PERSONAL HEALTH RECORD CD COVERSHEET

Dear: DR. CHURCH **Wellness Program Service Date:** _____ **Date:** 12/2/2011

Please review the information below & complete all missing information to ensure receipt of your personal CD health record.

Physician Name: WILLIAM GOLDBERG, MD **PID: 181** **Member ID: 2812552**

Patient Last: CHURCH **First: GEORGE** **Init:**

Date of Birth: 08/28/1954 **SEX:(M/F)** M

Home Address: 218 KENT ST **Apt #:**

City: BROOKLINE **State:** MA **Zip:** 02446 -5404

Home Phone#: (617) 277-6803 **Cell Phone#:** (617) 462-1347

Email Address: gmc@harvard.edu

Emergency Contact Name: (Print if missing)

Name: Ting Wu Relationship: Phone#: 617-277-6803

Allergic To: (Please Print)

Please ensure the accuracy of the information contained on this Personal Health record CD.
If you believe that any of the information contained on this personal health record CD is inaccurate please contact your physician immediately.

ORDER OF PRESENTATION

This Form	*** Required**
Wellness Program Dr Report	*** Required**
Lab Report	
EKG Report	
Spirometry Report	
Hearing Report	
Vision Report	
Other Reports	

* Please do not hole punch or staple paperwork

PRINT

Church, George M

57 Y old Male, DOB: 08/28/1954
218 Kent St, Brookline, MA-02446-5404
Home: 617-277-6803
Guarantor: Church, George M Insurance: Harvard Pilgrim Health Care
Payer ID: 04271
Appointment Facility: William E Goldberg MD

11/30/2011 **Progress Note: William E. Goldberg, MD, PC**

Current Medications

Coenzyme Q10(Co Q-10) 150 MG Capsule as directed
Omega 3(Linolenic Acid) 1200 MG Capsule as directed
Multivitamins Capsule as directed
Lovastatin 40 Tablet Extended Release 24 Hour 1 tablet at bedtime Once a day
Medication List reviewed and reconciled with the patient

Past Medical History

MI 1996 Neg Cath.
Longstanding narcolepsy, full work up, satisfied w functional status w/o pharmacotherapy, declined amphetamines and modafinil
Skin Cancer, Squamous Cell

Surgical History

oral only

Family History

Father: deceased 75 yrs heart disease, memory loss not Alzh.
Daughter(s): alive 19 yrs migraine
Spouse: alive
Mother: deceased 65 yrs neck cancer, organ unspecified
half siblings, obesity.

Social History

Children: one daughter.
Education: PhD.
Exercise: treadmill 20 minutes 3 times a week, walks to work.
Marital Status: married.
Occupation: scientist, professor of genetics, HMS.
DIET Vegan; DOES not smoke or drink alcohol.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

MI 1996

Review of Systems

GENERAL: Denies fever, chills, sweats, including night sweats, and fatigue. HEENT: Denies headaches, visual change, dizziness, earaches, sore throat, nasal discharge, blurred vision, ringing in the ears, deafness or decreased hearing, vertigo, nosebleeds, or hoarseness. CARDIOVASCULAR: Denies chest pain, help the patient's, shortness of breath with exertion, edema, PND, or diaphoresis. RESPIRATORY: Denies cough, phlegm, congestion, wheezing, shortness of breath, or coughing up blood.

Reason for Appointment

1. MDVIP PE

History of Present Illness

HPI Notes:

1) LIPID management, On Lovastatin 15 y, p Non STEMI in mid 90s w normal LHC; h/o arrhythmia > 20 y; Vegan > 5 y

2) Lifelong nasal congestion has lessened; now w decr nasal acuity and chronic prod post nasal cough

3) Sleep disorder, Scammel rec Provigil George declines and we review the medicine in detail; the narcolepsy does not impact his professinal or private life hence no need for it; he is not driving anymore

4) recurrent fungus in inguinal area

5) post r unning headaches and neck pain.

Vital Signs

Ht 76, Wt 247, Wt change -8 lb, BMI 30.06, Pulse sitting 60, HR 60, BP 120/82.

Physical Examination

GENERAL:

Appears younger than stated age. Build: tall. Eye contact: normal. General Appearance: well-appearing, well-developed, well-nourished, no acute distress.

HEENT:

Ear drums: normal . Ears: ear canals unremarkable, external ear unremarkable. EOM: intact. Eye lids: normal. Eyes: non-icteric sclera, PERRLA, EOMI, fundoscopic exam unremarkable, conjunctiva clear. Head: normocephalic, atraumatic. Lips: unremarkable, moist. Mouth: unremarkable. Nasal patency open . Nasal septum: midline. Nose: unremarkable. Oral cavity: no lesions seen, tongue unremarkable, normal dentition, uvula midline. Speech: physically unimpaired . Throat: clear. Turbinates: pale.

NECK:

C-spine unremarkable, nontender and FROM. Carotid bruit: none. Cervical lymph nodes: unremarkable, no lymphadenopathy. General: unremarkable, supple. Jugular venous distension: none. Muscles: normal, nontender and FROM. Neck Mass: none. ROM: normal. Thyroid: no thyromegaly, non tender, no nodules palpated.

CHEST:

Breath sounds: normal. Expansion: normal . Percussion: normal. Rales: none. Wheezes: none.

BACK:

General: unremarkable.

LUNGS:

Auscultation: CTA bilaterally.

HEART:

Heart sounds: normal S1S2. Murmurs: none. Rate: regular.

ABDOMEN:

Bowel sounds: normal. Bruits: none. General: normal. Liver, Spleen: non-enlarged. Masses: no. Rebound tenderness: absent. Rectal: normal sphincter

GASTROINTESTINAL: Denies anorexia, dysphagia, nausea/vomiting, abdominal pains, heartburn, diarrhea, constipation, bleeding per rectum. GENITOURINARY: Denies dysuria, urgency, freqency, nocturia, sexual dysfunction, vaginal or urethral discharge, incontinence, hesitancy, impotence, menstrual irregular, penile or genital ulcers. MUSCULOSKELETAL: Denies myalgia, back pain, joint pain, joint swelling, serious joint/bone injury. HEMATOLOGIC: Denies anemia, adenopathy, rashes, legs ulcers, bruising, or itching. NEUROLOGIC: Denies memory loss, confusion, weakness, ataxia, tremors, paresthesias. PSYCHIATRIC: Denies anxiety, depression, agitation, sedation, or disorientation.

tone. Scars: no.
GENITOURINARY - MALE:
Prostate: unremarkable, without nodules.
SKIN:
Color: good. Moles: none. Nails: unremarkable. Skin Lesion(s): none.
NEUROLOGICAL:
Babinski: negative. Cerebellar: WNL. Cognition: normal. Cortical Functions: normal. Cranial Nerves: CN's II-XII grossly intact. Romberg: negative. FTN:

normal

. Gait: normal. Mental Status: Alert & oriented x 3. Motor: normal strength bilaterally. Reflexes: 2+ bilaterally and symmetric. Sensory: normal sensation. Tremor: none.
PSYCHOLOGY:
Affect: appropriate. Mood: pleasant. Judgement: normal . Memory: good .
EXTREMITIES:
Pulses: 2+ bilateral. Varicose veins: not present.

Assessments

1. MDVIP Physical - V70-MDVIP (Primary)
2. Hypercholesterolemia - 272.0

Treatment

1. MDVIP Physical

LAB: Cleveland Heart Labs
LAB: PSA, TOTAL* (Ordered for 11/18/2011)

PSA, TOTAL	0.5	< OR = 4.0 - ng/mL

LAB: Urinalysis MDVIP Normal

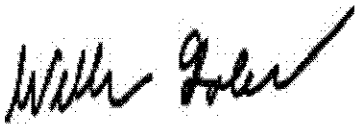
Appearance	clear
Urine-Color	yellow
Glucose	neg
Bilirubin	neg
Keytones	+
Specific Gravity	1.010
Blood	neg
pH	5.0
Protein	neg
Urobilinogen	neg
Nitrite	neg
Leukocytes	neg

Diagnostic Imaging:EKG
1) George has not been off Mevacor while vegan; LDL sub op; but here is trial for next 6 months; a) off Lovastatin 2 months and check lipids in 2 mon; b) assess response to Atorva in Feb and Mar and then compare 3 data points i) on Mevacor; ii) off statins; iii) on Atorovastatin
2) lesion under nail, derm eval
3) colonoscopy recommended
4) Post nasal drip Plan Grossans ENT 14 d and review
5) bump on back seb cyst rec bacitracin.

2. Hypercholesterolemia

LAB: CPK- CREATINE KINASE, TOTAL

CREATINE KINASE, TOTAL	169	44-196 - U/L



Electronically signed by William Goldberg , MD on 12/01/2011 at 01:49 PM EST

Sign off status: Completed

William E Goldberg MD
1101 Beacon St
Brookline, MA 02446-5587
Tel: 617-731-4400
Fax: 617-731-5500

ClevelandHeartLab®

Inflammation, a key contributor to heart disease and cardiac events

MDVIP - WILLIAM E. GOLDBERG, MD
1101 BEACON STREET
SUITE 2W
BROOKLINE, MA 02446

Patient Name: **CHURCH,GEORGE**

Requesting Physician: **GOLDBERG,WILLIAM**

Accession Number: L33000197

Patient I.D. #:

Fasting Status: UNKNOWN | Sex: MALE | Date of Birth: 08/28/1954 | Age: 57

Collection Date: NOT GIVEN

Report Date: 11/29/2011 08:05

TEST | CURRENT RESULTS | PREVIOUS RESULTS

Reprinted on: 11/30/2011 07:33

	LOW RISK	MODERATE RISK	HIGH RISK	Result	Date	GOAL	Units
CVD Inflammation Profile							
Myeloperoxidase [1]						<480	
Vitamin D, 25 Hydroxy [2]		29.1				>29.9	ng/mL
Hemoglobin A1c							
Hemoglobin A1C [3]		5.8				<5.7	%

	LOW RISK	MODERATE RISK	HIGH RISK	Result	Date	GOAL	Units
The VAP Test							
Direct-Measured Cholesterol Panel							
Total LDL [4]	120					<130	mg/dL
LDL-R		101				<100	mg/dL
Lp(a) Cholesterol	5.0					<10.0	mg/dL
IDL	15					<20	mg/dL
Total HDL			39			>39	mg/dL
HDL2			9			>9	mg/dL
HDL3	31					>29	mg/dL
Total VLDL	29					<30	mg/dL
VLDL 1+2	14.5					<20.0	mg/dL
VLDL 3			14			<10	mg/dL
Total Cholesterol	189					<200	mg/dL
Secondary and Emerging Risk Factors							
Triglycerides	140					<150	mg/dL
Non-HDL Cholesterol	149					<160	mg/dL
Remnant Lipoproteins	29					<30	mg/dL
LDL Density Pattern							
LDL Density (Pattern)	B					A	
LDL Subclass 1	17.3						mg/dL
LDL Subclass 2	22.4						mg/dL
LDL Subclass 3	50.9						mg/dL
LDL Subclass 4	10.2						mg/dL
Apolipoproteins, Calculated							
Apolipoprotein A1	132					>117	mg/dL
Apolipoprotein B100	105					<109	mg/dL
Apo B100/A Ratio	0.80					<0.92	

	Normal	Abnormal	Reference Range	Units
Thyroid Function				
Thyroid Stimulating Hormone	4.160		0.400-4.500	uU/mL

Medical Director: Stanley Hazen, MD, PhD

CLIA #: 36D1032987

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TEST	CURRENT RESULTS	PREVIOUS RESULTS

	Normal	Abnormal	Reference Range	Units
General Chemistry				
Total Protein	**6.6**		6.1-8.0	g/dL
Albumin	**4.5**		3.5-5.5	g/dL
Globulin	**2.1**		1.8-3.8	g/dL
Bilirubin, Total	**1.0**		0-1.5	mg/dL
ALP (alkaline phosphatase)	**73**		<150	U/L
ALT (SGPT)	**24**		5-50	U/L
AST (SGOT)	**25**		7-40	U/L
Glucose	**96**		65-99	mg/dL
Calcium, Total	**9.2**		8.5-10.5	mg/dL
Sodium	**140**		135-146	mmol/L
Potassium	**3.9**		3.4-5.3	mmol/L
Chloride	**107**		95-108	mmol/L
C02 (Carbon Dioxide)	**26**		21-33	mmol/L
BUN (blood urea nitrogen)	**15**		8-23	mg/dL
Creatinine	**0.80**		0.70-1.40	mg/dL
eGFR, Non-African descent	**>60**		>60	mL/min
eGFR, African descent	**>60**		>60	mL/min

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Report Date: 11/29/2011 08:05

TEST	CURRENT RESULTS	PREVIOUS RESULTS

	Normal	Abnormal	Reference Range	Units
Hematology/Coagulation				
CBC				
WBC [5]	**5.0**		3.7-10.8	K/uL
RBC	**5.08**		4.05-5.64	M/uL
Hemoglobin	**16.3**		13.5-17.5	g/dL
Hematocrit	**47.2**		40.5-52.5	%
MCV	**92.9**		83.0-97.0	fL
MCH	**32.1**		28.0-33.0	pg
MCHC	**34.5**		32.0-36.0	g/dL
Red Cell Distribution Width	**13.0**		11.7-15.2	%
Platelet Count	**191**		150-400	K/uL
Mean Platelet Volume	**10.4**		7.2-13.0	fL
Differential				
Neutrophil %	**65.2**		40.0-74.0	%
Neutrophil Absolute	**3.26**		1.50-7.50	K/uL
Lymphocyte %	**24.8**		19.0-48.0	%
Lymphocyte Absolute	**1.24**		1.00-4.50	K/uL
Monocyte %	**7.8**		4.0-12.0	%
Monocyte Absolute	**0.39**		0.10-0.80	K/uL
Eosinophil %	**2.0**		1.0-6.0	%
Eosinophil Absolute	**0.10**		0.00-0.50	K/uL
Basophil %	**0.2**		0.0-2.0	%
Basophil Absolute	**0.01**		0.00-0.20	K/uL

[1] Test not performed; no specimen received. Please resubmit.

[2] Incidence of 25-OH Vitamin D toxicity increases above 100 ng/mL and the majority of individuals with toxicity have values >150 ng/mL. Increased total calcium may be present.
Jones G Am J Clin Nutr 2008;88:582S

[3] >=6.5%: Consistent with Diabetes
5.7-6.4%: Consistent with Pre-Diabetes
<5.7%: Consistent with lower risk for Diabetes

Diabetes Care 2011;34:S12-S13.

[4] The VAP Test reports a total LDL that consists of the sum of LDL-R, IDL, and Lp(a) with a subsequent goal of <130 mg/dL for a moderate risk patient. All of the goals for the VAP are based on a moderate risk patient with a 10 year Framingham Risk Score of 10 - 20%.
Testing performed by: Atherotech Diagnostic Laboratory
201 London Parkway Birmingham, AL 35211

[5] Please note new reference range of 3.7 - 10.8 k/ul for adult males.

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Report Date: 11/29/2011 08:05

TEST	CURRENT RESULTS	PREVIOUS RESULTS

FINAL REPORT

Medical Director: Stanley Hazen, MD, PhD

CLIA #: 36D1032987

Church,George
ID: #111130115401

11/30/2011 11:54:14

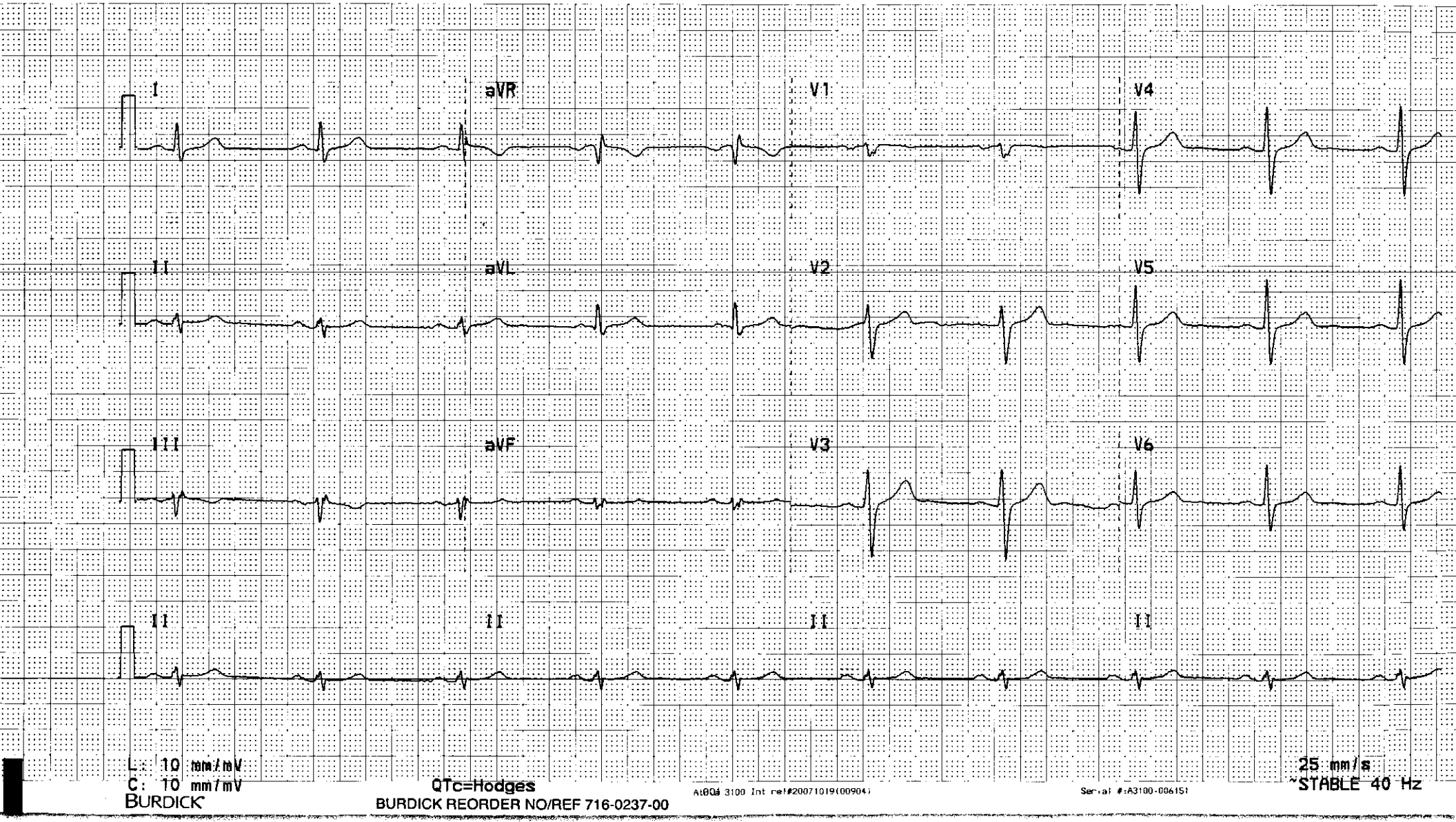
Sinus rhythm.

Normal ECG

* Unconfirmed Analysis *

D.O.B.:
MALE
Dr:
Tech:

Vent. Rate:	58 bpm
RR Interval:	1034 ms
PR Interval:	188 ms
QRS Duration:	104 ms
QT Interval:	422 ms
QTc Interval:	419 ms
QT Dispersion:	54 ms
P-R-T AXIS:	43° -3° 13°



BURDICK

QTc=Hodges

BURDICK REORDER NO/REF 716-0237-00

At60d 3100 Int rel#2007101901(00904)

Serial #:A3100-006151