

**Policy Id:**
**Client Name:** RRS DEMO

**Face Amount:** \$0.00

**DOB:** 01/01/1985    **Height:** 5'9" (01/30/2017)  
**Age:** 37                **Weight:** 227 Lbs (06/27/2018)  
**Gender:** Male            **BMI:** 33.52

**Last Dr Visit:** 06/27/2018    **Last EKG:**                **Last Lab:** 06/27/2018  
**Last TC:** 249(<200) (01/23/2017)    **Last HDL:** 42 (01/23/2017)  
**Last A1C:** 5.5 (04/02/2015)                **Last Glucose:** 100 (06/27/2018)

**Tobacco Use History**

**Use:** Non-Smoker  
**Type:** --  
**Quit Date:** --  
**Details:** Per 6/27/2018

**Alcohol Use History**

**Use:** Yes  
**Type:** Wine  
**Current Use:** 1-7/wk  
**Treatment:** No  
**Details:** 1 glass every day (per 6/27/2018)

**Blood Pressure Readings**

Last Reading	3 mo. Avg	6 mo. Avg	12 mo. Avg	18 mo. Avg	24 mo. Avg
128 / 80 (06/27/2018)	N/A	N/A	N/A	N/A	N/A

**Family History**

	Age	Alive	Cause of Death	Age	Alive	Cause of Death	
<b>Mother</b>	55	Alive	--	<b>Father</b>	58	Dead	Cardiac
<b>Sibling</b>	33	Alive	--	<b>Sibling</b>	52	Dead	Cancer

**Summary prepared for the following 1 document(s) received**

APS Redact One APS.Pdf (40) 09/18/2021

**High Level Snap Shot**

43 YOM [DOB redacted]

Provider: Reem Shafeh, MD, Patricia Sheridan, FNP/Steven Barrett, MD

## MEDICAL HX:

- \* Post-coital HA:
- Eval'd 6/27/18, Nml exam
- \* Intermittent CP:
- Noted 1/30/17.
- \* Obesity:
- Since 04/02/15.
- \*Abnml UA:
- 3/16 Life Insurance Exam

**Medical Summary**
**4/2/2015 - Peter Ransmeler, MD**
**Pg. 33-35**
**Functional/Social History**

SH: Exerc: Lifts weights heavily. Primary form of exer. cycling, weight lifting. Wt incr. 15lbs since working out; Limited exerc last 6 mos d/t knee pain.  
 3-4 glass wine/wk.

**MissingInfoAlert**

Records mentioned "abnormal life insurance labs", not available in the records submitted.

**OfficeVisit**

Vitals: 5.9.224; BP 138/80; p64.

sCr 1.0, GFR 102.01.

Annual exam. Labs 03/16 for life insurance physical, had elev urine glucose and Cr, chol. LDL ok and HDL low.

**Dx:**

Annual exam (V70.0)

Obesity NOS (278.00)

Glycosuria (791.5)

Plan: Labs.

**10/3/2016**
**Pg. 25-32**
**Functional/Social History**

SH: Exerc: Runs x several days/wk. 4.2oz.wk 7 glasses wine/wk.

Fhx: M (Breast Cancer); Mat Unc. D(42) MI/CAD

**MissingInfoAlert**

Records mentioned ER visit, not available in the records submitted.

**OfficeVisit**

Vitals: 246 lbs; BP 142/104; p100.

ER f/u, HTN. Checked BP at CVS, 170/110, had funny HA.

Labs/EKG Nml. HA resolved. Weight climbing over past year unsure why.

Visit to Minute clinic last winter and BP elev but did not f/u.

O/E: Obese.

**Dx:** Essential HTN. May need more than one med to control. Obesity d/t excess calories, unspec. severity.

**11/14/2016**

Pg. 20-24

**OfficeVisit**

Vitals: 250 lbs; BP 134/100; p94

F/u for elev BP.

**Dx:** Essential HTN. Not at goal. Add Zestril 20mg.

P: Check labs.

**1/9/2017**

Pg. 16-19

**Referral**

Bariatric surgery - future

**OfficeVisit**

Vitals: 254 lbs; BP 166/90; p100

F/u HTN. d/c both meds d/t decr libido. Started workout program/got nutrition guidance. Since then gained 13 lbs on record check it is 4 lbs. Feels no control over wt. and would like consult for surgical wt. loss.

**Dx:** Essential HTN: Not at goal, needs at least 2 meds until weight loss.

Non morbid obesity d/t excess calories.

Med side e?ects, initial encounter T88.7XXA - needs to balance risk and bene

**1/30/2017 - Patricia Sheridan, FNP/Steven Barrett, MD**

Pg. 9-15

**MissingInfoAlert**

Records mentioned plan for stress EKG, not available in records submitted.

**OfficeVisit**

Vitals: 5.9.245; BP 130/90; p122

Annual exam. Lost 9 lbs in 3 wks w/ diet. BP better, not at goal. Labs wnl. Lipids elev.

C/o intermittent CP. EKG at BH 10/16 wnl. CP dull ache Lt chest lasts few mins, few times a wk. No associated sx.

URI x 4 days.

PMH: Obesity

Benign HTN

O/E: Tachycardic w/ fever.

**Dx:**

Z00.00 - Encounter for general adult medical examination w/o abnormal

**6/27/2018 - Reem Shafeh, MD**

Pg. 6-8

**Functional/Social History**

SH: NS. 1 glass of wine every day.

**MissingInfoAlert**

Record mentioned plan for CT head, not available in records submitted.

**Neurological**

**Dx:** Post-coital HA. HA d/o (R51)

Discussed diff tx options and check BP w/ HA. No sx of increased intracranial pressure to suggest inter-cranial lesions like brain tumors or aneurysms.

Plan: CT head. Will arrange f/u based on that.

Rx: Inderal 10mg BID.

**OfficeVisit**

Vitals: 227 lbs; BP 128/80; p105.

Ref'd by Harlow Labarge, MD.

C/o severe HA during intercourse x 2 wks, duration 15 mins, resolves in 6 hours. Past Mild HA during sex. No dizziness, lightheadedness, LOC, N/V, blurred vision, numbness, tingling or weakness in extremities. One time, HA w/ exerc s/p weightlifting about 15 mins. Otherwise, no exer. induced HA's.

H/o HTN, d/c BP meds s/p 30 lbs wt. loss. Tried Cardizem, HCTZ and Lisinopril, d/c all med d/t wt. loss. Home Bp checks. Never checked BP w/ HA. Last 2 wks Wnl. Minute clinic visit w/ sx's about wk ago told poss. allergy. Advised Claritin-D, w/ no change. Allergy sx's improved.

HLD, last lipid Jan 2017. Never checked post losing weight.

O/E: Normal.

**Build Results for 37 Year Old Male**

Date	Weight	Height	BMI	Page	Document
06/27/2018	227 Lbs	--	--	Pg. 6-8	Redact One APS ...
01/30/2017	245 Lbs	5'9"	36.18	Pg. 9-15	Redact One APS ...
01/09/2017	254 Lbs	--	--	Pg. 16-19	Redact One APS ...
11/14/2016	250 Lbs	--	--	Pg. 20-24	Redact One APS ...
10/03/2016	246 Lbs	--	--	Pg. 25-32	Redact One APS ...
04/02/2015	224 Lbs	5'9"	33.08	Pg. 33-35	Redact One APS ...

**Blood Pressure Results for 37 Year Old Male**

Date	BloodPressure	Pulse	Page	Document
06/27/2018	128 / 80	105	Pg. 6-8	Redact One APS ...
01/30/2017	130 / 90	122	Pg. 9-15	Redact One APS ...
01/09/2017	166 / 90	100	Pg. 16-19	Redact One APS ...

11/14/2016	134 / 100	94	Pg. 20-24	Redact One APS ...
10/03/2016	142 / 104	100	Pg. 25-32	Redact One APS ...
04/02/2015	138 / 80	64	Pg. 33-35	Redact One APS ...

### Lab Results for 37 Year Old Male

Date	Value	Rating	Document
<b>Sugars</b>			
<b>Glucose</b>			
6/27/2018	100	Normal	Pg. 6-8
1/23/2017	91	Normal	Pg. 37-40
11/14/2016	87	Normal	Pg. 20-24
10/1/2016	108	Normal	Pg. 22-23
4/2/2015	77	Normal	Pg. 33-35
<b>A1c</b>			
4/2/2015	5.5	Normal	Pg. 33-35
<b>KFT</b>			
<b>BUN</b>			
6/27/2018	19	Normal	Pg. 6-8
1/23/2017	19	Normal	Pg. 37-40
11/14/2016	19	Normal	Pg. 20-24
10/1/2016	15	Normal	Pg. 22-23
4/2/2015	15	Normal	Pg. 33-35
<b>Creatinine</b>			
6/27/2018	1.1	Normal	Pg. 6-8
1/23/2017	1.07	Normal	Pg. 37-40
11/14/2016	1.09	Normal	Pg. 20-24
10/1/2016	1.1	Normal	Pg. 22-23
4/2/2015	1.10	Normal	Pg. 33-35
<b>GFR</b>			
1/23/2017	80.6	Normal	Pg. 37-40
11/14/2016	78.9	Normal	Pg. 20-24
10/1/2016	>60	Normal	Pg. 22-23
4/2/2015	78.4	Normal	Pg. 33-35
<b>GFR NAA</b>			
6/27/2018	81	Normal	Pg. 6-8
<b>GFR AA</b>			
6/27/2018	94	Normal	Pg. 6-8
<b>LFT</b>			
<b>AST</b>			
1/23/2017	22	Normal	Pg. 37-40
<b>ALT</b>			
1/23/2017	51	Normal	Pg. 37-40
<b>ALP</b>			
1/23/2017	75	Normal	Pg. 37-40
<b>TProtein</b>			
1/23/2017	7.8	Normal	Pg. 37-40
<b>Albumin</b>			
1/23/2017	4.7	Normal	Pg. 37-40
<b>TBili</b>			
1/23/2017	0.4	Normal	Pg. 37-40
<b>Lipids</b>			
<b>TC</b>			
1/23/2017	249(<200)	High	Pg. 37-40
<b>TG</b>			
1/23/2017	380(<150)	High	Pg. 37-40
<b>HDL</b>			
1/23/2017	42	Normal	Pg. 37-40
<b>TC/HDLRatio</b>			
1/23/2017	NaN	High	Pg. 37-40
<b>LDL</b>			
1/23/2017	131(<100)	High	Pg. 37-40
<b>CBC</b>			
<b>CBC</b>			
10/1/2016	Abs EOS 0.39H	Abnormal	Pg. 22-23

<b>Wbc</b>				
	1/23/2017	8.2	Normal	Pg. 37-40
	10/1/2016	6.47	Normal	Pg. 22-23
<b>Rbc</b>				
	1/23/2017	5.18	Normal	Pg. 37-40
	10/1/2016	5.15	Normal	Pg. 22-23
<b>Hb</b>				
	1/23/2017	15.5	Normal	Pg. 37-40
	10/1/2016	16.1	Normal	Pg. 22-23
<b>HCT</b>				
	1/23/2017	47.5	Normal	Pg. 37-40
	10/1/2016	47.4	Normal	Pg. 22-23
<b>MCV</b>				
	1/23/2017	91.6	Normal	Pg. 37-40
	10/1/2016	92	Normal	Pg. 22-23
<b>MCH</b>				
	1/23/2017	29.8	Normal	Pg. 37-40
	10/1/2016	31.3	Normal	Pg. 22-23
<b>MCHC</b>				
	1/23/2017	32.5	Normal	Pg. 37-40
	10/1/2016	34.0	Normal	Pg. 22-23
<b>RDW</b>				
	1/23/2017	12.0(12.1-14.0)	Low	Pg. 37-40
	10/1/2016	11.6	Normal	Pg. 22-23
<b>PLT</b>				
	1/23/2017	252	Normal	Pg. 37-40
	10/1/2016	249	Normal	Pg. 22-23
<b>Urine Analysis</b>				
<b>Rbc</b>				
	10/1/2016	3-10	Abnormal	Pg. 22-23
	4/2/2015	0-2	Normal	Pg. 33-35
<b>Wbc</b>				
	10/1/2016	0.5	Normal	Pg. 22-23
	4/2/2015	None seen	Normal	Pg. 33-35
<b>Glucose</b>				
	4/2/2015	Neg	Negative	Pg. 33-35
<b>Blood</b>				
	10/1/2016	Small	Abnormal	Pg. 22-23
	4/2/2015	Neg	Negative	Pg. 33-35
<b>Protein</b>				
	10/1/2016	Neg	Negative	Pg. 22-23
	4/2/2015	Trace	Abnormal	Pg. 33-35
<b>Creatinine</b>				
	4/2/2015	270.1		Pg. 33-35
<b>Microalbumin</b>				
	4/2/2015	1.3		Pg. 33-35
<b>Microalbumin/Creatinine Ratio</b>				
	4/2/2015	4.8		Pg. 33-35
<b>Misc</b>				
<b>FOBT</b>				
	1/31/2017	Neg	Negative	Pg. 36-0
	4/2/2015	Neg	Negative	Pg. 33-35
<b>Other</b>				
<b>Other1</b>				
	6/27/2018	Chloride 102	Normal	Pg. 6-8
	11/14/2016	Chloride 95	Low	Pg. 20-24
<b>Other2</b>				
	6/27/2018	Calcium 9.9	Normal	Pg. 6-8

Submit Date: 5/13/2022

Completed by ID:

Record Retrieval Solutions

Completed Date: 9/20/2021

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Case #: [REDACTED]  
Worked By: Emily Backus  
Method Received: Fax  
Number of Pages: 40  
Date: 4/8/2019

## Records Request

Name: [REDACTED]  
SSN: [REDACTED]  
DOB: [REDACTED]  
State: [REDACTED]  
Policy #: [REDACTED]

**Company:** 5991 - BISYS-WEST-BANNER  
**Account#:** 5991  
**Requester:** [REDACTED]  
**U/W Team:** [REDACTED]  
**Doc Type(s):** 5, 3  
[REDACTED]

**Facility:** FAMILY MEDICINE ASSOCIATES  
**Address:** 195 SCHOOL ST  
**City, St:** MANCHESTER, MA 01944  
**Phone/Fax:** 978-526-7507 / 978-526-7327

**Special Instructions:**

**RECORDS FROM 1/1/2014 TO PRESENT. INCLUDE LABS TESTING  
DOCTORS NOTES ETC. FAMILY MEDICINE ASSOCIATE**

**PHYSICAL EXAMINATION:** The patient is awake, alert and oriented x3, not in apparent distress. **HEENT:** PERRLA. EOMI. Nose without exudate. Throat without congestion. Neck: No JVD, goiter, adenopathy or carotid bruits. Chest: Clear, no rales, no wheeze. Heart: S1 and S2 normal, no gallop, no murmurs. Extremities: No edema. Neurologic: Nonfocal. Gait within normal.

#### ASSESSMENT AND PLAN:

- Post-coital headache. Discussed with the patient different mode of treatment from p.r.n. medication like indomethacin or Imitrex to maintenance medication of propranolol. Discussed with the patient that it will be helpful if he checks his blood pressure during the headache, especially with a history of hypertension he may need to go back on blood pressure medications. Discussed with the patient that post-coital headache may be a presentation of intracranial lesions like brain tumors or aneurysms; however, those patients usually have other symptoms of increased intracranial pressure to suggest that which he does not have. Symptoms include dizziness, lightheadedness, loss of consciousness, nausea, vomiting or blurred vision, which he does not have any of that. Plan is to give him a CAT scan of the head with contrast to rule out intracranial lesions.
- Discussed given Imitrex p.r.n. versus propranolol, he would like to go with propranolol 10 mg b.i.d. prescribed. We will contact the patient with CAT scan result and see how he is doing and we will arrange for followup based on that, patient is in agreement with the plan.

Reem I. Shafeh, MD

#### RIS:nts

D: 06/27/2018 14:52  
 T: 06/27/2018 18:41  
 J: E14319361 / 011266

#### Instructions

After Visit Summary (Printed 6/27/2018)

#### Additional Documentation

Vitals: BP 128/80 Pulse 105 Wt 103 kg (227 lb) ! (Abnormal) BMI 33.62 kg/m<sup>2</sup> BSA 2.24 m<sup>2</sup>  
 Flowsheets: Anthropometrics  
 Encounter Info: Billing Info, History, Allergies, Detailed Report

#### Orders Placed

Basic Metabolic Panel (Resulted 6/27/2018)  
 CT Head W Contrast

#### Medication Changes

As of 6/27/2018 2:48 PM

	Refills	Start Date	End Date
Added: propranolol (INDERAL) 10 MG tablet	2	6/27/2018	3/4/2019

Take 1 tablet (10 mg total) by mouth every morning & every evening. - Oral

#### Visit Diagnoses

Headache disorder R51



MRN: [REDACTED]

**Office Visit** 6/27/2018Family Medicine Associates, a  
Member of Lahey Health

Provider: Reem I Shafeh, MD (Internal Medicine)

Primary diagnosis: Headache disorder

Reason for Visit: Headache; Referred by Harlow F Labarge, MD

**Progress Notes**

Reem I Shafeh, MD (Physician) • Internal Medicine

This office note has been dictated.

**Progress Notes**

Reem I Shafeh, MD (Physician) • Hospital Medicine

GENERAL INTERNAL MEDICINE

06/27/2018

Name: [REDACTED]

LC#: [REDACTED]

DOB: [REDACTED]

CSN: [REDACTED]

REASON FOR VISIT: Headache.

**HISTORY OF PRESENT ILLNESS:** A 44-year-old male patient who has been having pain during intercourse for the last couple of weeks, same partner for long time. The patient rarely developed mild headache during sex in the past; however, over the last 2 weeks, every time he gets intercourse he feels severe throbbing headache that start in the back of his head and then goes all over the head the throbbing severe headache last for about 15 minutes and then start to become dull and milder and milder until it goes away in about 6 hours. He has no associated dizziness or lightheadedness or loss of consciousness or nausea or vomiting or blurred vision or numbness or tingling or weakness in extremities. One time, he had headache with exercise after doing weightlifting for about 15 times. Otherwise, no exercise-related headache. The patient has history of hypertension; however, after losing 30 pounds, he was able to stop blood pressure medication. He tried Cardizem and hydrochlorothiazide and lisinopril, but not all at the same time. Eventually, he was able to stop all the medication with losing weight. The patient checks his blood pressure at home and it has been normal. The patient never checked his blood pressure while he has the headache; however, he has checked a few times in the last 2 weeks and every time he checks it was within normal. The patient went to minute clinic with these symptoms about a week ago and he was told it could be allergy, he was advised to take Claritin-D, which he took on daily basis, which did not change his symptoms, it did improve his symptoms of allergy, runny nose and postnasal drip that he always have and it does not affect his blood pressure based on his readings. The patient has history of hyperlipidemia. Last lipid profile was done in January 2017; however, he lost weight after that and he never checked it again.

**SOCIAL HISTORY:** The patient does not smoke. He drinks 1 glass of wine every day. He drinks couple of coffees every day.

He has no known history of heart disease other than hypertension. He has no family history of coronary artery disease or stroke or aneurysms or diabetes.

MRN:

**Office Visit** 1/30/2017 Provider: Patricia A W Sheridan, FNP (Nurse Practitioner)  
Family Medicine Associates Cosigner: Steven A Barrett, MD (Internal Medicine)  
Manchester Primary diagnosis: PE (physical exam), annual  
Reason for Visit: Annual Exam; Referred by Steven A Barrett, MD

## **Progress Notes**

Patricia A W Sheridan, FNP (Nurse Practitioner) • Nurse Practitioner

HPI:

## **Chief Complaint Annual Exam**

Working hard at better diet, has lost 9 lbs in 3 weeks. BP better not quite at goal, has only been on this plan 3 weeks. Labs wnl except lipid profile elevated.  
Does admot to intermlttent CP. Had EKG at BH 10/16 and wnl. CP dull ache L chest lasts Few minutes, can happen a few times a week. No associated symptoms.

URI past 4 days, yesterday with low grade temp, states does not feel ill. Clear runny nose, no ST, dry cough, no exposure.  
Very optimistic about ability to reach goal of better health

**Past Medical History:**

#### **Past Medical History**

**Diagnosis** : Date :  
• Obesity  
• Benign essential hypertension

#### **MEDICAL PROBLEMS:**

There is no problem list on file for this patient.

**PAST SURGICAL HISTORY:**

### Past Surgical History

**Procedure Laterality Date**

**MEDICATIONS:**

## **Current Outpatient Prescriptions**

• diltiazem (CARDIZEM CD) 120 MG 24 hr capsule	Take 1 capsule (120 mg total) by mouth daily. Start 1 week after starting hydrodiuril	30 capsule	2
• amoxicillin (AMOXIL) 500 MG tablet	Take 1 tablet (500 mg total) by mouth every morning & every evening.	20 tablet	0
• hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet	Take 1 tablet (25 mg total) by mouth daily.	90 tablet	3

No current facility-administered medications for this visit.

#### ALLERGY:

No Known Allergies

#### IMMUNIZATION:

##### Immunization History

Administered	Date(s) Administered
• Tdap	06/21/2011

#### SOCIAL HISTORY:

##### Social History

###### Social History

- Marital Status: Married
- Spouse Name: N/A
- Number of Children: 4
- Years of Education: N/A

###### Occupational History

- Owner security company

###### Social History Main Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: 4.2 oz/week  
7 Glasses of wine per week
- Drug Use: No
- Sexual Activity: Not on file

###### Other Topics

- Not on file

###### Concern

###### Social History Narrative

*Lives with wife and 4 kids  
Exc Routine? None  
Hobbies? Family activities*

Seatbelt? Y  
 Sunscreen? Y  
 Smoke/CO det? Y  
 Guns? N  
 Family Violence? N  
 Regular dental care? Y  
 Eye exam? due  
 Diet? Better  
 Dairy? No  
 Caffeine? 1/day

### Social History

#### Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: 4.2 oz/week

7 Glasses of wine per week

### History

#### Smoking status

- Never Smoker

#### Smokeless tobacco

- Never Used

### History

#### Alcohol Use

- 4.2 oz/week
- 7 Glasses of wine per week

### History

#### Drug Use

No

### FAMILY HISTORY:

#### Family History

Problem	Relation	Age of Onset
• Coronary artery disease MI age 42	Maternal Uncle	
• Breast cancer	Mother	
• Osteoporosis	Mother	

### Review of Systems

Constitutional: Negative for diaphoresis, appetite change, fatigue and unexpected weight change.

Skin: Negative for rash, changing lesions, pruritis or bruising.

HENT: Negative for nasal congestion, epistaxis, ear pain/hearing loss, sore throat, trouble swallowing and voice change.

Eyes: Negative for pain, discharge, redness and visual disturbance.

Respiratory: Negative for choking, chest tightness, hemoptysis, shortness of breath and wheezing.

Cardiovascular: Negative for palpitations and leg swelling.

Gastrointestinal: Negative for changes in appetite, jaundice, nausea, vomiting, abdominal pain, diarrhea, constipation and blood in stool.

Genitourinary: Negative for dysuria, urgency, frequency, hematuria, flank pain, difficulty urinating or erectile dysfunction.

Musculoskeletal: Negative for myalgias, back pain, arthralgias and gait problem. No joint redness or swelling.

Allergic/Immunologic: Negative for environmental allergies or frequent infections.

Neurological: Negative for dizziness, tremors, seizures, speech difficulty, weakness, light-headedness, numbness and headaches.

Hematological: Negative for adenopathy, abnormal bleeding or bruising.

Endocrine: No hair loss, excess sweating, thirst, or urination.

Psychiatric/Behavioral: Negative for confusion, sleep disturbance and anxiety and depression.

#### PHYSICAL EXAM:

Constitutional: Normal demeanor. He appears tired. Obese body habitus.

Skin: Skin hot, dry and intact. No rashes or pallor.

Head: Normocephalic and atraumatic.

Right Ear: External ear normal. Canal and TM normal.

Left Ear: External ear normal. Canal and TM normal.

Nose: Nose normal. No obstruction or lesions.

Mouth/Throat: Oropharynx is clear and moist. Enlarged tonsils. Good dentition. No redness or lesions.

Eyes: Conjunctivae, EOM and lids are normal. Pupils are equal, round, and reactive to light.

Neck: Neck supple, normal range of motion. No JVD present. No tracheal deviation present. No thyromegaly present.

Cardiovascular: Tachycardic with fever, regular rhythm, normal heart sounds and intact distal pulses. No murmur heard.

Pulmonary/Chest: Effort normal, no respiratory distress. He has no wheezes, no rales, good aeration all lobes.

Back: No masses or tenderness, spine straight. No CVA tenderness

Abdominal: Soft. Normal aorta and bowel sounds are normal. There is no hepatosplenomegaly. There is no tenderness. There is no guarding. No hernia.

Genital: Normal penis, scrotum, testes. No hernia.

Rectal: Normal tone. No masses, tenderness or hemorrhoids. Prostate symmetrical, normal size, no tenderness, nodules.

Musculoskeletal: Normal range of motion, joints have no redness or swelling.

Lymphadenopathy: He has no cervical, axillary or inguinal node enlargement.

Neurological: He is alert and oriented to person, place, and time. He has normal strength and normal reflexes. No cranial nerve deficit. Coordination and gait normal.

Psychiatric: He has a normal mood and affect. His speech and behavior are normal. Judgment and thought content normal. Cognition and memory are normal.

Nursing note and vitals reviewed.

#### LAB RESULT POCT:

Results for orders placed or performed in visit on 01/30/17

POCT rapid strep A

Result	Value	Ref Range
Rapid Strep A Screen	Positive (A)	Negative, Equivocal, Immune, Non-Immune

## DIAGNOSIS/IMPRESSION:

### Encounter Diagnoses

Name [REDACTED] Primary? Yes

- PE (physical exam), annual
- Essential hypertension
- Obesity due to excess calories, unspecified obesity severity
- Other chest pain
- Fever, unspecified fever cause
- Strep pharyngitis
- Screening for colon cancer
- Pure hypercholesterolemia

[REDACTED] was seen today for annual exam.

Diagnoses and all orders for this visit:

**PE (physical exam), annual**

**Essential hypertension**

**Obesity due to excess calories, unspecified obesity severity**

**Other chest pain**

- ECG stress, treadmill; Future

**Fever, unspecified fever cause**

- POCT rapid strep A

**Strep pharyngitis**

- amoxicillin (AMOXIL) 500 MG tablet; Take 1 tablet (500 mg total) by mouth every morning & every evening.

**Screening for colon cancer**

- Fecal Occult Blood (LHCC); Future

**Pure hypercholesterolemia**

BP almost at goal, weight loss may accomplish the rest.

Recheck lipids in 3 months

We will book stress test.

### PATIENT INSTRUCTION:

#### **Patient Instructions**

Continue with healthy lifestyle, and increase your exercise as you are able. Continue on the same medications. Call if you have any new persistent symptoms, or questions about maintaining good health or disease prevention.

For sore throat take tylenol or ibuprofen for discomfort. Drink 6-8 glasses of fluid a day. May use lozenges as well. Follow up if symptoms worsen or do not improve over the next few days. Finish all the med even if you are feeling better.

## Instructions



Return in about 3 months (around 4/30/2017) for Recheck HTN, lipids.

Continue with healthy lifestyle, and increase your exercise as you are able. Continue on the same medications. Call if you have any new persistent symptoms, or questions about maintaining good health or disease prevention.

For sore throat take tylenol or ibuprofen for discomfort. Drink 6-8 glasses of fluid a day. May use lozenges as well. Follow up if symptoms worsen or do not improve over the next few days. Finish all the med even if you are feeling better.

Visit Summary (Printed 1/30/2017)

## Additional Documentation

Vitals: BP 130/90 Pulse 122 Temp 101.3 °F (38.5 °C) (Oral) Ht 1.75 m (5' 8.9")  
 Wt 111.1 kg (245 lb) ! (Abnormal) BMI 36.29 kg/m<sup>2</sup> BSA 2.32 m<sup>2</sup> More Vitals  
 Flowsheets: Anthropometrics  
 Encounter Info: Billing Info, History, Allergies, Detailed Report

## Orders Placed

POCT rapid strep A (Resulted 1/30/2017, Abnormal)  
 Fecal Occult Blood (LHCC) (Resulted 1/31/2017)  
 ECG stress, treadmill

## Medication Changes

As of 1/30/2017 6:54 PM

	Refills	Start Date	End Date
Added: amoxicillin (AMOXIL) 500 MG tablet	0	1/30/2017	2/9/2017

Take 1 tablet (500 mg total) by mouth every morning & every evening. - Oral

## Visit Diagnoses

PE (physical exam), annual Z00.00  
 Essential hypertension I10  
 Obesity due to excess calories, unspecified obesity severity E66.09  
 Other chest pain R07.89  
 Fever, unspecified fever cause R50.9  
 Strep pharyngitis J02.0  
 Screening for colon cancer Z12.11  
 Pure hypercholesterolemia E78.00



MRN: [REDACTED]

**Office Visit** 1/9/2017Family Medicine Associates  
Manchester

Provider: Patricia A W Sheridan, FNP (Nurse Practitioner)

Cosigner: Steven A Barrett, MD (Internal Medicine)

Primary diagnosis: Essential hypertension

Reason for Visit: Hypertension; Referred by Steven A Barrett, MD

**Progress Notes**

Patricia A W Sheridan, FNP (Nurse Practitioner) • Nurse Practitioner

**HPI:****Chief Complaint**  
**Hypertension**

He is here for f/u after postponing OV. He stopped both meds as he had decreased libido and that was not acceptable to him. He started a workout program, saw a personal trainer and got nutrition guidance. He states since then he gained 13 lbs but on record check it is only 4 lbs. He feels he has no control over his weight, he would like a consult for surgical weight loss. Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

**MEDICAL PROBLEMS:**

There is no problem list on file for this patient.

**Past Medical History****Diagnosis****Date**

- Obesity
- Benign essential hypertension

**PAST SURGICAL HISTORY:**

History reviewed. No pertinent past surgical history. ☑

**MEDICATIONS:****Current Outpatient Prescriptions****Medication****Sig****Dispense****Refill**

- diltiazem (CARDIZEM CD) 120 MG 24 hr capsule

Take 1 capsule (120 mg total) by mouth daily. Start 1 week after starting hydrodiuril

30 capsule

2

- hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet

Take 1 tablet (25 mg total) by mouth daily.

90 tablet

3

No current facility-administered medications for this visit.

**ALLERGY:**  
No Known Allergies

**IMMUNIZATION:**

**Immunization History**

Administered	Date(s) Administered
• Tdap	06/21/2011

**SOCIAL HISTORY:**

**Social History**

**Substance Use Topics**

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol Use:	4.2 oz/week

7 Glasses of wine per week

**History**

**Smoking status**

- Never Smoker

**Smokeless tobacco**

- Never Used

**History**

**Alcohol Use**

- 4.2 oz/week
- 7 Glasses of wine per week

**History**

**Drug Use**

No

**FAMILY HISTORY:**

**Family History**

Problem	Relation	Age of Onset
• Coronary artery disease MI age 42	Maternal Uncle	
• Breast cancer	Mother	

**Review of Systems**

A comprehensive review of ten systems was negative except for those noted in the HPI.

**Physical Exam**

**Constitutional:** He is oriented to person, place, and time. He appears well-developed and obese.

**Head:** Normocephalic and atraumatic.

**Eyes:** Pupils are equal, round, and reactive to light. Fundi benign.

**Neck:** Normal range of motion. No JVD present.

**Cardiovascular:** Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary/Chest: Effort normal and breath sounds normal. No adventitious sounds.  
 Musculoskeletal: Normal range of motion. He exhibits no edema.  
 Neurological: He is alert and oriented to person, place, and time. Coordination normal.  
 Skin: Skin is warm and dry.  
 Psychiatric: He has a normal mood and affect. His behavior is normal.  
 Vitals reviewed.

### **LAB RESULT POCT:**

**Results for orders placed or performed in visit on 11/14/16**

#### **Basic Metabolic Panel**

Result	Value	Ref Range
Sodium	135	133-143 meq/L
Potassium	3.9	3.5-5.1 meq/L
Chloride	95 (L)	98-107 meq/L
Total CO <sub>2</sub>	33	24-34 meq/L
Glucose	87	74-118 mg/dL
BUN	19	7-25 mg/dL
Creatinine, Blood	1.09	0.70-1.30 mg/dL
Calcium	9.7	8.6-10.3 mg/dL
GFR	78.9	

### **DIAGNOSIS/IMPRESSION:**

#### **Encounter Diagnoses**

Name	Primary?
• Essential hypertension	Yes
• Non morbid obesity due to excess calories	

████████ was seen today for hypertension.

Diagnoses and all orders for this visit:

#### **Essential hypertension**

- hydroCHLOROThiazide (HYDRODIURIL) 25 MG tablet; Take 1 tablet (25 mg total) by mouth daily.
- diltiazem (CARDIZEM CD) 120 MG 24 hr capsule; Take 1 capsule (120 mg total) by mouth daily. Start 1 week after starting hydrodiuril

#### **Non morbid obesity due to excess calories**

- Referral to Bariatric Surgery; Future

### **PATIENT INSTRUCTION:**

There are no Patient Instructions on file for this visit.

### **Instructions**

Return in about 1 month (around 2/9/2017) for Recheck bp.



We have discussed again at this visit the risks of uncontrolled blood pressure. The medication may affect libido but hypertension may cause permanent ED. We need to work together to find a good combination of meds to reduce your Cardiovascular risk. Please be in touch with us if you have any new side effects. You will need to have good BP control before surgery.

Call with any questions or concerns.

Visit Summary (Printed 1/9/2017)

## Additional Documentation

Vitals: BP 166/90 Pulse 100 Wt 115.2 kg (254 lb) ! (Abnormal) BMI 36.45 kg/m<sup>2</sup> BSA 2.39 m<sup>2</sup>

[More Vitals](#)

Flowsheets: Anthropometrics

Encounter Info: Billing Info, History, Allergies, Detailed Report

## Orders Placed

Referral to Bariatric Surgery Closed

## Medication Changes

As of 1/9/2017 9:38 PM

	Refills	Start Date	End Date
Added: diltiazem (CARDIZEM CD) 120 MG 24 hr capsule	2	1/9/2017	4/2/2017

Take 1 capsule (120 mg total) by mouth daily. Start 1 week after starting hydrodiuril - Oral

## Visit Diagnoses

Essential hypertension I10 - Not at goal, will need at least 2 meds until he can lose weight.

Non morbid obesity due to excess calories E66.09

Medication side effects, initial encounter T88.7XXA - Needs to balanc risk and benefit

**Office Visit** 11/14/2016  
 Family Medicine Associates  
 Manchester

Provider: Patricia A W Sheridan, FNP (Nurse Practitioner)  
 Cosigner: Steven A Barrett, MD (Internal Medicine)  
 Primary diagnosis: Essential hypertension  
 Reason for Visit: Hypertension; Referred by Steven A Barrett, MD

## Progress Notes

Patricia A W Sheridan, FNP (Nurse Practitioner) • Nurse Practitioner

### HPI:

### Chief Complaint

Hypertension

6 week f/u for elevated BP first noted at CVS and then went to ER. He was seen here and started on a HCTZ, at his request. He was advised that he may need more than one med to get him to goal. He is not there yet. Has not made any changes in diet or exercise. Patient denies any exertional chest pain, dyspnea, palpitations, syncope, orthopnea, edema or paroxysmal nocturnal dyspnea.

### MEDICAL PROBLEMS:

There is no problem list on file for this patient.

### Past Medical History

Diagnosis	Date
• Obesity	
• Benign essential hypertension	

### PAST SURGICAL HISTORY:

History reviewed. No pertinent past surgical history.

### MEDICATIONS:

#### Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
• hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet	Take 1 tablet (25 mg total) by mouth daily.	90 tablet	3
• lisinopril (ZESTRIL) 20 MG tablet	1/2 tab qd x 6 days then 1 tab qd	30 tablet	1

No current facility-administered medications for this visit.

### ALLERGY:

No Known Allergies

### IMMUNIZATION:

**Immunization History**

Administered  Yes  No      Date(s) Administered  06/21/2011  
 • Tdap

**SOCIAL HISTORY:****Social History****Substance Use Topics**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: 4.2 oz/week

7 Glasses of wine per week

**History****Smoking status**

- Never Smoker

**Smokeless tobacco**

- Never Used

**History****Alcohol Use**

- 4.2 oz/week
- 7 Glasses of wine per week

**History****Drug Use**

No

**FAMILY HISTORY:****Family History**

Problem	Relation	Age of Onset
• Coronary artery disease	Maternal Uncle	
MI age 42		
• Breast cancer	Mother	

**Review of Systems**

A comprehensive review of ten systems was negative except for those noted in the HPI.

**Physical Exam**

Constitutional: He is oriented to person, place, and time. He appears well-developed.

**obese****HENT:**

Head: Normocephalic and atraumatic.

Eyes: Pupils are equal, round, and reactive to light.

Neck: No JVD present. No thyromegaly present.

Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

Pulmonary/Chest: Effort normal.

Musculoskeletal: He exhibits no edema.

Neurological: He is alert and oriented to person, place, and time.

Skin: Skin is warm and dry.

Psychiatric: He has a normal mood and affect. His behavior is normal.

Vitals reviewed.

### LAB RESULT POCT:

Results for orders placed or performed during the hospital encounter of 10/01/16

#### Basic Metabolic Panel

Result	Value	Ref Range
Sodium	139	134-145 mmol/L
Potassium	3.9	3.5-5.1 mmol/L
Chloride	97	96-108 mmol/L
Total CO <sub>2</sub>	30	22-32 mmol/L
Anion Gap	12	6-16 mmol/L
BUN	15	6-23 mg/dL
Creatinine, Blood	1.1	0.5-1.2 mg/dL
Glucose, Plasma	108	74-118 mg/dL
Calcium	9.4	8.5-10.5 mg/dL
GFR African-Amer (CKD-EPI)	>60	>=60 mL/min/BSA
GFR Non African-Amer (CKD-EPI)	>60	>=60 mL/min/BSA

#### Urinalysis with Reflex to Urine Culture

Result	Value	Ref Range
Color Urine	Yellow	Colorless, Straw, Yellow
Clarity Urine	Clear	Clear, Slightly Cloudy
pH, Urine	6.0	5.0-7.5
Protein, Urine	Negative	Negative
Ketone Urine	Negative	Negative
Glucose Urine	Negative	Negative
Occult Blood Urine	Small (A)	Negative
Leukocyte Urine	Negative	Negative
Nitrite Urine	Negative	Negative
Specific Gravity, Urine	<1.001 (L)	1.001-1.035
Bilirubin, Urine	Negative	Negative
Urobilinogen	Negative	Negative, 0.2 mg/dL, 1.0 mg/dL
White Blood Cell	0-5	0-5 cells/HPF
Red Blood Cell, Urine	3-10 (A)	Sediment not performed, 0-2 cells/HPF

#### CBC and Differential

Result	Value	Ref Range
WBC	6.47	3.80-10.50 K/uL
RBC	5.15	4.10-5.60 M/uL
Hemoglobin	16.1	12.7-16.7 g/dL
Hematocrit	47.4	38.1-50.1 %
MCH	31.3	25.0-35.0 pg
MCHC	34.0	33.0-36.0 %
MCV	92	82-98 fL
RDW	11.6	11.5-14.5 %
Platelet Count	249	150-450 K/uL
MPV	10.2	6.0-14.0

Polys	53	%
Lymphocyte	31	%
Monocyte	7	%
Eosinophil	6	%
Basophil	1	%
Immature granulocytes (Metas, Myelos, Promyelocytes)	1	%
Absolute Gran Ct	3.45	2.20-8.60 K/uL
Absolute Lymph Ct	2.02	1.50-4.00 K/uL
Absolute Mono Ct	0.48	0.16-1.26 K/uL
Absolute Eos Ct	0.39 (H)	0.02-0.30 K/uL
Absolute Baso Ct	0.09	0.00-0.21 K/uL

## DIAGNOSIS/IMPRESSION:

### Encounter Diagnoses

Name: [REDACTED] Primary? [REDACTED]

- Essential hypertension

Comment:

[REDACTED]

Yes

Not at  
goal

[REDACTED] was seen today for hypertension.

Diagnoses and all orders for this visit:

### Essential hypertension

#### Comments:

Not at goal

#### Orders:

- lisinopril (ZESTRIL) 20 MG tablet; 1/2 tab qd x 6 days then 1 tab qd
- Basic Metabolic Panel; Future

Check lytes and kidney function after starting diuretic and before adding ACEI

## PATIENT INSTRUCTION:

### Patient Instructions

Continue with healthy lifestyle, and increase your exercise as you are able. Work on a 10% weight loss over the next 6 months to reduce the risk of chronic disease. Continue on the same medications. Call if you have any new persistent symptoms, or questions about maintaining good health or disease prevention.

## Instructions

[REDACTED] Return in about 6 weeks (around 12/26/2016) for Recheck HTN.

Continue with healthy lifestyle, and increase your exercise as you are able. Work on a 10% weight loss over the next 6 months to reduce the risk of chronic disease. Continue on the same medications. Call if you have any new persistent symptoms, or questions about maintaining good health or disease prevention.

## Additional Documentation

Vitals: BP 134/100 ! (Abnormal) Pulse 94 Wt 113.4 kg (250 lb) ! (Abnormal) BMI 35.87 kg/m<sup>2</sup>  
BSA 2.37 m<sup>2</sup> More Vitals

Flowsheets: Anthropometrics

Encounter Info: Billing Info, History, Allergies, Detailed Report

## Orders Placed

Basic Metabolic Panel (Resulted 11/14/2016, Abnormal)

## Medication Changes

As of 11/14/2016 5:04 PM

	Refills	Start Date	End Date
Added: lisinopril (ZESTRIL) 20 MG tablet 1/2 tan qd x 6 days then 1 tab qd	1	11/14/2016	2/18/2017

## Visit Diagnoses

Essential hypertension I10 - Not at goal

**Office Visit** 10/3/2016      Provider: Patricia A W Sheridan, FNP (Nurse Practitioner)  
**Family Medicine Associates**      Cosigner: Steven A Barrett, MD (Internal Medicine)  
**Manchester**      Primary diagnosis: Essential hypertension  
Reason for Visit: ED Follow-up, Hypertension; Referred by Steven A Barrett,  
MD

**Progress Notes**

Patricia A W Sheridan, FNP (Nurse Practitioner) • Nurse Practitioner

**HPI:****Chief Complaint**  
**ED Follow-up; Hypertension**

Checked his BP at CVS this weekend and was very high. He had a "funny" HA and it was 170/110. He was told to f/u here. Labs and ecg normal. HA now gone, denies, dizziness, weakness, vision changes, facial droop. States he runs for exercise several days a week and keeps to 1800-2000 cal/day. Eats out lunch daily, knows that it is high sodium. Weight climbing over past year or so, he is not sure why. Has 4 kids, wants to be healthy. Last here 4/15, BP was nl. Went to Minute Clinic last winter and BP elevated but did not f/u here. Wife takes diuretic and he feels that is what he wants too. States it took care of the BP totally. Then he adds she also takes lisinopril.

**MEDICAL PROBLEMS:**

There is no problem list on file for this patient.

**Past Medical History**

**Diagnosis** [REDACTED]      **Date** [REDACTED]

- Obesity
- Benign essential hypertension

**PAST SURGICAL HISTORY:**

No past surgical history on file. ☺

**MEDICATIONS:****Current Outpatient Prescriptions**

Medication	Sig	Dispense	Refill
• hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet	Take 1 tablet (25 mg total) by mouth daily.	30 tablet	1

No current facility-administered medications for this visit.

**ALLERGY:**

No Known Allergies

**IMMUNIZATION:**

**Immunization History**

Administered 06/21/2011 Date(s) Administered 06/21/2011  
• Tdap

**SOCIAL HISTORY:**

**Social History**

**Substance Use Topics**

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol Use: 4.2 oz/week

7 Glasses of wine per week

**History**

**Smoking status**

- Never Smoker
- Never Used

**Smokeless tobacco**

**History**

**Alcohol Use**

- 4.2 oz/week
- 7 Glasses of wine per week

**History**

**Drug Use**

No

**FAMILY HISTORY:**

**Family History**

Problem	Relation	Age of Onset
• Coronary artery disease	Maternal Uncle	
MI age 42		
• Breast cancer	Mother	

**Review of Systems**

A comprehensive review of ten systems was negative except for those noted in the HPI.

**Physical Exam**

**Constitutional:** He is oriented to person, place, and time. He appears well-developed.

**obese**

**HENT:**

**Head:** Normocephalic and atraumatic.

**Cardiovascular:** Normal rate, regular rhythm, normal heart sounds and intact distal pulses.

**Pulmonary/Chest:** Effort normal and breath sounds normal.

**Musculoskeletal:** Normal range of motion.

Neurological: He is alert and oriented to person, place, and time. He exhibits normal muscle tone. Coordination normal.  
 Skin: Skin is warm and dry.  
 Psychiatric: His behavior is normal. His mood appears anxious.  
 Vitals reviewed.

### LAB RESULT POCT:

Results for orders placed or performed during the hospital encounter of 10/01/16

#### Basic Metabolic Panel

Result	Value	Ref Range
Sodium	139	134-145 mmol/L
Potassium	3.9	3.5-5.1 mmol/L
Chloride	97	96-108 mmol/L
Total CO <sub>2</sub>	30	22-32 mmol/L
Anion Gap	12	6-16 mmol/L
BUN	15	6-23 mg/dL
Creatinine, Blood	1.1	0.5-1.2 mg/dL
Glucose, Plasma	108	74-118 mg/dL
Calcium	9.4	8.5-10.5 mg/dL
GFR African-Amer (CKD-EPI)	>60	>=60 mL/min/BSA
GFR Non African-Amer (CKD-EPI)	>60	>=60 mL/min/BSA

#### Urinalysis with Reflex to Urine Culture

Result	Value	Ref Range
Color Urine	Yellow	Colorless, Straw, Yellow
Clarity Urine	Clear	Clear, Slightly Cloudy
pH, Urine	6.0	5.0-7.5
Protein, Urine	Negative	Negative
Ketone Urine	Negative	Negative
Glucose Urine	Negative	Negative
Occult Blood Urine	Small (A)	Negative
Leukocyte Urine	Negative	Negative
Nitrite Urine	Negative	Negative
Specific Gravity, Urine	<1.001 (L)	1.001-1.035
Bilirubin, Urine	Negative	Negative
Urobilinogen	Negative	Negative, 0.2 mg/dL, 1.0 mg/dL
White Blood Cell	0-5	0-5 cells/HPF
Red Blood Cell, Urine	3-10 (A)	Sediment not performed, 0-2 cells/HPF

#### CBC and Differential

Result	Value	Ref Range
WBC	6.47	3.80-10.50 K/uL
RBC	5.15	4.10-5.60 M/uL
Hemoglobin	16.1	12.7-16.7 g/dL
Hematocrit	47.4	38.1-50.1 %
MCH	31.3	25.0-35.0 pg
MCHC	34.0	33.0-36.0 %
MCV	92	82-98 fL
RDW	11.6	11.5-14.5 %

Platelet Count	249	150-450 K/uL
MPV	10.2	6.0-14.0
Polys	53	%
Lymphocyte	31	%
Monocyte	7	%
Eosinophil	6	%
Basophil	1	%
Immature granulocytes (Metas, Myelos, Promyelocytes)	1	%
Absolute Gran Ct	3.45	2.20-8.60 K/uL
Absolute Lymph Ct	2.02	1.50-4.00 K/uL
Absolute Mono Ct	0.48	0.16-1.26 K/uL
Absolute Eos Ct	0.39 (H)	0.02-0.30 K/uL
Absolute Baso Ct	0.09	0.00-0.21 K/uL

#### DIAGNOSIS/IMPRESSION:

##### Encounter Diagnoses

Name:

- Essential hypertension

Comment:

Primary?  
Yes  
May  
take  
more  
than  
one  
med to  
control.  
I will  
honor  
his  
request  
to try  
diuretic  
first.

- Obesity due to excess calories, unspecified obesity severity

[REDACTED] was seen today for ed follow-up and hypertension.

Diagnoses and all orders for this visit:

##### Essential hypertension

###### Comments:

May take more than one med to control. I will honor his request to try diuretic first.

##### Obesity due to excess calories, unspecified obesity severity

###### Other orders

- hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet; Take 1 tablet (25 mg total) by mouth daily.

**PATIENT INSTRUCTION:****Patient Instructions****Controlling High Blood Pressure**

High blood pressure (hypertension) is called the silent killer. This is because many people who have it don't know it. High blood pressure is 140/90 or higher. Know your blood pressure and remember to check it regularly. Doing so can save your life. Here are some things you can do to help control your blood pressure.

**Choose heart-healthy foods**

- Select low-salt, low-fat foods.
- Limit canned, dried, cured, packaged, and fast foods. These can contain a lot of salt.
- Eat 8 to 10 servings of fruits and vegetables every day.
- Choose lean meats, fish, or chicken.
- Eat whole-grain pasta, brown rice, and beans.
- Eat 2 to 3 servings of low-fat or fat-free dairy products
- Ask your doctor about the DASH eating plan. This plan helps reduce blood pressure.

**Maintain a healthy weight**

- Ask your health care provider how many calories to eat a day. Then stick to that number.
- Ask your health care provider what weight range is healthiest for you. If you are overweight, a weight loss of only 3% to 5% of your body weight can help lower blood pressure.
- Limit snacks and sweets.
- Get regular exercise.

**Get up and get active**

- Choose activities you enjoy. Find ones you can do with friends or family.
- Park farther away from building entrances.

- Use stairs instead of the elevator.
- When you can, walk or bike instead of driving.
- Rake leaves, garden, or do household repairs.
- Be active at a moderate to vigorous level of physical activity for at least 40 minutes for a minimum of 3 to 4 days a week.

#### **Manage stress**

- Make time to relax and enjoy life. Find time to laugh.
- Visit with family and friends, and keep up with hobbies.

#### **Limit alcohol and quit smoking**

- Men should have no more than 2 drinks per day.
- Women should have no more than 1 drink per day.
- Talk with your health care provider about quitting smoking. Smoking increases your risk for heart disease and stroke. Ask about local or community programs that can help.

#### **Medications**

If lifestyle changes aren't enough, your health care provider may prescribe high blood pressure medicine. Take all medications as prescribed.

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## **Instructions**



Return in about 6 weeks (around 11/14/2016) for PE 3 months.

#### **Controlling High Blood Pressure**

High blood pressure (hypertension) is called the silent killer. This is because many people who have it don't know it. High blood pressure is 140/90 or higher. Know your blood pressure and remember to check it regularly. Doing so can save your life. Here are some things you can do to help control your blood pressure.



### **Choose heart-healthy foods**

- Select low-salt, low-fat foods.
- Limit canned, dried, cured, packaged, and fast foods. These can contain a lot of salt.
- Eat 8 to 10 servings of fruits and vegetables every day.
- Choose lean meats, fish, or chicken.
- Eat whole-grain pasta, brown rice, and beans.
- Eat 2 to 3 servings of low-fat or fat-free dairy products
- Ask your doctor about the DASH eating plan. This plan helps reduce blood pressure.

### **Maintain a healthy weight**

- Ask your health care provider how many calories to eat a day. Then stick to that number.
- Ask your health care provider what weight range is healthiest for you. If you are overweight, a weight loss of only 3% to 5% of your body weight can help lower blood pressure.
- Limit snacks and sweets.
- Get regular exercise.

### **Get up and get active**

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- Park farther away from building entrances.
- Use stairs instead of the elevator.
- When you can, walk or bike instead of driving.
- Rake leaves, garden, or do household repairs.
- Be active at a moderate to vigorous level of physical activity for at least 40 minutes for a minimum of 3 to 4 days a week

### **Manage stress**

- Make time to relax and enjoy life. Find time to laugh.
- Visit with family and friends, and keep up with hobbies.

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- Women should have no more than 1 drink per day.
- Talk with your health care provider about quitting smoking. Smoking increases your risk for heart disease and stroke. Ask about local or community programs that can help.

#### Medications

If lifestyle changes aren't enough, your health care provider may prescribe high blood pressure medicine. Take all medications as prescribed.

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Visit Summary (Printed 10/3/2016)

#### Additional Documentation

Vitals: BP 142/104 ! (Abnormal) Pulse 100 Wt 111.6 kg (246 lb) ! (Abnormal)  
BMI 35.30 kg/m<sup>2</sup> BSA 2.35 m<sup>2</sup> More Vitals

Flowsheets: Anthropometrics

Encounter Info: Billing Info, History, Allergies, Detailed Report

#### Orders Placed

None

#### Medication Changes

As of 10/3/2016 6:41 PM

	Refills	Start Date	End Date
Added: hydroCHLORothiazide (HYDRODIURIL) 25 MG tablet	1	10/3/2016	10/26/2016

Take 1 tablet (25 mg total) by mouth daily. - Oral

#### Visit Diagnoses

Essential hypertension I10 - May take more than one med to control. I will honor his request to try diuretic first.

Obesity due to excess calories, unspecified obesity severity E66.09

**Office/Outpatient Visit****Visit Date:** Thu, Apr 2, 2015 08:01 am**Provider:** Peter Ransmeier, MD (Assistant: Jeremy Cassidy, MA)**Location:** Family Medicine Associates Manchester

Electronically signed by Peter Ransmeler, MD on 04/02/2015 08:38:04 AM

Printed on 04/08/2019 at 11:54 am.

**SUBJECTIVE:****CC:**

[REDACTED] is a 41 year old White male. This is an established patient. He is here for an annual exam.

**HPI:**

3/16 had labs done for his life Insurance physical, those were reviewed with him on his phone, of note he had elevated urine glucose and creatinine.. cholesterol including ld l looked ok. hdl was a little bit on the low side...

we will check a repeat bmp and UA today. he will have a copy of those labs forwarded at his earliest convenience.

pt does states as a 10 year old had to miss a couple of hockey games bc of casts in his urine. the casts resolved on their own.

bp today was 138/80s.

>>exercises... lifts weights heavily.

pt could be hydrating better. he will work on that.

etoh a glass of wine 3-4 a week.

nutrition... tries to do low carbs. put on 15 lbs since working out.

>>wt does fluctuate a bit 190-220s, usually 200-205.

> no daytime sleepiness or snoring.

tdap 2011.

4 kids at home, keeping him busy. hockey in past. not now.

**ROS:**

**CONSTITUTIONAL:** Negative for chills, fatigue and fever. + weight gain

**EYES:** Negative for blurred vision and photophobia.

**E/N/T:** Negative for ear pain, tinnitus, nasal congestion, frequent rhinorrhea and sore throat.

**CARDIOVASCULAR:** Negative for chest pain, dizziness, palpitations and pedal edema.

**RESPIRATORY:** Negative for recent cough, chronic cough, dyspnea and frequent wheezing.

**GASTROINTESTINAL:** Negative for abdominal pain, constipation and nausea.

**GENITOURINARY:** Negative for dysuria, hematuria and polyuria.

**MUSCULOSKELETAL:** Negative for arthralgias, back pain, joint stiffness and myalgias.

**INTEGUMENTARY:** Negative for atypical mole(s), pruritis and rash.

**NEUROLOGICAL:** Negative for ataxia, dizziness, vertigo and weakness.

**HEMATOLOGIC/LYMPHATIC:** Negative for easy bruising and lymphadenopathy.

**ENDOCRINE:** Negative for polydipsia and polyphagia.

**ALLERGIC/IMMUNOLOGIC:** Negative for seasonal allergies and perennial allergies.

**PMH/FMH/SH:****Past Medical History:**

UNREMARKABLE

**Surgical History:**

NONE

**Family History:**

Osteoporosis in Mother. Coronary Artery Disease in Uncle-maternal and Mother. Cancer Breast in Mother. Maternal uncle

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MI deceased age 42

Positive for **Coronary Artery Disease** ( mother; mat. uncle ).Positive for **Breast Cancer** ( mother ).Positive for **Osteoporosis** ( mother ).**Social History:**

Occupation: Real Estate;

Marital Status: Married

Children: 4 children (ages age 10 to 2 months (3 girls and one boy) )

Exercise: Primary form of exercise is cycling, weight lifting, and limited exercise last 6 mos. due to pain in the knees.

**Tobacco/Alcohol/Supplements:**

Tobacco: Non-smoker;

Alcohol: He typically consumes red wine and/or white wine and few glasses per week.

Caffeine: He admits to consuming caffeine via coffee ( 1 serving per day ).

Supplements: Patient denies ever having used dietary supplements.

**Immunizations:**

Tdap (Tetanus toxoid, reduced DTaP adsorbed) 6/21/2011

**Allergies:**

No Known Drug Allergies.

**Current Medications:**

No Known Medications.

**OBJECTIVE:****Vitals:**

Current: 4/2/2015 8:07:08 AM

Ht: 5 ft, 9.25 in; Wt: 224 lbs; **BMI: 32.8****BP: 138/80 mm Hg** (right arm); P: 64 bpm (left radial); sCr: 1 mg/dL; **GFR: 102.01****Exams:****PHYSICAL EXAM:****GENERAL:** well developed and nourished; appropriately groomed; in no apparent distress; + obese abdomen**EYES:** lids and lacrimal system are normal in appearance; extraocular movements intact; conjunctiva and cornea are normal; PERRLA; fundoscopic exam reveals sharp disc margins;**E/N/T:** EARS: external auditory canal normal; bilateral TMs are normal; on gross hearing screen, he is able to hear finger rub at both ears;**NECK:** range of motion is normal;**RESPIRATORY:** normal appearance and symmetric expansion of chest wall; normal respiratory rate and pattern with no distress; normal breath sounds with no rales, rhonchi, wheezes or rubs; percussion is normal without hyperresonance or dullness;**CARDIOVASCULAR:** normal rate; rhythm is regular;**GASTROINTESTINAL:** nontender; normal bowel sounds; no organomegaly; rectal exam: normal tone; no masses; no hemorrhoids;**GENITOURINARY:** Negative for CVA tenderness penis; no lesions or urethral discharge; no testicular tenderness or

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masses; no inguinal hernia; normal scrotum without lesions or rashes prostate: no nodules, tenderness, or enlargement;

LYMPHATIC: no enlargement of cervical or facial nodes; no supraclavicular nodes;

SKIN: no significant rashes or lesions; no suspicious moles;

MUSCULOSKELETAL: normal gait; normal rom and strength in major muscle groups;

NEUROLOGIC: cn grossly intact;

PSYCHIATRIC: appropriate affect and demeanor; normal speech pattern; grossly normal memory;

**ASSESSMENT:**

V70.0 Annual exam

DDx:

278.00 Obesity, NOS

DDx:

791.5 Glycosuria

DDx:

**ORDERS:****Lab Orders:**

Basic Metabolic Panel (10165) (In-House)

Hemoglobin A1c (8181) (In-House)

Urine Microalbumin (6517) (In-House)

Stool Occult Blood (95627) (In-House)

Urinalysis (7909) (Send-Out)

**PLAN:****Annual exam**

LABORATORY: Labs ordered to be performed today include Basic Metabolic Profile, HgbA1C, Urine Microalbumin, FIT, and Urinalysis.

COUNSELING was provided today regarding the following topics: healthy eating habits, low cholesterol diet, low salt diet, regular exercise, alcohol, and sunscreen (apply SPF 30 or greater when exposed to sun).

**Orders:**

Basic Metabolic Panel (10165) (In-House)

Hemoglobin A1c (8181) (In-House)

Urine Microalbumin (6517) (In-House)

Stool Occult Blood (95627) (In-House)

Urinalysis (7909) (Send-Out)

**△ Basic Metabolic Panel**

Order: [REDACTED]

Collected: 6/27/2018 2:53 PM

**View Full Report**

	Ref Range & Units	9mo ago
Sodium	135 - 146 mmol/L	138
Potassium	3.4 - 5.2 mmol/L	4.0
Chloride	98 - 110 mmol/L	102
Total CO <sub>2</sub>	24 - 32 mmol/L	27
Anion Gap	2 - 15 mmol/L	9
BUN	7 - 24 mg/dL	19
Creatinine, Blood	0.5 - 1.1 mg/dL	1.1
Glucose, Blood	70 - 118 mg/dL	100
Calcium	8.5 - 10.5 mg/dL	9.9
GFR African-Amer (CKD-EPI)	>=60 mL/min/BSA	94
GFR Non African-Amer (CKD-EPI)	>=60 mL/min/BSA	81

**⌚ Result Notes for Fecal Occult Blood (LHCC)**

Notes Recorded by Patricia A W Sheridan, FNP on 2/1/2017 at 3:27 PM

NI letter

Order: [REDACTED]

**⌚ Fecal Occult Blood (LHCC)**

Collected: 1/31/2017 5:53 PM

**View Full Report**

	Ref Range & Units	2yr ago
Immunofecal Occult Blood Test	Negative	Negative

**⌚ Result Notes for POCT rapid strep A**Notes Recorded by Patricia A W Sheridan, FNP on 1/31/2017 at 10:11 AM  
treated

Order: [REDACTED] 9

**❗ POCT rapid strep A**

Collected: 1/30/2017 6:54 PM

**View Full Report**

	Ref Range & Units	2yr ago
Rapid Strep A Screen	Negative, Equivocal, Immune, Non-Immune	Positive !

## ⌚ Result Notes for LDL Cholesterol, Direct

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ❗ LDL Cholesterol, Direct

Order: [REDACTED] - Reflex for Order [REDACTED]

Collected: 1/23/2017 7:50 AM

#### [View Full Report](#)

	Ref Range & Units	2yr ago
Direct LDL	<130 mg/dL	153 ^

Comment: Desirable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.

## ⌚ Result Notes for CBC With Auto Differential (LHCC)

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ❗ CBC With Auto Differential (LHCC)

Order: [REDACTED]

Collected: 1/23/2017 7:50 AM

#### [View Full Report](#)

	Ref Range & Units	2yr ago
WBC	4.3 - 10.3 th/uL	8.2
RBC	4.40 - 6.00 mill/uL	5.18
Hemoglobin	14.0 - 18.0 g/dL	15.5
Hematocrit	42.0 - 52.0 %	47.5
MCV	82.0 - 101.0 fL	91.6
MCH	27.0 - 34.0 pg	29.8
MCHC	31.5 - 36.0 g/dL	32.5
RDW	12.1 - 14.0 %	12.0 ^
PLTs	140 - 440 th/uL	252
MPV	7.8 - 11.0 fL	8.9
Neutrophils	43.0 - 72.0 %	60.9
Neutrophils (Absolute)	1.6 - 7.5	5.0
Lymphs	18.0 - 43.0 %	26.0
Lymphocytes Absolute	0.9 - 3.4	2.1
Monocytes	4.0 - 12.0 %	8.1
Monocytes Absolute	0.0 - 1.2	0.7
Eos	0.0 - 8.0 %	4.1
Eosinophils Absolute	0.0 - 0.6	0.3

<b>Basos</b>	0.0 - 2.0 %	0.9
<b>Absolute Baso Ct</b>	0.0 - 0.3	0.1

## ⌚ Result Notes for Lipid Panel

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ❗ Lipid Panel

Order: [REDACTED]

Collected: 1/23/2017 7:50 AM

#### [View Full Report](#)

	Ref Range & Units	2yr ago
<b>Cholesterol, Total</b>	0 - 200 mg/dL	249 ▲
<b>Triglycerides</b>	0 - 150 mg/dL	380 ▲
<b>Ultra HDL</b>	23 - 92 mg/dL	42
<b>LDL</b>	0 - 100 mg/dL	131 ▲
<b>VLDL</b>	mg/dL	76

#### CORONARY RISK INTERPRETATION

5.9

Comment: MALE

FEMALE

Below Average	3.43	Below Average	3.43
Average	4.97	Average	4.44
2x Average	9.55	2x Average	7.05
3x Average	23.39	3x Average	11.04

## ⌚ Result Notes for Hepatic Function Panel

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ⌚ Hepatic Function Panel

Order: [REDACTED]

Collected: 1/23/2017 7:50 AM

#### [View Full Report](#)

	Ref Range & Units	2yr ago
<b>Protein, Total, Serum</b>	6.0 - 8.3 g/dL	7.8
<b>Albumin, Serum</b>	4.2 - 5.5 g/dL	4.7
<b>Bilirubin, Total</b>	0.0 - 1.5 mg/dL	0.4
<b>Bilirubin, Direct</b>	0.0 - 0.5 mg/dL	0.1
<b>Alkaline Phosphatase</b>	34 - 104 U/L	75
<b>AST (SGOT)</b>	13 - 39 U/L	22
<b>ALT (SGPT)</b>	7 - 52 U/L	51

## ⌚ Result Notes for Basic Metabolic Panel

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ⌚ Basic Metabolic Panel

Order: [REDACTED]

Collected: 1/23/2017 7:50 AM

#### View Full Report

	Ref Range & Units	2yr ago
Sodium, Serum	133 - 143 meq/L	139
Potassium, Serum	3.5 - 5.1 meq/L	3.8
Chloride, Serum	98 - 107 meq/L	98
Carbon Dioxide, Total	24 - 34 meq/L	31
Glucose, Serum	74 - 118 mg/dL	91
BUN	7 - 25 mg/dL	19
Creatinine, Serum	0.70 - 1.30 mg/dL	1.07
Calcium, Serum	8.6 - 10.3 mg/dL	9.9
GFR		80.6

Comment: Reference Range: &gt;60

Units = mL/min/1.73 m<sup>2</sup>

Glomerular filtration rate (GFR) is estimated based on the IDMS-traceable MDRD equation (NKEDEP).

For African Americans multiply results by 1.210.

## ⌚ Result Notes for CBC With Auto Differential (LHCC)

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM  
Pas 1/30 lipids

### ⌚ CBC With Auto Differential (LHCC)

Order: [REDACTED]

Collected: 1/23/2017 7:50 AM

#### View Full Report

	Ref Range & Units	2yr ago
WBC	4.3 - 10.3 th/uL	8.2
RBC	4.40 - 6.00 mill/uL	5.18
Hemoglobin	14.0 - 18.0 g/dL	15.5
Hematocrit	42.0 - 52.0 %	47.5
MCV	82.0 - 101.0 fL	91.6
MCH	27.0 - 34.0 pg	29.8
MCHC	31.5 - 36.0 g/dL	32.5
RDW	12.1 - 14.0 %	12.0 ✓

PLTs	140 - 440 th/uL	252
MPV	7.8 - 11.0 fL	8.9
Neutrophils	43.0 - 72.0 %	60.9
Neutrophils (Absolute)	1.6 - 7.5	5.0
Lymphs	18.0 - 43.0 %	26.0
Lymphocytes Absolute	0.9 - 3.4	2.1
Monocytes	4.0 - 12.0 %	8.1
Monocytes Absolute	0.0 - 1.2	0.7
Eos	0.0 - 8.0 %	4.1
Eosinophils Absolute	0.0 - 0.6	0.3
Basos	0.0 - 2.0 %	0.9
Absolute Baso Ct	0.0 - 0.3	0.1

## ⌚ Result Notes for LDL Cholesterol, Direct

Notes Recorded by Patricia A W Sheridan, FNP on 1/25/2017 at 12:38 PM

Pas 1/30 lipids

### ❗ LDL Cholesterol, Direct

Order: [REDACTED] Reflex for Order [REDACTED]

Collected: 1/23/2017 7:50 AM

#### View Full Report

	Ref Range & Units	2yr ago
Direct LDL	<130 mg/dL	153 ^

Comment: Desirable range <100 mg/dL for patients with CHD or diabetes and <70 mg/dL for diabetic patients with known heart disease.

## ⌚ Result Notes for Basic Metabolic Panel

Notes Recorded by Patricia A W Sheridan, FNP on 11/16/2016 at 12:35 PM

NI letter

### ❗ Basic Metabolic Panel

Order: 72814364

Collected: 11/14/2016 5:11 PM

#### View Full Report

	Ref Range & Units	2yr ago
Sodium, Serum	133 - 143 meq/L	135
Potassium, Serum	3.5 - 5.1 meq/L	3.9
Chloride, Serum	98 - 107 meq/L	95 ▼

Comment: VERIFIED BY REPEAT ANALYSIS

Carbon Dioxide, Total	24 - 34 meq/L	33
Glucose, Serum	74 - 118 mg/dL	87
BUN	7 - 25 mg/dL	19
Creatinine, Serum	0.70 - 1.30 mg/dL	1.09
Calcium, Serum	8.6 - 10.3 mg/dL	9.7
GFR		78.9

Comment: Reference Range: >60

Units = mL/min/1.73 m<sup>2</sup>

Glomerular filtration rate (GFR) is estimated based on the IDMS-traceable MDRD equation (NKEDEP).

For African Americans multiply results by 1.210.

Patient: [REDACTED]

DOB: [REDACTED] Sex: M

Acct #:

Ordering Provider: Ransmeier, Peter C

Order Number [REDACTED]

Collection: Thu, Apr 02, 17:39:00 2015

Results: Fri, Apr 03, 10:26:00 2015

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Note: This report contains memos which may follow after the printed results.

TEST DESCRIPTION	OUT-OF-RANGE	IN-RANGE	UNITS	EXPECTED	ABNORMAL FLAG	STATUS
<b>15000 - OCCULT BLOOD (FIT) (add-On)</b>						
<i>Location: 4 Family Medicine Associates 100 Cummings Center Beverly, MA 01915 (978)232-1273 Patricia Devine MD</i>		Negative		Negative		F
OCCULT BLOOD (FIT):						

Patient: [REDACTED]

DOB: [REDACTED] Sex: M

Acct #:

Ordering Provider: Ransmeier, Peter C

Order Number: [REDACTED]

Collection: Thu, Apr 02, 15:40:00 2015

Results: Fri, Apr 03, 13:26:00 2015

TEST DESCRIPTION	OUT-OF-RANGE	IN-RANGE	UNITS	EXPECTED	ABNORMAL FLAG	STATUS
<b>7909 - URINALYSIS REFLEX (add-On)</b>						
COLOR:	DARK YELLOW			YELLOW	Normal	F
APPEARANCE:	CLEAR			CLEAR	Normal	F
SPECIFIC GRAVITY:	1.026			1.001-1.035	Normal	F
PH:	7.0			5.0-8.0	Normal	F
GLUCOSE:	NEGATIVE			NEGATIVE	Normal	F
BILIRUBIN:	NEGATIVE			NEGATIVE	Normal	F
KETONES:	NEGATIVE			NEGATIVE	Normal	F
OCCULT BLOOD:	NEGATIVE			NEGATIVE	Normal	F
PROTEIN:	TRACE			NEGATIVE Abnormal (Non-Numeric)		F
NITRITE:	NEGATIVE			NEGATIVE	Normal	F
LEUKOCYTE ESTERASE:	NEGATIVE			NEGATIVE	Normal	F
WBC:	NONE SEEN	/HPF		< OR = 5	Normal	F
RBC:	0-2	/HPF		< OR = 2	Normal	F
SQUAMOUS EPITHELIAL CELLS:	NONE SEEN	/HPF		< OR = 5	Normal	F
BACTERIA:	NONE SEEN	/HPF		NONE SEEN	Normal	F
HYALINE CAST:	NONE SEEN	/LPF		NONE SEEN	Normal	F

**9350 - MICROALBUMIN,URINE (add-On)**

Location: 4

Family Medicine Associates

100 Cummings Center

Beverly, MA 01915

(978)232-1273

Patricia Devine MD

MICROALBUMIN, URINE:	1.3	mg/dL	F
URINE CREATININE:	270.1	mg/dL	F
URINE MICROALBUMIN CREAT RATIO:	4.8	ug/mg creat	F
Normal	<30	ug/mg creat	
Micro Albuminuria	30-299	ug/mg creat	
Clinical Albuminuria	>300	ug/mg creat	

Performing Laboratory: Quest Diagnostics Massachusetts LLC-Quest Diagnos, Quest Diagnostics Massachusetts LLC-Quest Diagnos# NL2

Patient: [REDACTED]

DOB: [REDACTED]

Sex: M

Acct #: [REDACTED]

Ordering Provider: Ramsmeier, Peter C

Order Number: [REDACTED]

Collection: Thu, Apr 02, 09:02:00 2015

Results: Thu, Apr 02, 14:38:00 2015

Note: This report contains memos which may follow after the printed results.

TEST DESCRIPTION	OUT-OF-RANGE	IN-RANGE	UNITS	EXPECTED	ABNORMAL FLAG	STATUS
<b>FASTING</b>						

6050 - BMP w/GFR PANEL (add-On)

Location: 4

Family Medicine Associates

100 Cummings Center

Beverly, MA 01915

(978)232-1273

Patricia Devine MD

SODIUM:	140	meq/L	133-143	F
POTASSIUM:	4.3	meq/L	3.5-5.1	F
CHLORIDE:	102	meq/L	98-107	F
CO2:	30	meq/L	24-34	F

Please note new reference range effective 11/26/13

GLUCOSE:	77	mg/dL	74-118	F
BUN:	15	mg/dL	7-25	F
CREATININE:	1.10	mg/dL	0.70-1.30	F
GFR:	78.4		>60.0	F

Units = mL/min/1.73 m<sup>2</sup>

Glomerular filtration rate (GFR) is estimated based on the IDMS-traceable MDRD equation (NKEOP).

For African Americans multiply results by 1.210.

CALCIUM:	9.3	mg/dL	8.6-10.3	F
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8400 - HEMOGLOBIN A1C (add-On)

Location: 4

Family Medicine Associates

100 Cummings Center

Beverly, MA 01915

(978)232-1273

Patricia Devine MD

HEMOGLOBIN A1C:	5.5	%	4.0-6.2	Normal	P
MEAN BLOOD GLUCOSE:	111	mg/dL			F