Lumbar Radiculopathy Patient Charts

# Chart 1

Patient Name: Jennifer Smith

Age/Sex: 72-year-old female

MRN: LR0001

Visit Date: 2025-08-05

Chief Complaint: Burning in left leg

## History of Present Illness (HPI):

For the better part of 40 weeks, Jennifer Smith has been dealing with persistent left leg pain in the L3 distribution. The onset followed an incident when she bent over awkwardly, after which the pain began and has never fully resolved. Since that time, she has noticed numbness, tingling, and weakness along the same distribution, which interfere with her daily activities.

She describes the pain as constant, averaging 9 out of 10 in severity, and aggravated by walking or standing. Her walking tolerance is currently limited to about 700 feet before she needs to stop due to worsening pain.

Conservative measures have been tried, including physical therapy, Tylenol, meloxicam, tramadol, and heat application. These provided only temporary or minimal relief. She has not had any prior spinal injections.

Despite the persistence of her symptoms, she denies systemic complaints such as fever, weight loss, or night sweats. She also denies bowel or bladder dysfunction.

## Past Medical History:

Hypertension, Blood clot, Diabetes, GERD

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

The patient has a BMI of 38.5 and demonstrates an antalgic gait, with diminished sensation in the left L3 distribution, diminished patellar reflex on the left, a positive straight leg raise at 30° on the left, and intact DP pulse.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps | 5/5 | **4/5** |
| Anterior Tibialis | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed her diagnosis and management options in detail. She will be referred to pain management for an L3-4 transforaminal epidural steroid injection. Coordination with her primary care physician will be arranged to optimize her HbA1c to below 8% prior to any surgical planning. She will follow up in 3 weeks for reassessment.

# Chart 2

Patient Name: Thomas Jones

Age/Sex: 40-year-old male

MRN: LR0002

Visit Date: 2025-08-15

Chief Complaint: Pain in back shooting down right leg

## History of Present Illness (HPI):

Thomas Jones reports that his back “gave out” approximately 36 weeks ago after lifting something heavy, followed by pain radiating down the right leg. Since then, he has experienced aching, tingling, and weakness affecting the L2 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications including Tylenol, meloxicam, tramadol, and the use of heat packs. He denies any red flag symptoms.

## Past Medical History:

GERD, Hyperlipidemia, Obstructive sleep apnea

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

The patient has a BMI of 47.9 and walks with an antalgic gait. Neurologic exam reveals diminished sensation in the right L2 distribution, weakness of the right quadriceps with strength graded 4/5, diminished right patellar reflex, and a positive straight leg raise at 30° on the right. Distal perfusion is preserved with intact DP pulse.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps | **4/5** | 5/5 |
| Anterior Tibialis | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We had a thoughtful discussion about the diagnosis and management options. Thomas understands that his BMI is currently over 40, and I explained that even a modest weight reduction of 10% could significantly improve his pain, function, and candidacy for surgical options in the future. We acknowledged how challenging this process can feel, and I reassured him that we will take this step by step together. For now, he will continue with conservative measures, and we will reassess his progress at follow-up in 3 weeks.

# Chart 3

Patient Name: John Martinez

Age/Sex: 74-year-old male

MRN: LR0003

Visit Date: 2025-07-13

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

For the better part of 48 weeks, John Martinez has been dealing with left leg pain in the L4 distribution. The onset followed bending over awkwardly, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. Corticosteroid injection 13 weeks ago with about 75% relief for 8 weeks. Pain 7/10. Walk tolerance 600 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Obstructive sleep apnea, Hypertension, Diabetes

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 46.9. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps | 5/5 | 5/5 |
| Tibialis Anterior | 5/5 | **4/5** |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 4

Patient Name: William Jones

Age/Sex: 56-year-old male

MRN: LR0004

Visit Date: 2025-06-17

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

For the better part of 28 weeks, William Jones has been dealing with right leg pain in the L3 distribution. The onset followed bending over awkwardly, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. No prior spine injections. Pain 7/10. Walk tolerance 400 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Hyperlipidemia, Hypertension

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 24 yrs. Remote cocaine use (no current use).

## Exam:

BMI 27.3. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension) | **4/5** | 5/5 |
| Tibialis Anterior | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 5

Patient Name: Robert Lopez

Age/Sex: 49-year-old male

MRN: LR0005

Visit Date: 2025-08-21

Chief Complaint: Pain in left leg

## History of Present Illness (HPI):

Robert Lopez’s back gave out about 24 weeks ago after bending over awkwardly, with pain radiating down the left leg. Since then, there has been aching, tingling, and weakness affecting the L4 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications including Tylenol, meloxicam, tramadol, and heat packs. A corticosteroid injection 15 weeks ago provided about 57% relief for 3 weeks. Current pain is rated 6/10, and walking tolerance is limited to about 300 feet before stopping.

At home, his cat has a habit of jumping onto his lap precisely when his back pain flares, serving as an unlicensed “physical therapist” who charges in scratches instead of co-pays.

He denies any red flag symptoms such as systemic illness, bowel, or bladder complaints.

## Past Medical History:

Hypertension, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 43.6. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 4/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We reviewed the diagnosis of L4 radiculopathy and discussed management options in detail. With a BMI over 40, weight reduction of at least 10% is recommended prior to surgical consideration, as this would improve both outcomes and recovery. Conservative care will be continued in the meantime, including activity modification, medications, and physical therapy as tolerated. Follow-up is planned in 3 weeks to reassess symptoms and functional status.

# Chart 6

Patient Name: David Gonzalez

Age/Sex: 76-year-old male

MRN: LR0006

Visit Date: 2025-07-12

Chief Complaint: Pain in right leg

## History of Present Illness (HPI):

For the better part of 32 weeks, David Gonzalez has been dealing with right leg pain in the L5 distribution. The onset followed bending over awkwardly, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. No prior spine injections. Pain 9/10. Walk tolerance 600 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Obstructive sleep apnea, Blood clot, Hypertension

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.9 ppd × 32 yrs. Remote cocaine use (no current use).

## Exam:

BMI 40.0. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee ext.) | 5/5 | 5/5 |
| Tibialis Anterior | 5/5 | 5/5 |
| Extensor Hallucis Longus (EHL, great toe extension, L5) | 4/5 | 5/5 |
| Gluteus Medius (hip abduction) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 7

Patient Name: Patricia Jones

Age/Sex: 80-year-old female

MRN: LR0007

Visit Date: 2025-08-07

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

For the better part of 48 weeks, Patricia Jones has been dealing with left leg pain in the L3 distribution. The onset followed lifting something heavy, and since then she has reported numbness, tingling, and weakness in the affected area. Conservative measures have included physical therapy, Tylenol, meloxicam, tramadol, and the use of heat. A corticosteroid injection 13 weeks ago provided about 61% relief for 7 weeks. Her current pain is 7/10, and she is able to walk about 600 feet before stopping.

She notes that standing in the kitchen while cooking has become one of the hardest activities — especially when preparing larger meals. On more than one occasion she has had to sit down halfway through chopping vegetables, joking that dinner sometimes takes two intermissions to finish.

She denies systemic symptoms as well as bowel or bladder complaints.

## Past Medical History:

Obstructive sleep apnea, Hypertension, Diabetes

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 47.6. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 3/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 3/5 |
| Tibialis Anterior | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We talked through the diagnosis and different management options together. With her BMI above 40, even a modest weight reduction of 10% could make a meaningful difference in both her symptoms and her readiness for surgical care if that becomes necessary. Just as important, optimizing her HbA1c to below 8% with the help of her primary care provider will support healing and reduce surgical risks. I acknowledged that these changes are not easy, but emphasized that they are achievable step by step. She will continue with conservative measures in the meantime, and we will meet again in 3 weeks to check in on her progress and adjust the plan as needed.

# Chart 8

Patient Name: Susan Davis

Age/Sex: 79-year-old female

MRN: LR0008

Visit Date: 2025-07-02

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

Susan Davis reports back and leg pain for 44 weeks with weakness in the affected right leg, relief only partial with medications tried, pain worsened by activity and improved with rest. Symptoms follow the L2 distribution. Pain 6/10. Walk tolerance ~600 ft. Tried meds, PT, heat. No prior spine injections. Denies bowel/bladder symptoms, no cancer history, no prior spine surgery.

## Past Medical History:

GERD, Smoking, Hyperlipidemia

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 10 yrs. Remote cocaine use (no current use).

## Exam:

BMI 35.5. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L2–L4) | 4/5 | 5/5 |
| Tibialis Anterior | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L2-3 TFESI. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 9

Patient Name: Charles Davis

Age/Sex: 70-year-old male

MRN: LR0009

Visit Date: 2025-06-10

Chief Complaint: Pain in back shooting down leg

## History of Present Illness (HPI):

Charles Davis reports that his back gave out about 48 weeks ago after feeling a pop in the back, with pain radiating down the leg. Since then, he has experienced aching, tingling, and weakness affecting the L4 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications including Tylenol, meloxicam, tramadol, and the use of heat packs. A corticosteroid injection 13 weeks ago provided about 42% relief for 8 weeks. His current pain is 6/10, and his walking tolerance is limited to about 800 feet before needing to stop. He denies any red flag symptoms such as systemic illness, bowel, or bladder complaints.

Charles reflected that one of the hardest adjustments has been giving up his long hikes. Before his injury, he enjoyed heading out on weekend trails that stretched for miles, often climbing into the foothills with a small backpack, some water, and a sandwich. He described the sense of peace he used to get when the only sounds around him were wind through the trees and the crunch of gravel under his boots. Now, he says, even short distances leave him stopping to catch his breath, leaning on his trekking poles while his leg throbs. He admitted it feels discouraging to turn back so soon, but he hopes with time and the right treatment plan he’ll be able to reclaim at least part of that routine.

## Past Medical History:

Smoking, Blood clot, Diabetes

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 27.0. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 2/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 2/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We reviewed the diagnosis of L4 radiculopathy and discussed available management options. Given his persistent symptoms and weakness, referral to pain management is recommended for consideration of an L4–5 transforaminal epidural steroid injection (TFESI). Coordination with his primary care provider will be important to optimize HbA1c to below 8% before any surgical planning. He will continue conservative measures in the meantime. Follow-up is scheduled in 3 weeks to reassess symptoms, functional status, and response to interventions.

# Chart 10

Patient Name: Jennifer Wilson

Age/Sex: 61-year-old female

MRN: LR0010

Visit Date: 2025-07-18

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

For the better part of 48 weeks, Jennifer Wilson has been dealing with left leg pain in the L3 distribution. The onset followed bending over awkwardly, and since then she reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. No prior spine injections. Pain 7/10. Walk tolerance 400 ft. Denies systemic symptoms, bowel or bladder complaints. This is not allowing Jennifer to play with her grandchildren so this is affecting her quality of life.

## Past Medical History:

Smoking, Blood clot, Hyperlipidemia

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 33.9. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior | 5/5 | 5/5 |
| EHL / Gluteus Medius | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Follow-up in 3 weeks.

# Chart 11

Patient Name: Maria Gonzalez

Age/Sex: 43-year-old female

MRN: LR0011

Visit Date: 2025-08-10

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

Maria Gonzalez reports that her back gave out about 40 weeks ago after bending over awkwardly, with pain radiating down the right leg. Since then, she has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications such as Tylenol, meloxicam, tramadol, and the use of heat packs. A corticosteroid injection 11 weeks ago provided about 70% relief for 4 weeks. Her current pain is rated 9/10, and her walking tolerance is limited to about 600 feet before stopping. She denies any red flag symptoms such as systemic illness, bowel, or bladder complaints.

Maria shared how the pain has changed her daily rhythm — she used to enjoy walking with her sister every evening after dinner, something that gave her both exercise and connection. Now, she often has to cut the walks short or skip them entirely, leaving her feeling left behind and frustrated. She described the emotional toll of watching others go about normal routines while she is constantly reminded of her limitations, and how she worries about losing the independence that mattered so much to her.

## Past Medical History:

Hypertension, GERD, Blood clot

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 37.3. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| EHL / Gluteus Medius (L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Injection <12 weeks; defer surgery consideration until interval has passed. Follow-up in 3 weeks.

# Chart 12

Patient Name: William Martinez

Age/Sex: 36-year-old male

MRN: LR0012

Visit Date: 2025-08-21

Chief Complaint: Pain in left leg

## History of Present Illness (HPI):

For the better part of 40 weeks, William Martinez has been dealing with left leg pain in the L5 distribution. The onset followed feeling a pop in the back, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. Corticosteroid injection 24 weeks ago with about 61% relief for 7 weeks. Pain 8/10. Walk tolerance 600 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Hypertension, GERD, Obstructive sleep apnea, Hyperlipidemia

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.9 ppd × 24 yrs. Remote cocaine use (no current use).

## Exam:

BMI 33.7. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 4/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We discussed her diagnosis and the management options available. Given the severity of her symptoms, referral to pain management is recommended for consideration of an L5–S1 transforaminal epidural steroid injection (TFESI) to provide relief. We also talked about the importance of nicotine cessation — not only for surgical candidacy, where cotinine testing will be required, but also for overall healing and long-term health. I acknowledged how difficult this change can be, but emphasized that it will directly improve her recovery and quality of life. She was reassured that she will not be navigating these steps alone, and that together we will move forward at a steady pace. A follow-up is scheduled in 3 weeks to reassess her progress and support her next steps.

# Chart 13

Patient Name: David Gonzalez

Age/Sex: 63-year-old male

MRN: LR0013

Visit Date: 2025-08-26

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

This is a 63-year-old male who has been struggling with his left leg for the past 48 weeks. The pain began after feeling a pop in the back, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L3 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 14 weeks ago with about 78% relief for 6 weeks. Pain currently 7/10, walking tolerance ~800 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Smoking, Blood clot, GERD

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 32 yrs. Occasional marijuana use.

## Exam:

BMI 26.4. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 3/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 3/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 14

Patient Name: Christopher Thomas

Age/Sex: 60-year-old male

MRN: LR0014

Visit Date: 2025-07-23

Chief Complaint: Pain in right leg

## History of Present Illness (HPI):

For the better part of 28 weeks, Christopher Thomas has been dealing with right leg pain in the L3 distribution. The onset followed feeling a pop in the back, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. Corticosteroid injection 10 weeks ago with about 40% relief for 5 weeks. Pain 7/10. Walk tolerance 400 ft. Denies systemic symptoms, bowel or bladder complaints.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 4/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Past Medical History:

Blood clot, Diabetes, Hyperlipidemia, GERD

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 15 yrs. No illicit drug use.

## Exam:

BMI 39.3. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Injection <12 weeks; defer surgery consideration until interval has passed. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 15

Patient Name: Charles Johnson

Age/Sex: 53-year-old male

MRN: LR0015

Visit Date: 2025-08-11

Chief Complaint: Burning in left leg

## History of Present Illness (HPI):

Charles Johnson reports that his back gave out about 36 weeks ago after lifting something heavy, with pain radiating down the left leg. Since then, he has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications such as Tylenol, meloxicam, tramadol, and the use of heat packs. A corticosteroid injection 9 weeks ago provided about 72% relief for 4 weeks. His current pain is 7/10, and his walking tolerance is limited to about 400 feet before stopping. He denies any red flag symptoms such as systemic illness, bowel, or bladder complaints.

Charles shared that one of the most frustrating parts of his pain is how it has taken away his ability to enjoy his morning walks with his dog. Before his injury, he made it a routine to circle the block twice before breakfast, enjoying the fresh air while his dog trotted happily beside him. Now, he often has to cut the walk short, turning back halfway while his dog looks at him with puzzled eyes, still full of energy. He admitted that it makes him feel like he’s letting his companion down, and he misses the sense of normalcy those walks gave him at the start of the day.

## Past Medical History:

Smoking, Diabetes, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 33 yrs. No illicit drug use.

## Exam:

BMI 26.9. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 4/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Injection <12 weeks; defer surgery consideration until interval has passed. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 16

Patient Name: William Martin

Age/Sex: 52-year-old male

MRN: LR0016

Visit Date: 2025-08-03

Chief Complaint: Shooting pain down right leg

## History of Present Illness (HPI):

William Martin tells me the back gave out about 40 weeks ago after feeling a pop in the back, with pain radiating down the right leg. Since then he has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. No prior spine injections. Current pain 9/10, can walk only about 300 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Obstructive sleep apnea, Blood clot, Diabetes

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.4 ppd × 27 yrs. Remote cocaine use (no current use).

## Exam:

BMI 28.9. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for S1-S2 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 17

Patient Name: Charles Anderson

Age/Sex: 75-year-old male

MRN: LR0017

Visit Date: 2025-07-22

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

Charles Anderson reports back and left leg pain for the past 32 weeks, accompanied by stiffness after periods of inactivity. He has difficulty with walking, climbing stairs, or standing for prolonged periods. The pain follows the L5 distribution, worsens with activity, and improves with rest. His current pain is 9/10, and his walking tolerance is limited to about 400 feet. Conservative measures have included medications, physical therapy, and the use of heat, but relief has been limited. He has not undergone prior spine injections. He denies bowel or bladder symptoms, has no cancer history, and no prior spine surgery.

Charles described how the pain has intruded on one of his favorite routines — helping his grandchildren with weekend soccer practice. He used to enjoy jogging beside them on the sidelines and demonstrating a few kicks, but now even standing through a full practice is a challenge. He said it’s difficult watching from the bench while others take his place, and it leaves him feeling like he’s missing out on both the activity and the connection. He expressed hope that with the right treatment he can get back to being more present in those moments.

## Past Medical History:

Blood clot, Hyperlipidemia, Smoking, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 36.7. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 4/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L5-S1 TFESI. Follow-up in 3 weeks.

# Chart 18

Patient Name: Mary Thomas

Age/Sex: 80-year-old female

MRN: LR0018

Visit Date: 2025-08-18

Chief Complaint: Numbness in leg

## History of Present Illness (HPI):

Mary Thomas tells me the back gave out about 40 weeks ago after feeling a pop in the back, with pain radiating down the leg. Since then she has had aching, tingling, and weakness affecting the L5 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 12 weeks ago with about 71% relief for 3 weeks. Current pain 7/10, can walk only about 600 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Hypertension, Blood clot, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 24.1. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We reviewed the diagnosis of L5 radiculopathy and discussed available management options. Given his persistent pain and functional limitations, referral to pain management is recommended for consideration of an L5–S1 transforaminal epidural steroid injection (TFESI). He will continue conservative measures in the meantime, including activity modification, medications, and physical therapy as tolerated. Follow-up is planned in 3 weeks to reassess symptoms, walking tolerance, and treatment response.

# Chart 19

Patient Name: Jennifer Williams

Age/Sex: 55-year-old female

MRN: LR0019

Visit Date: 2025-08-21

Chief Complaint: Tingling in right leg

## History of Present Illness (HPI):

This is a 55-year-old female who has been struggling with her right leg for the past 48 weeks. The pain began after bending over awkwardly, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the L4 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 15 weeks ago with about 53% relief for 8 weeks. Pain currently 8/10, walking tolerance ~500 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Hypertension, Smoking, GERD

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 32 yrs. No illicit drug use.

## Exam:

BMI 48.3. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 4/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 20

Patient Name: David Brown

Age/Sex: 65-year-old male

MRN: LR0020

Visit Date: 2025-08-03

Chief Complaint: Numbness in left leg

## History of Present Illness (HPI):

This is a 65-year-old male who has been struggling with his left leg for the past 36 weeks. The pain began after feeling a pop in the back, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L5 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. No prior spine injections. Pain currently 8/10, walking tolerance ~600 ft. He denies bowel or bladder incontinence or saddle anesthesia.

He shared that one of the hardest changes has been giving up his daily walks with his neighbor. What used to be an easy mile together has turned into a struggle to reach even the end of the street. He says it makes him feel older than his age and leaves him frustrated that pain, rather than energy, is setting his limits. He expressed hope that treatment will allow him to get back to those walks and reclaim part of his normal routine.

## Past Medical History:

GERD, Smoking

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 30 yrs. Remote cocaine use (no current use).

## Exam:

BMI 24.4. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 4/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We reviewed his diagnosis and management options thoroughly. Given the persistent pain and weakness, referral to pain management is recommended for consideration of an L5–S1 transforaminal epidural steroid injection (TFESI). We also discussed the importance of nicotine cessation, both for surgical candidacy and for overall healing, with cotinine testing required before moving forward with surgical planning. He was reassured that these changes, though challenging, are achievable and will help him reach his goal of resuming daily walks. Follow-up is planned in 3 weeks to reassess symptoms, function, and progress toward nicotine cessation.

# Chart 21

Patient Name: Dorothy Jackson

Age/Sex: 52-year-old female

MRN: LR0021

Visit Date: 2025-07-26

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

Dorothy Jackson tells me the back gave out about 28 weeks ago after feeling a pop in the back, with pain radiating down the left leg. Since then she has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 23 weeks ago with about 58% relief for 3 weeks. Current pain 8/10, can walk only about 400 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Obstructive sleep apnea, Smoking, Diabetes, Hyperlipidemia

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 24.8. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 3/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 3/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for S1-S2 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 22

Patient Name: Linda Taylor

Age/Sex: 74-year-old female

MRN: LR0022

Visit Date: 2025-06-10

Chief Complaint: Pain in left leg

## History of Present Illness (HPI):

This is a 74-year-old female who has been struggling with her left leg for the past 36 weeks. The pain began after lifting something heavy, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the L3 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 14 weeks ago with about 73% relief for 7 weeks. Pain currently 8/10, walking tolerance ~800 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Smoking, GERD, Blood clot, Diabetes

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 20 yrs. No illicit drug use.

## Exam:

BMI 39.5. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 23

Patient Name: Michael Hernandez

Age/Sex: 41-year-old male

MRN: LR0023

Visit Date: 2025-07-12

Chief Complaint: Pain in right leg

## History of Present Illness (HPI):

This is a 41-year-old male who has been struggling with his right leg for the past 24 weeks. The pain began after feeling a pop in the back, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L5 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. No prior spine injections. Pain currently 6/10, walking tolerance ~800 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Blood clot, Hypertension

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 32.5. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 4/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L5-S1 TFESI. Follow-up in 3 weeks.

# Chart 24

Patient Name: William Taylor

Age/Sex: 49-year-old male

MRN: LR0024

Visit Date: 2025-08-12

Chief Complaint: Numbness in left leg

## History of Present Illness (HPI):

his is a 49-year-old male who has been struggling with his left leg for the past 32 weeks. The pain began after bending over awkwardly, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L2 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. No prior spine injections. Pain currently 8/10, walking tolerance ~600 ft. He denies bowel/bladder incontinence or saddle anesthesia.

He explained that one of the hardest adjustments has been in his work life. As a mechanic, he was always on his feet, crouching and leaning over cars. Now, even simple tasks like standing at the workbench or walking across the garage floor are cut short by pain and weakness. He shared that it frustrates him to rely on his coworkers for help, when he used to be the one others turned to. More than the physical pain, he worries about losing a sense of independence and identity tied to his job.

## Past Medical History:

Diabetes, Obstructive sleep apnea, GERD, Smoking

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.9 ppd × 22 yrs. Remote cocaine use (no current use).

## Exam:

BMI 42.1. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We reviewed his diagnosis of L2 radiculopathy and discussed management options in detail. With a BMI over 40, weight reduction of at least 10% is recommended prior to surgical planning, as this will improve both surgical outcomes and recovery. Coordination with his primary care provider will be important to optimize his HbA1c to below 8%. He was counseled on nicotine cessation, and we explained that cotinine testing will be required before surgical planning.

I acknowledged how difficult these changes may feel on top of his daily pain, especially given how much his condition has already affected his work and independence. We emphasized that each step — weight loss, glucose control, and nicotine cessation — is not only a prerequisite for surgery but also a path to improving his long-term health and function. He was reassured that he will not face these steps alone, and that our team will support him through the process.

Follow-up is scheduled in 3 weeks to reassess symptoms, progress, and next steps.

# Chart 25

Patient Name: Maria Martinez

Age/Sex: 54-year-old female

MRN: LR0025

Visit Date: 2025-08-17

Chief Complaint: Numbness in left leg

## History of Present Illness (HPI):

Maria Martinez reports back and left leg pain for 48 weeks with difficulty with walking, stairs, or prolonged standing, numbness or tingling sensation in the distribution, pain worsened by activity and improved with rest. Symptoms follow the L4 distribution. Pain 6/10. Walk tolerance ~300 ft. Tried meds, PT, heat. No prior spine injections. Denies bowel/bladder symptoms, no cancer history, no prior spine surgery.

## Past Medical History:

Hypertension, Smoking

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 26.0. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 4/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L4-5 TFESI. Follow-up in 3 weeks.

# Chart 26

Patient Name: Barbara Taylor

Age/Sex: 36-year-old female

MRN: LR0026

Visit Date: 2025-07-26

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

This is a 36-year-old female who has been struggling with her right leg for the past 24 weeks. The pain began after lifting something heavy, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the L3 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 24 weeks ago with about 51% relief for 3 weeks. Pain currently 9/10, walking tolerance ~800 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Hypertension, Hyperlipidemia, GERD

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 45.5. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 4/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Follow-up in 3 weeks.

# Chart 27

Patient Name: Joseph Anderson

Age/Sex: 42-year-old male

MRN: LR0027

Visit Date: 2025-07-25

Chief Complaint: Shooting pain down right leg

## History of Present Illness (HPI):

This is a 42-year-old male who has been struggling with his right leg for the past 32 weeks. The pain began after bending over awkwardly, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the S1 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 19 weeks ago with about 66% relief for 7 weeks. Pain currently 7/10, walking tolerance ~400 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Hyperlipidemia, Diabetes

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 25.0. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for S1-S2 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 28

Patient Name: Christopher Jones

Age/Sex: 35-year-old male

MRN: LR0028

Visit Date: 2025-06-11

Chief Complaint: Tingling in right leg

## History of Present Illness (HPI):

For the better part of 24 weeks, Christopher Jones has been dealing with right leg pain in the L4 distribution. The onset followed bending over awkwardly, and since then he reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. Corticosteroid injection 17 weeks ago with about 40% relief for 7 weeks. Pain 6/10. Walk tolerance 700 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Hyperlipidemia, Smoking, Diabetes

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 37.4. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 3/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 3/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L4-5 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 29

Patient Name: Linda Taylor

Age/Sex: 43-year-old female

MRN: LR0029

Visit Date: 2025-07-19

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

This is a 43-year-old female who has been struggling with her left leg for the past 24 weeks. The pain began after bending over awkwardly, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the S1 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. No prior spine injections. Pain currently 6/10, walking tolerance ~800 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Hypertension, Smoking, Obstructive sleep apnea, Blood clot

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.8 ppd × 24 yrs. Occasional marijuana use.

## Exam:

BMI 26.6. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 2/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 2/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for S1-S2 TFESI. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 30

Patient Name: Christopher Hernandez

Age/Sex: 45-year-old male

MRN: LR0030

Visit Date: 2025-08-11

Chief Complaint: Tingling in right leg

## History of Present Illness (HPI):

Christopher Hernandez reports back and right leg pain for 32 weeks with difficulty with walking, stairs, or prolonged standing, relief only partial with medications tried, pain worsened by activity and improved with rest. Symptoms follow the L3 distribution. Pain 8/10. Walk tolerance ~500 ft. Tried meds, PT, heat. No prior spine injections. Denies bowel/bladder symptoms, no cancer history, no prior spine surgery.

## Past Medical History:

Hypertension, Diabetes, Obstructive sleep apnea, Smoking

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 27.3. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 4/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 31

Patient Name: Linda Jackson

Age/Sex: 71-year-old female

MRN: LR0031

Visit Date: 2025-07-05

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

For the better part of 28 weeks, Linda Jackson has been dealing with left leg pain in the L5 distribution. The onset followed lifting something heavy, and since then she has reported numbness, tingling, and weakness in the affected area. Conservative measures have included PT, Tylenol, meloxicam, tramadol, and heat. A corticosteroid injection 24 weeks ago provided about 57% relief for 4 weeks. Pain is currently 8/10, and she can walk only about 500 feet before needing to stop. She denies systemic symptoms, bowel or bladder complaints.

Linda shared that one of the most difficult changes has been how her pain has limited her time with her grandchildren. She used to enjoy taking them to the park and walking alongside them as they played, but now she finds herself sitting on the bench, watching from a distance. She expressed that while she is grateful to still be present, it is hard not to feel left out of those moments. Her hope is that with treatment, she will be able to rejoin those activities instead of watching from the sidelines.

## Past Medical History:

Hypertension, Smoking, Obstructive sleep apnea, Blood clot

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 31 yrs. No illicit drug use.

## Exam:

BMI 32.3. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We reviewed her diagnosis and management options in detail. Given her persistent symptoms and functional limitations, referral to pain management is recommended for consideration of an L5–S1 transforaminal epidural steroid injection (TFESI). We also discussed the importance of nicotine cessation, not only because cotinine testing will be required before surgical planning, but also because quitting will directly improve her healing and long-term he

# Chart 32

Patient Name: Mary Martinez

Age/Sex: 67-year-old female

MRN: LR0032

Visit Date: 2025-08-04

Chief Complaint: Shooting pain down right leg

## History of Present Illness (HPI):

For the better part of 36 weeks, Mary Martinez has been dealing with right leg pain in the L4 distribution. The onset followed lifting something heavy, and since then she has reported numbness, tingling, and weakness in the affected area. Conservative measures have included PT, Tylenol, meloxicam, tramadol, and heat. She has not had prior spine injections. Pain is currently 9/10, and her walking tolerance is limited to about 500 feet. She denies systemic symptoms, bowel, or bladder complaints.

Mary shared that one of the hardest adjustments has been giving up her gardening. She once spent hours tending to her flowers and vegetables, finding peace in the routine of watering, pruning, and harvesting. Now, even short periods of bending or standing outside leave her with intense pain, forcing her to leave tasks unfinished. She admitted it is frustrating to watch her garden overgrow when caring for it used to bring her so much joy, and she worries about losing a hobby that connected her to both nature and family.

## Past Medical History:

Smoking, Blood clot

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 24.6. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 3/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 3/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L4-5 TFESI. Follow-up in 3 weeks.

# Chart 33

Patient Name: Linda Smith

Age/Sex: 75-year-old female

MRN: LR0033

Visit Date: 2025-08-06

Chief Complaint: Burning in left leg

## History of Present Illness (HPI):

This is a 75-year-old female who has been struggling with her left leg for the past 32 weeks. The pain began after feeling a pop in the back, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the L2 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. A corticosteroid injection 17 weeks ago provided about 55% relief for 4 weeks. Pain is currently 8/10, and her walking tolerance is limited to about 600 feet. She denies bowel or bladder incontinence or saddle anesthesia.

She shared that one of the most difficult changes has been her inability to continue her weekly outings with friends. Before her back problems, she loved meeting them at the mall to walk, shop, and enjoy lunch together. Now, she often has to stop halfway through the walk from the parking lot to the entrance, leaving her exhausted before she even makes it inside. She admitted it makes her feel like she is losing not only her mobility but also the social connections that have always been so important to her.

## Past Medical History:

GERD, Hypertension, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 45.7. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Follow-up in 3 weeks.

# Chart 34

Patient Name: David Moore

Age/Sex: 57-year-old male

MRN: LR0034

Visit Date: 2025-08-20

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

David Moore tells me the back gave out about 24 weeks ago after bending over awkwardly, with pain radiating down the left leg. Since then he has had aching, tingling, and weakness affecting the L3 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 14 weeks ago with about 40% relief for 3 weeks. Current pain 9/10, can walk only about 400 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Blood clot, Hyperlipidemia, Obstructive sleep apnea, Smoking

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 32.3. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Follow-up in 3 weeks.

# Chart 35

Patient Name: Maria Thomas

Age/Sex: 74-year-old female

MRN: LR0035

Visit Date: 2025-06-21

Chief Complaint: Shooting pain down left leg

## History of Present Illness (HPI):

Maria Thomas tells me the back gave out about 24 weeks ago after feeling a pop in the back, with pain radiating down the left leg. Since then she has had aching, tingling, and weakness affecting the L4 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 21 weeks ago with about 74% relief for 6 weeks. Current pain 6/10, can walk only about 700 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Smoking, Blood clot

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 42.0. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 4/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed the diagnosis and reviewed management options in detail. With a BMI greater than 40, weight reduction of at least 10% is recommended prior to surgical planning in order to improve both safety and long-term outcomes. The patient was reassured that even modest progress can have a meaningful impact on pain, mobility, and overall health. Follow-up is scheduled in 3 weeks to reassess symptoms and progress toward these goals.

# Chart 36

Patient Name: John Jackson

Age/Sex: 56-year-old male

MRN: LR0036

Visit Date: 2025-06-01

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

For the better part of 24 weeks, John Jackson has been dealing with right leg pain in the S1 distribution. The onset followed feeling a pop in the back, and since then he has reported numbness, tingling, and weakness in the affected area. Conservative measures have included PT, Tylenol, meloxicam, tramadol, and heat. A corticosteroid injection 8 weeks ago provided about 58% relief for 5 weeks. Pain is currently 8/10, and his walking tolerance is limited to about 300 feet. He denies systemic symptoms, bowel, or bladder complaints.

John explained that one of the most discouraging changes has been giving up his Saturday morning trips to the local farmers market. He used to enjoy walking through the stalls, picking fresh produce, and chatting with vendors he’s known for years. Now, the walk from the parking lot alone often leaves him needing to sit and rest before he even gets inside. He shared that missing out on those outings has left him feeling disconnected from a routine that once gave him both joy and community.

## Past Medical History:

Hypertension, GERD, Blood clot

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 38.2. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. Injection <12 weeks; defer surgery consideration until interval has passed. Follow-up in 3 weeks.

# Chart 37

Patient Name: Margaret Lopez

Age/Sex: 67-year-old female

MRN: LR0037

Visit Date: 2025-07-14

Chief Complaint: Pain in back shooting down right leg

## History of Present Illness (HPI):

Margaret Lopez tells me the back gave out about 44 weeks ago after lifting something heavy, with pain radiating down the right leg. Since then she has had aching, tingling, and weakness affecting the L4 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 8 weeks ago with about 57% relief for 7 weeks. Current pain 6/10, can walk only about 800 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Hyperlipidemia, Hypertension

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 39.7. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 4/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed the diagnosis and management options. As the most recent injection was performed less than 12 weeks ago, surgical consideration will be deferred until that interval has passed to ensure safety and maximize potential benefit. In the meantime, the patient was reassured that their symptoms will continue to be monitored closely. Follow-up is scheduled in 3 weeks to reassess pain, function, and progress.

# Chart 38

Patient Name: Elizabeth Rodriguez

Age/Sex: 71-year-old female

MRN: LR0038

Visit Date: 2025-06-15

Chief Complaint: Pain in left leg

## History of Present Illness (HPI):

Elizabeth Rodriguez reports that her back gave out about 28 weeks ago after bending over awkwardly, with pain radiating down the left leg. Since then, she has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included six weeks of physical therapy, as well as medications such as Tylenol, meloxicam, tramadol, and the use of heat packs. She has not had prior spine injections. Pain is currently 8/10, and her walking tolerance is limited to about 500 feet. She denies red flag symptoms such as systemic illness, bowel, or bladder complaints.

Elizabeth shared that one of the most difficult changes has been her inability to continue her evening walks with her husband. She used to look forward to them as a way to unwind and talk about their day, but now she often has to stop midway, leaning on a fence or sitting on a nearby bench until the pain eases. She admitted it leaves her feeling like a burden and has taken away a simple but meaningful part of their routine together.

## Past Medical History:

Smoking, GERD, Hypertension

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 47.8. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 4/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Follow-up in 3 weeks.

# Chart 39

Patient Name: Elizabeth Anderson

Age/Sex: 47-year-old female

MRN: LR0039

Visit Date: 2025-07-13

Chief Complaint: Burning in right leg

## History of Present Illness (HPI):

Elizabeth Anderson reports back and right leg pain for 44 weeks with relief only partial with medications tried, pain worsened by activity and improved with rest, difficulty with walking, stairs, or prolonged standing. Symptoms follow the S1 distribution. Pain 7/10. Walk tolerance ~600 ft. Tried meds, PT, heat. No prior spine injections. Denies bowel/bladder symptoms, no cancer history, no prior spine surgery.

## Past Medical History:

Diabetes, Obstructive sleep apnea, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 47.1. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We reviewed the diagnosis and management options together. With a BMI over 40, weight reduction of at least 10% is recommended prior to surgical planning in order to improve both safety and outcomes. Coordination with the primary care provider will also be important to optimize HbA1c to below 8% before moving forward.

I acknowledged how challenging these steps can feel on top of dealing with chronic pain, but emphasized that each goal is achievable and will make a real difference in recovery and long-term health. Follow-up is scheduled in 3 weeks to reassess progress and discuss next steps.

# Chart 40

Patient Name: Michael Martin

Age/Sex: 49-year-old male

MRN: LR0040

Visit Date: 2025-07-15

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

This is a 49-year-old male who has been struggling with his right leg for the past 44 weeks. The pain began after feeling a pop in the back, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L3 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. He has not had prior spine injections. Pain is currently 8/10, and his walking tolerance is limited to about 300 feet. He denies bowel or bladder incontinence or saddle anesthesia.

He explained that the hardest part has been at work. He owns a small landscaping business and used to spend his days moving easily from one property to the next, hauling equipment, climbing steps, and walking long stretches of lawn. Now, even carrying tools to the truck or standing for more than a few minutes brings on sharp pain in his leg. He admitted it has been humbling to depend on his crew for tasks he once handled himself, and he worries about the future of his business if he cannot stay physically involved.

## Past Medical History:

Diabetes, GERD, Obstructive sleep apnea, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 22.3. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 4/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L3-4 TFESI. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 41

Patient Name: David Johnson

Age/Sex: 47-year-old male

MRN: LR0041

Visit Date: 2025-07-08

Chief Complaint: Shooting pain down left leg

## History of Present Illness (HPI):

David Johnson tells me the back gave out about 32 weeks ago after lifting something heavy, with pain radiating down the left leg. Since then he has had aching, tingling, and weakness affecting the L5 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. No prior spine injections. Current pain 9/10, can walk only about 500 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Smoking, Hypertension, Obstructive sleep apnea

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 39.0. Antalgic gait. Diminished sensation in L5 distribution. Weakness of extensor hallucis longus, strength 4/5. Reflexes normal. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 4/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L4-5 with disc height loss and facet arthropathy. Findings match L5 radiculopathy.

## Assessment:

Lumbar radiculopathy in L5 distribution from L4-5 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L5-S1 TFESI. Follow-up in 3 weeks.

# Chart 42

Patient Name: Patricia Jackson

Age/Sex: 42-year-old female

MRN: LR0042

Visit Date: 2025-06-12

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

For the better part of 40 weeks, Patricia Jackson has been dealing with left leg pain in the L3 distribution. The onset followed lifting something heavy, and since then she reports numbness, tingling, and weakness in the affected area. Conservative measures included PT, Tylenol, meloxicam, tramadol, and heat. Corticosteroid injection 9 weeks ago with about 47% relief for 3 weeks. Pain 9/10. Walk tolerance 700 ft. Denies systemic symptoms, bowel or bladder complaints.

## Past Medical History:

Hyperlipidemia, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 41.7. Antalgic gait. Diminished sensation in L3 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L2-3 with disc height loss and facet arthropathy. Findings match L3 radiculopathy.

## Assessment:

Lumbar radiculopathy in L3 distribution from L2-3 disc herniation.

## Plan:

We reviewed the diagnosis and management options in detail. As the most recent injection was performed less than 12 weeks ago, surgical consideration will be deferred until that interval has passed. The patient was reassured that this timeline is designed to ensure both safety and the best possible outcome. Follow-up is scheduled in 3 weeks to reassess symptoms and functional status.

# Chart 43

Patient Name: John Jones

Age/Sex: 60-year-old male

MRN: LR0043

Visit Date: 2025-08-18

Chief Complaint: Numbness in right leg

## History of Present Illness (HPI):

This is a 60-year-old male who has been struggling with his right leg for the past 40 weeks. The pain began after lifting something heavy, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L4 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. He has not had prior spine injections. Pain is currently 7/10, and his walking tolerance is limited to about 700 feet. He denies bowel or bladder incontinence or saddle anesthesia.

He shared that one of the biggest challenges has been giving up his weekend fishing trips. Before his back trouble, he would spend hours by the lake, carrying his gear down the path and standing along the water’s edge. Now, the walk from the car alone leaves him exhausted and in pain, forcing him to cut outings short or skip them altogether. He admitted it has been discouraging to lose not just the activity but also the sense of peace and camaraderie he found there.

## Past Medical History:

Diabetes, Hypertension

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 35 yrs. Remote cocaine use (no current use).

## Exam:

BMI 49.1. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 2/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 2/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 44

Patient Name: Susan Jackson

Age/Sex: 61-year-old female

MRN: LR0044

Visit Date: 2025-07-21

Chief Complaint: Pain in back shooting down left leg

## History of Present Illness (HPI):

Susan Jackson tells me the back gave out about 40 weeks ago after lifting something heavy, with pain radiating down the left leg. Since then she has had aching, tingling, and weakness affecting the L2 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. Corticosteroid injection 13 weeks ago with about 71% relief for 7 weeks. Current pain 8/10, can walk only about 700 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Blood clot, Hyperlipidemia, Smoking

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 46.8. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Follow-up in 3 weeks.

# Chart 45

Patient Name: Joseph Martinez

Age/Sex: 55-year-old male

MRN: LR0045

Visit Date: 2025-08-22

Chief Complaint: Shooting pain down left leg

## History of Present Illness (HPI):

This is a 55-year-old male who has been struggling with his left leg for the past 44 weeks. The pain began after lifting something heavy, and he recalls a sudden onset of symptoms. Now he describes the pain as aching and sometimes shooting, radiating down into the L2 distribution. He has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. Corticosteroid injection 8 weeks ago with about 78% relief for 6 weeks. Pain currently 6/10, walking tolerance ~300 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Blood clot, Hyperlipidemia, Smoking

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 16 yrs. Occasional marijuana use.

## Exam:

BMI 45.2. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We reviewed the diagnosis and management options together. Because the most recent injection was performed less than 12 weeks ago, surgical consideration will be deferred until that interval has passed. In the meantime, the patient was counseled on the importance of nicotine cessation, with the understanding that cotinine testing will be required before any surgical planning. The patient was reassured that these steps are intended to optimize safety and outcomes. Follow-up is scheduled in 3 weeks to reassess symptoms, function, and readiness for next steps.

# Chart 46

Patient Name: Dorothy Johnson

Age/Sex: 73-year-old female

MRN: LR0046

Visit Date: 2025-08-26

Chief Complaint: Pain in left leg

## History of Present Illness (HPI):

For the better part of 36 weeks, Dorothy Johnson has been dealing with left leg pain in the S1 distribution. The onset followed lifting something heavy, and since then she has reported numbness, tingling, and weakness in the affected area. Conservative measures have included PT, Tylenol, meloxicam, tramadol, and heat. She has not had prior spine injections. Pain is currently 8/10, and her walking tolerance is limited to about 500 feet. She denies systemic symptoms, bowel, or bladder complaints.

Dorothy shared that one of the most difficult changes has been giving up her morning walks with a close friend. They used to walk a mile together before breakfast, catching up on life and enjoying the fresh air. Now, she finds herself turning back long before the halfway point, often leaving her friend to continue alone. She admitted it makes her feel left behind and more isolated, and she misses the sense of connection and accomplishment those walks once gave her.

## Past Medical History:

Blood clot, Smoking, Diabetes, Obstructive sleep apnea

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 49.4. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 4/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Coordinate with PCP for HbA1c optimization (<8%) prior to surgical planning. Follow-up in 3 weeks.

# Chart 47

Patient Name: Joseph Miller

Age/Sex: 35-year-old male

MRN: LR0047

Visit Date: 2025-08-12

Chief Complaint: Burning in right leg

## History of Present Illness (HPI):

Joseph Miller tells me the back gave out about 48 weeks ago after lifting something heavy, with pain radiating down the right leg. Since then he has had aching, tingling, and weakness affecting the S1 dermatome. Conservative measures have included PT for six weeks, medications including Tylenol, meloxicam, tramadol, and heat packs. No prior spine injections. Current pain 8/10, can walk only about 500 ft before stopping. No red flag symptoms reported.

## Past Medical History:

Hyperlipidemia, Obstructive sleep apnea, GERD

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 19 yrs. Remote cocaine use (no current use).

## Exam:

BMI 26.6. Antalgic gait. Diminished sensation in S1 distribution. Weakness of gastrocnemius, strength 4/5. Diminished Achilles reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 4/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L5-S1 with disc height loss and facet arthropathy. Findings match S1 radiculopathy.

## Assessment:

Lumbar radiculopathy in S1 distribution from L5-S1 disc herniation.

## Plan:

We reviewed the diagnosis and discussed management options in detail. Referral to pain management is recommended for consideration of an S1–S2 transforaminal epidural steroid injection (TFESI) to help relieve symptoms and improve function. The importance of nicotine cessation was emphasized, both for overall health and because cotinine testing will be required prior to any surgical planning.

I acknowledged how challenging it can feel to face these lifestyle changes while also dealing with daily pain, and reassured the patient that each step in this process is meant to reduce symptoms, improve mobility, and support a safe recovery if surgery becomes necessary. Follow-up is scheduled in 3 weeks to reassess progress and next steps.

# Chart 48

Patient Name: Maria Davis

Age/Sex: 35-year-old female

MRN: LR0048

Visit Date: 2025-08-22

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

For the better part of 44 weeks, Maria Davis has been dealing with left leg pain in the L2 distribution. The onset followed lifting something heavy, and since then she has reported numbness, tingling, and weakness in the affected area. Conservative measures have included PT, Tylenol, meloxicam, tramadol, and heat. A corticosteroid injection 21 weeks ago provided about 50% relief for 7 weeks. Pain is currently 8/10, and her walking tolerance is limited to about 300 feet. She denies systemic symptoms, bowel, or bladder complaints.

Maria shared that one of the most discouraging changes has been how her pain has disrupted her cooking routine. She used to spend hours in the kitchen preparing family meals — something she enjoyed both for the creativity and for the chance to bring everyone together. Now, she often has to stop halfway through chopping vegetables or stirring a pot to sit down, leaving meals unfinished until someone else steps in. She admitted that it makes her feel like she’s lost a piece of herself, and she misses the joy of serving her family the way she once did.

## Past Medical History:

Smoking, Hypertension

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 29 yrs. No illicit drug use.

## Exam:

BMI 39.6. Antalgic gait. Diminished sensation in L2 distribution. Weakness of quadriceps, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 4/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 5/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L1-2 with disc height loss and facet arthropathy. Findings match L2 radiculopathy.

## Assessment:

Lumbar radiculopathy in L2 distribution from L1-2 disc herniation.

## Plan:

We discussed diagnosis and management options. Refer to pain management for L2-3 TFESI. Patient counseled on nicotine cessation; cotinine testing required before surgical planning. Follow-up in 3 weeks.

# Chart 49

Patient Name: Margaret Williams

Age/Sex: 62-year-old female

MRN: LR0049

Visit Date: 2025-07-18

Chief Complaint: Tingling in left leg

## History of Present Illness (HPI):

This is a 62-year-old female who has been struggling with her left leg for the past 44 weeks. The pain began after lifting something heavy, and she recalls a sudden onset of symptoms. Now she describes the pain as aching and sometimes shooting, radiating down into the L4 distribution. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but the pain persists. No prior spine injections. Pain currently 6/10, walking tolerance ~500 ft. Denies bowel/bladder incontinence or saddle anesthesia.

## Past Medical History:

Diabetes, Smoking

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 22.8. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 4/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We reviewed the diagnosis and management options together. Referral to pain management is recommended for consideration of an L4–5 transforaminal epidural steroid injection (TFESI). Coordination with the primary care provider will be necessary to optimize HbA1c to below 8% before surgical planning.

I acknowledged how difficult it has been to live with pain day after day, especially when it interferes with normal routines and independence. We emphasized that while recovery is a process, each step in the plan — from medical optimization to interventional treatment — is designed to help improve mobility, decrease pain, and restore quality of life. Follow-up is scheduled in 3 weeks to reassess symptoms and progress.

# Chart 50

Patient Name: Christopher Moore

Age/Sex: 37-year-old male

MRN: LR0050

Visit Date: 2025-06-05

Chief Complaint: Tingling in right leg

## History of Present Illness (HPI):

Christopher Moore reports back and right leg pain for 32 weeks, with stiffness after periods of inactivity. Pain is worsened by activity and improves with rest. He has difficulty with walking, climbing stairs, and prolonged standing. Symptoms follow the L4 distribution. Current pain is 9/10, and his walking tolerance is about 700 feet. He has tried medications, physical therapy, and heat, but relief has been limited. No prior spine injections. He denies bowel or bladder symptoms, has no cancer history, and no prior spine surgery.

Christopher shared that the hardest part has been giving up his weekend yard work. He used to take pride in keeping his lawn and garden neat, mowing on Saturdays and tending to his vegetables on Sundays. Now, he can only manage a fraction of the work before his leg pain forces him to stop and sit down. He admitted that it feels discouraging to watch the weeds grow where he used to have order and routine, and he worries about losing the independence he once felt in caring for his own home.

## Past Medical History:

Smoking, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol, Medrol dose pack.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 47.9. Antalgic gait. Diminished sensation in L4 distribution. Weakness of tibialis anterior, strength 4/5. Diminished patella reflex. Positive straight leg raise at 30° on affected side. DP pulse intact.

**Motor Strength (0–5 scale):**

| **Muscle Group** | **Right** | **Left** |
| --- | --- | --- |
| Deltoid | 5/5 | 5/5 |
| Biceps | 5/5 | 5/5 |
| Wrist Extensors | 5/5 | 5/5 |
| Triceps | 5/5 | 5/5 |
| Wrist Flexors | 5/5 | 5/5 |
| Finger Flexors | 5/5 | 5/5 |
| Finger Abductors | 5/5 | 5/5 |
| Iliopsoas (hip flexion, L2–L3) | 5/5 | 5/5 |
| Hip Adductors | 5/5 | 5/5 |
| Quadriceps (knee extension, L3–L4) | 5/5 | 5/5 |
| Tibialis Anterior (ankle dorsiflexion, L4) | 5/5 | 4/5 |
| Extensor Hallucis Longus (great toe extension, L5) | 5/5 | 5/5 |
| Gluteus Medius (hip abduction, L5) | 5/5 | 5/5 |
| Peroneals | 5/5 | 5/5 |
| Gastrocnemius–Soleus (plantarflexion, S1) | 5/5 | 5/5 |

## Imaging:

MRI shows paracentral disc herniation at L3-4 with disc height loss and facet arthropathy. Findings match L4 radiculopathy.

## Assessment:

Lumbar radiculopathy in L4 distribution from L3-4 disc herniation.

## Plan:

We discussed diagnosis and management options. BMI >40; weight reduction ≥10% recommended prior to surgical planning. Follow-up in 3 weeks.