL (Ref: 32.0-36.0) - NORMAL
- **RDW:** 12.8 % (Ref: 11.5-14.5) - NORMAL
- **PLATELET COUNT:** 255 K/uL (Ref: 150-450) - NORMAL
- **NEUTROPHILS:** 58 % - NORMAL
- **LYMPHOCYTES:** 32 % - NORMAL
- **MONOCYTES:** 7 % - NORMAL
- **EOSINOPHILS:** 2 % - NORMAL
- **BASOPHILS:** 1 % - NORMAL

IMPRESSION:
All results for the Comprehensive Metabolic Panel and Complete Blood Count are within normal limits. There is no laboratory evidence of inflammation, infection, anemia, or metabolic/hepatic derangement.
'''

■ *OLD COLONOSCOPY REPORT*

Report Text:
'''

FACILITY: Community Gastroenterology Clinic
PATIENT NAME: Cox, Perry
DOB: 1965-06-15
MRN: MRN-228
DATE OF PROCEDURE: 2021-08-20

PROCEDURE: Colonoscopy
INDICATION: Routine colorectal cancer screening
PRE-PROCEDURE DIAGNOSIS: Z12.11 - Encounter for screening for malignant neoplasm of colon.

ANESTHESIA: Monitored Anesthesia Care (MAC) with Propofol.

INSTRUMENT: Olympus CF-HQ190L Video Colonoscope.

PROCEDURE DESCRIPTION:
The patient was placed in the left lateral decubitus position. After induction of anesthesia, the colonoscope was inserted into the rectum and advanced under direct visualization to the cecum. The cecal landmarks, including the appendiceal orifice and the ileocecal valve, were clearly identified and photo-documented. The quality of the bowel preparation was excellent.

The colonoscope was then slowly withdrawn with careful mucosal inspection. The entire examined colon, from the cecum to the rectum, was evaluated.

FINDINGS:
- **Terminal Ileum:** A brief intubation of the terminal ileum was performed and showed normal-appearing mucosa.
- **Cecum:** Normal mucosa. Appendiceal orifice visualized.
- **Ascending Colon:** Normal vascular pattern. No polyps, masses, or inflammation.
- **Transverse Colon:** Normal haustral folds. No abnormalities noted.
- **Descending Colon:** Mucosa appeared normal. No lesions identified.
- **Sigmoid Colon:** A few scattered diverticula were noted, consistent with diverticulosis. There were no signs of inflammation or diverticulitis.
- **Rectum:** Normal-appearing rectal mucosa. A retroflexion maneuver was performed and showed no hemorrhoids or other lesions.

IMPRESSION:
1. **Normal Colonoscopy:** Successful examination to the cecum. There is no endoscopic evidence of neoplasia, polyps, or significant inflammatory disease.
2. **Diverticulosis of the Sigmoid Colon:** Mild, uncomplicated diverticulosis...

■ *GASTROENTEROLOGY CONSULT*

Report Text:
'''
FACILITY: Sacred Heart Gastroenterology
PATIENT NAME: Cox, Perry
DOB: 1965-06-15
MRN: MRN-228
DATE OF CONSULT: 2024-05-22

REASON FOR CONSULTATION: Chronic abdominal pain.

HISTORY OF PRESENT ILLNESS:
Mr. Cox is a 59-year-old male referred by Dr. John Dorian for evaluation of chronic abdominal pain. The patient reports approximately 6-7 months of intermittent, vague abdominal discomfort. He describes the pain as dull and migratory, without a consistent location. He emphatically denies any relationship to food intake, specific food types, or bowel habits. He denies nausea, vomiting, fevers, chills, melena, or hematochezia. His weight is stable. A recent screening colonoscopy in 2021 was entirely normal, aside from incidental diverticulosis. Recent laboratory studies

(CBC, CMP) performed by Dr. Dorian are unremarkable.

The patient exhibits a highly anxious and cynical demeanor. He expresses frustration with the lack of a diagnosis. He notes significant occupational stress. He drinks alcohol daily and has a diet he admits is suboptimal.

REVIEW OF SYSTEMS: As per referring provider note. Focused GI review is negative for any alarm symptoms.

PAST MEDICAL HISTORY: Hypertension, GERD. Normal colonoscopy 2021.

OBJECTIVE:
- GENERAL: Alert, irritable male in no acute distress.
- ABDOMEN: Soft, non-distended. Normoactive bowel sounds. There is diffuse, mild tenderness to deep palpation, which seems to vary with patient attention. No guarding, rebound, or organomegaly.

ASSESSMENT:
This is a 59-year-old male with a several-month history of chronic, vague abdominal pain. He has multiple factors that point towards a functional, rather than organic, etiology.

1. **Symptom pattern:** The migratory nature of the pain, lack of relationship to physiologic functions (eating, defecating), and absence of alarm symptoms (weight loss, bleeding) are classic for a functional GI disorder.
2. **Psychosocial factors:** The patient has sign

■ *PROGRESS NOTE*

Report Text:
'''
FACILITY: Sacred Heart Hospital - Clinic A
PATIENT NAME: Cox, Perry
DOB: 1965-06-15
MRN: MRN-228
DATE OF SERVICE: 2024-05-29

SUBJECTIVE:
Patient returns for follow-up to discuss results. He is aware that his CBC and CMP were normal. He also has seen the consult note from Dr. Glazer. The patient is extremely dissatisfied with the diagnosis of "functional abdominal pain." He states, "So you're telling me a ten-year-old could have told me it's all in my head? I want a real test, a picture, something definitive!" He dismisses the recommendations for lifestyle changes and stress management as "psychobabble."

He continues to report the same vague, intermittent abdominal pain. No new symptoms. He is now insistent on having an imaging study performed to "find what everyone else has missed." He specifically requested a CT scan with some form of biopsy to get a tissue sample.

OBJECTIVE:
- VITALS: BP 140/88, HR 82. Appears agitated.
- ABDOMEN: Exam is unchanged. Soft, with mild, non-focal tenderness to deep palpation. No peritoneal signs.

ASSESSMENT & PLAN:

Reviewed the completely normal lab results with the patient. Also reviewed Dr. Glazer's detailed gastroenterology consultation note, highlighting the specialist's opinion that further imaging is not indicated and that the diagnosis is most consistent with a functional syndrome.

The patient was not receptive to this assessment. Despite a long discussion about the low yield of further testing, the lack of any target lesion to biopsy, and the recommendations of the GI specialist, the patient remains adamant that an invasive procedure is necessary. He is fixated on the idea of a CT-guided needle placement.

While this procedure is not clinically indicated based on current evidence and specialist recommendation, the patient-physician relationship is becoming strained due to his insistence. In an effort to address his significant anxiety (and to get him to stop yell...
