Metropolitan Life Insurance Company

01/20/2688

MetLife

FAX COVER PAGE 01/16/26 02:53:00 PM

To: Dr Rey Marquino

Fax Number: 8175105927

From: DLA Admin
Phone Number:
Fax Number:

Subject: 110113998743

Pages (including cover): 2
If there are problems with this facsimile call:

Message:

MetLife
Metropolitan Life Insurance Company
PO Box 14590, Lexington, KY 40511
Fax: 800-230-9531

01/16/2026

Patient Name: SHAWN R WALKER
D.O.B: 08/18/1971
Claim Number: 110113998743

Dear Dr. Rey Marquino,

Thank you in advance for your help to expedite the processing of your patient's claim, as a decision is contingent upon receipt of the requested information.
Please respond back ASAP so we can proceed with the handling of your patients disability leave.

Shawn Walker

If additional information is needed, we will contact you directly. 8/18/71

- Diagnosis:
- Reported and observed symptoms:
- Office Visit notes:
- Test results:
- Dates you certify the patient out of work:
- Date of surgery, if applicable:
- Name of surgery/procedure performed, if applicable:
- Date of delivery, if applicable:
- Follow up appointment date:

If you choose, please provide any other details you believe may be pertinent about your patient's condition and their inability to perform their job functions at this time.

Thank you for taking the time to provide the requested information. We appreciate your partnership.

MetLife Disability

Walker, Shawn Ray

MRN: 5540328

Marquino, Rey Co, MD
Physician
Specialty: Internal Medicine.

Progress Notes
Signed

Encounter Date: 1/19/2026

Texas Health Physicians Group

Shawn Ray Walker 8/18/1971
MRN: 5540328
Visit Date: 1/19/2026
Encounter Provider: Rey Co Marquino, MD
Note initiated by: Rey Co Marquino

Subjective

Chief Complaint:

Chief Complaint

Patient presents with

- Stroke

This is a 54-year-old white male, patient is here today for hospital follow-up, he was admitted to Harris HEB Hospital on January 12 and discharged on January 13 following an extensive workup. Patient has past medical history significant for prior stroke, hypertension, hyperlipidemia, chronic anemia and tobacco use. The patient presented to the emergency room with acute right-sided numbness, facial paresthesia, dizziness and tunnel vision. Patient's symptoms began on January 10, 2026 and worsened on the day of admission prompting hospital presentation. Patient was worked up quite extensively and MRI of the brain revealed a tiny punctate area of diffusion restriction in the right cerebellar hemisphere consistent with a subacute infarction. CTA of the head and neck demonstrated mild to moderate intracranial and extracranial atherosclerotic disease without large vessel occlusion or aneurysm.

Neurology was consulted and confirmed the diagnosis of subacute cerebellar infarction and recommended dual antiplatelet therapy with aspirin and Plavix for 90 days and following that aspirin monotherapy with high-dose aspirin. High intensity statin with atorvastatin 80 mg p.o. nightly was also initiated. The patient's metoprolol was discontinued due to sinus bradycardia. Patient's echocardiogram was done with a bubble study which showed negative for PFO and hypercoagulable blood workup was done which showed no evidence of hypercoagulable state. Due to suspicion of probable cardioembolic phenomenon the patient was advised further evaluation by cardiologist for arrhythmia evaluation. She was also asked to follow-up with neurologist.

During hospitalization patient remained neurologically stable with no speech or swallow deficits patient was evaluated by speech therapy and cleared she was also evaluated by physical therapy and was able to ambulate independently. Patient has chronic mild anemia which was stable. Patient was also diagnosed with prediabetes for which counseling and importance of a low-carb carb diet was recommended.

Patient is here today for follow-up accompanied by wife. Patient since the stroke has been experiencing increased anxiety driving his blood pressure up. Patient currently on Wellbutrin. Patient reports increased stress at work. He tried to go back to work yesterday but experienced an episode of dizziness for which he he felt unsafe to drive. He drives a forklift for work and transfers cars from 1 place to another. With his recurrent intermittent and transient dizziness, he feels he is at risk for accident potential. He is asking for possible 60-day rest to recover. Patient currently on new medications including aspirin and Plavix as well as blood pressure medications.

Stroke

The current episode started in the past 7 days. The problem occurs 2 to 4 times per day. The problem has been waxing and waning. This is a recurrent problem. He has tried immobilization, lying down, position changes, relaxation, rest, sleep and walking for the symptoms. The treatment provided mild relief. The symptoms are aggravated by bending, exertion, standing, stress and walking. Associated symptoms include arthralgias, fatigue, numbness, vertigo, a visual change and weakness. Pertinent negatives include no abdominal pain, anorexia, change in bowel habit, chest pain, chills, congestion, coughing, diaphoresis, fever, headaches, joint swelling, myalgias, nausea, neck pain, rash, sore throat, swollen glands, urinary symptoms or vomiting.
Check hospital labs

ROS:
Constitutional: Positive for fatigue. Negative for chills, fever and diaphoresis.
E/N/T: Negative for sore throat and congestion.
Cardiovascular: Negative for chest pain.
Respiratory: Negative for cough.
Gastrointestinal: Negative for abdominal pain, anorexia, change in bowel habit, nausea and vomiting.
Musculoskeletal: Positive for arthralgias. Negative for myalgias, joint swelling and neck pain.
Integumentary: Negative for rashes.
Neurological: Positive for weakness, numbness and vertigo. Negative for headaches.

I reviewed, discussed, and updated the following historical information during this visit: Tobacco | Allergies | Meds | Problems | Med Hx | Surg Hx | Fam Hx |

Past Medical History

Past Medical History:

Diagnosis	Date
• CVA (cerebral vascular accident) (HCC)	09/05/2016
• Annual physical exam	03/05/2019
• Anemia	
• Atrial fibrillation (HCC)	
• Chest pain	
• Chest pain	
• High cholesterol	
• High cholesterol	
• Hypertension	
• Liver disorder	
• Pericarditis	

Past Surgical History

Past Surgical History:

Procedure	Laterality	Date
• NO PAST SURGERIES		

Social History

Socioeconomic History

- Marital status: Married
  - Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History

- Occupation: logistics

Tobacco Use

- Smoking status: Former
  - Current packs/day: 0.00
  - Average packs/day: 0.5 packs/day for 30.0 years (15.0 ttl pk-yrs)
  - Types: Cigarettes
  - Quit date: 1/10/2026
  - Years since quitting: 0.0
- Smokeless tobacco: Never
- Tobacco comments:
  He is trying hypnosis.

Vaping Use

- Vaping status: Never Used

Substance and Sexual Activity

- Alcohol use: Not Currently
  - Alcohol/week: 6.0 standard drinks of alcohol
  - Types: 6 Cans of beer per week
  - *Comment: 12 pack daily*
- Drug use: Not Currently
  - Types: Marijuana
  - *Comment: Zero*
- Sexual activity: Not Currently
  - Partners: Female
  - Birth control/protection: Abstinence

Other Topics — Concern

- Not on file

Social History Narrative

Occupation - Roofer/Logistics
Alcohol use: Heavy alcohol use, Recently quit alcohol use.
Tobacco use: Recently quit tobacco use. - quit on 9/5/16
Marital status: Married.
Living situation: Lives with spouse.
No drug use

Social Drivers of Health

Financial Resource Strain: Low Risk (1/12/2026)

Overall Financial Resource Strain (CARDIA)

- Difficulty of Paying Living Expenses: Not hard at all

Food Insecurity: No Food Insecurity (1/12/2026)

Hunger Vital Sign

- Worried About Running Out of Food in the Last Year: Never true
- Ran Out of Food in the Last Year: Never true

Transportation Needs: No Transportation Needs (1/12/2026)

PRAPARE - Transportation

- Lack of Transportation (Medical): No
- Lack of Transportation (Non-Medical): No

Physical Activity: Sufficiently Active (1/12/2026)

Exercise Vital Sign

- Days of Exercise per Week: 7 days
- Minutes of Exercise per Session: 40 min

Recent Concern: Physical Activity - Insufficiently Active (11/20/2025)

Exercise Vital Sign

- Days of Exercise per Week: 3 days
- Minutes of Exercise per Session: 20 min

Stress: No Stress Concern Present (11/20/2025)

Finnish Institute of Occupational Health - Occupational Stress Questionnaire

- Feeling of Stress: Only a little

Social Connections: Unknown (11/20/2025)

Social Connection and Isolation Panel

- Frequency of Communication with Friends and Family: Patient declined
- Frequency of Social Gatherings with Friends and Family: Patient declined
- Attends Religious Services: Patient declined
- Active Member of Clubs or Organizations: Patient declined
- Attends Club or Organization Meetings: Patient declined
- Marital Status: Married

Intimate Partner Violence: Not on file

Housing Stability: Low Risk (1/12/2026)

Housing Stability Vital Sign

- Unable to Pay for Housing in the Last Year: No
- Number of Times Moved in the Last Year: 0
- Homeless in the Last Year: No

Family History

Family History

Problem	Relation	Name	Age of Onset
• Hypertension	Mother	Terry	
• Other *Thalassemia*	Mother	Terry	
• High Cholesterol	Mother	Terry	
• Heart *Endarterectomy*	Mother	Terry	
• Heart *Bypass x4*	Father	CHARLES	60
• Hypertension	Father	CHARLES	
• Heart attack	Father	CHARLES	60
• No Known Problems	Sister		
• Cancer	Maternal Grandmother	Elizabeth Ann	
• Heart attack	Maternal Grandfather	C.R.	62
• Heart *Bypass x4*	Maternal Grandfather	C.R.	62
• Dementia	Paternal Grandmother	Ann	
• Heart *Endarterectomy*	Paternal Grandmother	Ann	
• Liver Cancer	Paternal		

• Lung Cancer	Grandfather Paternal Grandfather

Allergies as of 1/19/2026 Reviewed by Marquino, Rey Co, MD on 1/19/2026

	Noted	Reaction Type	Reactions
Nkda [no Known Drug Allergies]	06/02/2010		

Objective

Vitals:

	01/19/26 0800
BP:	134/72
Pulse:	85
Resp:	16
Temp:	98.1 °F (36.7 °C)
SpO2:	99%
Weight:	65.9 kg (145 lb 3.2 oz)
Height:	5' 4" (162.6 cm)

Body mass index is 24.92 kg/m².

Physical Exam:

CONSTITUTIONAL
Vitals and nursing notes reviewed.
GENERAL APPEARANCE: Well-developed and well-nourished.
GROOMING: Well groomed.
EYES:
LIDS/CONJUCTIVA: Lids and conjunctiva are normal.
PUPILS/IRIS: normal pupils/iris.
ENT
EXTERNAL EARS/NOSE:External ears and nose are normal.
HEARING: Hearing within defined limits.
EARS EAC/TM: EAC, TM normal
LIPS/TEETH/GUMS: Normal lips, teeth and gums.
OROPHARYNX: Oropharynx normal.
NECK: Neck normal.
THYROID: Thyroid is normal to palpation.
RESPIRATORY
EFFORT AND PATTERN: Effort normal.
AUSCULTATION: Normal breath sounds with no rales, rhonchi, wheezes or rubs.
CARDIOVASCULAR
AUSCULTATION: Rate: Is normal. Rhythm: regular. Heart sounds: S1 is normal. S2 is normal. S3/S4 not present. With no murmurs heard.
GASTROINTESTINAL
BOWEL SOUNDS: Normal
MASSES: No mass.

TENDERNESS: No tenderness.
ORGANOMEGALY: No organomegaly.
HERNIA: No hernias present.
LYMPHATIC
OTHER NODES: No neck adenopathy.
MUSCULOSKELETAL
DIGITS/NAILS: Normal.
INTEGUMENTARY
SKIN INSPECTION: Normal.
NEUROLOGICAL
CRANIAL NERVES: Cranial nerves normal.
COORDINATION/CEREBELLAR: Passed finger-nose-finger test. Passed heel-to-shin test.
SENSATIONS: Sensations normal.
MENTAL STATUS
Oriented to person, place, and time.
Level of consciousness: alert
Knowledge: good.
Able to name object.
GAIT, COORDINATION, REFLEXES
Gait: normal
Coordination
Romberg: negative
Finger to nose coordination: normal
Heel to shin coordination: normal
Tremor
Resting tremor: absent
MOTOR EXAM
Muscle bulk: normal
Overall muscle tone: normal
Right arm tone: normal
Left arm tone: normal
Right arm pronator drift: absent
Left arm pronator drift: absent
Right leg tone: normal
Left leg tone: normal
SENSORY EXAM
Right arm light touch: normal
Left arm light touch: normal
Right leg light touch: normal
Left leg light touch: normal
PSYCHIATRIC
ORIENTATION: He is alert and oriented to person, place and time.

Results/Procedures:

Assessment & Plan

Cerebellar stroke (HCC)

-New onset
-Manifested by episodes of dizziness and tunnel vision transient, has been recurrent since stroke symptoms first appeared January 10.
-MRI as well as CTA reviewed with patient
-Small right cerebellar stroke present
-Follow-up with neurology
-Follow-up with cardiology to workup and rule out cardiac arrhythmia and cardioembolic phenomenon.
-Advised rest and recovery for the next 6 to 8 weeks prior to going back to work.
-Medical therapy recommended to continue with antiplatelet therapy with aspirin and Plavix for 90 days and then go on aspirin 325 mg thereafter
-Continue to monitor blood pressure
-Consider physical therapy, at this time patient is able to ambulate without difficulty.

Essential hypertension

-Blood pressure seems to be controlled on current medications
-Counseled on importance of strict blood pressure control
-Keep blood pressure below 140/90
-Continue irbesartan hydrochlorothiazide 300 over 12.5 mg once daily and metoprolol XL which was taken off the hospital due to sinus bradycardia patient is to only take amlodipine 10 mg once daily along with irbesartan.
-Low-salt diet/2 g to 3 g of salt per day
-Start daily exercise

Hyperlipidemia LDL goal <100

-High intensity statin recommended
-Continue atorvastatin 80 mg p.o. nightly
-Low-fat diet recommended

Chronic anxiety

- Currently uncontrolled, increased anxiety symptoms with recent stroke
- Continue with Wellbutrin XL 150 mg once daily
- Referred to video-psychiatry for counseling
- Advise coping mechanisms and relaxation techniques to avoid stress and increased anxiety which can oftentimes drive his blood pressure up and can cause problems.
- Patient has always been a type A personality advised coping mechanisms as above

Additional information (if applicable):
Cerebellar stroke (HCC) (Primary)
- OP REFERRAL CARDIOLOGY
- OP REFERRAL NEUROLOGY

Essential hypertension
Overview:
BY CLINICAL HISTORY, UNCLEAR SEVERITY OF HYPERTENSION, query whether patient has history of acute end organ damage due to hypertension, Goal BP <130/80.

CHECK BP EVERY VISIT!!!

Hyperlipidemia LDL goal <100
Overview:
HYPERLIPIDEMIA as evidenced by labs, Goal is LDL <70, Rx, Monitor Lipid panel and LFT's every 4-6 months as discussed with patient.

Chronic anxiety

- OP REFERRAL TEXAS HEALTH OUTPATIENT-VIRTUAL PSYCHIATRY REFERRAL (INDIVIDUAL THERAPY & MED MANAGEMENT)

Medical Decision Making

The following were reviewed during todays visit and affected the Medical Decision Making:
Labs/Radiology Reviewed External Notes Reviewed

No LOS data to display

Followup:

Follow up in about 2 months (around 3/19/2026) for Clearance back to work appointment .

Office Visit on 1/19/2026 *Note viewed by patient*

Additional Documentation

Vitals: BP 134/72 Pulse 85 Temp 98.1 °F (36.7 °C) Resp 16 Ht 5' 4" (162.6 cm) Wt 65.9 kg (145 lb 3.2 oz) SpO2 99% BMI 24.92 kg/m² BSA 1.73 m² Pain Sc 00 No Pain

Flowsheets: Patient-Reported Data, ED Vitals

Encounter Status

This encounter has been electronically signed by Marquino, Rey Co, MD on 1/19/26 at 22:37

Orders Placed

OP REFERRAL CARDIOLOGY Authorized
OP REFERRAL NEUROLOGY Authorized
OP REFERRAL TEXAS HEALTH OUTPATIENT-VIRTUAL PSYCHIATRY REFERRAL (INDIVIDUAL THERAPY & MED MANAGEMENT) Closed

Medication Changes

As of 1/19/2026 8:50 AM

None

Visit Diagnoses

Primary: **Cerebellar stroke (HCC)** I63.9
Essential hypertension I10
Hyperlipidemia LDL goal <100 E78.5
Chronic anxiety F41.9