PERSONAL HEALTH RECORD CD COVERSHEET

Dear: Dr. Church **Physical Exam Date:** _____ **Date:** 11/8/2010

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	**SS#:**		**SEX:(M/F)**	M
Home Address:	218 Kent St		**Apt #:**		
City:	Brookline		**State:** MA	**Zip:**	02446 -5404
Home Phone#:	(617) 277-6803	**Work Phone#:**		**Cell Phone#:**	(617) 462-1347
Email Address:	gmc@harvard.edu				

Emergency Contact Name: (Print if missing)

Name: Relationship: Phone#:

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**
Physical Exam / Dr Report	*** Required**
Lab Report	
EKG Report	
Spirometry Report	
Hearing Report	
Vision Report	
Other Reports	

* Please do not hole punch or staple paperwork

PRINT

11/01/2010 **Progress Note: William E. Goldberg, MD, PC**

Current Medications

Lovastatin 20 MG 1 tablet at bedtime Once a day
Coenzyme Q10 150 MG as directed
Omega 3 1200 MG as directed
Multivitamins as directed

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. GASTROINTESTINAL: Denies anorexia, dysphagia, nausea/vomiting, abdominal pains, heartburn, diarrhea, constipation, bleeding per rectum. GENITOURINARY: Denies dysuria, urgency, freqency, nocturia, sexual dysfunction, vaginal or

Reason for Appointment

1. MDVIP PE

History of Present Illness

HPI Notes:
-- funcitonal GI sx: large portions nuts blood and pain, blood on t.p. not stool
-- strained right shoulder a month ago, improving, but notes it lying on right side in hard bed.
-- Ting (spouse) notes more 'huffing and puffing' walks daily, does not note pain or SOB.

Examination

General Examination:

6'5" 242# 106/70 72

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 tone. Scars: no.
GENITOURINARY - MALE:
Prostate: unremarkable, without nodules.

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.

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
2. Hypercholesterolemia - 272.0

In good health; 1--lipids LDL normal but HDL low, 2-- lose weight, for cardiac health + will bring HDL Up, 3-- dyspnea: Plan Stress Echo, 4- shoulder pain, improving, if set back plan PT.

Treatment

1. Hypercholesterolemia

LAB: LIPID PANEL

TRIGLYCERIDES	124	<150 - mg/dL N
CHOLESTEROL, TOTAL	156	125-200 - mg/dL N
HDL CHOLESTEROL	35	> OR = 40 - mg/dL L
LDL-CHOLESTEROL	96	<130 - mg/dL (calc) N
CHOL/HDLC RATIO	4.5	< OR = 5.0 - (calc) N

LAB: COMPREHENSIVE METABOLIC PANEL W/EGFR

GLUCOSE	92	65-99 - mg/dL N
UREA NITROGEN (BUN)	19	7-25 - mg/dL N
CREATININE	0.86	0.76-1.46 - mg/dL N
eGFR NON-AFR. AMERICAN	>60	> OR = 60 - mL/min/1.73m2 N
eGFR AFRICAN AMERICAN	>60	> OR = 60 - mL/min/1.73m2 N
BUN/CREATININE RATIO	NOT APPLICABLE	6-22 - (calc)
SODIUM	138	135-146 - mmol/L N
POTASSIUM	4.0	3.5-5.3 - mmol/L N
CHLORIDE	105	98-110 - mmol/L N
CARBON DIOXIDE	26	21-33 - mmol/L N
CALCIUM	8.9	8.6-10.2 - mg/dL N
PROTEIN, TOTAL	6.6	6.2-8.3 - g/dL N
ALBUMIN	4.3	3.6-5.1 - g/dL N
GLOBULIN	2.3	2.1-3.7 - g/dL (calc) N
ALBUMIN/GLOBULIN RATIO	1.9	1.0-2.1 - (calc) N
BILIRUBIN, TOTAL	1.3	0.2-1.2 - mg/dL H
ALKALINE PHOSPHATASE	64	40-115 - U/L N
AST	23	10-35 - U/L N
ALT	24	9-60 - U/L N

LAB: CREATINE KINASE, TOTAL

CREATINE KINASE, TOTAL	182	44-196 - U/L N
LAB: CARDIO CRP(R)		
CARDIO CRP(R)	0.8	- mg/L N

Diagnostic Imaging

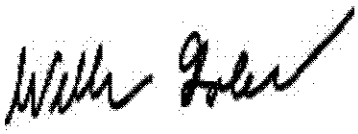
Stress Echocardiagram Murray,Kerri E 11/1/2010 8:43:31 AM > MI 1996, D.O.E. Murray,Kerri E 11/1/2010 8:43:31 AM > MI 1996, D.O.E., EKG- MDVIP

Labs

Lab: TSH, 3RD GENERATION (Ordered for 10/28/2010)		
TSH, 3RD GENERATION	2.65	0.40-4.50 - mIU/L N
Lab: CBC (INCLUDES DIFF/PLT) (Ordered for 10/28/2010)		
WHITE BLOOD CELL COUNT	5.5	3.8-10.8 - Thousand/uL N
RED BLOOD CELL COUNT	4.81	4.20-5.80 - Million/uL N
HEMOGLOBIN	15.9	13.2-17.1 - g/dL N
HEMATOCRIT	46.6	38.5-50.0 - % N
MCV	97.0	80.0-100.0 - fL N
MCH	33.1	27.0-33.0 - pg H
MCHC	34.2	32.0-36.0 - g/dL N
RDW	13.1	11.0-15.0 - % N
PLATELET COUNT	180	140-400 - Thousand/uL N
NEUTROPHILS	71.2	- % N
ABSOLUTE NEUTROPHILS	3916	1500-7800 - cells/uL N
LYMPHOCYTES	19.5	- % N
ABSOLUTE LYMPHOCYTES	1073	850-3900 - cells/uL N
MONOCYTES	7.6	- % N
ABSOLUTE MONOCYTES	418	200-950 - cells/uL N
EOSINOPHILS	1.2	- % N
ABSOLUTE EOSINOPHILS	66	15-500 - cells/uL N
BASOPHILS	0.5	- % N
ABSOLUTE BASOPHILS	28	0-200 - cells/uL N
MPV	8.7	7.5-11.5 - fL N
Lab: PSA, TOTAL (Ordered for 10/28/2010)		
PSA, TOTAL	0.5	< OR = 4.0 - ng/mL N

Preventive Medicine

flu 2010; colon 2006



Electronically signed by William Goldberg on 11/08/2010 at 09:18 AM EST

Sign off status: Completed

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Church,George
ID: #101101084009

11/01/2010 8:40:20

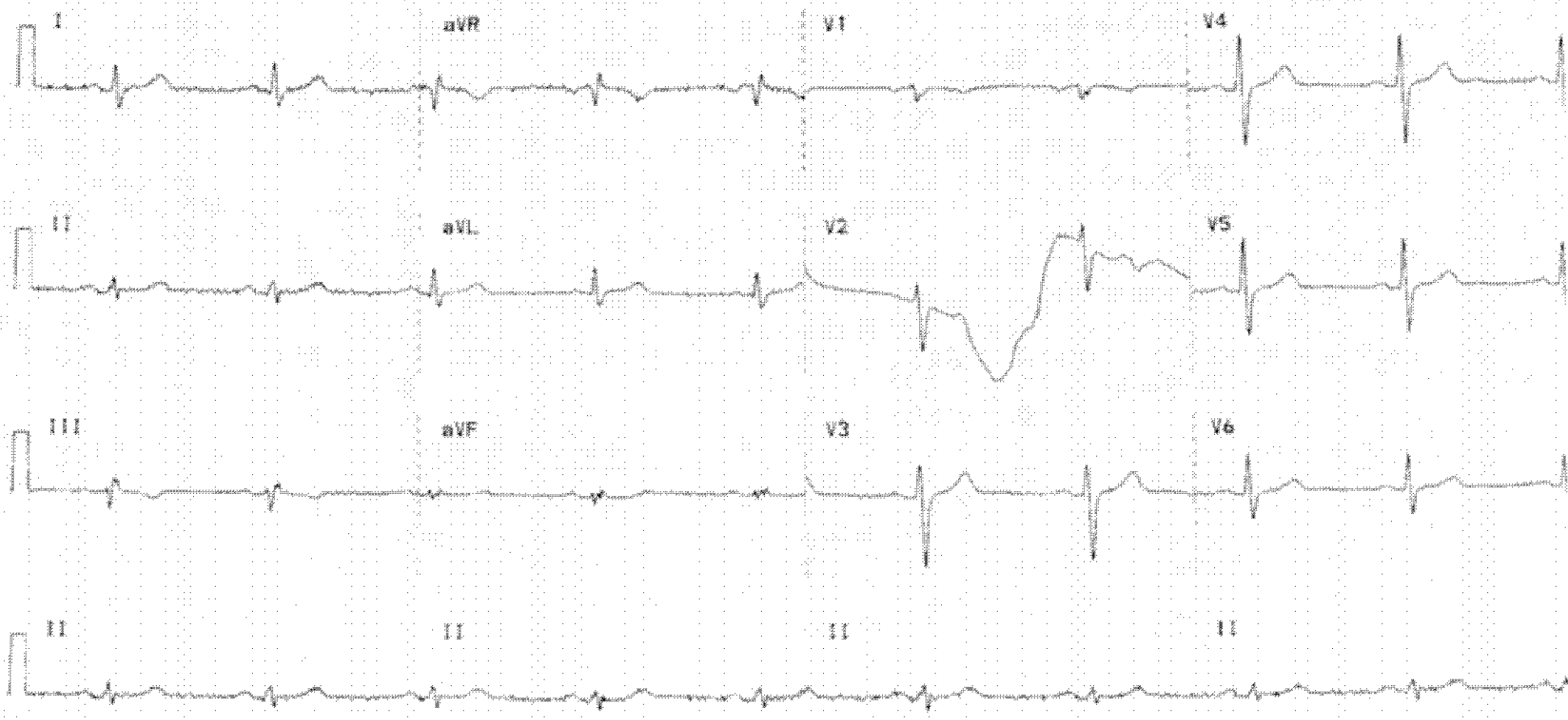
Sinus rhythm.

Normal ECG

* Unconfirmed Analysis *

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

Vent. Rate:	57	bpm
RR Interval:	1046	ms
PR Interval:	178	ms
QRS Duration:	104	ms
QT Interval:	430	ms
QTc Interval:	425	ms
QT Dispersion:	54	ms
P-R-T AXIS:	45° 17°	13°



L: 10 mm/mV
C: 10 mm/mV

QTc=Hodges

25 mm/s
STABLE 40 Hz