CHIEF COMPLAINT: , Worsening seizures.,HISTORY OF PRESENT ILLNESS: ,A pleasant 43-year-old female with past medical history of CP since birth, seizure disorder, complex partial seizure with secondary generalization and on top of generalized epilepsy, hypertension, dyslipidemia, and obesity. The patient stated she was in her normal state of well being when she was experiencing having frequent seizures. She lives in assisted living. She has been falling more frequently. The patient was driving a scooter and apparently was hitting into the wall with unresponsiveness in association with this. There was no head trauma, but apparently she was doing that many times and there was no responsiveness. The patient has no memory of the event. She is now back to her baseline. She states her seizures are worse in the setting of stress, but it is not clear to her why this has occurred. She is on Carbatrol 300 mg b.i.d. and she has been very compliant and without any problems. The patient is admitted for EMU monitoring for the characterization of these episodes and for the possibility of complex partial epilepsy syndrome or better characterization of this current syndrome.,PAST MEDICAL HISTORY: ,Include dyslipidemia and hypertension.,FAMILY HISTORY: ,Positive for stroke and sleep apnea.,SOCIAL HISTORY: , No smoking or drinking. No drugs.,MEDICATIONS AT HOME: , Include, Avapro, lisinopril, and dyslipidemia medication, she does not remember.,REVIEW OF SYSTEMS:, The patient does complain of gasping for air, witnessed apneas, and dry mouth in the morning. The patient also has excessive daytime

sleepiness with EDS of 16.,PHYSICAL EXAMINATION:,VITAL SIGNS: Last blood pressure 130/85, respirations 20, and pulse 70.,GENERAL: Normal.,NEUROLOGICAL: As follows. Right-handed female, normal orientation, normal recollection to 3 objects. The patient has underlying MR. Speech, no aphasia, no dysarthria. Cranial nerves, funduscopic intact without papilledema. Pupils are equal, round, and reactive to light. Extraocular movements intact. No nystagmus. Her mood is intact. Symmetric face sensation. Symmetric smile and forehead. Intact hearing. Symmetric palate elevation. Symmetric shoulder shrug and tongue midline. Motor 5/5 proximal and distal. The patient does have limp on the right lower extremity. Her Babinski is hyperactive on the left lower extremity, upgoing toes on the left. Sensory, the patient does have sharp, soft touch, vibration intact and symmetric. The patient has trouble with ambulation. She does have ataxia and uses a walker to ambulate. There is no bradykinesia. Romberg is positive to the left. Cerebellar, finger-nose-finger is intact. Rapid alternating movements are intact. Upper airway examination, the patient has a Friedman tongue position with 4 oropharyngeal crowding. Neck more than 16 to 17 inches, BMI elevated above 33. Head and neck circumference very high.,IMPRESSION:,1. Cerebral palsy, worsening seizures.,2. Hypertension.,3. Dyslipidemia.,4. Obstructive sleep apnea.,5. Obesity.,RECOMMENDATIONS:,1. Admission to the EMU, drop her Carbatrol 200 b.i.d., monitor for any epileptiform

activity. Initial time of admission is 3 nights and 3 days.,2. Outpatient polysomnogram to evaluate for obstructive sleep apnea followed by depression if clinically indicated. Continue her other medications.,3. Consult Dr. X for hypertension, internal medicine management.,4. I will follow this patient per EMU protocol.