CHIEF COMPLAINT: ,Hip pain.,HISTORY OF PRESENTING ILLNESS: ,The patient is a very pleasant 41-year-old white female that is known to me previously from our work at the Pain Management Clinic, as well as from my residency training program, San Francisco. We have worked collaboratively for many years at the Pain Management Clinic and with her departure there, she has asked to establish with me for clinic pain management at my office. She reports moderate to severe pain related to a complicated past medical history. In essence, she was seen at a very young age at the clinic for bilateral knee and hip pain and diagnosed with bursitis at age 23. She was given nonsteroidals at that time, which did help with this discomfort. With time, however, this became inadequate and she was seen later in San Francisco in her mid 30s by Dr. V, an orthopedist who diagnosed retroverted hips at Hospital. She was referred for rehabilitation and strengthening. Most of this was focused on her SI joints. At that time, although she had complained of foot discomfort, she was not treated for it. This was in 1993 after which she and her new husband moved to the Boston area, where she lived from 1995-1996. She was seen at the Pain Center by Dr. R with similar complaints of hip and knee pain. She was seen by rheumatologists there and diagnosed with osteoarthritis as well as osteophytosis of the back. Medications at that time were salicylate and Ultram.,When she returned to Portland in 1996, she was then working for Dr. B. She was referred to a podiatrist by her local doctor who found several fractured sesamoid bones in her both feet, but

this was later found not to be the case. Subsequently, nuclear bone scans revealed osteoarthritis. Orthotics were provided. She was given Paxil and Tramadol and subsequently developed an unfortunate side effect of grand mal seizure. During this workup of her seizure, imaging studies revealed a pericardial fluid-filled cyst adhered to her ventricle. She has been advised not to undergo any corrective or reparative surgery as well as to limit her activities since. She currently does not have an established cardiologist having just changed insurance plans. She is establishing care with Dr. S, of Rheumatology for her ongoing care. Up until today, her pain medications were being written by Dr. Y prior to establishing with Dr. L.,Pain management in town had been first provided by the office of Dr. F. Under his care, followup MRIs were done which showed ongoing degenerative disc disease, joint disease, and facet arthropathy in addition to previously described sacroiliitis. A number of medications were attempted there, including fentanyl patches with Flonase from 25 mcg titrated upwards to 50 mcg, but this caused oversedation. She then transferred her care to Ab Cd, FNP under the direction of Dr. K. Her care there was satisfactory, but because of her work schedule, the patient found this burdensome as well as the guidelines set forth in terms of monthly meetings and routine urine screens. Because of a previous commitment, she was unable to make one unscheduled request to their office in order to produce a random urine screen and was therefore discharged.,PAST MEDICAL HISTORY: ,1. Attention deficit disorder.,2. TMJ

arthropathy.,3. Migraines.,4. Osteoarthritis as described above.,PAST SURGICAL HISTORY:,1. Cystectomies.,2. Sinuses.,3. Left ganglia of the head and subdermally in various locations.,4. TMJ and bruxism.,FAMILY HISTORY: ,The patient's father also suffered from bilateral hip osteoarthritis.,MEDICATIONS:,1. Methadone 2.5 mg p.o. t.i.d.,2. Norco 10/325 mg p.o. q.i.d.,3. Tenormin 50 mg q.a.m.,4. Skelaxin 800 mg b.i.d. to t.i.d. p.r.n.,5. Wellbutrin SR 100 mg q.d.,6. Naprosyn 500 mg one to two pills q.d. p.r.n.,ALLERGIES: , IV morphine causes hives. Sulfa caused blisters and rash.,PHYSICAL EXAMINATION: , A well-developed, well-nourished white female in no acute distress, sitting comfortably and answering questions appropriately, making good eye contact, and no evidence of pain behavior.,VITAL SIGNS: Blood pressure 110/72 with a pulse of 68.,HEENT: Normocephalic. Atraumatic. Pupils are equal and reactive to light and accommodation. Extraocular motions are intact. No scleral icterus. No nystagmus. Tongue is midline. Mucous membranes are moist without exudate.,NECK: Free range of motion without thyromegaly.,CHEST: Clear to auscultation without wheeze or rhonchi.,HEART: Regular rate and rhythm without murmur, gallop, or rub.,ABDOMEN: Soft, nontender.,MUSCULOSKELETAL: There is musculoskeletal soreness and tenderness found at the ankles, feet, as well as the low back, particularly above the SI joints bilaterally. Passive hip motion also elicits bilateral hip pain referred to the ipsilateral side. Toe-heel walking is performed without

difficulty. Straight leg raises are negative. Romberg's are negative.,NEUROLOGIC: Grossly intact. Intact reflexes in all extremities tested. Romberg is negative and downgoing.,ASSESSMENT:,1. Osteoarthritis.,2. Chronic sacroiliitis.,3. Lumbar spondylosis.,4. Migraine.,5. TMJ arthropathy secondary to bruxism.,6. Mood disorder secondary to chronic pain.,7. Attention deficit disorder, currently untreated and self diagnosed.,RECOMMENDATIONS:,1. Agree with Rheumatology referral and review. I would particularly be interested in the patient pursuing a bone density scan as well as thyroid and parathyroid studies.,2. Given the patient's previous sulfa allergies, we would recommend decreasing her Naprosyn usage.