HISTORY OF PRESENT ILLNESS: , The patient is a 53-year-old right-handed gentleman who presents to the clinic for further evaluation of diplopia. He states that he was in his usual state of health when he awoke one morning in January 2009. He had double vision. He states when he closed each eye, the double vision dissipated. The double vision entirely dissipated within one hour. He was able to drive. However, the next day he woke up and he had double vision again. Over the next week, the double vision worsened in intensity and frequency and by the second week, it was severe. He states that he called Sinai Hospital and spoke to a physician who recommended that he come in for evaluation. He was seen by a primary care physician who sent him for an ophthalmologic evaluation. He was seen and referred to the emergency department for an urgent MRI to evaluate for possible aneurysm. The patient states that he had a normal MRI and was discharged to home.,For the next month, the double vision improved, although he currently still experiences constant diplopia. Whereas in the past, when he would see two objects, they were very far apart in a horizontal plane; now they are much closer together. He still does not drive. He also is not working due to the double vision. There is no temporal fluctuation to the double vision. More recently, over the past month, he has developed right supraorbital pain. It actually feels like there is pain under his right lid. He denies any dysphagia, dysarthria, weakness, numbness, tingling, or any other neurological symptoms.,There is a neurology consultation in the computer system. Dr. X saw the patient on

February 2, 2009, when he was in the emergency department. He underwent an MRI that showed a questionable 3 mm aneurysm of the medial left supraclinoid internal carotid artery, but there were no abnormalities on the right side. MRV was negative and MRI of the brain with and without contrast was also negative. He also had an MRI of the orbit with and without contrast that was normal. His impression was that the patient should follow up for a possible evaluation of myasthenia gravis or other disorder.,At the time of the examination, it was documented that he had right lid ptosis. He had left gaze diplopia. The pupils were equal, round, and reactive to light. His neurological examination was otherwise entirely normal. According to Dr. X's note, the ophthalmologist who saw him thought that there was ptosis of the right eye as well as an abnormal pupil. There was also right medial rectus as well as possibly other extraocular abnormalities. I do not have the official ophthalmologic consultation available to me today.,PAST MEDICAL HISTORY: , The patient denies any previous past medical history. He currently does not have a primary care physician as he is uninsured.,MEDICATIONS:, He does not take any medications.,ALLERGIES: , He has no known drug allergies.,SOCIAL HISTORY: , The patient lives with his wife. He was an IT software developer, but he has been out of work for several months. He smokes less than a pack of cigarettes daily. He denies alcohol or illicit drug use.,FAMILY HISTORY: , His mother died of a stroke in her 90s. His father had colon cancer. He is unaware of any family members with neurological disorders.,REVIEW OF

SYSTEMS: , A complete review of systems was obtained and was negative except for as mentioned above. This is documented in the handwritten notes from today's visit.,PHYSICAL EXAMINATION:,Vital Signs: BP 124/76