

Visit Note

Date of Exam: 9/16/2013
Patient Name: Robert Plock
Date of Birth: 07/26/1968

Past History:

Surgical History:

No Surgical History Reported

Family History:

Father has history of hypertension and diabetes. Mother has history of diabetes. Sibling has history of hypertension and diabetes.

Social History:

Patient is right handed. Patient reports the use of alcohol, caffeine. Patient does not use .

Allergies:

No known allergies

Review of Systems:

Constitutional:	Patient has history of weakness, weight loss or gain and fatigue.
Eyes:	Patient has history of blurred vision.
HEENT:	Patient has history of earaches, hay fever, nosebleeds and frequent sore throats.
Cardiovascular:	No chest pains or palpitations or high blood pressure
Respiratory:	No shortness of breath or cough
Gastrointestinal:	No abdominal pain, heartburn, hepatitis or bleeding
Genitourinary:	No dysuria or hematuria
Musculoskeletal:	Patient has history of Joint Pain, muscular weakness, stiffness and muscular pain.
Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolympathic:	Patient has history of skin rashes.
Immunological:	No bruising, swollen glands or anemia

Chief Complaint:

Low back

History of Present Illness:

Lumbar: The patient presents today for his preoperative appointment and fitting of lumbar brace. He is scheduled to undergo ALIF with cage and instrumentation and bone, PSF L5-S1, laminectomy L5-S1 with instrumentation and open treatment of L5 fracture. He feels worse since last office visit. The pain is constant. He notes to have mostly bad days than good. The pain is described as stabbing, pressure, and sharp. The pain is much worse with activity. The pain is relieved when lying. He also notes to have BLE numbness and tingling. He rates his pain 8/10 on a pain scale.

Thoracic:

Exam:

Physical examination today shows no acute neurologic changes noted

Strength and sensation are unchanged

No bowel or bladder dysfunction noted

Gait is non-antalgic with no assistive device. Stance is erect.

GEN: Appears stated age. Not in any acute distress.

PSYCH: Cooperative and appropriate. Alert and oriented times three.

HEAD: Normocephalic and atraumatic.

EYES: Extraocular movements intact.

ENT: Gross visualization of ears, nose and mouth show no significant abnormalities.

RESP: Patient shows no signs of difficulty breathing.

SKIN: Inspection and palpation of skin shows no significant rashes, lesions or ulcers

NEURO: The patient's heel/toe, finger/nose & heel/shin are normal.

CARDIO: Pulses are palpable. No swelling or peripheral edema noted

LYMPH: Palpation of lymph nodes is normal

MUSC: Inspection, percussion and/or palpation shows no tenderness, masses or effusions

ROM: Range of motion shows no pain crepitation or contracture

Impression:

SCIATICA

LUMBOSACRAL RADICULOPATHY

Plan:

Lumbar: The patient presents today for his preoperative appointment. He reports his right leg pain is worse than the left leg pain. He was fitted and given his lumbar brace today in the office as well as his post-operative medication prescriptions. He is scheduled to have an ALIF with cage and instrumentation and bone, PSF L5-S1, Laminectomy L5-S1 with instrumentation and open treatment of L5 fracture. We discussed his surgery and recovery in detail. I answered all the patient's questions today in the office.

Medications Prescribed:

NORCO 10-325 TABLET QTY: 120

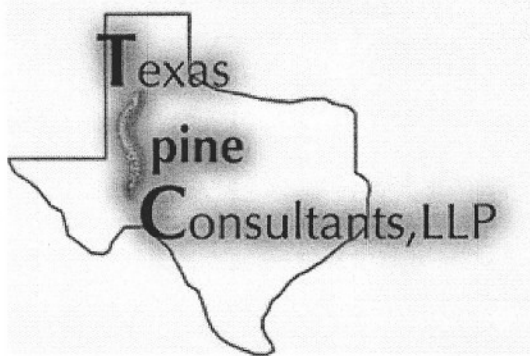
FLEXERIL 10 MG 1 TABLET QTY: 90

A handwritten signature in black ink, appearing to be 'Andrew Park', written in a cursive style.

Andrew Park, MD

Electronically signed on 9/16/2013 3:14:14 PM

Scribe: Tyler Grimes



Visit Note

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Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolympathic:	Patient has history of skin rashes.
Immunological:	No bruising, swollen glands or anemia

Chief Complaint:

Lumbar: .

Thoracic:

History of Present Illness:

Lumbar: The patient presents today for his preoperative appointment and fitting of lumbar brace. He is scheduled to undergo ALIF with cage and instrumentation and bone, PSF L5-S1, laminectomy L5-S1 with instrumentation and open treatment of L5 fracture. He feels worse since last office visit. The pain is constant. He notes to have mostly bad days than good. The pain is described as stabbing, pressure, and sharp. The pain is much worse with activity. The pain is relieved when lying. He also notes to have BLE numbness and tingling. He rates his pain 8/10 on a pain scale.

Thoracic:

Exam:

Physical examination today shows no acute neurologic changes noted

Strength and sensation are unchanged

No bowel or bladder dysfunction noted

Gait is non-antalgic with no assistive device. Stance is erect.

GEN: Appears stated age. Not in any acute distress.

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LYMPH: Palpation of lymph nodes is normal

MUSC: Inspection, percussion and/or palpation shows no tenderness, masses or effusions

ROM: Range of motion shows no pain crepitation or contracture

Impression:

SCIATICA

LUMBOSACRAL RADICULOPATHY

Plan:

Lumbar: The patient presents today for his preoperative appointment. He reports his right leg pain is worse than the left leg pain. He was fitted and given his lumbar brace today in the office as well as his post-operative medication prescriptions. He is scheduled to have an ALIF with cage and instrumentation and bone, PSF L5-S1, Laminectomy L5-S1 with instrumentation and open treatment of L5 fracture. We discussed his surgery and recovery in detail. I answered all the patient's questions today in the office. We reviewed and discussed the consent form which the patient signed today in the office.

Medications Prescribed:

NORCO 10-325 TABLET QTY: 120

FLEXERIL 10 MG 1 TABLET QTY: 90

A handwritten signature in black ink, consisting of a series of connected loops and a long horizontal stroke extending to the right.

Andrew Park, MD
Electronically signed on 9/16/2013 3:18:48 PM
Scribe: Tyler Grimes



Follow Up Note

Date of Exam: 7/24/2013
Patient Name: Robert Plock
Date of Birth: 07/26/1968

Past History:

Surgical History:
No Surgical History Reported

Family History:
Father has history of hypertension and diabetes. Mother has history of diabetes. Sibling has history of hypertension and diabetes.

Social History:
Patient is right handed. Patient consumes alcohol. Patient consumes caffeine.

Allergies:
No Known Drug Allergies

Review of Systems:

Constitutional:	Patient has history of weakness, weight loss or gain and fatigue.
Eyes:	Patient has history of blurred vision.
HEENT:	Patient has history of earaches, hay fever, nosebleeds and frequent sore throats.
Cardiovascular:	No chest pains or palpitations or high blood pressure
Respiratory:	No shortness of breath or cough
Gastrointestinal:	No abdominal pain, heartburn, hepatitis or bleeding
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Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolympathic:	No bruising, swollen glands or anemia
Immunological:	Patient has history of skin rashes.

History:

Thoracic:

Exam:

GEN: Appears stated age. Not in any acute distress.

PSYCH: Cooperative and appropriate. Alert and oriented times three.

HEAD: Normocephalic and atraumatic.

EYES: Extraocular movements intact.

ENT: Gross visualization of ears, nose and mouth show no significant abnormalities.

RESP: Patient shows no signs of difficulty breathing.

NEURO: No acute neurological changes noted from previous visit.

No acute changes noted from previous visit.

Impression:

SCIATICA

Plan:

Thoracic: The patient

Medications Prescribed:

Norco 5-325 mg - tablet QTY: 120

TRAMADOL HCL 50 MG 1 tablet TABLET QTY: 180

FLEXERIL 10 MG 1 TABLET QTY: 90

IBUPROFEN 800 MG TABLET QTY: 90



Andrew Park, MD

Electronically signed on 7/24/2013 4:22:58 PM



Follow Up Note

Date of Exam: 7/24/2013
Patient Name: Robert Plock
Date of Birth: 07/26/1968

Past History:

Surgical History:

No Surgical History Reported

Family History:

Father has history of hypertension and diabetes. Mother has history of diabetes. Sibling has history of hypertension and diabetes.

Social History:

Patient is right handed. Patient consumes alcohol. Patient consumes caffeine.

Allergies:

No Known Drug Allergies

Review of Systems:

Constitutional:	Patient has history of weakness, weight loss or gain and fatigue.
Eyes:	Patient has history of blurred vision.
HEENT:	Patient has history of earaches, hay fever, nosebleeds and frequent sore throats.
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Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic:	No bruising, swollen glands or anemia
Immunological:	Patient has history of skin rashes.

History:

Lumbar: The patient presents today for a follow up after repeat L5-S1 lumbar ESI done by Dr. Lloyd. He reports that the second injection was not as beneficial as the first one. The injection gave him minimal relief. He feels unchanged since last office visit. The pain is described as soreness and burning. The pain is much worse when bending, activity, rest, driving / riding in a car, and doing overhead work. He rates his pain 7/10 on a pain scale.

Exam:

Physical examination today shows no acute neurologic changes noted
Strength and sensation are unchanged
No bowel or bladder dysfunction noted

Gait is non-antalgic with no assistive device. Stance is erect.

GEN: Appears stated age. Not in any acute distress.

PSYCH: Cooperative and appropriate. Alert and oriented times three.

HEAD: Normocephalic and atraumatic.

EYES: Extraocular movements intact.

ENT: Gross visualization of ears, nose and mouth show no significant abnormalities.

RESP: Patient shows no signs of difficulty breathing.

SKIN: Inspection and palpation of skin shows no significant rashes, lesions or ulcers

NEURO: The patient's heel/toe, finger/nose & heel/shin are normal.

CARDIO: Pulses are palpable. No swelling or peripheral edema noted

LYMPH: Palpation of lymph nodes is normal

MUSC: Inspection, percussion and/or palpation shows no tenderness, masses or effusions

ROM: Range of motion shows no pain crepitation or contracture

Plan:

Lumbar: The patient presents today for a follow up after a repeat L5-S1 lumbar ESI. He states that this injection was not as helpful as the first. The patient reports that his symptoms seem to be getting worse. We discussed doing a fusion to fix his problem. We discussed the surgery and recovery in detail. The patient will sit and schedule surgery with Emily. I prescribed him Norco 5/325, 120 with one refill, Ibuprofen 800, 90 with one refill, Tramadol, 180, Flexeril 10, 90.

Medications Prescribed:

Norco 5-325 mg - tablet QTY: 120

TRAMADOL HCL 50 MG 1 tablet TABLET QTY: 180

FLEXERIL 10 MG 1 TABLET QTY: 90

IBUPROFEN 800 MG TABLET QTY: 90



Andrew Park, MD

Electronically signed on 7/24/2013 4:24:25 PM

Scribe: Tyler Grimes



Follow Up Note

Date of Exam: 5/22/2013

Patient Name: Robert Plock

Date of Birth: 07/26/1968

Past History:

Surgical History:

No Surgical History Reported

Family History:

Father has history of hypertension and diabetes. Mother has history of diabetes. Sibling has history of hypertension and diabetes.

Social History:

Patient is right handed. Patient consumes alcohol. Patient consumes caffeine.

Allergies:

No Known Drug Allergies

Review of Systems:

Constitutional:	Patient has history of weakness, weight loss or gain and fatigue.
Eyes:	Patient has history of blurred vision.
HEENT:	Patient has history of earaches, hay fever, nosebleeds and frequent sore throats.
Cardiovascular:	No chest pains or palpitations or high blood pressure
Respiratory:	No shortness of breath or cough
Gastrointestinal:	No abdominal pain, heartburn, hepatitis or bleeding
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Musculoskeletal:	Patient has history of Joint Pain, muscular weakness, stiffness and muscular pain.
Skin:	Patient has history of rashes, dryness and itching.
Neurological:	Patient has history of Headache and loss of sensation.
Psychiatric:	No mood change, depression or nervousness
Endocrine:	No thyroid enlargement, sweating or excessive thirst
Hematolymphatic:	No bruising, swollen glands or anemia
Immunological:	Patient has history of skin rashes.

History:

Lumbar: The patient presents today to review results of Cervical, Thoracic, and Lumbar Mri. The pain is describe as throbbing, dull ache, sharp, stabbing, and burning. The pain is much worse with activity and doing overhead work. The pain is constant. He continues to have good and bad days. The pain radiates in BLE. He rates his pain 7/10 on a pain scale.

Exam:

Physical examination today shows no acute neurologic changes noted
Strength and sensation are unchanged
No bowel or bladder dysfunction noted

Gait is non-antalgic with no assistive device. Stance is erect.

GEN: Appears stated age. Not in any acute distress.

PSYCH: Cooperative and appropriate. Alert and oriented times three.

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MUSC: Inspection, percussion and/or palpation shows no tenderness, masses or effusions

ROM: Range of motion shows no pain crepitation or contracture

Imaging:

MRI LUMBAR SPINE W/DYE: 5/17/13

reviewed images and report in detail

agree with radiologist interpretation

Plan:

Lumbar: The patient presents to review results of his lumbar, cervical and thoracic MRI. We reviewed and discussed his images in detail. The patient has degenerative changes as well as a slip, a fracture and a pinched nerves. We discussed treatment options in detail such as surgery. We discussed surgery and recovery in detail. If the patient cannot do surgery at this time we will continue with an injection in the meantime. The patient states that he cannot have surgery at this time and will have to figure out his work schedule before planning surgery. The patient will get an injection at L5-S1 ESI with Dr. Lloyd. I will see the patient back in two months.

Medications Prescribed:

Norco 5-325 mg - tablet QTY: 120



Andrew Park, MD

Electronically signed on 5/23/2013 8:02:40 AM

Scribe: Tyler Grimes