

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

12609



3 - OUTPATIENT

DATE 3-2-97

HISTORY: <sup>at 12:00</sup> clb lump on @side of throat x 1 Day

T 991

Asymptomatic

MEDS - scp qd

BP 118/76

ALLERGIES: - Pen - ?

PE: NORMAL ABNORMAL

HEAD

EARS

THROAT

NECK

HEART

LUNGS

ABDOMEN

EXTREMITIES

SKIN

Firm enlargement  
@ Thyroid  
Noch nrv

DX. Mass @ Thyroid Lobe

RX. Ultra Sound

cancelled  
over

ophthalm

[Redacted]

DATE:

HISTORY:

Verbal report bilateral thyroid lobe nodules. Clinically correlation recommends flu

[Redacted]

MEDS:

Rt Thyroid 4.1cm

ALLERGIES:

Lt. Thyroid 3.7cm

PE:

NORMAL

ABNORMAL

HEAD

EARS

THROAT

NECK

HEART

LUNGS

ABDOMEN

EXTREMITIES

SKIN

at mid portion of Rt lobe there is a 2.5cm complex nodule predominantly cystic + in lower pole of Lt. Thyroid there is a 110mm hypo-ecchoic nodule containing a small calcification

Thyroid US  
10:30  
3/3/97

[Redacted]

DX:

RX:

DATE: 3/4/97

HISTORY:

here to discuss Thyroid test results + Dr [Redacted]

[Redacted]

Preliminary Report

Thyroid scan uptake - dominant cold nodule Rt. upper pole 21%

8:30 am 3-5-97

MEDS:

NFD after midnight

ALLERGIES:

PE:

NORMAL

ABNORMAL

HEAD

EARS

THROAT

NECK

HEART

LUNGS

ABDOMEN

EXTREMITIES

SKIN

as seen

Flammigan

CBC  
chem. profile

Thyroid profile

Thyroid scan

DX:

Thyroid nodule  
- (2) Boreas mass.

RX:

of thyroid scan  
→ refer to

show cold nodule  
surgon

000003

NAME: [REDACTED]

DATE: \_\_\_\_\_

IMPRESSION: ① Thyroid nodule  
② Breast mass ④

TREATMENT PLAN: ① CBC  
② Thyroid profile  
③ Chem. profile

LABS/X-RAY ④ Thyroid scan  
⑤ Mammograms

REFERRALS:

RECOMMENDATIONS/INSTRUCTIONS: If thyroid scan is (+) →  
will refer to a surgeon.

PATIENT EDUCATION: DIET  EXERCISE  SE, BREASTS OR TESTES   
TOBACCO  ALCOHOL  SUBSTANCE ABUSE   
SEX PRACTICES  BEREAVEMENT/DEPRESSION   
VISIT-SPECIFIC:

MEDICATIONS PRESCRIBED:

Name	Dose	Freq.	# Refills

FOLLOW-UP VISIT: 2 wks

PHYSICIAN: [REDACTED] MD

DATE: 3/4/97

NAME: [REDACTED]

DOB: [REDACTED]

DATE: 3/4/97

CHIEF COMPLAINT: Thyroid gland enlargement

TEMPERATURE 98 PULSE 96 RESPIRATION 18  
BLOOD PRESSURE 130/80 HEIGHT 5'6" WEIGHT 160 lbs

GENERAL CONDITION: essentially (N)

EXAM - N = NEGATIVE		POSITIVE FINDINGS
SKIN	N	
HEAD/FACE	N	
FUNDOSCOPIC	N	uncorrected OD 20/20, OS 20/20
EARS	N	
HEARING ACUITY	N	
NOSE	N	
NECK	<del>N</del>	→ palpable nodular mass @ thyroid gland
THROAT/MOUTH	N	
CHEST	N	
HEART	N	
BREASTS	-	LAST MAMMO: none so far RESULTS:
LUNGS		→ palpable mass in @ breast, near the areola
LYMPHATIC	N	
ABDOMEN	N	
GENITAL		
PELVIC	N	LAST PAP: 6 mos. ago RESULTS: allegedly (-)
RECTAL		to gynecologist
EXTREMITIES	N	
BACK/SPINE	N	
NEURO	N	
EMOTIONAL	N	

000005

DATE: 3/7/97

HISTORY: called for Verbal results of Thyroid Scan, [redacted]

\*A Dominant Cold Nodule Rt. Upper Pole 21% Uptake.

MEDS.

ALLERGIES

Mammo - Verbal - No Evidence of

PE:

NORMAL

ABNORMAL

HEAD

Malignancy. Sensitivity - Somewhat limited due to tissue density. Clinical

EARS

THROAT

Suspicious Palpable Abnormal. Warrant further evaluation despite - neg mammo.

NECK

HEART

LUNGS

ABDOMEN

EXTREMITIES

SKIN

3/7/97

patient notified

Tues March 11<sup>th</sup>

8:15 p.m.

DX:

results

Ref: Refer to a Surgeon

ENT

pt. notified

DATE: 3/12/97

HISTORY: Pt phoned name of Surgeon for referral for Lt breast mass. DR [redacted]. Referral written per pt request.

MEDS.

ALLERGIES

PE:

NORMAL

ABNORMAL

HEAD

EARS

THROAT

NECK

HEART

LUNGS

ABDOMEN

EXTREMITIES

SKIN

per Dr [redacted] to Endocrinologist re: results Thyroid U5

For April 2<sup>nd</sup> 1997

Pt aware - results + referral passed to [redacted] group

DX

RX

000006

NAME		DATE	
ADDRESS		DATE	
DATE: 8/1/97	HISTORY: Pt. states she saw Dr. [redacted] for follow up on problems taking Synthroid, especially having side effects, tried to contact Dr. [redacted] but is not in today, having chest palpitations. Was on Synthroid 0.075 mg. → had		
BP - 108/78	MEDS: BCP 0.05 mg. but patient		
PA - 80, regular	ALLERGIES: PCN		
	PE:	NORMAL	ABNORMAL
[redacted]	HEAD		continued to have
[redacted]	EARS	✓	side effects from Synthroid discontinued
8/2/97 [redacted]	THROAT	-	2 days ago. Symptoms
[redacted]	NECK	✓	breath;
Pt. in/norm	HEART	✓	throat inflamed
of [redacted]	LUNGS	✓	thyroid gland not enlarged
to [redacted]	ABDOMEN		
of [redacted]	EXTREMITIES		
of [redacted]	SKIN		Hand sounds (R) + regular
8/2/97 [redacted]	DX:	Acute pharyngitis / Thyroid nodules	
Pt. not present	RX:	Eryc 250 mg qid x 10 days to start if PCN	
8/2/97 [redacted]			
DATE: 8-9-97	HISTORY: Pt states having heart palpitations, Vomiting & Diarrhea no appetite x 3 days Pt seen [redacted] ER on 8-7-97 (Swollen lymph nodes x 4 months)		
T 98.8	hx of thyroid cyst (C), (C) breast mass w/pt was evaluated and confirmed to be benign.		
BP - 130/106	MEDS: Xanax 0.5, til, Valium not phr, Hydrocortisone 200 mg		
P - 86 R - 20	ALLERGIES PCN, Synthroid		
	PE:	NORMAL	ABNORMAL
No associated fever. Had a little bit of vomiting today & some diarrhea. hx of infectious mononucleosis	HEAD	-	190.005, quite nervous
	EARS	-	
	THROAT		normal
	NECK		no palpable mass
	HEART		tachycardia but regular. NO murmurs or gallops heard
	LUNGS		clear
	ABDOMEN		flat & soft. hyperactive bowel sounds. No tenderness or guarding
	EXTREMITIES		
	SKIN		
	DX:	R/S Urinal syndrome	
	RX:	Tigan Suppository 200 mg T.I.D. as needed. fluids only until vomiting & diarrhea stops. Advise to come in for recheck 11 Aug 97.	
		CBC, SMA done	

000007

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 03/03/1997 11:32AM

ACCOUNT NO: [REDACTED] DATE OF BIRTH: [REDACTED] 27Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] THYROID

WORKING DIAGNOSIS: MASS

FINDINGS: The right thyroid lobe is 4.1 cm long. The parenchyma is mildly inhomogeneous. At the mid-portion of the right lobe, there is a 2.5 cm complex nodule predominantly cystic with a few internal echoes and suggestion of mural calcification.

The left thyroid lobe is 3.7 cm long. In the lower pole, there is a 10 mm hypoechoic nodule containing a small calcification.

IMPRESSION: Bilateral thyroid lobe nodules, with the above sonographic characteristics. Clinical correlation and follow-up are suggested.

[REDACTED] 1).

ULTRASOUND ACCREDITED BY THE [REDACTED]

[REDACTED] 03/03/1997 / 07:55PM  
Print Date/Time: 5-MAR-97/17:30:35

[REDACTED]

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 03/03/1997 11:32AM

ACCOUNT NO: [REDACTED] DATE OF BIRTH: [REDACTED] 27Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] - THYROID

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IMPRESSION: Bilateral thyroid lobe nodules, with the above sonographic characteristics. Clinical correlation and follow-up are suggested.

[REDACTED]  
03/03/1997

ULTRASOUND ACCREDITED BY THE [REDACTED]

[REDACTED] 03/03/1997 / 07:55PM  
Print Date/Time: 5-MAR-97/17:30:35





Sample [REDACTED] Date: 02-04-97

Patient Name: [REDACTED] Sex: M

DOB: [REDACTED] City: F State: [REDACTED]

Code	Unit	Value	Range #1	Code	Unit	Value	Range #1	Code	Unit	Value	Range #1
WBC	10 <sup>3</sup> /L	10.5	4.5-10.5	PRC	%	47.2	40.0-60.0	Plt	10 <sup>3</sup> /L	370	150-450
Hgb	g/dL	10.7	12.0-16.0	Hct	%	30.7	37.0-47.0	MPV	fL	7.4	8.0-11.0
Hct	%	30.7	37.0-47.0	MCV	fL	28.4	80.0-100.0				
RDW	%	13.3	11.5-14.5	RDW	%	13.3	11.5-14.5				

REVIEW RESULT

ACCESSION ID: [REDACTED]

DEQUIRY ID: [REDACTED]

03/05/97

REQUISITION NO: [REDACTED]

SEX: (F) COLLECTION DATE: (04-MAR-97) ACCESSION DATE: (05-MAR-97) REPORT DATE: (05-MAR-97) ACCOUNT NO: [REDACTED] ORDERING PHYSICIAN: [REDACTED] REFILL: [REDACTED]

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
TESTS ORDERED: THYROID COMPREHENSIVE, AUTO CHEM PANEL.				
AUTO CHEM PANEL:				
GLUCOSE	96		65-115	MG/DL
BUN	10		5-26	MG/DL
CREATININE	0.9		0.5-1.5	MG/DL
SODIUM	148		135-148	MEQ/L
POTASSIUM	4.7		3.5-5.5	MEQ/L
CHLORIDE	104		96-109	MEQ/L
URIC ACID	3.7		2.2-7.7	MG/DL
T. PROTEIN	7.9		6.0-8.5	G/DL
ALBUMIN	4.5		3.5-5.5	G/DL
GLOBULIN	3.4		2.2-4.1	G/DL
A/G RATIO	1.3		0.9-2.0	RATIO
CALCIUM	9.8		8.5-10.6	MG/DL
PHOSPHORUS	3.4		2.5-4.5	MG/DL
CHOLESTEROL	183		100-199	MG/DL
TRIGLYCERIDE	131		0-199	MG/DL
ALKALINE PHOS	81		40-150	U/L
SGOT (AST)	17		0-45	U/L
SGPT (ALT)	18		0-50	U/L
LDH	123		100-250	U/L
TOTAL BILIRUBIN	0.4		0.1-1.2	MG/DL
GGT	20		0-70	U/L
IRON		27 LO	40-180	MCG/DL
THYROID PROFILE:				
T-3 UPTAKE		22.9 LO	25.0-39.0	%
THYROXINE (T4)		12.1 HI	4.5-12.0	MCG/DL
T4 INDEX	2.8		1.6-3.7	INDEX
SH-HIGHLY SENSITIVE:				
TSH-HIGHLY SENS	0.96		0.35-5.50	MCIU/ML
T3, TOTAL:				
T3, TOTAL	131		60-181	NG/DL

↑ binding proteins

00x  
00x  
00x  
x00x  
x00x

T3\*

000011



DEPARTMENT OF RADIOLOGY

PATIENT: [REDACTED]  
BIRTH DATE: [REDACTED]  
PATIENT #: [REDACTED]

PHYSICIAN: [REDACTED]  
EXAM DATE: 3/5/97

**BILATERAL MAMMOGRAPHY**

CLINICAL HISTORY: BASELINE EXAM. PATIENT CLAIMS HER PHYSICIAN HAS PALPATED A BREAST ABNORMALITY. HISTORY OF BREAST CANCER IN MOTHER.

FINDINGS: No dominant mass, suspicious cluster of microcalcifications or area of skin irregularity is seen to suggest malignancy in either breast.

IMPRESSION: NO EVIDENCE OF MALIGNANCY. THE SENSITIVITY OF THIS STUDY IS SOMEWHAT LIMITED DUE TO THE TISSUE DENSITY.

A CLINICALLY SUSPICIOUS PALPABLE ABNORMALITY WARRANTS FURTHER EVALUATION DESPITE NEGATIVE MAMMOGRAPHY.

THANK YOU KINDLY FOR YOUR REFERRAL.



[REDACTED]  
D 3/6/97  
T 3/7/97  
[REDACTED]



000012

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 03/06/1997 12:21PM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 27Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] - THYROID UPTAK W SCAN [REDACTED]

WORKING DIAGNOSIS: NODULES

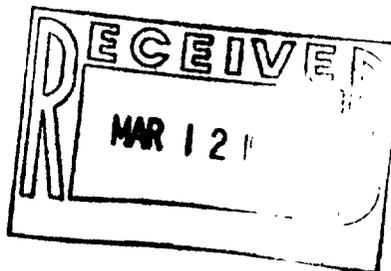
FINDINGS: Thyroid uptake: After oral ingestion of 6.9uCi of I-131, 2- and 24-hour uptake values are 7.0% and 21.9%. These are in the euthyroid range.

A scan was performed after IV injection of 10mci of Tc-99m pertechnetate. The scan shows a large, dominant cold nodule deforming the mid- and upper pole of the right thyroid lobe. This corresponds to the cystic lesion seen on the ultrasound examination. The left lobe is more normal in size and has minimal inhomogeneity with no clear-cut dominant mass.

IMPRESSION: 1. There is a dominant cold nodule arising from the mid-to upper pole of the right thyroid lobe corresponding to the cystic lesion seen on the recent ultrasound exam. 2. Normal iodine uptake with 21.9% measured at 24 hours.

[REDACTED] M.D.  
03/07/1997

[REDACTED] 03/07/1997 / 12:15PM  
Print Date/Time: 7-MAR-97/18:15:48



PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 03/06/1997 12:21PM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 27Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] THYROID UPTAK W SCAN [REDACTED]

WORKING DIAGNOSIS: NODULES

FINDINGS: Thyroid uptake: After oral ingestion of 6.9uCi of I-131, 2- and 24-hour uptake values are 7.0% and 21.9%. These are in the euthyroid range.

A scan was performed after IV injection of 10mci of Tc-99m pertechnetate. The scan shows a large, dominant cold nodule deforming the mid- and upper pole of the right thyroid lobe. This corresponds to the cystic lesion seen on the ultrasound examination. The left lobe is more normal in size and has minimal inhomogeneity with no clear-cut dominant mass.

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1. There is a dominant cold nodule arising from the mid- to upper pole of the right thyroid lobe corresponding to the cystic lesion seen on the recent ultrasound exam.
  2. Normal iodine uptake with 21.9% measured at 24 hours.

[REDACTED] M. D.  
03/07/1997

[REDACTED] 03/07/1997 / 12:15PM  
Print Date/Time: 7-MAR-97/18:15:46

000014

CONSULTATION REPORT

TO:

[REDACTED]

March 13, 1997

RE:

[REDACTED]

DOB

[REDACTED]

POSITIVE FINDINGS.

3/11/97 (C) Young woman, 27 years old, who noted a lump in her neck a week or two ago. She went to her primary care doctor where she had a thyroid scan and apparently an ultra sound. Do not have report of ultra sound but thyroid scan shows a dominant cold nodule in R thyroid lobe. Patient has no symptoms referable to hyper or hypothyroidism. Thyroid function studies, by the way, are normal. No history of radiation to her head or neck. She does have history of endometriosis and takes birth control pills for regulation of her periods. She takes occasional nonsteroidal anti-inflammatories for chronic inflammation of her eye. Only surgery in the past was overectomy for the endometriosis. She is a 1 pack per day cigarette smoker, no alcohol or drug abuse. There is family history of cancer. ALLERGIC TO PENICILLIN.

PE: young woman in no acute distress.

Ears: canals and drums clear.

Nose: clear.

M & T: no lesions.

Larynx: a little redness of cords, they move well.

Neck: approximately 2 1/2-3 cm. slightly firm mass in R thyroid lobe area. Non tender. I do not palpate any masses in L thyroid lobe. No other enlarged nodes or masses in the neck.

I elected to perform fine needle aspiration and got into what appeared to be a cyst and approximately 1 1/2 cc of serous fluid which did become a little bloody at the end. This did shrink the size of the mass down to about 2 cm. I then repeated the fine needle aspiration and sent slides both for cytology as well as liquid for cell block exam.

I discussed implication of her thyroid disease. Most likely diagnosis would be ~~thyroid cancer~~. However, if anything suggestive at all of malignancy, then thyroid surgery would be indicated. Assuming nothing to suggest malignancy, then a course of thyroid suppression would probably be the next step indicated, which could be carried out either by her primary care physician or with referral to an endocrinologist. Patient is to be seen by me in a week to discuss results of fine needle aspirations.

[REDACTED]

[REDACTED]

M.D.

[REDACTED]

000015

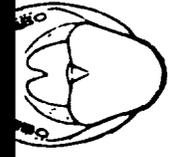
Name  
Addr  
Bill  
Date 03/11/97  
DOB

Ins#1  
Ins#2

Referred By

Employer:  
Age 27  
Home Phn:

Work Phn:



3/11/97 (C) Young woman, 27 years old, who noted a lump in her neck a week or two ago. She went to her primary care doctor where she had a thyroid scan and apparently an ultra sound. Do not have report of ultra sound but thyroid scan shows a dominant cold nodule in R thyroid lobe. Patient has no symptoms referable to hyper or hypothyroidism. Thyroid function studies, by the way, are normal. No history of radiation to her head or neck. She does have history of endometriosis and takes birth control pills for regulation of her periods. She takes occasional nonsteroidal anti-inflammatories for chronic inflammation of her eye. Only surgery in the past was orectomy for the endometriosis. She is a 1 pack per day cigarette smoker, no alcohol or drug abuse. There is family history of cancer. ALLERGIC TO PENICILLIN.  
PE: Young woman in no acute distress.  
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Att #1

and sent slides both for cytology as well as liquid for cell block exam.  
I discussed implication of her thyroid disease. Most likely diagnosis would be multinodular goiter with cystic degeneration. However, if anything suggestive at all of malignancy, then thyroid surgery would be indicated. Assuming nothing to suggest malignancy, then a course of thyroid suppression would probably be the next step indicated, which could be carried out either by her primary care physician or with referral to an endocrinologist. Patient is to be seen by me in a week to discuss results of fine needle aspirations. -12

3/17/97 Maxed Path Report to Primary . . .

3/18/97 NO SHOW - SPOKE WITH ROOM MATE ABOUT HER RETURNING FOR FOLLOW-UP. SHE WILL HAVE HER CALL US SHORTLY TO RESCHEDULE.

NOTE: PT. CALLED BACK. IS NOT RETURNING ON ADVICE OF OUR OFFICE - JUST FOLLOWING UP WITH HER PRIMARY HAS ALSO SEEN ANOTHER SURGEON WHO REBX. HER NECK AND AGREES EVERYTHING IS O.KAY.

AH #1

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE  
DIVISION OF ANATOMIC PATHOLOGY



NON GYNECOLOGICAL CYTOLOGY REPORT

NAME: [REDACTED]

LOC: [REDACTED]  
ORDERED FROM: [REDACTED]

DOB: [REDACTED]  
MED REC#: [REDACTED]  
ACCT #: [REDACTED]

DR: [REDACTED]



COLLECTED: 03/11/97  
RECEIVED: 03/12/97

Copy To:

SOURCE: FNA THYROID

DESCRIPTION: PRESMEARED + FLUID

CLINICAL DX/HX: THYROID NODULE

PRIOR BX/CYTOLOGY: UNSPECIFIED

THERAPY: UNSPECIFIED

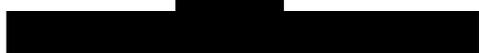
DIAGNOSIS:

SMEARS AND CELL BLOCK:

Histiocytes and colloid; although the findings are consistent with a benign colloid nodule, no epithelial component is identified and therefore, clinical correlation is recommended.



CYTOTECHNOLOGIST



CYTOPATHOLOGIST

REPORTED: 03/13/1997

000018

██████████  
Office visit:  
03/17/97

██████████ is a 27-year old referred by Dr. ██████████ for evaluation of a left breast mass, and a right thyroid lesion. The patient noted a questionable lump in the left lower outer quadrant on routine physical examination. She is tentatively scheduled to see Dr. ██████████ in the near future, but presents for evaluation of the lesion at this time. A mammogram was performed on 03/05/97, and this did not define a dominant mass nor where any other suspicious signs for malignancy identified.

The patient's past history is positive for an RSO and appendectomy, which was performed in 1994 because of endometriosis. She apparently has been free of symptoms since that time until very recently when she again began to have similar abdominal complaints. She also had a cyst on her neck excised many years ago. She had menarche at age 12 or 13, her periods are regular. She is presently on birth control pills, and has been for two years. She is nulliparas. Her family history is distantly positive with a maternal grandmother and maternal great grandmother who both had breast cancer. Her mother is free of disease. There is no other family history of malignancies. She denies the use of coffee, cola, and chocolate. She drinks tea on an every other day basis. She has an allergy to Penicillin. She states that she has never had Penicillin, but has a very strong family history, so she has been told to state this as an allergy. She also apparently is allergic to Compazine. Her only medications are Ortho-Cyclen and Ansaid. She smokes somewhat less than a pack of cigarettes a day. She averages five to six alcoholic beverages a week, and does not use aspirin.

During a routine physical exam the patient was also noted to have a mass in her neck. She had noted a sore throat, and brought this to Dr. ██████████ attention. She had seen Dr. ██████████ at the ██████████ for a physical examination as part of her PHP initiation, and apparently Dr. ██████████ noted the lesion in her neck as well as a mass in the upper outer aspect of the left breast. The patient was referred to Dr. ██████████ who apparently performed a biopsy of the thyroid without an effect on the size of the lesion. The patient has had thyroid function studies performed which are essentially normal. She had a thyroid scan which showed a cold nodule in the superior pole of the right lobe of the thyroid. An ultrasound however, suggested that this was a cyst. The cytology was benign. However, in the face of the ultrasound findings the aspiration that was performed did not really coincide with the previous studies.

[REDACTED]

Office visit:  
03/17/97

On examination her blood pressure is 110/74. Her chest is clear, heart is regular. Abdominal exam is benign. She has the 2cm lesion in the superior pole of the right lobe of the thyroid. On breast exam the breasts are symmetrical without adenopathy. There is a 1 x 2cm lesion basically at 2 o'clock just off the nipple areolar margin on the left hand side. I performed aspirations of both lesions. The breast mass was sent for cytology as a fine needle aspirate. On attempting aspiration of the thyroid, I entered a cyst and removed 3cc of a serosanguinous fluid with complete disappearance of the mass in the patient's neck. This also was sent for cytology.

If this is benign, I would like to reevaluate the patient in two months time. If there is a recurrence of the cyst in the neck, the superior aspect of the lobe should be removed. If the cyst does not recur, no further intervention should be needed. The breast intervention will depend upon the results of cytology and clinical follow-up.

[REDACTED] M.D.

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE  
DIVISION OF ANATOMIC PATHOLOGY



NON GYNECOLOGICAL CYTOLOGY REPORT

NAME: [REDACTED]

LOC: [REDACTED]  
ORDERED FROM: [REDACTED]

DOB: [REDACTED]  
MED REC#: [REDACTED]  
ACCT #: [REDACTED]

DR: [REDACTED]



COLLECTED: 03/17/97  
RECEIVED: 03/18/97

Copy To:

SOURCE: LT. [REDACTED] BREAST

DESCRIPTION: PRESMEARED

CLINICAL DX/HX: UNSPECIFIED

PRIOR BX/CYTOLOGY: UNSPECIFIED

THERAPY: UNSPECIFIED



DIAGNOSIS:

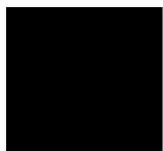
No epithelial component identified (see note).

Note: Hypocellular specimen consisting of fibroadipose tissue, histiocytes and fat. Please correlate with clinical and mammographic findings.

[REDACTED]  
CYTOTECHNOLOGIST

[REDACTED]  
CYTOPATHOLOGIST

REPORTED: 03/19/1997



000021

DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE  
DIVISION OF ANATOMIC PATHOLOGY



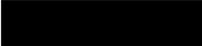
NON GYNECOLOGICAL CYTOLOGY REPORT

NAME: [REDACTED]

LOC: [REDACTED]  
ORDERED FROM: [REDACTED]

DOB: [REDACTED]  
MED REC#: [REDACTED]  
ACCT #: [REDACTED]

DR: [REDACTED]



COLLECTED: 03/17/97  
RECEIVED: 03/18/97

Copy To:

SOURCE: [REDACTED] THYROID

DESCRIPTION: 2cc BLOODY FLUID [REDACTED]

CLINICAL DX/HX: UNSPECIFIED

PRIOR BX/CYTOLOGY: UNSPECIFIED

THERAPY: UNSPECIFIED

DIAGNOSIS:

CATEGORY: NON-DIAGNOSTIC.

Specimen consists only of colloid and numerous histiocytes. No follicular epithelium identified.

[REDACTED]  
CYTOTECHNOLOGIST

[REDACTED]  
CYTOPATHOLOGIST

REPORTED: 03/20/1997



[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

INITIAL OFFICE VISIT

[REDACTED]

APRIL 25, 1997

**HISTORY OF PRESENT ILLNESS:** [REDACTED] is a 27 year old white female kindly referred by Dr. [REDACTED] for a full evaluation of her thyroid. The patient noted a lump in her neck one day in March and was seen on 3/4/97 at [REDACTED]. At that time she had normal thyroid function tests and was subsequently seen by Dr. [REDACTED] for further evaluation. She had a biopsy which was negative, but limited because there was no epithelium. She subsequently saw Dr. [REDACTED] and had a repeat biopsy which was benign. She is scheduled to follow up with him next month. The second biopsy caused significant shrinkage of the nodule and it has not recurred. There is no known family history of thyroid disease and no known exposure to radiation.

The patient notes no local neck symptoms, no pain, discomfort, hoarseness, stridor or dysphagia. She reports that her energy is adequate. Over the last 2 weeks her skin has been severely itchy at night which keeps her up. There is no visible rash, although it is slightly dry. Her weight increased 40 pounds approximately 5 years ago and she has been unable to lose it since. She is now taking something called Direct Health which is herbs for weight loss. She notes no shakiness or palpitations, but she does have a slight tremor that is chronic. She has some slight nausea which seems related to the herbs that she is taking and she also notes some polyuria since taking them. There has been no associated polydipsia. She has had menarche at age 12 or 13. They have always been regular and she has had significant discomfort. She recently has had some breakthrough bleeding.

**PAST MEDICAL HISTORY:** Significant for endometriosis. She is status post a right oophorectomy and appendectomy. She is followed by Dr. [REDACTED]. She also has had a recurrent problem with scleritis or episcleritis. She recently had an aspiration of a cyst in her left breast by Dr. [REDACTED]. She reports that she used to have a lot of problems with her stomach although there was no clear diagnosis and this resolved after college. She is allergic to Penicillin but does not know what reaction she had. Her current medications are Ansaid prn for eye pain and Orthocyclin.

**FAMILY HISTORY:** There is no known family history of thyroid disease, diabetes mellitus, or CVA. All of her grandparents have hypertension. Mother has arthritis, father is healthy. Maternal grandmother and maternal great grandmother had breast cancer. Paternal grandmother - status post MI in the 70's

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

000023

APRIL 25, 1997

INITIAL OFFICE VISIT  
PAGE 2

and apparently there is one cousin with Crohn's disease. There is a strong family history of fibrocystic breast disease as well.

**SOCIAL HISTORY:** The patient is single and has no children. She is presently working part time and working on her dissertation in Sociology. She smokes less than 1 pack per day intermittently for 10 years and drinks several <sup>weeks</sup> ~~one~~ <sup>drinks</sup> one time per week.

**REVIEW OF SYSTEMS:** Was completely negative except for as mentioned in the HPI.

**PHYSICAL EXAMINATION:** The patient is a very pleasant young female who is in no acute distress. Her current weight is 163 pounds. Blood pressure is 120/82 with a pulse of 88. HEENT examination: Pupils are equally round and reactive to light and accommodation. Extraocular movements are intact. On the inferior portion of her left eye there is injection. There is no drainage or tearing. There is mild photosensitivity. The fundi are without lesions. There is no exophthalmos or lid lag. Canals are clear, tympanic membranes are intact. The oral mucosa and pharynx are without lesions. The neck is supple without adenopathy. The thyroid on palpation: The left side is normal on palpation without palpable nodularity. The right is enlarged to approximately 2 times normal, but I am unable to appreciate any discreet nodularity to it. Lungs are clear. Cardiac exam reveals a regular rate and rhythm. S1, S2 without murmur rub, or gallops. Abdomen is soft, non-tender, positive bowel sounds without masses or organomegaly. Extremities: There is no clubbing, cyanosis or edema. Neurologic exam: There are no focal, motor or sensory deficits. The cranial nerves are intact. The reflexes are brisk and symmetric with normal relaxation phase and no tremor is present.

**LABORATORY DATA:** The patient had blood work done on 3/4/97. She had a TSH of 0.96, a total T3 of 131 and a T7 index of 2.8, all of which are normal. Her T3 uptake was low at 22.9 and her total T4 was elevated at 12.1 consistent with her being on the birth control pills. Thyroid ultrasound revealed a mid-right sided nodule measuring 2.5 cm which was complex and predominantly cystic and on the left lobe there was a 10 mm hypoacoustic nodule containing a small calcification. She also had a thyroid scan and uptake and the uptakes were normal. The scan revealed a large, dominant cold nodule in the mid to upper pole of the right lobe and the left lobe had minimal inhomogeneity with no clear cut dominant mass. Her

8-8-97: W: Kanax 0.5mg qd: Tpo TTD ~~head~~   
 Ambien 10 mg QHS -coll ~~not coming~~ liquids bar   
 000024

APRIL 25, 1997

INITIAL OFFICE VISIT  
PAGE 3

first biopsy with Dr. [redacted] was on 3/11/97 and revealed histiocytes and colloid. Although these findings were consistent with benign colloid nodule, no ~~affiliate~~ <sup>epithelial</sup> component was identified. I have not yet received a copy of her second biopsy. This was reportedly benign. We will need to obtain this from Dr. [redacted]

**ASSESSMENT:**

This is a 27 year old white female with a history of a thyroid cyst, but there is apparently some solid component to this as well and her biopsies were reportedly negative.

**PLAN:**

We discussed at length the use of Synthroid for suppression. We will discuss this further after I have reviewed her final pathology report. She is to call next week to go over these results and also I have prescribed some Sarna lotion for her to use for the itching. If it persists we will need to look further into its etiology. Her skin is quite dry in spots which is hopefully all that is going on. She will return for follow up here in the office in 8 weeks time and we plan to get some blood work on her then which will include a CBC, iron, TIBC, anti-thyroid antibodies, rheumatoid factor, ANA and sed. rate. Consideration should be given to a Rheumatologic referral regarding her scleritis and episcleritis and any possible associated illnesses.

[redacted]  
[redacted] M.D.

cc: Dr. [redacted]

bx Dr. [redacted] colloid + numerous histiocytes, no follicles  
epith. identified. Plan re r end of April, consider  
flu u/s + repeat bx based on exam.

[redacted]  
7/10/97 000025

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

5/29/97

[REDACTED] is being followed for a thyroid irregularity. It was apparently a cyst that had shrunken away after her second biopsy. Both biopsies turned out to be not fully diagnostic although there is no suggestion of any malignant process. Patient had noted no local neck discomfort in the region of her thyroid and no enlargement there. However, she has had slight pain in the right upper neck by the jaw line. It is a pressure and uncomfortable sensation which is there most of the time and has been present for the last week or so. It should be noted that the patient had a scan that showed a large dominant cold nodule in the right mid to upper lobe and a thyroid ultrasound revealed a right sided nodule measuring 2.5 cm. which was complex, predominantly cystic and on the left a 10 mm. hypoechoic nodule containing a small calcification. Lastly the patient has a history of episcleritis and no clear cut etiology has been found for this.

**PHYSICAL EXAMINATION:** Current Weight 162 lbs., down 1 lb. from her last visit. Blood Pressure 108/72. Pulse 96. Neck is supple with a tender 1 cm. right anterior cervical lymph node just below the mandible. Below this there is a small nodule. The nodules are somewhat tender and are freely mobile. There is no other significant adenopathy that I can palpate. On examination of her thyroid it is soft and approximately two times normal. It is slightly irregular, but I do not appreciate any discreet nodularity. Lungs are clear. Cardiac exam reveals a regular, rate and rhythm, S1, S2 without murmur, rub or gallop. The reflexes are brisk and symmetric with normal relaxation phase and no tremor is present.

**ASSESSMENT:** A non-toxic multinodular goiter by ultrasound with a dominant cold nodule on scan. The nodule has shrunken and possibly disappeared after the second biopsy. Unable to appreciate any discreet nodules on her examination at the present time.

**PLAN:** The plan at this time is to obtain thyroid function tests, anti-thyroid antibodies, CBC, iron studies, RF, ANA and Sed Rate. We will be obtaining a repeat ultrasound at [REDACTED] and based on this we will determine whether any further biopsies are necessary.

[REDACTED]

[REDACTED]

[REDACTED] M.D.

2297. [REDACTED] : X-ray D.Smy [REDACTED] : Tpo TTA # [REDACTED]

000026

[REDACTED]

[REDACTED]

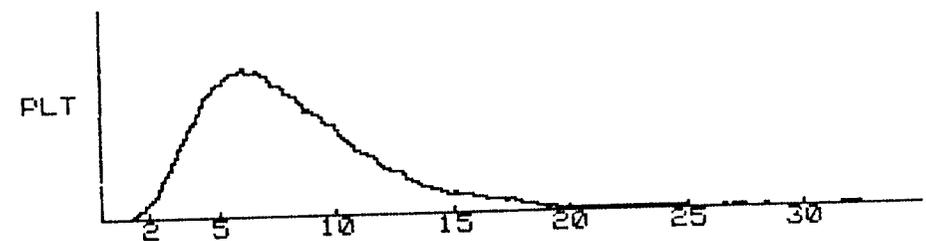
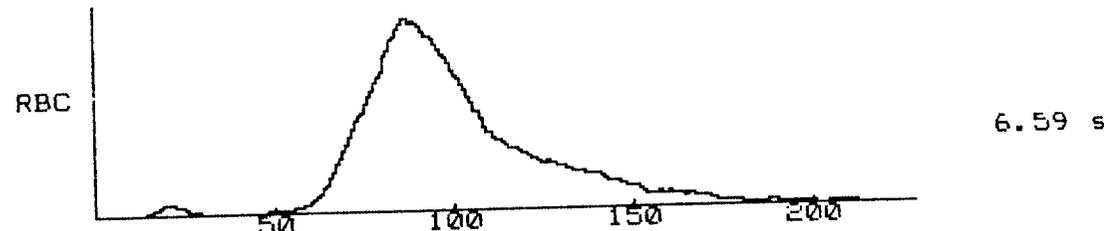
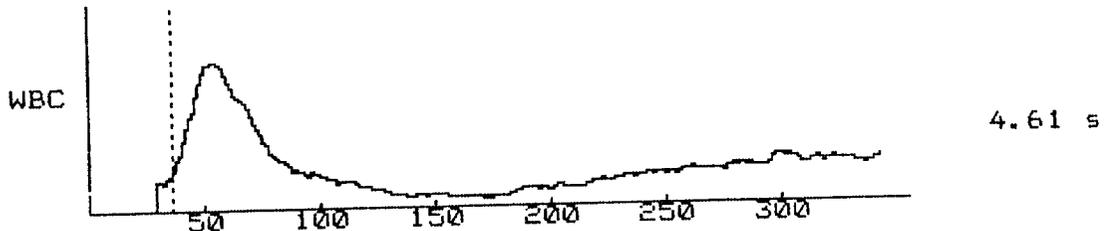
SPECIMEN DATA REPORT

Specimen ID# :  
Type: PATIENT  
(Open)  
WBC: 8.2 K/uL  
LYM: 2.6 31.6 %L  
\*MID: 0.4 4.3 %M  
GRAN: 5.3 64.1 %G

May 29 1997  
Operator I.D.:  
Sequence # :

15:19

RBC: 4.05 M/uL  
HGB: 12.7 g/dL  
HCT: 37.3 %  
MCV: 92. fL  
MCH: 31.4 pg  
MCHC: 34.0 g/dL  
RDW: 15.8 %



\* MID cells may include less frequently occurring and rare cells correlating to monocytes, eosinophils, basophils, blasts and other precursor white cells.

[REDACTED]

000027

[REDACTED]

PATIENT

ACCESSION NO. [REDACTED] REQUESTED BY [REDACTED]

[REDACTED] .05/30/97

REQUISITION NO. [REDACTED]

AGE 28 SEX F COLLECTION DATE 28-MAY-97 ACCESSION DATE 30-MAY-97 REPORT DATE 31-MAY-97 ACCOUNT NO. [REDACTED] ORDERING PHYSICIAN [REDACTED] ROUTE [REDACTED]

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
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TESTS ORDERED: T3, TOTAL, RA LATEX, ANTI-NUCLEAR ANTIBODY, IRON, UIBC, TIBC, % SAT PROF, ANTITHYROID AB, FERRITIN.

IRON: IRON 119 40-180 MCG/DL

T3, TOTAL: T3, TOTAL 203 HI 60-181 NG/DL

RA LATEX: RHEUMATOID FACTOR <10 0-10 IU/mL

RF LATEX RESULTS ARE REPORTED IN INTERNATIONAL UNITS (IU). FOR YOUR CONVENIENCE WE ARE PROVIDING THE FOLLOWING IU/TITER TABLE OF CORRELATION.

IU/ML	TITERS
0-10	1:20
10-20	1:40
20-40	1:80
40-60	1:160
60-130	1:320
130-260	1:640
260-540	1:1280
540-1100	1:2560
1100-2200	1:5120

ANTI-NUCLEAR ANTIBODY: RN ANA, Quant NEGATIVE

Negative for all staining patterns including Anti-Centromere. ANA patterns routinely detected include: Smooth (homogenous or diffuse), Nucleolar, Speckled, Centromere, Peripheral, and Spindle. Hep-2 substrate used.

Negative <=1:40  
Borderline =1:80  
Positive >=1:160

PLEASE NOTE: ANA titer was obtained by automated image system. It may be higher than titers derived manually due to increased sensitivity of the system.

000028

ACCESSION NO.

REQUESTED BY

REQUISITION NO.

05/30/97

AGE

SEX

COLLECTION DATE

ACCESSION DATE

REPORT DATE

ACCOUNT NO.

ORDERING PHYSICIAN

ROUTE

29

F

28-MAY-97

30-MAY-97

31-MAY-97

TEST NAME

WITHIN RANGE

OUTSIDE RANGE

REFERENCE RANGE

UNITS

TESTS ORDERED: T3, TOTAL, RA LATEX, ANTI-NUCLEAR ANTIBODY,  
IRON, UIBC, TIBC, % SAT PROF, ANTITHYROID AB, FERRITIN.

IRON BINDING CAPACITY:

UIBC

263

150-375

MCB/DL

TIBC

382

250-480

MCB/DL

% SATURATION

31

15-55

%

ANTITHYROID AB:

ANTITHYROGLOBULIN A

<1:10

<1:10

TITER

THY MICROSOMAL AB

<1:100

<1:100

TITER

FERRITIN:

FERRITIN

16

10-291

NG/ML

000029

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 06/16/1997 11:46AM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] GUIDANCE FOR BIOPSY

WORKING DIAGNOSIS: THYROID NODULE

FINDINGS: Under aseptic conditions and utilizing ultrasound as guidance, a nodule in the lower pole of the left lobe of the thyroid gland is percutaneously biopsied. Utilizing a 22 gauge spinal needle, aspirate was obtained. Three separate samples were obtained. The samples were sent to the Department of Pathology for evaluation.

IMPRESSION: Percutaneous biopsy of the left lobe of the thyroid gland.

[REDACTED] M. D.  
06/17/1997

ULTRASOUND ACCREDITED BY THE [REDACTED]

[REDACTED] 06/18/1997 / 10:35AM  
Print Date/Time: 19-JUN-97/15:21:54

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 06/03/1997 04:34PM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] THYROID ULTRASOUND

WORKING DIAGNOSIS: NODULE

FINDINGS: Comparison is made with 3/03/97.

There has been interval aspiration of a right lobe nodule.

The right lobe measures 4.1 x 1.5 cm. There are a couple of hypoechoic nodules, 4 mm at the mid-portion of the gland, 8 mm in the lower pole. There is a focus of calcification in the upper pole.

The left lobe measures 3.7 x 1.4 cm. There is a 10 mm hypoechoic nodule with central calcification noted in the lower pole, stable after comparison.

IMPRESSION: Bilateral small thyroid nodules, as described. Clinical correlation and follow-up are suggested.

[REDACTED] M. D.  
06/03/1997

ULTRASOUND ACCREDITED BY THE [REDACTED]

[REDACTED]/06/04/1997 / 10:37AM  
Print Date/Time: 6-JUN-97/14:04:57

*bx of dom. nodule*

[REDACTED]

000031

NAME  
DOB  
MRN  
LOC  
CASE

CC:

---

CYTOPATHOLOGY REPORT

---

Date collected: 06/16/97  
Date received: 06/17/97

Specimen submitted: THYROID NODULE  
SMEARS AND CELL BLOCK  
Clinical data: THYROID NODULE

---

**Interpretation:**

**NON DIAGNOSTIC SPECIMEN**

**ESSENTIALLY BLOOD WITH ONLY RARE BENIGN FOLLICULAR CELLS PRESENT.**

Pathologist: M.D.

Cytotechnologist:

REF CODES

Document reviewed and electronically signed by - 06/17/97 15:42

000032

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 07/07/1997 02:02PM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

*pt done flv T med h*

EXAMINATION: [REDACTED] - CT NECK W/CONTRAST [REDACTED]

WORKING DIAGNOSIS: NODULAR GOITER

FINDINGS: During intravenous administration of contrast, 5 mm scans were obtained from the skull base through the upper mediastinum.

There are small areas of non-homogeneous enhancement in both lobes of the thyroid gland inferiorly. There is no definable thyroid mass. A small fleck of calcification is noted in the left lobe of the thyroid gland as well. There is no evidence of tracheal compression, displacement or narrowing.

Lymph nodes are noted in the internal jugular chain bilaterally, measuring up to 1 x 1.5 cm in the left jugulodigastric region. None of these lymph nodes demonstrates central hypodensity or abnormal enhancement.

The tongue base and parapharyngeal fat appear unremarkable. The salivary glands are within normal limits. Normal vascular opacification is noted bilaterally.

IMPRESSION: Bilateral internal jugular chain lymph nodes, measuring up to 1 x 1.5 cm in the right jugulodigastric region. None of these lymph nodes demonstrates worrisome size or CT features for malignancy, although the right jugulodigastric node is at the upper limit of normal. If there is ongoing clinical concern for adenopathy, a repeat CT scan might be obtained in 6-8 weeks.

DONOVAN, [REDACTED]  
ACCT NO: [REDACTED]  
RADIOLOGY NO: [REDACTED]

EXAM DATE: 07/07/1997 02:02PM  
PROCEDURE: CT NECK W/CONTRAST

No specific, focal mass is noted in the thyroid gland.  
Correlation with previous ultrasound and radionuclide  
findings is recommended.

[REDACTED] M. D.

07/07/1997

[REDACTED] 07/07/1997 / 10:30PM  
Print Date/Time: 11-JUL-97/14:10:33

[REDACTED]

[REDACTED]

UPDATE NOTE

[REDACTED]

AUGUST 8, 1998

[REDACTED] was started on Synthroid, 75 mcg 1/2 tablet q day for 1 week, then 1 po q day. After she had been taking the Synthroid for approximately 2 weeks at the full strength she developed some chills, difficulty sleeping, depressed feeling, irritability and wondered if it was the medication. We decreased her to 50 mcg q day and checked thyroid function tests. The thyroid function tests were still within the normal range and her symptoms have continued to progress. Several days after we decreased the dose, we discontinued the Synthroid altogether and her symptoms really have not improved. She has a racing of her heart, tremors, panic attacks that have been interfering with her ability to function and when I initially spoke to her on August 4th, she was starting to feel better, however, symptoms have recurred with a vengeance and on 8/7 I spoke to her and it sounded like she was having panic attacks. The symptoms are quite intermittent, although she never feels quite normal in between. The amount of Synthroid left in her blood stream at this point should be negligible. The patient, in the middle of the night last night, woke up with terrible symptoms and ended up going to the Emergency Room. We will need to eventually obtain these records. They gave her a small dose of Ativan which helped her to feel better and they also wrote her a script for Propranolol. We had talked about her taking this, however I was worried that she may, in fact have more symptoms from taking this than benefit. I spoke with her roommate today who will come in to pick her up a script for Xanax 0.5 mg tid. She will need further evaluation and this will need to be arranged through her primary, Dr. [REDACTED]

[REDACTED]

[REDACTED]

000035

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

8/10/97

As noted previously the patient was seen in the Emergency Room on Thursday evening with what appeared to be a gastroenteritis, but she also has been having symptoms consistent with anxiety attacks.

The patient was given Donnatal which she has not required and Propranolol. She did take some of the Propranolol without relief and I had prescribed her some Xanax 0.5 mg. tid. I spoke with her today and the Xanax initially seemed to help, but she subsequently has developed significant symptomatology again which is why she had tried taking the Propranolol in addition. Also she was seen in the interim again at [REDACTED] because she remained unable to eat solid foods. She really does not have nausea per se, but is unable to tolerate eating. She has not actually vomited and is able to take liquids fairly well. She was prescribed Ambien there for sleep 10 mg. q h.s. and felt this helped last night.

As of today she will increase her Xanax to 1 mg. tid, continue to take the liquid, then try to eat some bland foods, at least several bites at a time to see if she is able to tolerate them. I have called in a script for the Ambien which she may continue to take. I asked her to call [REDACTED] to get a referral to psychiatry or psychology regarding these panic attacks.

[REDACTED]

STT: [REDACTED]

cc: [REDACTED] M.D.

000036

[REDACTED]



PATIENT

[REDACTED] 08/26/97  
 [REDACTED]  
 REQUISITION NO [REDACTED]

AGE 28 SEX F COLLECTION DATE [REDACTED] ACCESSION DATE 26-AUG-97 REPORT DATE 05-SEP-97 ACCOUNT NO [REDACTED] ORDERING PHYSICIAN [REDACTED] ROUTE [REDACTED]

TEST NAME	WITHIN RANGE	OUTSIDE RANGE	REFERENCE RANGE	UNITS
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TOTAL URINE VOLUME: 1200

TESTS ORDERED: CORTISOL, FREE-URINE, CREATININE-URINE, CORTISOL, URINE-CHEMILUMINOMETRIC.

CORTISOL, FREE-URINE: BN Cortisol, F, ug/L, U Not Established				ug/L
CREATININE-URINE: URINE TOTAL VOLUME	1200			ML
COLL PERIOD	24			HOURS
URINE CREAT. CONC.	82.0			MG/DL
CREAT. OUTPUT	984		800-1800	MG/24HRS

CORTISOL, URINE-CHEMILUMINOMETRIC:

Please Note:  
A result cannot be obtained on this sample by HPLC assay due to interfering substances. The sample has been forwarded to another to be assayed by chemiluminometric method.

[REDACTED] Cortisol, Urine	54			mcg/L
[REDACTED] Not Established Cortisol, Urine	64		<105	mcg/24 hr

000038

[REDACTED]

FOLLOW UP NOTE

DECEMBER 10, 1997

[REDACTED] is being followed for a nontoxic multinodular goiter. She had an ultrasound guided biopsy of the dominant nodule in June of 1997. Subsequent to this, the patient was started on Synthroid for suppression and had a multitude of problems. She appeared to develop severe panic attacks, etc. and was hospitalized and saw many doctors. She was taking diet pills at the time and it turns out that they contained MaHuang which is apparently a Chinese herb which is equivalent to Ephedra. The patient stopped all of her medications and eventually got better, but again, ended up being hospitalized and had multiple psychiatric evaluations at that time. She continues to have no local neck symptoms and has no current symptoms of thyroid dysfunction.

PHYSICAL EXAMINATION: Her current weight is 148 pounds, down 14 pounds from her last visit. Blood pressure is 112/76 with a pulse of 84. There is no exophthalmos or lid lag. The thyroid on palpation reveals that the right lobe is approximately 2 x normal, the left 1.5 x normal. It is diffusely mildly irregular and there may be a prominence in the left upper pole, but no discreet nodularity is noted. Lungs are clear. Cardiac exam reveals a regular rate and rhythm, S1, S2 without murmur, rub or gallop. The reflexes are brisk and symmetric with normal relaxation phase and no tremor is present.

ASSESSMENT: Multinodular goiter by ultrasound with a dominant cold nodule on thyroid scan. The patient has undergone a biopsy of the dominant nodule which was negative. She recently had significant difficulty when she started on the Synthroid and although the Synthroid may have interacted with the other medications, I do not think that this would, itself cause the problems. However, this was a very traumatic experience for her and we are going to hold on Synthroid for the present time. We have discussed this at length and our goal at this point is to simply monitor her and at some point we may consider reinstating Synthroid at very low dosage. The patient will have thyroid function tests and a follow up ultrasound today and we will plan on seeing her back in approximately 6 months time assuming that the ultrasound remains stable.

[REDACTED] sbdo nodules

[REDACTED]

FAXED

[REDACTED]

[REDACTED]

Specimen #	Type	Primary L	Report Status
[REDACTED]			P
Additional Information			
[REDACTED]			
Patient Name		Sex	Age (Yr/Mcs)
[REDACTED]		F	28
Patient Address			
[REDACTED]			
Date Collected	Date Entered	Date Reported	
11-DEC-97	12-DEC-97	12-DEC-97	

Clinical Information	
Procedure ID	Patient ID
[REDACTED]	[REDACTED]
Account	
[REDACTED]	

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
-------	--------	------	-------	--------------------	-----

TESTS ORDERED: T3, TOTAL.

T3, TOTAL:					
T3, TOTAL	131		NG/DL	60-181	



000040

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 12/15/1997 01:40PM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] NECK/THYROID/SOFT TISSUE

WORKING DIAGNOSIS: NODULE

FINDINGS: There are no significant changes noted when compared with the previous study done 6/3/97. There is interval percutaneous biopsy of the left lobe lower pole nodule.

Both thyroid lobes are stable in size and texture pattern. There is a small calcification and a couple of hypoechoic nodules in the right lobe. In the left lobe, the lower pole hypoechoic nodule with central calcification is noted and appears unchanged.

No new findings are seen.

IMPRESSION: Stable thyroid ultrasound, with the above findings. Clinical correlation and follow-up are suggested.

[REDACTED]

[REDACTED] M. D.  
12/15/1997

ULTRASOUND ACCREDITED BY THE [REDACTED]

[REDACTED] 12/15/1997 / 06:19PM  
Print Date/Time: 16-DEC-97/10:42:39

[REDACTED] 12/19/97  
*cont to monitor*



HYROID FLOW CHART

NAME M F D.O.B

HISTORY

GENERAL EXAM

wt 163 lbs

THYROID EXAM

FAMILY HISTORY

DIAGNOSIS

OTHER DIAGNOSIS

BASELINE

SERUM T4

FREE T4

T3 RESIN UPTAKE

SERUM TSH

T3

STUDIES

ANTIBODIES - ANTI-MICROSOMAL (TPO)

OTHER ABS

THYRO - Tg GLOBULIN

THYROID UPTAKE - 4h 6h

24h

THYROID SCAN

ULTRASOUND

NEEDLE ASP.

SIGNS & SYMPTOMS

DATE

27 y.o. W♀

ORT

noted lump one day in March

3/4/97

nl TFTS

→ Dr [redacted] bx - ⊖ but reopitve

→ Dr [redacted] repeat bx

benign has flu next month

BLOOD PRESSURE

HEART RATE

THYROID

INVESTIGATIONS

TSH

T4

T3 - RESIN UPTAKE

FREE T4

T3

2nd bx → shrinkage \* has not recurred

Fam Hx -  
⊖ thyroid dz pm, CVA  
grandparents - htr  
parents - m arthritis  
F - healthy

pm - 90mi 70's  
? IUSM ⊖ (Crohn's)

MEDICATIONS

mGM, mGGM - breast CA

strong hx fibrocystic dz

pmH - endometriosis - Dr [redacted]  
s/p ⊕ oophorectomy / oppy  
?? scleritis, episcleritis

NOTES

recent aspir of cyst ⊕ breast Dr [redacted]

SUBSEQUENT VISITS AND FINDINGS

DATE		SUBSEQUENT VISITS AND FINDINGS
MO	DAY	
AUG	13 1997	<p>CPY - clo doxacin caused "panic attacks" get 158 P 112/78</p> <p>3) lymphadenopathy? not appreciated to any ✓ DR [redacted] records</p> <p>4) upon leaving - patient experienced a cramp in (R) lower leg calf muscle administered 2nd dose of xanax (muscle relaxant)</p> <p>5) Endoneuritis follows with DR [redacted]</p>
8/15	97	<p>Call - from patient can not get an appointment with any psychiatrist left messages (myself) - with DR [redacted] and DR [redacted] Patient is feeling somewhat depressed. Informed her may be Xanax if she is feeling a crisis sometime → crisis at [redacted]</p> <p>HAS apt tomorrow with [redacted] Psychologist</p>
8/19	97	<p>patient HAS apt to DR [redacted] tomorrow will leave apartment at last will cancel apt to DR [redacted] DR [redacted] apt</p>
8/14	97	<p>Weight loss - unable to eat not feeling depressed at this time, diarrhea 12-4/day - referred denies pregnancy needs Xanax 4mg QID BCP Anxied pro Ambien 10mg qhs pro</p> <p>WT 152 lbs BP 106/76 T- 98.9 LMP 1 mth [redacted] PKD</p>

CASE NO  
PATIENT'S NAME  
SHEET NO

DATE  
MO DAY YR

(cont)

SUBSEQUENT VISITS AND FINDINGS

8/19/97

Anxiety has gone  
insomnia - slept well last week night -  
took Ambien + Xanax

HNS apt w/ Dr [redacted] tomorrow

PE young white & looks well.

ca reg of mob  
lung perc

abd FBS soft med - mod. epigastric tenderness

A/P 1) Anxiety, diarrhea

diarrhea most likely 2° to patient only  
drinking water → reassurance

think of pilosic 70 qd 14 samples  
maybe component of gastritis →

also 2° ? psych component  
recalls from Dr [redacted] F/U well

2) anxiety d/o ? provoked by symptoms

apt w/ Dr [redacted] tomorrow.

AUG 25 1997

F/u Anxiety - wt ↓ 3 lbs

Ⓡ eye bloodshot this wk - Ⓣ eye cleared by  
itself last wk.

WT-149  
BP 110/70  
Lmg 7.25.97  
Vision 20/200m

meds: BCP qd  
Xanax 3 mg QID (in total)  
Pilosic 20 mg qd  
Ambien 10 mg qhs prn  
Paxil 20 mg qd (De Stock)  
Clasid prn

allergies: PCN  
Compazine →

rx scleritis tapering Xanax anxiety, nausea  
continue

PE 28 y w

neck. R eye → conjunctiva injected  
neck of adenopathy - multinodular goiter  
ca reg of mob  
lung perc

DATE		SUBSEQUENT VISITS AND FINDINGS
MO	DAY	
9	25	<p>abd + BS soft - mild epigastric tenderness</p> <p>APP. 1) anxiety, nausea, fatigue</p> <ul style="list-style-type: none"> <li>- anxiety tapered</li> <li>- follows with or [redacted] apr - [redacted]</li> <li>- pain began</li> </ul> <p>A/O GI small pathology - JUCI</p> <p>abd US.</p> <p>in ER yesterday - LABS WDL</p> <p>with excuse → 2 weeks post [redacted] to ruled out</p> <p>2) schedules</p> <p>apr tomorrow with [redacted]</p> <p>not new</p> <p>R/U 1 week [redacted]</p>
9	26	<p>call from [redacted] - patient has developed w/ks on abdomen/back. of wheeze a difficulty breathing addressed to [redacted] check</p>
meo		<p>PE young W - appears tired BP 100/70</p> <p>(R) eye conjunctiva → injected</p>
HEP		<p>en [redacted] - MCG</p>
X-ray		<p>lungs. Bost of wheeze</p>
3mg qd		<p>abd / back fading areas of [redacted]</p>
ambien 10m		<p>possible allergic rxn to UGI [redacted]</p>
Maxid 20/40/10		<p>Zyrtec 10mg prn #9 OR</p> <p>arted [redacted] with recent history</p>

CASE NO

PATIENT'S NAME

SHEET NO

DATE		SUBSEQUENT VISITS AND FINDINGS
MO	DAY   YR	
9/1/97		<p>Phone call - (ON CALL) from pt's mother [redacted]</p> <p>Expressed concerns about daughter "vegetating &amp; not getting out of bed"</p> <p>Denies she has suicidal ideation</p> <p>[redacted] would not talk to her or tell her the name of her psychiatrist or called me. I did not give mother this info. - Note appetite &amp; advised in pt severely, need to go to crisis center</p> <p>Advised she should see psychiatrist. Will discuss E.D. [redacted]</p> <p>Addendum: Also advised pt's mother stay in pt. over weekend. Mother reluctant [redacted]</p>
9-2-97		<p>Text message at [redacted] answering machine left message at mother's answering machine 1045 AM</p> <p>left message at Dr. [redacted] answering machine</p>
9-2-97		<p>prelim abd US - reading NK abd ps.</p>
9-2-97		<p>patient returned phone call → taking more qulony enzyme down having side effects from Paxil she spoke to Dr. [redacted] yesterday. was advised to stay on lower dose</p> <p>MNS apt @ Dr. [redacted] tomorrow</p> <p>MNS apt ree on Thursday [redacted]</p>

CASE NO

PATIENT'S NAME

SHEET NO

DATE			SUBSEQUENT VISITS AND FINDINGS
MO	DAY	YR	
9	19	97	Pt. states c/nausea + vomiting all noc. to leaving office yest. Ate 5 day old chef salad. Prior to Vthru this A.M. c/ racing heart rate + dizziness. Ate 2 crackers, fluids today. States is "calming down". denies fever. Instructed to cont c/ crackers + ↑ fluid intake as tol. If no better to RTO.

9	25	97	Pt called + clo "chest pain @ am upon awakening describes as dull - sometimes sharp then I go back to sleep." Said "pain under control". Said has "some pain in late afternoon or early PM - lasts approx 30 min" Said dr [REDACTED] recommended more extensive heart tests than EKG. Apppt given today
---	----	----	---

SEP 25 1997

meds	allergies	WT: 147
- Plavix 75 - 2mg QD	PCN	B/A 10/78
- St John's wort QD = Valerian		Lmp: 9/10/97

AS ABOVE. CONSISTENTLY IN AM. SOMETIMES IN AFTERNOON OR EVENING NOT ASSOCIATED WITH EXERCISE OR EXHAUST. SOMETIMES PALPITATIONS

Brought in printout on ephedra - chest medicine she had been on for 3 months

PE 28 40 W X NAD  
 Ca reg 4 M O G  
 lungs BCT

All palpitations, atypical C.P

- ✓ Holter m.
- ✓ ECHO

10	4	97	left message / returned message
----	---	----	---------------------------------

10	8	97	left message [REDACTED] to call
----	---	----	---------------------------------

DATE		SUBSEQUENT VISITS AND FINDINGS
MO	DAY	
9	2	97 Call from Mother - States [redacted] is agitated and "off the wall" - won't answer phone. I told her that [redacted] had talked to [redacted] today - and that she had an appt with Dr [redacted] and with us Thursday - if necessary can go to crisis ctr @ [redacted] - When do [redacted] age she should call us directly / [redacted]
SEP	04	1997 Called up & inquired re P.O. cancellation - stated "I was together yesterday & doctor took me off percocet. I didn't know a word & I didn't feel I could drive I'm drinking because I can't sleep. I need help to schedule weekend I can get a ride." [redacted]
9	9	97 Pt's mother called - pt. was admitted thru ER to psychiatric unit for Depression yesterday. Mother to keep DR. [redacted] informed.
9	15	97 Pt. advised R to post-hosp. Has appt. 9/17/97 [redacted]
SEP	18	1997 Flouidist - Dr from hospital 9/12/97 - Dr from [redacted] 9/11/97. - clo w/ urinary urgency/retention <u>meals</u> - ortho consult (PI) - started 2 <del>400mg</del> 5mg po 4-5x/day - avoid from alcohol turnover during urinary - stopped suzine saw Dr [redacted] yesterday doing much better during 3 meals/day anxiety, but no panic attacks PE 20 yow T NAD ca 10% of moc lungs B CRT a/p. 1) anxiety, anxiety improving seeing Dr [redacted] (was hosp at [redacted] - had episode) 2) urinary frequency most with 20 suzine [redacted]

CASE NO

PATIENT'S NAME

SHEET NO

DATE			SUBSEQUENT VISITS AND FINDINGS
MO	DAY	YR	

10 5 97 Patient wishes to see Dr [redacted] - nerves or things -  
 has seen him in the past  
 one coughing at night this time of year? all yrs  
 advised probably not a prudent idea to risk  
 inhale - to be simulated!

10/10/97 Call to pt - advised echo and holter monitor  
 normal [redacted]

FEB 20 1998 U.V. speaking feeling in throat P. 88 Wt 147 lbs  
 Hypoxia had scratchy feeling in throat B.P. 126/80 T. 99.6  
 that comes + goes w/ 30% duration. When LMP - 2/12/98  
 she gets scratchy feeling gets coughing. Allergic - PEN ->  
 cough  
 Medications: Compazine ->  
 Lorazepam ->  
 Ephedrine ->  
 anxiety

three weeks ago had cut down  
 cigarettes switched to 11/12/10 - feel like  
 tickle in back of throat & nasal congestion NO PR  
 PE unimpaired NAD  
 post pharynx -> NL  
 Cx also - Normal  
 Lung -> Post  
 (USA + 55 SMI NT @ - 7315)

1) Cough - UGT 1997 NL  
 cough? 20 vial syncline?  
 Robitussin AC 1-2 tsp po q 4h pain cough # 1120-0  
 FU 2 weeks w/ no ill-

2) Tobacco - advised smoking program  
 Wellbutterin - patient does  
 not wish to try d/c therapy

she not smoke enough for patch w/ cigarettes

CASE NO  
 PATIENT'S NAME  
 SHEET NO

General Exam

[Redacted] M.D., P.C.  
[Redacted] M.D.  
[Redacted] M.D.  
[Redacted] M.D.

Patient: [Redacted]

Date: 8.13.97

Age: 28

C.C.:

HPI: Took patient off Synthroid last panic attack - Thursday two weeks prior

Panic Attack - heart races, room closing in, hands shake

LMP: 8/1/97

No Psychiatrist

PMH: frequent urinate -> not changed

Med/Surg.: aff and n anemia

Panic Attack - began p starting Synthroid 2 weeks prior

3 Thyroid nodules -> NL TTTS 3bx all undiagnosed

Swollen lymph nodes - Neck supraclavicular - cat scan

depression 11 years prior s/p. Sk ovary removal

Endometriosis, Schistosomiasis

FHX: O -> ↑ 59 A + W Q -> ↑ 56 R.A., O.A s/p. multiple Sx

Grandmother & Brother + lung

Current Meds:

Allergies: PCN

- ethocycline QD (endometriosis)
- Tazac 5mg PO qd TID per
- Ansed 250 (scleritis)
- Ambien 10mg PO qhs per

Diet: balanced

Substance: Smoking: 1 PPD

Alcohol: 1-2 beer 40week

Drug abuse: denies

Social: occupation: [Redacted] researcher T.A./Student

H.O.S.: LAST PAP OR PSA: Dr [Redacted] 5/97

LAST MAMMOGRAM: Dr [Redacted] 5/97

LAST EYE EXAM: 7 Syrs

000051

PATIENT: [REDACTED]

DATE: 8.13.97

PE:

General: Young w & narcs

VS: BP: 112/78 (obese cuff), P= regular, T=

Height: 5'7" / 66" Weight: 158

Integument: NL

HEENT: PERAL Fundi: NL  
Pharynx: NA adenopathy noted

NECK: JVP: none Carotids: no Bruits

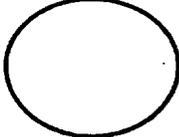
Thyroid: Sit enlarged, nodular

BREASTS: No masses

Cor: reg S1, S2, No S3 axilla  
No adenopathy

LUNGS: clear

expiratory phase: NL

ABDOMEN:  + BS SNTT NT

EXTREMITIES:

edema: none  
pulses: F: P.T. D.P.

NEURO: strength: 5/5 TO Babinski:   
DTR's: 2+ to

PELVIC: Defended to

RECTAL: DR [REDACTED] prostate: N/A  
hemocult:

Pro I
Pro II
CBC
T4, TSH
Lipid profile
Cor Risk profile
PSA
Urinalysis
Urine Culture
EKG
PFT's
CXR
Mammogram
Flex. sig.
BE
ppd titer
tetanus 000052
flu / pneumovax
other: _____

dipstick

pap done

\* A/P 1) Panic Attacks - unclear if  
IMP: related to mechanism of symptoms  
has been with x 2 wks.

Plan: give 4 names of psychiatrists - advised  
to call -> call us with name to pick  
up report

2) thyroid nodules - ✓ DR [REDACTED]

results [REDACTED]

00B

Feb

phone

6V = 8

(w)  
(h)

(PHP) 8/19/97

single  
roommate  
(partner)  
♀

28% Panic attacks. Thought she was on Synthroid. Saw a psychiatrist who <sup>talked to her</sup> wanted her to stop Xanax <sup>and</sup> start Paxil. 11 yrs ago depression - a little bit - Tofranil & Prozac. Hated being <sup>on</sup> drugs & took self off. Xanax ~~took~~ 1 1/2 wks. Sleep poor. Doesn't feel major dep.

New job - hard to go to. Works for ~~as~~ as research interviewer. Flex hours supposed to be 40 hrs/wk. - Started last week. Used to teach Sociology - working on dissertation

Initial

8/20/97

"It's been one long confusing mess." Was on an herbal all natural program to loose wt. since 11/96 \* 8-9 months (until recently) Lump in neck 7/97 → Bx - US - 3 nodules on thyroid. TFT's always nl. Couldn't get good samples → undiagnostic (all 3 Bx's). Synthroid to try to suppress nodules. 4 wks into ~~tx~~ heart palp's, sweating, shakiness, sensitivity to heat + cold (sweats + chills), trouble sleeping (prev. ~~sleep~~ sleep ok) - started a few wks ago. Dr. ~~endocrin.~~ endocrin. → stop a few days & re-start on lower dose. ~~After~~ After off Synthroid 1 day, had panic attack. Started to feel strange <sup>shaky</sup> <sup>trous</sup> palp's, diarrhea, vomited, panic, palp's - racing heart, sweating, desensitization <sup>hyperreflexia</sup>. Calmed self down after 1 hour by breathing, praying would get onset feelings - anxiety

000053

Cont'd

8/20/97

I'm normally a happy-go-lucky person." Dr. told to stop Synthroid w/ 1 wk. later. Feeling back to normal, gradually. A few days later started to panic - less severe attack - after dinner & friends. Had to go home later same evening on the way to a drive-in. Watched scary movie at home - panicked again. That wk-end no more attacks - withdrew, depressed, kept trying to calm self down - anxious. Felt better Mon. Got hired at new job. Another attack in her office at [redacted].

Went thru training & felt "fine".

Appetite ↓ during this time. Dr. said - 1 wk to get Synthroid out of system. 2 wks ago had most severe panic attack - vomited & diarrhea.

② Pacing: didn't want anyone around. Asked [redacted] roommate to take her to hosp. at 2:30 am. [redacted]. Given Ativan, Propranolol - but the Dr didn't want her on it (It could backfire) - placed on Xanax 0.5 T Q, & pm → ~~double~~ didn't work herself - stopped eating → said she could double dose. Another for sleep - resisted sleeping, tried Valerian, instead. Wasn't able to sleep through night. → doubled dose x last five days - 7, 5 & 9 pm was waking up 6:30 & 4 am. (Even w/ Ambien). Cut out Valerian, Takes a 4th dose of Xanax in middle of night

000054

Initial, cont'd

8/20/97

Current medo: ① Oral contraceptives x 3 yrs, for endometriosis ② Prilosec for GI problems ③ Ansed - for scleritis ④ Xanax 1mg q1d ⑤ Ambien 10 mg qHS - last 3 nights but not every night.

PMH: Endometriosis; s/p ② oophorectomy s/p app'y. Scleritis, recurrent cyst ② breast - aspirated; GI probs, no dx, in past. Nodular thyroid.

Allergies: PCN - ? rxn.

Depression ↑ 1mg. Sx's are a.m. ↑ depression (on waking), helplessness; sleep problems, anxiety, ⊖ SI.

PxH: Depression 10 years ago, 1986 - treated w/ Imipramine & Prozac - r/t family / relationship issues, sexuality, o/w status ⊖ depression, generally.

Px: Panic Disorder (300.01)

Depression NOS (311)

Plan Paxil 10 mg 1/2 q am x 4 d then 11 q am #30 refx ⊕

↓ Xanax by 0.5 mg qd - q3 days then continue to 4 by 0.5 mg qd q2d

(21)

8/27/97

Sleep bad. Wakes 1-3 hrs. Takes Ambien → wakes again ~ 2 hrs. Takes 2nd Xanax ~ 3 am. Wakes again ~ 4:30 am and ⊕ in & out of sleep after that.

000055

cut a.m. dose Xanax to 0.5 mg then 3 days cut firm 11 am to 0.5 mg

[redacted] (cont'd) 8/27/97

→ less tired & drowsy, so cut p.m. dose out completely. Current dosing:  
Kanax 0.5 q am, 1 mg q HS, 1 mg at 3 am  
Paxil 20 mg q am (x 2 days)  
Yesterday went for VET series & US of abdomen. Broke out in hives after tests. Yesterday only episode of mild anxiety [redacted] was at ophthalmologist's office - felt closed in & lack of air. Able to eat a little bit, past 2 days; sleep worse, ⊖ panic attacks. Hasn't gone to work. Losing her job is a major fear. Also ~~worries~~ worries that her current problems will spoil her relationship w/ S.O., because she wants to be left alone most of the time.

↑ Paxil to 11 am; pm x 4 d, then  
120mg  
11 BID #30 9 ref

Kanax 1 q am & 11 q HS und  
0.5 mg 11 pm anxiety #60  
try Benadryl 50 mg q HS

9/1/97 phone conversation w/ pt:

Jittery, shaken yesterday when I'd to 40 mg Paxil - was all day. I'd to 30 mg Paxil & was jitter in a.m. Feels worse; started eating a little

9/2/97 phone conversation w/ pt's mother:

She is worried abt. pt.  
Roommate says pt. is very shaky & not wanting to communicate

000056

[Redacted]

(31) 9/3/97

↓ Paxil to 30 mg qd from 40 mg qd (only one day). Mon. night took 1.5 mg Xanax & 50 mg Benadryl → only slept MNT to 3am. Body shakes (tremors) - pretty badly - whole body - ~~extreme~~ extreme anxiety during these times. No full blown panic attacks. Sometimes can eat, sometimes not. Wt loss ~ 20 lb. Weighs 144 lb, 5'6". Sleep very poor every night. Takes 2.5 mg Xanax / day (3 qHS, 1 middle of night & 1 in am. - often no Xanax during rest of day. - some extras. Feels better later in the day. <sup>4:00 pm</sup> Anxiety high in am., then varied - tries to nap ~~during~~ during the day. Friends and family call & she doesn't want to talk to them. Feels more comforted & ~~is~~ crying every morning - "I can't take it anymore." Didn't have jitters / shakiness before started Paxil. ⊕ Depression. Suicide attempt 1986 age 17 - almost successful. o/c'd on drugs, in college dorm. Roommate thought she was sleeping. Had SI age 14-17. No further suicide attempts. Has been pretty happy since then, until now. ⊕ SI at this time. Agree to contact me to call / go to hospital if serious SI tentises to plan / attempt. ⊕ Nausea / diarrhea.

↓ Paxil today  
tomorrow, 20 mg Paxil x <sup>1-3</sup> 3 d.  
then 10 mg Paxil

000057

Xanax 0.5 mg qam & afternoon & evening  
(Total 3.5 mg) 2 mg qHS + 150 mg Benadryl

9/4/97 Phone conv.

(cont'd) 9/3/97

Slept a little better. No Paxil yesterday  
Still shaky & jittery. - Took 10 mg Paxil today  
Plan = D/C Paxil. ↑ Xanax to 1mg TID or  
2mg qHS.

(with mother) (41) 9/8/97

Taking 4-5 mg / day. Sleep not  
improved. Takes 2mg Xanax 50 mg Benadryl  
at bedtime. Falls asleep pretty quickly  
~ 11:00 pm; wakes 3-6 am usu. goes  
back until 5:30 am - shaky & jitters awake  
sometimes takes Xanax. - Very anxious  
& depressed - crying / shaking all  
day. Starts to feel better at 6 pm.  
Doesn't usually eat & ensure sometimes  
during day. Watches TV or reads - hard  
to concentrate. Called Crisis Center  
at [redacted] & spoke to charge nurse. -  
[redacted]

000058

9/12/97

(5/ )

9/12/97

[REDACTED]  
[REDACTED]  
[REDACTED]

returning my call  
to therapist.

[REDACTED] Dr. [REDACTED] - I called Tues, Sept 9  
my call was not returned. (~6 minutes of her time)

Switched from Xanax to Klonopin.

Sept 9 - Klon 0.5 mg BID, [REDACTED] D/C Xanax

Sept 9 - Wellbutrin 100mg BID -

N/V - held Wellbutrin → D/C'd today  
wasn't sleeping at all 1st few nights  
appetite poor. - slept 4-5 hrs. last 2 nights

Sept 10 Klon 0.5 QID - Benadryl 50mg

panic attack ~ 5/10 ~~2 days~~ Weds

panic attack ~ 4/5 Thurs (yesterday)

general anxiety is ↓

tremor are mostly gone.

slept last night 6 hrs - 50 mg Benadryl +  
+ Klonopin 0.5 → for 1st time.

1.PPD - stopped

← Ativan 0.5 mg TID and  $\frac{1}{2}$  0.5 mg qHS #25

Someone 100 mg qHS x 4 d  
then 100 mg BID

#32 Dref.

[REDACTED]  
[REDACTED]

✓ send a triplicate:

→ for emergency prescription

000059

[REDACTED]

9/17/97  
~~9/16/97~~

[redacted] (d)

Serzone 100 mg BID ↑ & from 100 qd [redacted] yesterday. Ativan 0.5 TID and 0.5-1 mg qHS. Feels better. No tremors - a little shakiness in hands. ~~Ativan~~ Blurry vision - doesn't feel comfortable driving. Feels urinary urgency / full bladder & then doesn't urinate. No panic attacks. Got anxious when in restaurant - resolved [redacted] 5 reaching high level. A little anxious early a.m. & late evening → if can't sleep quickly - not every evening. Feels depressed only in a.m. on first waking. Eating a lot - increasing each day. ↑ 5 lb in past week. ~~Ativan~~ ⊖ vomiting, only slight nausea occasionally. Deep. Slept well Fri night 6-7 hrs straight. Sun a.m. woke early. Got to sleep 5 probs. The last 2 nights had trouble getting to sleep. Bendruyl 25 mg qHS x last 2 nights 50 mg qHS.

Her job requires driving to people's houses & clear concentration ⊖ Exercise Recommended exercising 30-45 min. per day - brisk walk.

Ativan 7am, noon, 5pm, 10pm - (q 5 hrs) Hands shake a little before dosing.

O/C Serzone - none today, or tomorrow. Start Ativan's work Friday. 300

Ativan 0.5 mg TID & 1 qHS #150

(71) 9/24/97  
[redacted] Fri  
(called [redacted] at a.m. c/o P sv's after  
NIN - one night no panic associated,  
then had panic attack next day).

Felt sick Fri → today → lessened  
gradually - still a little today.  
Starting to feel like she did on  
the Xanax. Wakes at 5 or 5:30 am  
every morning feels heart fluttering  
& chest pain. Taking 3mg qd of  
Ativan. Not having any more panic  
attacks. Taking 3/day of St John's  
[redacted] ~~for~~ went since Saturday. Wants  
to stay with that, rather than try  
another prescription anti-depressant.

Klonopin 0.5 q 10 nights pm. #150

Suggested additional use of Valerian

000061

(8) 9/25/97  
Drove here by herself.  
Doing somewhat better since switched  
to Klonopin. Noty Calmo Forte 11 ac & 11 PM.  
Taking a "rescue remedy" made up in  
breads - taking 3 Top. / day. Klonopin  
0.5 q 10 Tues. Went yesterday skipped  
a dose of treatment [redacted] (0.5 T 10). Going  
to be w 11-12 MNT. Wakes 6:30 am - 7am.  
Still has CP in a.m. [redacted] a little anxious.  
St John's Wort 300 mg T 10 + Valerian 1 T 10  
is dose of SJW. ~~Ativan~~ When wakes  
in a.m., only a little anxious. No getting  
heart fluttering in a.m. anymore. [redacted]  
[redacted] Fine diet pills included [redacted]

[redacted] (cont'd) 9/25/97

more a  
try to get  
personally  
than  
in words

On H.S. was a straight "A" student,  
president of her class, played sports,  
Leaders Club. Skipped 9<sup>th</sup> year &  
graduated early ( [redacted] band chorus  
worked at Burger King. 'College'  
was easy for her - grad. ~ 3.0 average  
[redacted] had depression in H.S. <sup>it</sup> always  
smiled - people called her "Smiley".  
Wasn't happy at home - didn't get  
along w/ Mom (& Dad to lesser extent).  
Made suicide attempts in H.S. (x2  
w/ ASA & tylenol) father found out  
but didn't get her help.

Suggested she talk to her friend abt  
the CP.

000062

(91) 10/2/97

meds. Klonopin 0.5 mg TID;  
Calmo Forte 100 mg. No HE meds & sleeping  
well & through the night - 6-8 hrs/night.  
Eating - appetite is back - if anything,  
is over-eating. Took her toward to eating;  
No nausea. St John's Wort + Valerian  
1 each TID. [redacted] MD gave

her an ECG monitoring & Holter  
monitor. (went up to an "Event Monitor"  
which will record 1 hour before & after  
a panic attack. Open - attacks.  
A couple of moments where anxiety  
went up - eating in public - [redacted]  
family, after finding out that  
her father's fiancée knows abt them. [redacted]  
[redacted] [redacted] [redacted]

cont'd 10/2/97

"I hated [my mother] in H.S.  
"She wanted me to be a girl." Bought  
clothes for her, even in H.S. Fa.  
encouraged her in sports. Was in  
her room w/ the door closed in H.S.  
(years). Still, would buy me anything  
I wanted. Fa. was the disciplinarian.  
(<sup>from 8th grade</sup> Mo. & I sisters - closest one 5-6 yrs  
older). On trip to Texas. — He told her  
father she's a lesbian many years  
ago. Mo. doesn't communicate directly.  
"I find myself like that." Her  
area in sociology was deviance & crime,  
but she went into sexuality/gay  
experience. Her parents don't know  
what her dissertation is about.  
Mo. hasn't told her mother b/c  
Fa. asked her not to. She had some  
depression — now takes Elavil & isn't  
depressed.

(Mo. was on Demerol throughout  
her pregnancy & <sup>Mo.</sup> felt that  
<sup>she</sup> reported her, in childhood.  
Doesn't have memories of Mo. from  
childhood, except bad memories.

Keep making the same.

000063

(10/ )

10/2/97

"The trap wasn't going so good as I  
would like." Has been working daily.  
Has a pretty constant level of  
anxiety, all the time. Used to come  
and go more. Now it's less severe.

[REDACTED] (cont'd.) 10/9/97  
 but more constant. No panic attacks. The job's been ok. - keeping her busy. meds ~~0.5 TIO~~ 0.5 TIO Klon, SJW TIO, Valerian + TIO, Calms forte 1 pm  
 woke at 5:4 am, two last couple of nights - <sup>5-6</sup> coughing - has an inhaler - used it 5 then couldn't sleep. ~~the~~ The only thing different is that she ran out of the homeopathic remedy her friends had given her. (3 remedies). [REDACTED]  
 She's on ~~oral~~ oral contraceptives for ~ 3 years.

10/16/97  
 ↓ 2 Klonopin to 0.5 mg BID (cont'd)  
 SJW TIO - will be 4 wks this Sat. Val + TIO, Calms forte as needed. Anxiety level has been similar to last week - slightly better - always worse in mornings. Takes a.m. dose. Klon 3 am. Wakes up anxious, but less anxious than previously. Not sleeping through nights - varies. Sunday night up every hour on the hour ~~but~~ <sup>out</sup> until 2 am. Wonder if the waking is caused by her problems. When put on TIO + Valerian, constant feeling of anxiety. Not exercising.  
Plan: ↓ Klonopin to 0.25 mg BID.  
 There's a FH of paradoxical v. to meds, esp. to [REDACTED] 000064  
 - 12 FDA is investigating Ephedra, 5 then sent her paperwork. Has an interview Tues for [REDACTED]

10/23/97

Fri. evening came close to having a panic attack while eating. Felt better & better afterwards. Last night woke up in pain (abd.) Gyn-Doc. [redacted] thinks it might be endometriosis. Started

Ytx at [redacted] -- working  
[redacted] a Ph.D candidate for

behavioral / cognitive tx. for her anxiety will see once / week. Klonopin 0.25 BID Doing better, if anything. Notes sl, tremor in hand. (has always had a very sl. tremor - so does mo. and other relatives. SJW TID & Calmes Forte or Rescue Remedy as needed. Able to perform job & problems. ~~it's~~

Appears anxious today - says it's r/t her abd. pain & worries that she'll need surgery again (last 3 yrs ago)

Plan: try to ↓ Klonopin to 0.25 qd - go back up, if necessary. Eliminate the night dose. Started to get H/A's & stopped regular use of Valerian.

000065

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 08/26/1997 10:37AM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] - GI/AIR CONTRAST W/KUB

WORKING DIAGNOSIS: ABD PAIN/NAUSEA

FINDINGS: The scout view demonstrates an unremarkable bowel gas pattern. No unusual calcifications are identified. The retroperitoneum is predominantly obscured by bowel gas and feces and is difficult to see. In those areas of it which are visualized, there are no masses.

Examination of the dorsal esophagus demonstrates no masses or mucosal abnormalities. There is no hernia or reflux. There are no masses or ulcers in the stomach. The duodenal bulb is normal. Unfortunately, this study does not exclude all pathology or all small lesions. If symptoms persist, endoscopy may be needed.

IMPRESSION: Unremarkable upper GI series.

Incidentally noted is a subtle scoliosis of the lumbar spine centered at the thoracolumbar junction, convexed toward the left.

[REDACTED] M.D.  
08/26/1997

[REDACTED] 09/01/1997 / 03:46PM  
Print Date/Time: 1-SEP-97/18:11:37

PT TYPE/LOC AT ORDER: [REDACTED]

CURRENT LOC: /

RADIOLOGY NO: [REDACTED]

MED. REC. NO: [REDACTED]

PATIENT: [REDACTED]

EXAM DATE: 08/26/1997 09:41AM

ACCOUNT NO: [REDACTED]

DATE OF BIRTH: [REDACTED] 28Y /F

PHYSICIAN: [REDACTED]

EXAMINATION: [REDACTED] - ABDOMEN COMPLETE ULTRASOUND

WORKING DIAGNOSIS: ABD PAIN/NAUSEA

FINDINGS: The liver is normal in size and contour without focal abnormality. The gallbladder is physiologically distended without evidence of stone or inflammation. The biliary ducts are normal in caliber. The pancreas is normal in size and contour without focal abnormality. The kidneys and spleen are unremarkable. The abdominal aorta is normal in caliber.

IMPRESSION: Normal abdominal ultrasound. No evidence of gallbladder disease.

[REDACTED] M.D.  
08/26/1997

ULTRASOUND ACCREDITED BY [REDACTED]

[REDACTED]/09/02/1997 / 10:49AM  
Print Date/Time: 2-SEP-97/17:49:14

[REDACTED]

[REDACTED]

## ECHOCARDIOGRAPHIC REPORT

<b>Patient:</b> [REDACTED]	<b>Referring MD:</b> [REDACTED] MD
<b>DOB:</b> [REDACTED]	<b>Date of Service:</b> 9/30/97
<b>Age:</b> 28	<b>Medical Record #:</b> [REDACTED]
<b>Sex:</b> female	<b>Patient Status:</b> Outpatient
	<b>Inpatient Room No.:</b> OP

**INDICATIONS:** Chest pain/pallpitations

**M-MODE MEASUREMENTS:**

		Normal Values			Normal Values
<b>Aortic Root</b>	2.5	2.0 - 3.7 cm	<b>LV Diastole</b>	4.3	3.5 - 5.6 cm
<b>Left Atrium</b>	3.0	1.9 - 4.0 cm	<b>LV Systole</b>	2.5	2.2 - 4.3 cm
<b>Right Ventricle</b>	1.8	1.0 - 2.6 cm	<b>LV Volume-Diastole</b>	80	51 - 155 ml
<b>Septum Diastole</b>	1.0	0.7 - 1.2 cm	<b>LV Volume-Systole</b>	23	16 - 83 ml
<b>Septum Systole</b>	1.5		<b>Stroke Volume</b>	58	35 - 103 ml
<b>LV Free Wall</b>	0.9	0.7 - 1.2 cm	<b>Ejection Fraction</b>	72%	53% - 80%

**COMMENTS:**

1. The left ventricle is of normal size and shape. Overall ventricular function appears intact and there are no segmental wall motion abnormalities noted.
2. No evidence of left ventricular hypertrophy is noted.
3. The left and right atria are of normal dimensions.
4. The right ventricle is of normal dimensions and appears to contract normally.
5. The aortic, mitral and tricuspid valves are all well visualized and appear structurally intact. Mitral valve prolapse is not noted.
6. Doppler interrogation reveals no significant regurgitant or stenotic lesions.

**IMPRESSIONS:**

Normal study.

**APPROVING MD:** [REDACTED]

**Echocardiographer:** [REDACTED]

**Tape No.:** [REDACTED]

**Report Status:** [REDACTED]

[REDACTED]

**000068**



**Holter Monitor**

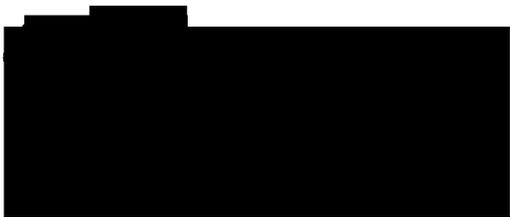
Name: [REDACTED]  
DOB: [REDACTED]

Date: October 1, 1997  
MR#: [REDACTED]

**Referring Physician:** [REDACTED] MD

1. Technically adequate 24 hour holter monitor.
2. The predominant rhythm was sinus. The heart rates ranged from 72 bpm to 163 bpm, with an average rate of 102 bpm.
3. There was no evidence of ventricular tachycardia.
4. There were no significant supraventricular premature complexes.
5. There were no significant bradydysrhythmia.
6. There were no significant ST segment changes.
7. Frequent recordings of chest pain and fluttering was documented without anything significant being found on the holter monitor. The patient was in a sinus rhythm during her symptoms.

**IMPRESSION: Benign 24 hour holter monitor recording.**



Control # \_\_\_\_\_

(For \_\_\_\_\_ Use Only)

MENTAL HEALTH TREATMENT REPORT

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: F Marital Status: S

Member Number: \_\_\_\_\_ Occupation: Sociology researcher

Onset of Condition: ~ 3/97

Prior Treatment (specify time periods and type of treatment)

\_\_\_\_\_ MD - mads, Spring/Summer 1997  
1986 - treated for depression w/ Imipramine & Prozac  
Hospitalized - \_\_\_\_\_ 9/8/97 - 9/12/97.

Presenting complaints: Panic attacks and severe anxiety since Spring 1997 after going on Synthroid, while on herbal diet pills which contained Ephedra. Includes diarrhea, vomiting, other symptoms of panic; insomnia - severe; depression - more recent, since onset of panic symptoms, anorexia & 15 lb

Precipitating events: on Synthroid tx, for thyroid nodules; Herbal diet pills which contained Ephedra, at some time that panic & fo developed.

Mental status abnormalities: severe anxiety; pressured speech.

Diagnosis (DSM-IV): I 300.01 / 311 / 1  
II Ø V (current) 43 (past year) 85  
III thyroid nodules; result use of Ephedra & Synthroid  
IV just hired for new job, and unable to work due to current symptoms

Disability in Social/Vocational Functioning: Unable to work  
due to severity of illness (anxiety / panic)

Goals of Treatment or Service: (1) Decrease / alleviate panic  
attacks (2) Decrease / alleviate general anxiety  
(3) Increase coping skills for dealing with  
anxiety symptoms (4) Decrease / <sup>alleviate</sup> depression

Service Plan:

Evaluation (hours of psychological testing) ∅

Psychotherapy (type, frequency, session length) individual,  
once per week, 50 min

Medications (name of each drug, current dosages) (~~██████████~~ and serzone  
Paxil, → D/C due to  
side effects; Klonopin 0.5 mg TID; St John's Wort 300mg T

TOTAL NUMBER OF SESSIONS REQUESTED (including inplan sessions): 20

Referring Physician: ██████████ MD Provider #: ██████████

I hereby authorize the sharing of the above information with my primary care  
provider. \_\_\_\_\_

Patient's Signature

Date

Providers group name: \_\_\_\_\_ Provider #: ██████████

Name of Provider ██████████ Date 10/1/97 Signature ██████████

Address \_\_\_\_\_ Telephone # \_\_\_\_\_

For ██████████ use only: Plan # \_\_\_\_\_ Select \_\_\_\_\_ PPO \_\_\_\_\_

## INTAKE ASSESSMENT REPORT

NAME: [REDACTED]

DATE: October 21, 1997

### I. Presenting Problem (Include Duration, Frequency of Onset, Relationship to Situational Precipitants, Maintaining Factors, Secondary Gain)

Miss [REDACTED] presented with Panic Disorder. The history of her panic disorder began during the last week of July, 1997, when she experienced her first full panic attack. At that time she was presumably under very little stress, but was taking a new medication called Synthroid. She was prescribed with Synthroid five months prior to this panic attack when it was suddenly decreased by her physician. At the time of her first panic attack, Miss [REDACTED] claims she had smoked marijuana. She also claims she had been regularly using two OTC weight loss drugs, Ephedra and Maxx, both of which are central nervous system stimulants. Miss [REDACTED] also reports to have experienced three more full panic attacks during the month of August. During the last week of August, 1997, she was hospitalized for her panic symptoms. She experienced no panic attacks in October, but claims she "felt great anxiety" throughout October. At this time, Miss [REDACTED] would like treatment to assist her with the possibility that she may have future panic attacks and for her feelings of anxiety throughout the day.

### II. Mental Status

#### A. Appearance, Attitude, Behavior

Miss [REDACTED] appeared neatly dressed and groomed. Her attitude was pleasant and cooperative throughout the intake interview. Her behavior was unremarkable.

#### B. Mental Functions

##### 1. Orientation and Memory

Based on the content of her response, Miss [REDACTED] seemed fully oriented.

##### 2. Intellectual Estimate

Based on the content of her responses, Miss [REDACTED] is above average intelligence. She is currently working on her dissertation at the [REDACTED] Ph.D. program.

##### 3. Thought Processes

Miss [REDACTED] thought processes appear well organized and coherent. She exhibited no evidence of a thought disturbance. She denied any suicidal ideation.

##### 4. Reasoning and Judgment

Miss [REDACTED] appears to exercise appropriate reasoning and judgment, with the exception of her mixing/combining four different central nervous system active drugs at once: Synthroid, Ephedra, Maxx, and Marijuana.

000072

**C. Mood**

Miss ██████ reported feeling frequently hostile to her roommate, anxious, and restless. In session, Miss ██████ exhibited mild pressure of speech.

**III. History**

**A. Brief Relevant Personal/Family History**

Miss ██████ reports a previous psychiatric hospitalization at the age of 17 for a suicide attempt in which she took a bottle of Tylenol. She was stoned on marijuana at the time. Miss Donovan claims she had a depressive episode then and since this time, she has also had two other suicide attempts where she inflicted superficial cuts to her wrists. She has had no other attempts since age 18.

**B. Brief Medical History (Include Current Medications)**

In early March, 1997, Miss ██████ was diagnosed with three enlarged thyroid nodules and a breast lump. Both were found to be benign. Miss ██████ was placed on Synthroid at that time and terminated this medication in early August, 1997. She was placed on Clonipin for anxiety in August, 1997. She was recently diagnosed with Endometriosis. Miss ██████ takes St. John's Wort for depression by choice.

**C. Substance Abuse History**

Miss ██████ claims she has smoked marijuana on and off for several years now. She is a moderate drinker of alcoholic beverages. She currently refrains from marijuana due to its association with her panic attack.

**IV. Diagnostic/Clinical Impression**

**1. Primary: Symptoms, Behaviors, Other Problems**

Miss ██████ presented with Panic Disorder. Her symptoms include palpitations, fear of dying, fear of going crazy, shortness of breath, and depersonalization. She claims to have experienced four to five full panic attacks between the months of late July and end of August, 1997.

**2. Secondary: Relevant Personality Characteristics**

No Axis II diagnoses were assigned.

**3. Psychosocial Stressors**

Miss ██████ reports only mild levels of psychosocial stress currently. She is in a doctoral program which presents stressors in terms of academic work.

4. Global Functioning: Degree of Dysfunction:

	Severe	Moderate	Mild	Absent
a. Psychosocial	_____	<u>  X  </u>	_____	_____
b. Occupational/ Educational	_____	_____	_____	<u>  X  </u>
c. Social	_____	_____	<u>  X  </u>	_____

5. Psychological Strengths

Miss [REDACTED] appears highly motivated to pursue treatment in the area of panic disorder. She attempts to educate herself using bibliotherapy in the area of panic. This insight will prove useful to her in treatment.

V. Treatment Factors

A. Previous Treatment Attempts

Miss [REDACTED] was hospitalized at [REDACTED] for one week due to her panic disorder. At that time she was seen by a private psychiatrist. She is also seen by her current psychiatrist, [REDACTED] M.D. Dr. [REDACTED] has also noted Miss [REDACTED] pressured speech.

B. Motivation/Insight

Miss [REDACTED] is equipped with excellent insight with regards to her acceptance of the form of treatment that will be provided to her. Her motivation is excellent.

C. Prognosis

Given Miss [REDACTED] level of motivation and insight, I would consider her prognosis to be very good.

D. Appropriateness for [REDACTED] and Treatment Recommendations (Contingency for Treatment)

Miss [REDACTED] is appropriate for services at [REDACTED]. She will be provided with a cognitive-behavioral treatment that focuses on faulty cognitions in response to physical sensations and interoceptive exposure.

**VI. Further Assessment Issues That Require Additional Clinical Information**

I need to explore further how Miss [REDACTED] health issues are associated with the panic disorder  
Her health issues need to be addressed before treatment can begin.

**VII. Additional Comments (Test Results, if any):**

None.

Submitted by:

[REDACTED]  
[REDACTED]  
[REDACTED]  
Psychological Trainee

Approved by:

[REDACTED]  
[REDACTED]  
[REDACTED] Ph.D.  
Psychological Supervisor

**000075**

RECORD OF CONTACTS

Client's Name: [REDACTED]

DATE

10-21-97 Supervisory Note

I observed Ms [REDACTED] initial interview, in part, with this Pt and discussed the case with her today. She appears to have had an initial panic attack in the summer. This may have been triggered by the OTC drug she was taking at the discontinuation of her thyroid medication. Regardless of that, she became briefly agoraphobic and continues to have both full blown panic attacks and limited symptom attacks. I suggested that she [REDACTED] treatment and that she have the Pt educate herself about Panic Disorder. I also strongly urged that the patient discontinue all of her OTC medications.

[REDACTED], Ph.D.  
Licensed Psychologist

① 10/21/97 met with [REDACTED] for her intake today. She reports that Panic symptoms/attacks began approximately <sup>four</sup> three months ago. ~~she~~ At that time she was taking Synthroid for enlarged thyroid nodules she was prescribed with Synthroid in early March, 97. [REDACTED] claims that she was under little stress at the time of her first full panic attack in July, 97. However, she claims that she was taking weight loss medications: Ephedra + Maxx, both of which are CNS stimulants. [REDACTED] was also stored on pot the day of her first panic attack. Therefore, she had four CNS drugs in her system at once at the time of her first attack. She claims to have experienced the classic panic Sx's which

Cont'd -

RECORD OF CONTACTS

Client's Name: [REDACTED]

DATE Cont'd

① Consist of depersonalization, fear of dying, fear of going crazy, & palpitations. She had 4 panic attacks (full) between the end of July to the end of August, 1997. She claims she felt/experienced no panic symptoms in October, 97', but claims she has managed to "talk herself out of it", especially during meal time when she tends to experience anxiety most [REDACTED] claims she had a panic attack during a meal and this has appeared to generalize in terms of anxiety symptomatology to other meals. She "waits to see" if a panic attack will surface during meal time and appears hypervigilant about internal sensations & cues. [REDACTED] stopped taking Synthroid, her weight loss medication, & got since August, 97'. She is currently prescribed with Clonidine for her anxiety and is mixing this with St. John's Wort for depression. In late August, [REDACTED] was hospitalized for 1 week at [REDACTED] for her panic symptoms. At that time her psychiatrist noted her pressured speech. At this time she was invited to terminate Synthroid. Miss [REDACTED] will be treated at [REDACTED] for her panic symptomatology.

Psychology Trainee

② 10/22/97 [REDACTED] was on time for her appointment today. We continued with her intake assessment information. She claims her Thyroid is functioning well and is not abnormal. The goal was to investigate any biological/physiological contributions to Panic disorder & there appear to be none at this time. She informed me, however, she was recently diagnosed with endometriosis and this is

RECORD OF CONTACTS

Client's Name: [REDACTED]

Cont'd.

DATE

②  
10/25/97  
Coping Stress for her [REDACTED] claims she again attempted to fend off "panic like feelings", although she has not experienced any full panic attacks this past week. Again she appears to be hypervigilant with body sensations, particularly around meal time. For today's session, we discussed D. Clark's Cognitive Model of Panic Attack and how this model pertains to her experience. We discussed the nature of anxiety, what it consists of & how it is maintained. I went over with her the treatment rationale and what we would be focusing on together in treatment. She was provided with several readings to educate her on panic & to prepare her for the next session. ————— Psychology Trainee —————

③  
11/4/97  
[REDACTED] was on time for her session today. She informed me that she has improved greatly in that she is sleeping better & no longer experiences a constant anxiety. However, she has experienced more discrete, acute anxiety, especially in the morning. We reviewed her homework monitoring assignment & her record clearly shows greater depression & anxiety in the morning. [REDACTED] explained her attempts to avoid & escape feelings of anxiety by distracting herself with TV, the computer, etc. For session 2 of her treatment, we reviewed what <sup>we</sup> went over during last week's session - Clark's Model of Panic, the 3 Response System of "Thinking, feeling, & doing" in response to PANIC. I then discussed with her the handouts she [REDACTED] was given last week & reviewed what the handouts were all about in terms of the survival value & physiological aspects of anxiety.

RECORD OF CONTACTS

Client's Name: [REDACTED]

DATE

②  
11/4/17

We then discussed how interoceptive Conditioning has maintained her Panic State + anxiety + how it can be broken by exposure. Some Components from Acceptance + Commitment Therapy were used (ACT Therapy) involving avoidance of internal cues + literalness of language regarding "fear of dying or going crazy". Metaphorical stories were provided to encourage her to be "willing" to experience the internal sensations without avoiding them. I showed her a behavioral drill that mimics the feeling of "leaning into the experience" of Physical Sensations. I then had her hyperventilate for 1.5 minutes to simulate Panic Sensations. She was successful at this + experienced from 0-8 Scale, a 5 for Anxiety and a 6 for Similarity to anxiety symptoms. She was taught how to control her breathing, was provided with breathing exercises homework, + asked to continue monitoring her anxiety for the week.

[REDACTED]

Psychology Trainee

③  
11/18/17

It has been two weeks since Miss [REDACTED] has been seen. Her homework - Monitoring Sheets indicate Zero Panic Attacks and mild levels only of anxiety. Her depression, however, continues to be elevated. Thus, her anxiety has markedly improved. For today's session, we reviewed last session's material briefly. We discussed her breathing homework assignment. [REDACTED] claims she performed the breathing techniques as needed but that she got distracted often. Otherwise, she claims she is bored of the

RECORD OF CONTACTS

Client's Name: [REDACTED]

4

DATE Cont'd.

11/18/17

[REDACTED] tapes she has been ~~listening to~~ ~~based~~ listening to & that it is difficult to perform the breathing along with the tapes. She was encouraged to perform the exercises with instrumental music only at this point. I showed her an exercise where she was taught to breathe through the Diaphragm. She was asked to perform this exercise while doing her breathing assignments. We then went into Cognitive Restructuring. [REDACTED] was taught to identify her automatic thoughts during a Panic attack, to question them by formulating hypotheses about them, to refute them, & then to formulate a rational response. She was given examples of how to do this & was sent home with the homework to identify AT's, to assign Cognitive Distortions to them (ie - Overgeneralizing), to refute these distortions, & to come up with a dispute handle. Interceptive Exposure begins next week.

Psychology Trainee

5  
11/25/17

[REDACTED] was on time for her appointment today. For today's session we focussed on breathing techniques & a discussion of her depression, which [REDACTED] has had since her Panic began. She was assigned new homework to check in on her breathing 5x/day & to practice diaphragmatic breathing each time for 2 mins. Her monitoring log shows that [REDACTED] anxiety & depression has gone up somewhat. We then reviewed Cognitive Restructuring & she was presented with specific examples. She was asked to fill in her Cognitive distortions on a homework

Cont'd

000080

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_



DATE Cont'd

⑤ 11/25/97 Sheet provided for her. For the remainder of the Session, we began interoceptive exposure. [redacted] was asked to spin in a chair for 1 minute & to provide Automatic Thoughts. She rated this experience as Moderately close to sensations she felt during a real panic attack. Her AT's were refuted & she was taught how to use interoceptive exposure outside of the session & then educated on how this can be generalized to instances where she truly experiences a physical sensation.



Psychoanalogue Trainer

⑥ 12/12/97 [redacted] was on time for her appointment today. Her Monitoring Sheets indicate that her depression, Anxiety, & worry about panic has declined dramatically since I last saw her. She continues to practice her breathing exercises daily - checking it 5x/day and practicing diaphragmatic breathing. She claims the breathing component has been most helpful to her in her treatment. We then reviewed Cognitive restructuring and [redacted] claims she has been using this technique when needed & that she understands the process well. There was one point within the past 3 weeks where she had guests over to her house for dinner & they smoked pot - this triggered fears that the pot would result in panic, so she left & went up to her room for a few minutes & this was effective. This led to the possibility of non-avoidance of activities (not necessarily pot smoking, however) that may not result in panic. She was encouraged to engage in activities she normally avoids (ie - scary movies, going to the hairdresser) to hypoxia.

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_

⑥ DATE

12/11/17 test her fears. we then explored more interoceptive exposure. \_\_\_\_\_ was asked to breathe thru a Straw for 2mins to simulate the feeling of ~~choke~~ choking. This was not as effective & it was agreed that she should focus on activities (Exposure) that resulted in dizziness or derealization. She was asked to perform these exposures at home 1x/day \_\_\_\_\_

Psychology Trainee.

⑦ 12/16/17.

Met with \_\_\_\_\_ today. we reviewed last week's session which consisted of interoceptive exposure techniques. \_\_\_\_\_ performed several homework assignments where she performed interoceptive exposures - blowing thru a Straw, hyperventilation, placing head between legs & standing straight up, Shaking head side to side. \_\_\_\_\_ gains most from any exercise that involves dizziness. The hyperventilation exercise provides a score of 4-5 on an Anxiety Scale of 0-8, as well as for similarity to actual panic. She was requested to continue w/ hyperventilation until she achieves a score of 2 on this scale. we also reviewed her breathing exercises & \_\_\_\_\_ continues to do them. \_\_\_\_\_ asked when her sessions should end. It was discussed that as long as \_\_\_\_\_ can confidently do the techniques ~~and~~ as well as understand that Panic is Not permanently cured - treatment can soon end. In other words, if her expectation is for Panic to never return, we would have more work to do together. For now, at least 2-3 more sessions will be spend on Situational avoidance, how to get involved in activities she currently

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_



⑦ DATE

12/16/17 avoids, and reviewing everything learned in sessions. avoids driving in cars as a Passenger, going to the hair dresser, & traveling on busses due to fears of Panic on these activities. This remains to be addressed. Otherwise, Panic sk's, future fear of Panic, & depression have remained at 1-2 (None to only Mild) —



Psychology Trainee

⑧ 1/6/18

met w/ \_\_\_\_\_ - she was on time for her appointment. Her vacation went well. She rode with friends in her car & back & felt Super driving with them. She also went to the hairdresser & got her hair cut - she explained that she felt derealization & "funny" at times, but that she effectively used cognitive techniques to manage her fear. We discussed her current Situational avoidance and ranked from 0-4 (no fear to high fear) her anxiety regarding several situations. She ranked highest anxiety for being a passenger in a car & going to the Supermarket. We set, as a goal, the assignment of exposing herself to these situations several times during the week. She was taught how to record these assignments. We also reviewed <sup>the</sup> last week's session's activities & spent some time discussing breathing control. She was taught to use an imagery technique to manage periods when she wakes up abruptly for sleep.



Psychology Trainee

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_

DATE

1-13-98 Supervisory Note

I observed portion of \_\_\_\_\_ session on 1-6-98 and discuss the case with her. I discuss in her assessment and treatment plan. It has seems to have been some progress in controlling panic attacks.

\_\_\_\_\_  
Licensed Psychologist

1/13/98

\_\_\_\_\_ cancelled her appt. today and is rescheduled for next Tuesday - 1-20-98

\_\_\_\_\_  
Psychology Trainee

①  
1/20/98

\_\_\_\_\_ was on time for her appointment today. She appeared to be upset and crying but was unable to pinpoint why or to discuss what recent led up to her being upset. She did mention feeling particularly worried so I made a more formal assessment of this. She met all GAD criteria except for that she has not had the worry for at least 6 months. I provided her with a worry exposure task which involves setting aside 1/2 hr. to 1 hour of doing nothing but worrying. She also instructed on how to fill out a worry exposure sheet. \_\_\_\_\_ reports shifting from one worry to another and not really thinking out the worst of her worries or alternative explanations. This exercise will encourage her to do that. We reviewed last week's session on avoidance behavior. Again she was provided with a rationale for ~~the~~ situation exposure. We reviewed ~~the~~ a mastery exposure chart for recording her exposure successes. \_\_\_\_\_ reported that she ~~is~~ rode as a passenger only once during the past week & for only a short ride. She ~~is~~ was encouraged

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_

9 DATE

1/20/98 to continue as a passenger & to leave her Safety Signs & devices behind. The rationale for this was also explained. [redacted] was informed that as long as she holds onto Safety devices, she is only Partially exposing herself, which is not as effective. She agreed to give this a try & to also spend time in a crowded grocery store & stand in a long line. [redacted] claims she has been using the imagery exercise I prescribed to her last time we met & that this has been working well for her.

Psychology Trainee.

10  
1/27/98

[redacted] informed me that the opportunity to drive in a Car as a Passenger arose, but she turned it down because she did not feel motivated to go. She also felt that the fear and avoidance overcame her. Despite this, she has many excuses why she chose not to drive as a Passenger with her friend for 1/2 hr. to [redacted] and back. She feared that she would not be able to drive home because the car is standard & she does not know how to drive a standard vehicle. [redacted] also stated that she feared the drive because there is "no escape". To assist her with this fear & avoidance I practiced with her <sup>the</sup> Cognitive Restructuring to use for this task. I encouraged her to continue with the Situational exposure, but to take it slower than I was encouraging her to go. She was encouraged to have her friend pull over to the side of the road once or twice so she can get out & walk around - as an "escape" as long as she restructures during the break and sits back in the passenger seat once the break is over. [redacted] also informed me that

Cont'd  
000085

RECORD OF CONTACTS

Client's Name: \_\_\_\_\_

⑩ DATE  
1/27/98

it is possible that her roommate (+ others) tailor their activities around her Situational avoidance, such that her roommate brings home food to her, does all the grocery shopping, and generally reinforces her Situational avoidance. One idea was to bring in her roommate for a session to discuss Situational avoidance. \_\_\_\_\_ will check into this as a possibility, but does not believe so due to her roommate's schedule. For the remainder of the session, we discussed \_\_\_\_\_ worry Exposure assignment. \_\_\_\_\_ states that the assignment caused her much anxiety. However, it seems too early at this point to determine whether or not the assignment is successful or if it should be terminated. I looked over her worry homework assignments and \_\_\_\_\_ claims she worried about moving to \_\_\_\_\_ with her roommate "\_\_\_\_\_" and whether or not they will be happy. She was encouraged to continue the assignment for now.

Psychotherapy Notes

⑪  
2/3/98

\_\_\_\_\_ showed me her monitoring log. She shows worrying 30-55% of her days. Her anxiety + depression have increased as well. She decided not to do her worry exposure homework because she became too anxious from doing it. I explained to her that the homework would cause temporary anxiety because it involves facing up to one's fears, but that the anxiety would dissipate in time. She agreed to resume <sup>the</sup> worry exposure + to change her imagery skills on the "possible alternatives" section - I advised her to imagine scenes that were contrary to death (ie - imagining

RECORD OF CONTACTS

Client's Name: [REDACTED]

① DATE

Cont'd:

2/3/98

life as an older person [REDACTED] agreed she would give this a try. For today's session, we discussed her worries from the week. She continued to fear that she will suffer an early death and that loved ones will be unable to cope. I discussed with her how worries contribute to anxiety & how they reinforce more worries to occur if the individual does not process or work through the worries fully. [REDACTED] problem is that she skips from worry to worry & does not allow herself to habituate to one particular worry at a time. We reviewed her worries individually, broke them down, & attempted to come up with evidence in support of each one. [REDACTED] unable to come up with convincing evidence for any of her worries. I showed her how to use this form of reasoning to contradict her worries and to use this form of reasoning to decrease her level of anxiety and her ratings of how probable her worries are likely to occur. We reviewed how to "de-catastrophize" her worries and she was assisted to go through the steps. [REDACTED] informed me that she recently was offered an interview for a faculty position at [REDACTED]. This poses another worry for her. But she claims that this is a "healthy" worry and she is glad this is an opportunity for her.

[REDACTED]  
Psychology Trainee.

2/16/98 SU Note

I observed part of session (2/3) and discussed case w/ trainee. So will continue intervention in the same way.

[REDACTED] PLD 000087  
Licensed Psychologist

RECORD OF CONTACTS

Client's Name: [REDACTED]

(12) DATE

2/10/98

[REDACTED] was about 5 mins. late for her appointment today. We began by discussing her worry exposure homework. [REDACTED] claims she didn't feel she needed to do it because she believes she has "gotten over" her worries about death. She states her father almost got killed at his construction site on a bridge & that this has prompted [REDACTED] to think about death. After I spent some time addressing [REDACTED] fear of death & how it would affect her family especially her mother, I had determined that "death" continued to pose concerns for her. At one point her eyes appeared to well with tears when she was prompted to discuss how her death would affect her mother.

[REDACTED] was encouraged to continue her worry exposure re: death but to do it on tape (cassette recorder) so that this would expose her emotions & to see as to whether or not she performs the exposure comedly. We discussed methods [REDACTED] could discuss death with her loved ones & to test the hypothesis that they would not be able to cope. One method was to directly discuss how family members would cope in the event of death directly with family members. [REDACTED] claimed that this would be difficult to do with her mother & we explored why & how she could do this. We also explored the idea of bringing her friend [REDACTED] into the session to explore utilizing her as a coach. Lastly, we explored her recent avoidant behaviors and it appears she has continued to avoid her salary. She also assigned the task of doing the grocery shopping prior to our next session in 2 weeks. She has a job interview at [REDACTED] next week (Tuesday).

[REDACTED] 000088  
 Psychology Trainee

RECORD OF CONTACTS

Client's Name: [REDACTED]

DATE

2/24/18 [REDACTED] rescheduled her appointment for today - She will be rescheduled for next Tuesday at 1 p.m. [REDACTED]

Psychology Trainee.

3/3/18 [REDACTED] again rescheduled her appointment for next week at 1 p.m. [REDACTED]

Psychology Trainee.

3/20/18 [REDACTED] ~~the~~ sbt was open for her today at 1 p.m. She failed to show up for her appointment and did not cancel herself. She was called and [REDACTED] left a message on her answering machine to return our call if she wishes to remain in Services [REDACTED]

Psychology Trainee.

INTERIM SUMMARY

[Redacted]

Client's Name

1/20/98

Date

1. Status of Presenting Problem or Recent Problems

[Redacted] has made much progress with her panic & average anxiety throughout such well she has been in treatment. She has had no panic since beginning treatment. Her level of depression & worry, however, appear to have increased recently. She continues to avoid some situations (ie- dining out), but has made some small progress with exposing herself to other feared situations (ie- riding in the car). With regard to alleviating actual panic, the treatment has been successful.

2. Current Mental Status

[Redacted] mood and affect have recently become more depressed, albeit she appears less anxious. Her speech appears spontaneous and her behavior is less agitated. Her thought processes are organized, with absence of hallucinations, delusions, & suicidal ideation. She is fully oriented. Her memory, judgment, and reasoning remain intact.

3. Course of Treatment to Date

We have been working on [Redacted] tendency to avoid situations due to her fear that she will suffer a panic attack (ie- riding as a passenger in a car, going to the hairdresser, grocery store, etc.). Situational exposure treatment has been ongoing and treatment for [Redacted] was implemented only recently (on 1/20/98). Thus far, [Redacted] has successfully been treated for her panics via relaxation, cognitive restructuring, and interoceptive exposure.

000090

4. Treatment Plan

The current treatment plan will involve an integration of interventions: a) Situational Exposure will continue b) Breathing Retraining and relaxation will continue, as [Redacted] continues to have problems with hyperventilation, and lastly c) Treatment for GAD will involve worry exposure, cognitive restructuring, & relaxation.

[Redacted]

Student's Signature

[Redacted]

Supervisor's Signature

PHI 1/2

CLOSING SUMMARY

Name: [REDACTED]

Date: March 17th, 1998.

1. Problems Treated and/or Noted:

[REDACTED] presented with Panic Disorder. She completed Panic Control treatment successfully and began to work on avoidance issues as well as several worries that have been very distressing for her. Specifically, [REDACTED] has been avoiding supermarkets, riding in cars as a passenger, and going to the hairdresser (i.e. places where she could be trapped).

2. Course of Treatment:

[REDACTED] received the Panic Control treatment protocol and has not experienced a panic attack since our first few sessions. Breathing retraining seemed most effective for her as [REDACTED] appeared to hyperventilate frequently. We explored her avoidant tendencies via exposure treatment and also investigated her worries. Such worries (i.e. fear of death) created autonomic responses.

3. Current Status:

[REDACTED] has moved out of the area as she has accepted a job in [REDACTED]. She has, therefore, discontinued treatment with [REDACTED]. As per our last session, she continued to remain panic free. Nevertheless, she still continues to exhibit avoidance behavior and worries that contribute to autonomic responses.

4. Indication for Further Treatment:

[REDACTED] will need to continue her treatment to assist her with her tendency to avoid certain situations in fear that she will lose control or experience a future panic attack. [REDACTED] needs to expose herself to riding in a car as a passenger, go to the hairdresser, and shop in the supermarket. She also needs to continue to address her worries that contribute to her distress.

Submitted by:

[REDACTED]  
Psychology Trainee

Approved by:

[REDACTED] *RD*  
Ph.D.  
Licensed Psychologist/Supervisor

000091

MONTHLY MENTAL STATUS REPOF

Client's Name: \_\_\_\_\_

**I. Appearance, Attitude, and Behavior**

A. Appearance:

Neat    \_\_\_ Unkempt    \_\_\_ Other\*: \_\_\_\_\_

B. Attitude:

Cooperative    \_\_\_ Uncooperative    \_\_\_ Suspicious  
\_\_\_ Hostile    \_\_\_ Passive

C. Behavior:

Normal    \_\_\_ Hyperactive    \_\_\_ Agitated    \_\_\_ Slow

**II. Speech**

\_\_\_ Normal    \_\_\_ Slurred    \_\_\_ Excessive     Pressured  
\_\_\_ Perseverative    \_\_\_ Other\*: \_\_\_\_\_

**III. Mood and Affect**

A. Affect

\_\_\_ Appropriate    \_\_\_ Inappropriate    \_\_\_ Labile    \_\_\_ Expansive  
\_\_\_ Flat     Other\*: Nervous appearance

B. Mood

\_\_\_ Normal    \_\_\_ Depressed     Anxious    \_\_\_ Euphoric    \_\_\_ Angry

**IV. Mental Functions**

A. Thought Process:

Organized    \_\_\_ Circumstantial    \_\_\_ Flight of Ideas  
\_\_\_ Loosening of Associations    \_\_\_ Other\*: \_\_\_\_\_

B. Thought Content:

1. Hallucinations:     Absent    \_\_\_ Present  
2. Delusions:     Absent    \_\_\_ Present  
3. Suicidal Ideation:     Absent    \_\_\_ Present  
4. Homicidal Ideation:     Absent    \_\_\_ Present

000092

C. Orientation:

Fully Oriented    \_\_\_ Disoriented:    \_\_\_ Time    \_\_\_ Person    \_\_\_ Place

D. Memory:

Intact    \_\_\_ Impaired:    \_\_\_ Short-term    \_\_\_ Longer-term

E. Judgment and Reasoning:

Intact    \_\_\_ Impaired (describe): \_\_\_\_\_

**V. Other Comments:**

None  
\_\_\_\_\_  
\_\_\_\_\_

Psychologist/line \_\_\_\_\_ Date 10/3/87 Supervisor \_\_\_\_\_ Date 1-13-88

\* - Please Comment

MONTHLY MENTAL STATUS RE

Client's Name: [REDACTED]

I. Appearance, Attitude, and Behavior

A. Appearance:

Neat  Unkempt  Other\*: \_\_\_\_\_

B. Attitude:

Cooperative  Uncooperative  Suspicious  
 Hostile  Passive

C. Behavior:

Normal  Hyperactive  Agitated  Slow

II. Speech

Normal  Slurred  Excessive  Pressured  
 Perseverative  Other\*: \_\_\_\_\_

III. Mood and Affect

A. Affect

Appropriate  Inappropriate  Labile  Expansive  
 Flat  Other\*: \_\_\_\_\_

B. Mood

Normal  Depressed  Anxious  Euphoric  Angry

IV. Mental Functions

A. Thought Process:

Organized  Circumstantial  Flight of Ideas  
 Loosening of Associations  Other\*: \_\_\_\_\_

B. Thought Content:

1. Hallucinations:  Absent  Present  
2. Delusions:  Absent  Present  
3. Suicidal Ideation:  Absent  Present  
4. Homicidal Ideation:  Absent  Present

C. Orientation:

Fully Oriented  Disoriented:  Time  Person  Place

D. Memory:

Intact  Impaired:  Short-term  Longer-term

E. Judgment and Reasoning:

Intact  Impaired (describe): \_\_\_\_\_

V. Other Comments:

000093

[REDACTED] 11/18/97 [REDACTED] 11-18-97  
Psychology Trainee Date Supervisor Date

\* - Please Comment

MONTHLY MENTAL STATUS REF

Client's Name: [REDACTED]

I. Appearance, Attitude, and Behavior

- A. Appearance:
  - Neat     Unkempt     Other\*: \_\_\_\_\_
- B. Attitude:
  - Cooperative     Uncooperative     Suspicious
  - Hostile     Passive
- C. Behavior:
  - Normal     Hyperactive     Agitated     Slow

II. Speech

- Normal     Slurred     Excessive     Pressured
- Perseverative     Other\*: \_\_\_\_\_

III. Mood and Affect

- A. Affect
  - Appropriate     Inappropriate     Labile     Expansive
  - Flat     Other\*: \_\_\_\_\_
- B. Mood
  - Normal     Depressed     Anxious     Euphoric     Angry

IV. Mental Functions

- A. Thought Process:
  - Organized     Circumstantial     Flight of Ideas
  - Loosening of Associations     Other\*: \_\_\_\_\_
- B. Thought Content:
  - 1. Hallucinations:     Absent     Present
  - 2. Delusions:     Absent     Present
  - 3. Suicidal Ideation:     Absent     Present
  - 4. Homicidal Ideation:     Absent     Present
- C. Orientation:
  - Fully Oriented     Disoriented:     Time     Person     Place
- D. Memory:
  - Intact     Impaired:     Short-term     Longer-term
- E. Judgment and Reasoning:
  - Intact     Impaired (describe): \_\_\_\_\_

V. Other Comments:

000094

Psychologist [REDACTED] 12/10/97 Date    Supervisor [REDACTED] 12-16-97 Date

\* - Please Comment

MONTHLY MENTAL STATUS REPO

Client's Name: [REDACTED]

I. Appearance, Attitude, and Behavior

A. Appearance:
[checked] Neat \_\_\_ Unkempt \_\_\_ Other\*: \_\_\_\_\_

B. Attitude:
[checked] Cooperative \_\_\_ Uncooperative \_\_\_ Suspicious
\_\_\_ Hostile \_\_\_ Passive

C. Behavior:
[checked] Normal \_\_\_ Hyperactive \_\_\_ Agitated \_\_\_ Slow

II. Speech

[checked] Normal \_\_\_ Slurred \_\_\_ Excessive \_\_\_ Pressured
\_\_\_ Perseverative \_\_\_ Other\*: \_\_\_\_\_

III. Mood and Affect

A. Affect
[checked] Appropriate \_\_\_ Inappropriate \_\_\_ Labile \_\_\_ Expansive
\_\_\_ Flat \_\_\_ Other\*: \_\_\_\_\_

B. Mood
\_\_\_ Normal \_\_\_ Depressed [checked] Anxious \_\_\_ Euphoric \_\_\_ Angry

IV. Mental Functions

A. Thought Process:
[checked] Organized \_\_\_ Circumstantial \_\_\_ Flight of Ideas
\_\_\_ Loosening of Associations \_\_\_ Other\*: \_\_\_\_\_

B. Thought Content:
1. Hallucinations: [checked] Absent \_\_\_ Present
2. Delusions: [checked] Absent \_\_\_ Present
3. Suicidal Ideation: [checked] Absent \_\_\_ Present
4. Homicidal Ideation: [checked] Absent \_\_\_ Present

C. Orientation:
[checked] Fully Oriented \_\_\_ Disoriented: \_\_\_ Time \_\_\_ Person \_\_\_ Place

D. Memory:
[checked] Intact \_\_\_ Impaired: \_\_\_ Short-term \_\_\_ Longer-term

E. Judgment and Reasoning:
[checked] Intact \_\_\_ Impaired (describe): \_\_\_\_\_

V. Other Comments:

000095

[REDACTED] 1/13/98 [REDACTED] 1-13-98
Psychology Trainee Date Supervisor Date

MONTHLY MENTAL STATUS REPORT

Client's Name: [REDACTED]

I. Appearance, Attitude, and Behavior

A. Appearance:

Neat     Unkempt     Other\*: \_\_\_\_\_

B. Attitude:

Cooperative     Uncooperative     Suspicious  
 Hostile     Passive

C. Behavior:

Normal     Hyperactive     Agitated     Slow

II. Speech

Normal     Slurred     Excessive     Pressured  
 Perseverative     Other\*: \_\_\_\_\_

III. Mood and Affect

A. Affect

Appropriate     Inappropriate     Labile     Expansive  
 Flat     Other\*: \_\_\_\_\_

B. Mood

Normal     Depressed     Anxious     Euphoric     Angry

IV. Mental Functions

A. Thought Process:

Organized     Circumstantial     Flight of Ideas  
 Loosening of Associations     Other\*: \_\_\_\_\_

B. Thought Content:

1. Hallucinations:     Absent     Present  
2. Delusions:     Absent     Present  
3. Suicidal Ideation:     Absent     Present  
4. Homicidal Ideation:     Absent     Present

C. Orientation:

Fully Oriented     Disoriented:     Time     Person     Place

D. Memory:

Intact     Impaired:     Short-term     Longer-term

E. Judgment and Reasoning:

Intact     Impaired (describe): \_\_\_\_\_

V. Other Comments:

000036

[REDACTED]  
Psychology Trainee

2/17/98  
Date

[REDACTED]  
Supervisor

4/7/98  
Date