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

ARMS#

13021

3 - OUTPATIENT

MedWatch
Project #1[illegible]21

Name [redacted]

If Minor - Parents Name

Address [redacted]

Telephone Number [redacted]

Business [redacted]

Business Address [redacted]
(If housewife give husband's business)

Business Telephone [redacted]

Nearest Relative [redacted] Address [redacted]

Reference [redacted]

Age 32 Birth Date [redacted] Weight Height

Temperature Pulse Date 6-11-87

#8. R 150/80 C 120/80

CHPx ⊖ $\bar{x}$ ↑chol / U.A.

Plan: ↓chol diet
Rtcin Time.

[redacted]

7.21.87 #[redacted]
chol/uno

C 130/80

made fig sim lunch habits and
lost 6-8 lbs.

Dup mild ↑ in chol.

Run: RTC in 2 mos for CHOL.

[redacted]

8-31-88 # [redacted]

Meds: Ø

All: Ø

BP: 124/80

Would like to lose 10 lbs and wanted to be sure he was OK to do that. Also it nurses heard irreg heart beat ~~wthg~~ when giving blood recently

CMPx ⊖

RAN: Rt c in 2 wks for TMT

[redacted]

9-16-88 # [redacted]

TMT/AB

TMT ⊖

RAN: may ex @ will
wt goal 160

[redacted]

Name [redacted] Date: 6/15/8[illegible]

Chief Compl[redacted]

Internal History:

Age

Urine

Comp. Bld [redacted]

EKG

Hr. p.p

PA + Lat [redacted]

X-Ray

Review of Systems HEENT

CR,

GI

GYN

GU

NM

Medications:

Family History Update:

Father: DM

Mother:

Siblings: Sister c̄ DM

Immunizations: Tetanus - '85

Flu Shot - —

Pneumonia Shot - —

TB test - yes

## Physical Examination

| Temp. | BP | | Pulse | Resp. | Ht. 5'9½" / Wt. 125.2 |
|---|---|---|---|---|---|

| | Normal | Abnormal | Description of Abnormalities |
|---|---|---|---|
| 1. General Appearence | ✓ | | mild T in wgt. |
| 2. Skin | ✓ | | freckled |
| 3. Glands | ✓ | | |
| 4. Eyes | ✓ | | glasses |
| 5. Pupils, EOM | ✓ | | |
| 6. Ears | ✓ | | some wax |
| 7. Nose | ✓ | | |
| 8. Throat/Mouth | ✓ | | |
| 9. Neck | ✓ | | |
| 10. Breasts | ✓ | | |
| 11. Chest | ✓ | | |
| 12. Lungs | ✓ | | |
| 13. Heart | ✓ | | no murmur |
| 14. Abdomen | ✓ | | |
| 15. Genitalia | ✓ | | uncirc. |
| 16. Cervix | — | | |
| 17. Uterus | — | | |
| 18. Adnexa | — | | |
| 19. Rectal | ✓ | | guaiac stool |
| 20. Extremities | ✓ | | |
| 21. Neurologic | ✓ | | |

Impression:

Disp:

[redacted]

12-16-88
6-15-89 # [redacted]
chpx
BP 110/72
meds ⊖

CMK ⊖ ⊼ some back pain

Rxn: Cold on man for chol.
Rt cin 3 mos.

[redacted]

6-20-89 chol. ↑. get 8 wk chol dure
see 1 mo - 6 wks

7-31-92 # 10 persistent
cough x
CRP / KM several wks
c̄ ↓ed energy

Meds
⊖

DMP asthma / CMK ⊖

Rxn: medical Dx ⊼ [redacted]
Rt cin 2 wks.

[redacted]

Name: [redacted] Date: 7/31/92

Chief Co[redacted] "persistant cough + wheezing"

Internal History:

Age

Urine

Comp. Bld [redacted]

EKG

Hr. p.p.

X-Ray 2V [redacted]

Review of Systems HEENT ⊖ cots / ⊖ glauc / ⊖ thy

CR, ⊖ mi / ⊖ polp / ⊖ HBP / ⊖ smoke
⊖ lungs

GI ⊖ ulcers / ⊖ HH / ⊖ hep / ⊖ GB
⊖ drink / ⊖ hems / ⊖ Const.

GYN —

GU ⊖ UTI / ⊖ stones

NM ⊖ arth.

Medications: —

Family History Update:
Father: DM / ↓ of MI ~59
Mother: A+W
Siblings: A+W T sister ODM

Immunizations: Tetanus - < 10 yrs.

Flu Shot -

Pneumonia Shot -

## Physical Examination

| Temp. | BP 128/80 | | Pulse | Resp. | Ht. | Wt. 174 |
|---|---|---|---|---|---|---|

| | Normal | Abnormal | Description of Abnormalities |
|---|---|---|---|
| 1. General Appearence | ✓ | | mod fine wgt. |
| 2. Skin | ✓ | | freckles |
| 3. Glands | ✓ | | |
| 4. Eyes | ✓ | | |
| 5. Pupils, EOM | ✓ | | |
| 6. Ears | ✓ | | |
| 7. Nose | ✓ | | |
| 8. Throat/Mouth | ✓ | | |
| 9. Neck | ✓ | | no goiter |
| 10. Breasts | ✓ | | |
| 11. Chest | ✓ | | |
| 12. Lungs | ✓ | | no wheezes |
| 13. Heart | ✓ | | no (m) |
| 14. Abdomen | ✓ | | |
| 15. Genitalia | ✓ | | unremarkable. |
| 16. Cervix | — | | |
| 17. Uterus | — | | |
| 18. Adnexa | — | | |
| 19. Rectal | ✓ | | heme (-) stool |
| 20. Extremities | ✓ | | |
| 21. Neurologic | ✓ | | |

Impression: _____

Disp: _____

PHONE CALL

Doctor [redacted] Date 8-6-92 Time 11:08 Operato[redacted]

Patient Name _____ Phone # [redacted]

Caller Name [redacted]

COME IN-○ SICK-⊗ TEST RESULTS-○ NEED MEDICINE-○ SCHEDULE TEST-○ REFERRAL-○ ***OTHER-[redacted]

REQUEST: still coughing

Medical DP x 1

PLAN Cough is now dry - RASPY [redacted]

Chest hurts

very persistant

no phlegm

non-productive in any way

appt next Friday

ALLERGIES: _____ Time _____

Pharmacy # [redacted] Nurse [redacted]

8-14-92 Some better but still some coughing. Cough when he exerts himself.

PE: Lungs: clear 5 wheezes or rale

DMP persistant cough

RAN: prednisone 10 mg # 21 TRF

appt c Dr [redacted]

Rtcin 3 mo for CAP

[redacted]

8-21-92 # [redacted]

[redacted]

Pulmonary Consultation

[redacted]
8/21/92
Referred by Dr. [redacted]

**Present Illness:** [redacted] is a 37 year old man who has been coughing for 5 to 6 weeks. The sputum is clear but occasionally become green. He describes lots of wheezing. He saw Dr. [redacted] 2 weeks ago and was given two separate tapered doses of Prednisone of 6 days each. He was assumed to have asthma but he didn't improve a great deal. Two of his sons have asthma. Mr. [redacted] has never been diagnosed as having asthma but age 10 he had a paper route and he remembers in the spring and fall having attacks of coughing. He denies any esophageal reflux symptoms. He denies any upper respiratory symptoms. He is a non-smoker.

**Past Medical History:** No allergies. No alcohol use. No previous operations or hospitalizations.

**Review of Systems:** Is notable for a heart murmur detected in 1972 and followed without evidence of heart disease. No TB exposure. No environmental allergies known. No occupational or work exposure history.

**Family and Social History:** His father coughed a lot and had diabetes. He works in the insurance business selling life insurance.

**Physical Examination:** Weight 167, BP 110/72, pulse 74, respiratory rate 20, SAO2 97%. HEENT exam is normal. The neck is supple without goiter, jugular venous distention or adenopathy. His lungs are clear to auscultation and percussion even on forced expiration. I thought I might have heard a wheeze on forced expiration but I could not reproduce that. Heart rhythm is regular with no murmurs, gallops or rubs. The extremities show no clubbing, edema, or cyanosis.

**Chest x-ray:** This was reviewed from about 2 weeks ago and is normal.

**Pulmonary Function Tests:** His baseline spirometry is normal and a Methacholine test shows only 16% drop in FEV1 after inhalation of 1 to 5 inhalation units of Methacholine.

**Impression:**

1) Coughing with history suggestive of asthma but with negative Methacholine challenge test.

**Assessment:**

Either Mr. [redacted] is one of 10% of people who have asthma with a negative Methacholine inhalation challenge test, or his symptoms are due to another illness such as bronchitis. He very well may have bronchitis with mucus plugging of small airways producing his wheezing rather asthma. I would suggest that we treat him for both conditions for one to two weeks and then assess his response. I think it will become evident in the near future whether he indeed has asthma.

**Recommendations:**

1) Prednisone 40 mgs a day for 1 week then 30 mgs a day until I see him again in 10 days
2) Ceclor 250 mgs p.o.t.i.d.

[redacted] M.D. / [redacted]

[redacted]

[redacted]

9/1/92

S: Returns for follow-up of coughing. Cough is almost entirely resolved with a course of steroids and Ceclor. Still has mild dysphonia but that is improving.

O: Vital signs stable. Chest clear. No coughing noted. Normal sinus rhythm.

A: 1) Essentially resolved cough, probably secondary to mild asthma

P: 1) Taper off Prednisone over next 10 days
2) Finish Ceclor
3) Long term follow-up per Dr. [redacted]
4) If coughing returns, I will see him again and consider longer term asthma therapy.

[redacted] M.D. / [redacted]

[redacted]

[redacted]
11/19/93

S: Presents with acute wheezing and purulent sputum. Minimal sinus symptoms. Exactly same syndrome as he had about a year ago when I saw him and treated him with steroids and Ceclor and he improved.

O: Very minimal wheezing. Rough cough. Normal sinus rhythm.

A: 1) Acute asthmatic bronchitis

P:
1) Proventil 2 puffs q4h prn
2) Prednisone 40 mgs a day for 1 week, then 20 mgs on 8th day, then stop
3) Augmentin 250 mgs p.o.t.i.d. for 1 week
4) He wishes to return prn to see me
5) Long term follow-up per Dr [redacted]

[redacted] M.D. [redacted]

[redacted]

PHONE CALL

Doctor [redacted] Date 2-10-94 Time 11:46 am Operator [redacted]

Caller Name _____ Phone # [redacted]

Patient Name [redacted]

COME IN-○ SICK-○ TEST RESULTS-○ NEED MEDICINE-○ SCHEDULE TEST-○ REFERRAL-○ ***OTHER-○

REQUEST: PT [redacted] < Blood discharge

PLAN: Appt Dr [redacted] Tues - 15th

ALLERGIES: _____ Time _____

Pharmacy # _____ Nurse _____

PHONE CALL

Doctor [redacted] Date 6-2-94 Time 4:43 Operator [redacted]

Caller Name _____ Phone # [redacted]

Patient Name [redacted]

COME IN-○ SICK-○ TEST RESULTS-○ NEED MEDICINE-○ SCHEDULE TEST-○ REFERRAL-○ ***OTHER-○

REQUEST: Foot infection

went to [redacted] 10 days ago

PLAN: left msg 5:06

ALLERGIES: _____ Time _____

Pharmacy # _____ Nurse _____

6-03-94

WT 161 1/2 c 8 kgs

BP 142/90

Infection in toe

(S) 39 yo WO ↗ pmd & Fl

c/o pain & Swelling to @ Great Toe →

Started on Antibiotics in 1 wk Keflex 500 g Bilg

Summary

Seen by [redacted] 1 wk Ago

↳ Gout w/u (-)

↑ Mas

no ⊘

(O) (L) Great Toe Swelling to Proxphalanx

No pain No Fluctuation

Min tender

(A) Cellulitis @ Great Toe

Rn subunchal Abscess

(P) (1) Cipro 500 g Bis

(2) Rev in 4 d

Van Sash [redacted]

000015

[redacted]

6-7-94 (R) Great Toe

[redacted]

wt 161.6

BP- 120/70

[redacted] Sister ↓ pay
↓ Surgery
↓ [illegible]

Tony Ashbrook

[redacted]

[redacted]

[redacted]

(C) (R) Foot Great Toe
↓ [illegible] (↓ 30%)
↓ Surgery

[redacted]

No Fluctuation

(A) Cellulitis (R) Great Toe

(A) Lead Capsulitis Bay

[redacted]

[redacted]

[redacted] 7/u [redacted] [redacted]

6-14-94

wt - 162.8

BP - 120/64

State → Screen ↓↓

Swelling ↓↓

Redness ↓↓

PE NT

oxygen ↓

No fluctuation

↓ Cellulitis @ Great Toe

Cipro 500 mg BID

#10

[redacted]

PHONE CALL

Doctor [redacted] Date 8/7/96 Time 12:00 Operator [redacted]

Caller Name [redacted] Phone # [redacted]

Patient Name [redacted]

COME IN-○ SICK-[redacted] EDICINE-○ SCHEDULE TEST-○ REFERRAL-○ ***OTHER-○

REQUEST:

diabetes & cholesterol & visit

PLAN:

with Dr [redacted]

left message

ALLERGIES: _____ Time _____

Pharmacy # _____ Nurse _____

10-15-96 C.R. Bld. sugar

[redacted] [redacted]

10-17-96
WT. 162
BP 132/78

[redacted]

Chol 290 @ chol screen @ work

PE: ⊖ carotid bruits
PR ≤ (m)
heme ⊖ stool
prostate ⊖

DMP: Stable

RAN: Rt in 6 mos.

[redacted]

PHONE CALL

Doctor [redacted] Date 10/13/97 Time 10:56 Operator [redacted]

Caller Name _____ Phone # [redacted]

Patient Name [redacted] leave msg.

COME IN-☒ SICK-○ TEST RESULTS-○ NEED MEDICINE-○ SCHEDULE TEST-○ REFERRAL-○ ***OTHER-○

REQUEST: Chestpain

PLAN: after he eats mid Chestpain 1:30 today

Axid 150mg X 2wks - Has not tried Any Antacids

#30 [illegible] - If no better in 2weeks, come in

ALLERGIES: NKA Time [redacted]

Pharmacy [redacted] Nurse [redacted]

[redacted]

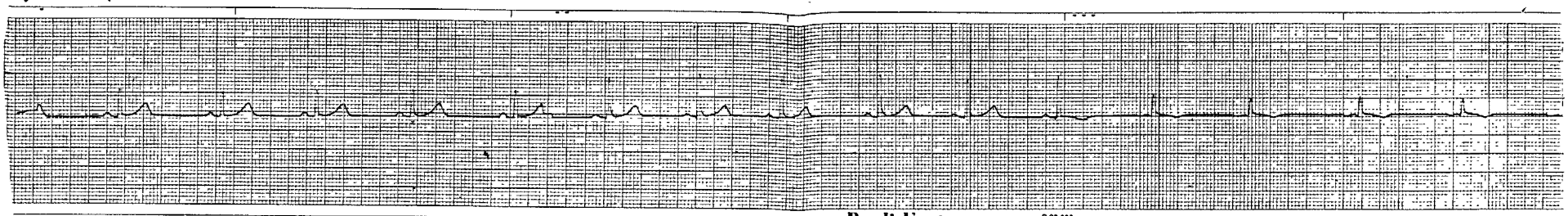
PATIENT: [redacted]
DOCTOR: [redacted]
COLLECTED: 6/9/87
REMARKS: FASTING

AGE/SEX: 32/M
SEQ#: [redacted]
ROOM#:

HOSPITAL#: [redacted]
ACCESSION# [redacted]
REPORTED: 6/10/1987 [redacted]
OPERATOR [redacted]

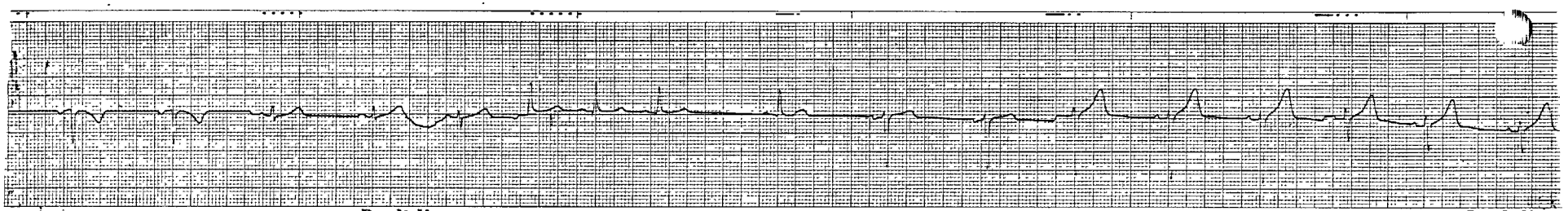
| TEST | RESULT | | UNITS | MALE REFERENCE RANGE | LOW | REF | HIGH |
|---|---|---|---|---|---|---|---|
| ALBUMIN | 4.9 | | GM/DL | 3.8 - 5.0 | | X | |
| TOTAL PROTEIN | 6.9 | | GM/DL | 6.0 - 8.0 | | X | |
| GLOBULIN | 2.0 | | GM/DL | 2.0 - 4.0 | X | | |
| A/G RATIO | 2.5 | H | | 1.2 - 2.3 | | | * |
| BUN | 13.1 | | MG/DL | 6 - 22 | | X | |
| CREATININE | 1.2 | | MG/DL | 0.5 - 1.3 | | X | |
| CHOLESTEROL | 239 | H | MG/DL | 140 - 220 | | | * |
| ALK PHOSPHATASE | 73 | | IU/L | 39 - 120 | | X | |
| TOTAL BILIRUBIN | 0.47 | | MG/DL | < 1.1 | | X | |
| CALCIUM | 9.5 | | MG/DL | 8.2 - 10.2 | | X | |
| GLUCOSE | 88 | | MG/DL | 70 - 110 | | X | |
| SGOT (AST) | 16 | | IU/L | < 37 | | X | |
| LDH | 122 | | IU/L | 113 - 242 | X | | |
| TRIGLYCERIDE | 205 | H | MG/DL | < 200 | | | * |
| URIC ACID | 8.3 | H | MG/DL | 3.4 - 7.0 | | | * |
| SODIUM | 143 | | MEQ/L | 135 - 145 | | X | |
| POTASSIUM | 4.6 | | MEQ/L | 3.5 - 5.0 | | X | |

CAL | 1 | 2 | 3



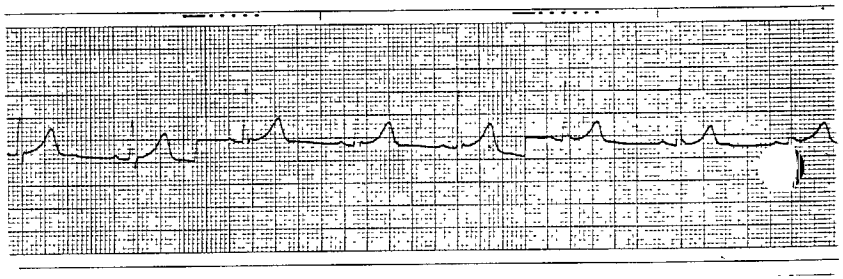
Burdick P/N 007873 C-00-605

aVR | aVL | aVF | V1 | V2 | V3



Burdick P/N 007873 Burdick

V4 | V5 | V6



ATRIAL RATE _____ RHYTHM _____

VENT. RATE _____ P WAVES _____

P-R INTERVAL _____ T WAVES _____

QRS INTERVAL _____ S-T SEGMENT _____

Q-T INTERVAL _____ REMARKS _____

ELEC. AXIS _____

ELEC POS _____

PATIENT POS. _____

[redacted] 6/1/87

000021

[redacted]

PATIENT [redacted] AGE/SEX: 32/M HOSPITAL#: [redacted]
DOCTOR: [redacted] SEQ#: [redacted] ACCESSION# [redacted]
COLLECTED: 7/21/87 ROOM#: REPORTED: 7/22/1987
REMARKS: FASTING OPERATOR_[redacted]

| TEST | RESULT | | UNITS | MALE REFERENCE RANGE | LOW | REF | HIGH |
|---|---|---|---|---|---|---|---|
| CHOLESTEROL | 236 | H | MG/DL | 140 - 220 | _ _ [ | _ _ _ | ] * _ |

[redacted]

PATIENT NAME [redacted]

PATIENT I.D. NUMBER [redacted]

ACCESSION NO. [redacted]

| AGE | SEX | DATE DRAWN | TIME DRAWN | RECEIVED |
|---|---|---|---|---|
| .0 | M | 08/29/88 | 00:00 | 08/29/88 |

REFERRING PHYSICIAN [redacted]

ROOM NUMBER [redacted]

LOCATION [redacted]

CLIENT LAB NO.

REPORTED 08/30/88

| TEST | RESULT NORMAL | RESULT ABNORMAL | REFERENCE RANGE | | UNITS |
|---|---|---|---|---|---|
| CORONARY RISK PROF | | | | | |
| CHOLESTEROL | | 204H | 125 | 200 | MG/DL |
| HDL CHOLESTEROL | 37 | | 30 | 70 | MG/DL |
| TRIGLYCERIDES | | 306H | 10 | 150 | MG/DL |
| LDL CHOLESTEROL | 105.8 | | 70 | 130 | MG/DL |
| CHOL/HDL RATIO | | 5.5H | 1.0 | 3.5 | |

[redacted]

[redacted]

[redacted]

MEDICAL DIRECTOR: [redacted]

[redacted]

[redacted]

[redacted] M.D.
[redacted] M.D.
[redacted] M.D.

[redacted]

[redacted] M.D.
[redacted] D.
[redacted] D.

**GRADED EXERCISE TEST (GXT)**

Nam[redacted] Age 34 Referring MD [redacted] Date 9-16-88

Clinical Information Irregular heart beat

Functional Classification by history Class (I) II III IV

Medications: Digitalis preparation, Vasodilator, other None

Resting supine EKG WNL

Monitoring Leads ____ II, AVF, $V_5$

Monitor Lead — supine N

Predicted GXT heart rate: 171/191

| STAGE | STOP TIME | MHR | RHYTHM | ST-T CHANGES | B.P. | SYMPTOMS |
|---|---|---|---|---|---|---|
| CONTROL (STANDING) | | 91 | S | N | 132/84 | |
| 0-3 min. 1.7 mph 10% | | 107 | S | N | 138/86 | |
| 3-6 min. 2.5 mph 12% | | 123 | S | N | 144/84 | |
| 6-9 min. 3.4 mph 14% | | 137 | S | N | 188/50 | |
| 9-12 min. 4.2 mph 16% | 12:10 | 165 | S | N | 172/52 | |
| min. mph | | | | | | |
| Post-exercise I ( 1 M) | | 123 | S | N | 140/88 | |
| II ( 3 M) | | 117 | S | N | 122/80 | |

Factors which terminated treadmill testing Finished protocol

Monitored EKG Response N

Post Exercise EKG Response N

INTERPRETATION Neg treadmill test

[redacted]

000024

PATIENT NAME [redacted]

PATIENT I.D. NUMBER [redacted]

ACCESSION NO. [redacted]

AGE .0

SEX M

DATE DRAWN 06/15/89

TIME DRAWN 00:00

RECEIVED 06/15/89

REFERRING PHYSICIAN DR [redacted]

ROOM NUMBER [redacted]

LOCATION [redacted]

CLIENT LAB NO.

REPORTED 06/15/89

| TEST | RESULT NORMAL | RESULT ABNORMAL | REFERENCE RANGE | | UNITS |
|---|---|---|---|---|---|
| SMAC PROFILE | | | | | |
| GLUCOSE, SERUM | 75 | | 65 | 110 | MG/DL |
| BUN | 15 | | 8 | 25 | MG/DL |
| CREATININE SERUM | 1.3 | | 0.5 | 1.4 | MG/DL |
| BUN/CREAT RATIO | 11.5 | | 10 | 24 | |
| CHOLESTEROL | | 245H | 125 | 200 | MG/DL |
| TRIGLYCERIDES | | 319H | 10 | 150 | MG/DL |
| SODIUM SERUM | 140 | | 137 | 148 | MEQ/L |
| POTASSIUM SERUM | 4.1 | | 3.5 | 5.5 | MEQ/L |
| CHLORIDE SERUM | 101 | | 95 | 110 | MEQ/L |
| BICARBONATE | 27 | | 22 | 32 | MEQ/L |
| IRON SERUM | 87 | | 45 | 210 | MCG/DL |
| URIC ACID | 8.2 | | 3.3 | 9.0 | MG/DL |
| PROTEIN, TOTAL | 7.5 | | 6.0 | 8.3 | GM/DL |
| ALBUMIN | 4.7 | | 3.5 | 5.3 | GM/DL |
| GLOBULIN | 2.8 | | 1.9 | 4.4 | GM/DL |
| A/G RATIO | 1.7 | | 1.0 | 2.2 | |
| BILIRUBIN, TOTAL | 0.6 | | 0.1 | 1.3 | MG/DL |
| ALKALINE PHOSPHATASE | 83 | | 20 | 130 | MU/ML |
| SGPT | 18 | | 0 | 50 | MU/ML |
| LDH | 140 | | 90 | 255 | MU/ML |
| SGOT | 16 | | 0 | 50 | MU/ML |
| CALCIUM | 9.6 | | 8.5 | 10.7 | MG/DL |
| PHOSPHORUS | 3.2 | | 2.3 | 4.5 | MG/DL |

[redacted]

[redacted]

MEDICAL DIRECTOR: [redacted] M. D. PHD

[redacted]

000025

[redacted]

[redacted] X-RAY RECORD

Patien[redacted]

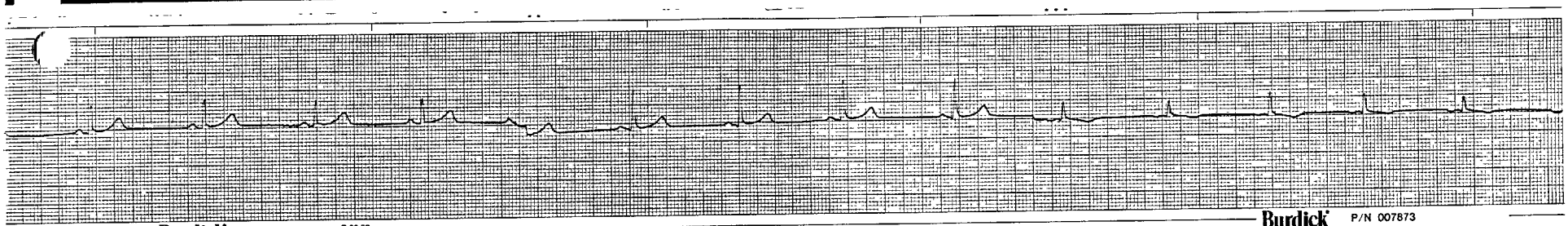
No. [redacted] Dr. [redacted]

| Date | COMMENTS | NORMAL | FOLLOW-UP | INTERPRETER |
|---|---|---|---|---|
| 6/15/89 | CXR 2V borderline T in car [redacted] | | | |

PLEASE FILE IN BACK OF CHART

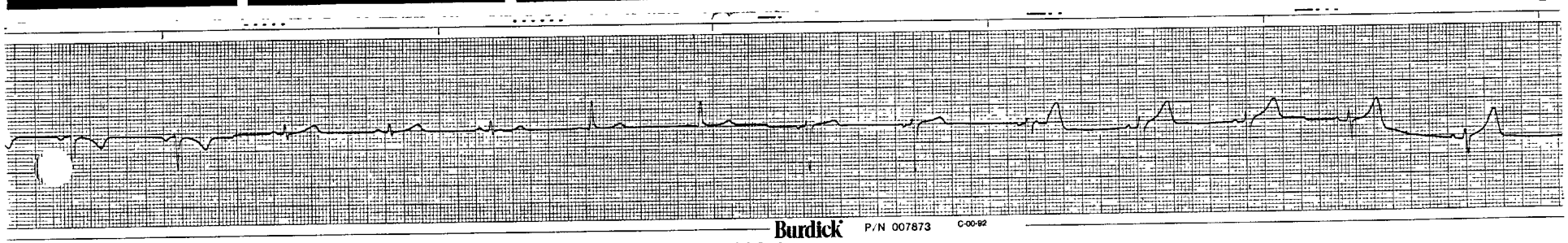
000027

1 | 2 | 3



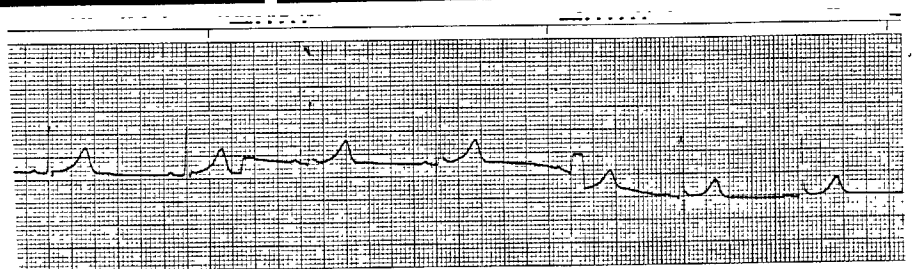
Burdick P/N 007873 C-00-92 Burdick P/N 007873

aVR | aVL | aVF | V1 | V2 | V3



Burdick P/N 007873 C-00-92

V4 | V5 | V6



Burdick P/N 007873

[redacted] 6/15/89

ATRIAL RATE _____ RHYTHM _____

ENT RATE _____ P WAVES _____

-R INTERVAL _____ T WAVES _____

RS INTERVAL _____ S-T SEGMENT _____

-T INTERVAL _____ REMARKS _____

LEC. AXIS _____

LEC. POS. _____

ATIENT POS _____

[redacted] X-RAY RECORD

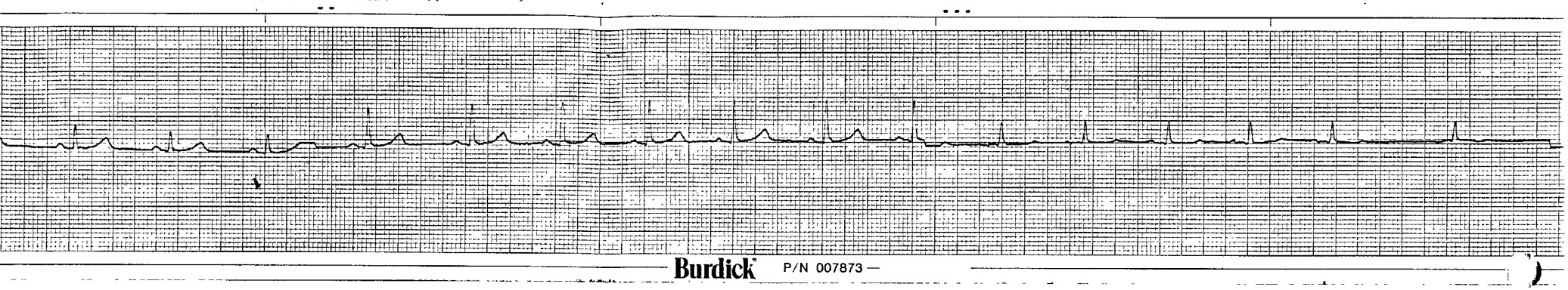
Patient [redacted]

No. [redacted] Dr. [redacted]

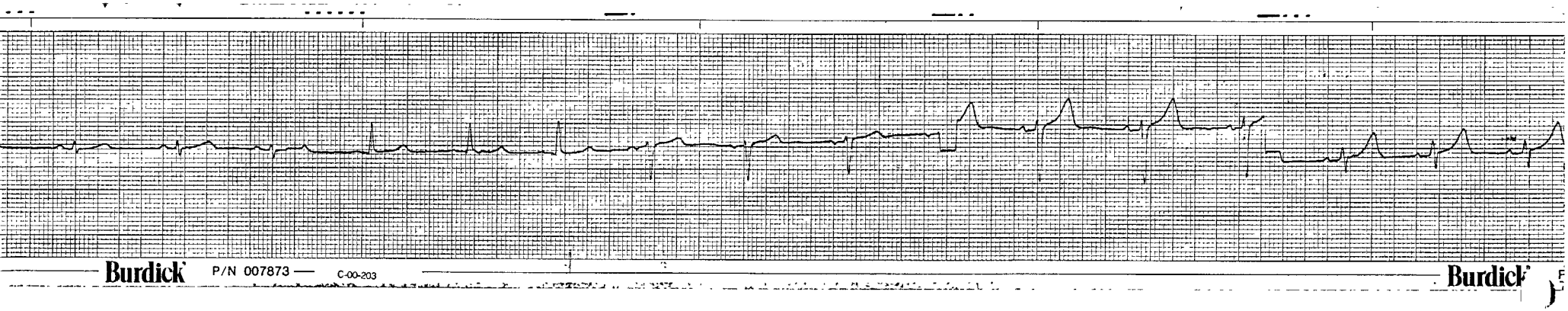
| Date | COMMENTS | NORMAL | FOLLOW-UP | INTERPRETER |
|---|---|---|---|---|
| 7/31/92 | CXR 2V / KM mild T in car surge | | | [redacted] |

PLEASE FILE IN BACK OF CHART

1 | 2 | 3




aVL | aVF | V1 | V2 | V3

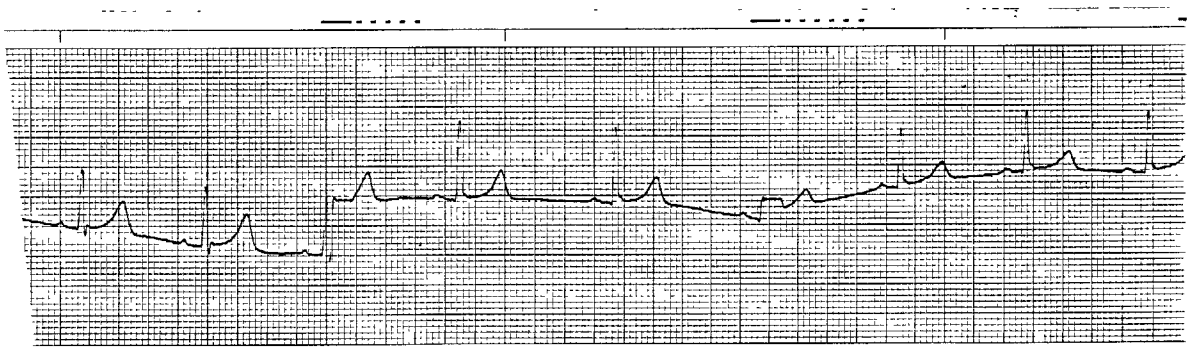



000029 [redacted] 7/31/92

Normal EKG

ENT [redacted]

V4 | V5 | V6



PATIENT NAME [redacted]

PATIENT I.D. NUMBER [redacted]

[redacted]

| AGE | SEX | DATE DRAWN | TIME DRAWN | RECEIVED |
|---|---|---|---|---|
| .0 | M | 07/31/92 | 00:00 | 07/31/92 |

REFERRING PHYSICIAN: DR. [redacted] / FAST

ROOM NUMBER: [redacted] LOCATION: [redacted] CLIENT LAB NO.

REPORTED: 08/01/92

| TEST | RESULT NORMAL | RESULT ABNORMAL | REFERENCE RANGE | | UNITS |
|---|---|---|---|---|---|
| HEALTH PROF. 6 | | | | | |
| GLUCOSE, SERUM | 79 | | 65 | 110 | MG/DL |
| BUN | 11 | | 8 | 25 | MG/DL |
| CREATININE SERUM | 1.2 | | 0.5 | 1.4 | MG/DL |
| BUN/CREAT RATIO | | 9.2L | 10 | 24 | RATIO |
| CHOLESTEROL | | 212H | 125 | 200 | MG/DL |
| TRIGLYCERIDES | | 445H | 10 | 150 | MG/DL |
| HDL CHOLESTEROL | | 29L | 30 | 70 | MG/DL |
| LDL CHOLESTEROL | LDL CALCULATION IS INVALID WITH TRIG >400 | | | | |
| VLDL | | 89.0H | 5 | 40 | MG/DL |
| CHOL/HDL RATIO | | 7.3H | 1.0 | 3.5 | RATIO |
| SODIUM SERUM | 141 | | 137 | 148 | MEQ/L |
| POTASSIUM SERUM | 4.2 | | 3.5 | 5.5 | MEQ/L |
| CHLORIDE SERUM | 104 | | 95 | 110 | MEQ/L |
| BICARBONATE | 24 | | 22 | 32 | MEQ/L |
| IRON SERUM | 111 | | 45 | 210 | MCG/DL |
| URIC ACID | | 10.7H | 3.3 | 9.0 | MG/DL |
| PROTEIN, TOTAL | 6.8 | | 6.0 | 8.3 | GM/DL |
| ALBUMIN | 4.1 | | 3.5 | 5.3 | GM/DL |
| GLOBULIN | 2.7 | | 1.9 | 4.4 | GM/DL |
| A/G RATIO | 1.5 | | 1.0 | 2.2 | RATIO |
| BILIRUBIN, TOTAL | 0.6 | | 0.1 | 1.3 | MG/DL |
| ALKALINE PHOSPHATASE | 75 | | 20 | 130 | MU/ML |
| SGPT | 18 | | 0 | 50 | MU/ML |
| LDH | 159 | | 90 | 255 | MU/ML |
| SGOT | 18 | | 0 | 50 | MU/ML |
| CALCIUM | 9.3 | | 8.5 | 10.7 | MG/DL |
| PHOSPHORUS | 3.1 | | 2.3 | 4.5 | MG/DL |

[redacted]

needs wt loss of 5-10 lbs. called [redacted]

[redacted]

* * * * * * * * * F I N A L  R E P O R T * * * * * * * * *

MEDICAL DIRECTOR: [redacted]

[redacted]

[redacted]

[redacted]

Name: [redacted]

Age: 37 Years
Sex/Race: Male / Caucasian
Height: 69 in 175 cm
Weight: 167 lbs 76 kg

ID#: [redacted]
Room: [redacted] Date: 21-AUG-92
Temp/Pres: 21 C / 764 mmHg
Physician: [redacted]
Tested by: [redacted]
Prev Study:
Medication:

Diagnosis:
Dyspnea: Yes How Long: 4 wks
Cough: Yes How Long: 4 wks
Smoker: No

Resting: No Exer: Yes
Productive: Yes Vol:mod

SPIROMETRY (BTPS)

| | PRE | BASE | Lev1 | Lev2 | Lev3 | Lev4 | Lev5 | Lev6 | Lev7 | Lev8 | Lev9 | POST |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| AGENT: Methacholine mg/ml | | | 0.15 | 0.31 | 0.62 | 1.25 | 2.50 | 5.00 | 10.0 | 25.0 | 50.0 | |
| FVC (Pred. 5.03 Liters) | | | | | | | | | | | | |
| Actual | 4.33 | 4.33 | | | | 3.96 | | 3.91 | | 3.56 | | |
| % Pred | 86 | 86 | | | | 78 | | 77 | | 71 | | |
| % Chg | | +0 | | | | -9 | | -10 | | -18 | | |
| FEV1 (Pred. 3.90 Liters) | | | | | | | | | | | | |
| Actual | 3.25 | 3.25 | | | | 3.22 | | 3.07 | | 2.72 | | |
| % Pred | 83 | 83 | | | | 82 | | 79 | | 70 | | |
| % Chg | | +0 | | | | -1 | | -6 | | -16 | | |
| FEV1/FVC (Pred: 77 %) | | | | | | | | | | | | |
| Actual | 75 | 75 | | | | 81 | | 79 | | 76 | | |
| % Pred | 98 | 98 | | | | 106 | | 103 | | 99 | | |
| % Chg | | +0 | | | | +8 | | +5 | | +1 | | |
| FEF25-75% (Pred: 4.09 L/Sec) | | | | | | | | | | | | |
| Actual | 2.81 | 2.81 | | | | 3.13 | | 2.79 | | 2.42 | | |
| % Pred | 69 | 69 | | | | 78 | | 68 | | 59 | | |
| % Chg | | +0 | | | | +13 | | -1 | | -14 | | |
| PEF (Pred: 9.18 L/Sec) | | | | | | | | | | | | |
| Actual | 4.92 | 4.92 | | | | 5.77 | | 5.20 | | 4.53 | | |
| % Pred | 54 | 54 | | | | 63 | | 57 | | 49 | | |
| % Chg | | +0 | | | | +17 | | +6 | | -8 | | |

PC20 (FEV1) Above 25.0 mg/ml

CALIBRATION: PRED: 3.33 ACTUAL: EXP 3.36 INSP 3.30
IBS-0110-02 N-1804-4

Name: [redacted] ID#: [redacted]

* = OUTSIDE 95% CONFIDENCE INTERVAL * = OUTSIDE NORMAL RANGE
CALIBRATION: PRED: 3.32 ACTUAL: EXP 3.36 INSP 3.30
IPS-0L10-04 IPS-0H10-04 N-2103-4

COMPUTERIZED INTERPRETATION:

There is a minimal obstructive lung defect. On the basis of this study, more detailed pulmonary function testing may be useful if clinically indicated.

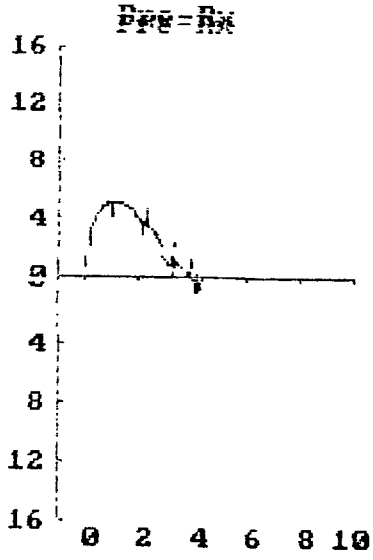
***THIS COMPUTER GENERATED REPORT SUGGESTS POSSIBLE MEDICAL SIGNIFICANCE OF DATA REPORTED TO IT. THIS REPORT IS NOT TO BE USED IN THE CLINICAL MANAGEMENT OF THE PATIENT UNTIL CONFIRMED BY:

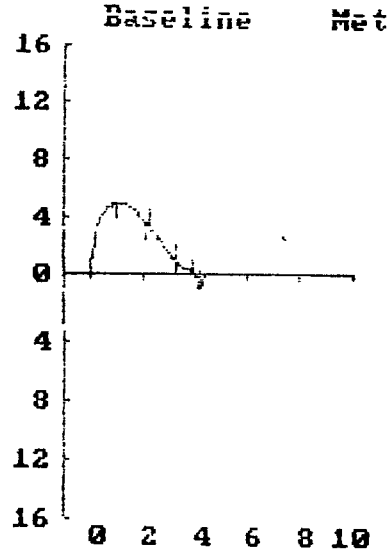
DR. _____

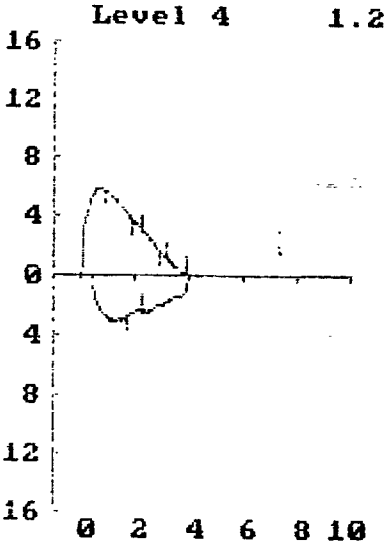
[redacted]

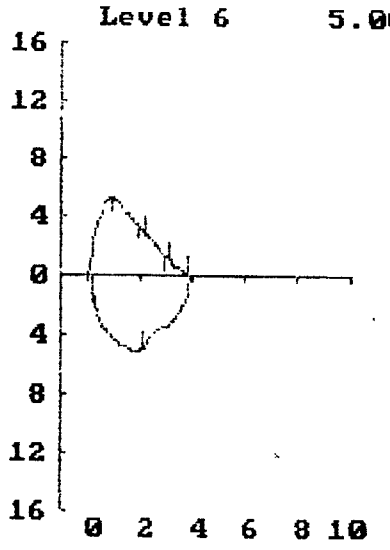
Name: [redacted]
ID #:

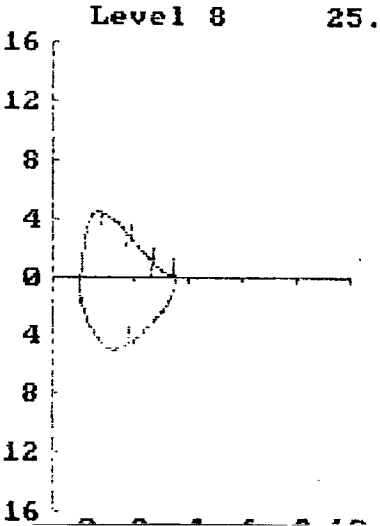
Date: 21-AUG-92



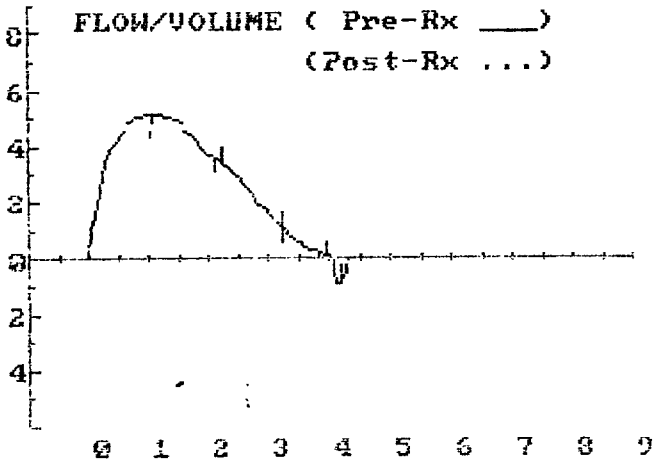



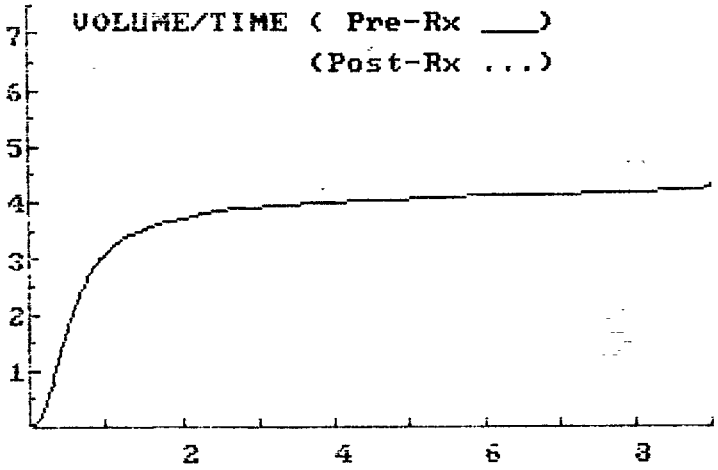
[redacted]

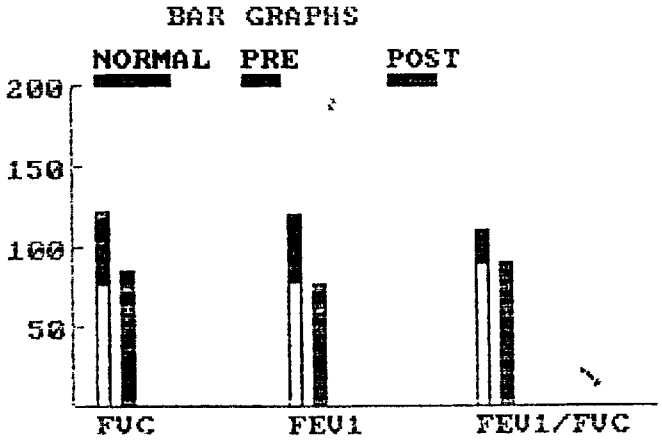
| | | | |
|---|---|---|---|
| Name: | [redacted] | ID#: | [redacted] |
| Age: | 37 Years | Room: | [redacted] Date: 21-AUG-92 |
| Sex/Race: | Male / Caucasian | Temp/Pres: | 21 C / 764 mmHg |
| Height: | 69 in 175 cm | Physician: | [redacted] |
| Weight: | 167 lbs 76 kg | Tested by: | [redacted] |

Prev Study:
Medication:

| | | | | | |
|---|---|---|---|---|---|
| Diagnosis: | | | | | |
| Dyspnea: | Yes | How Long: 4 wks | Resting: | No | Exer: Yes |
| Cough: | Yes | How Long: 4 wks | Productive: | Yes | Vol: mod |
| Smoker: | No | | | | |



[redacted]

Name: [redacted]
Age: 37 Years
Sex/Race: Male / Caucasian
Height: 69 in 175 cm
Weight: 167 lbs 76 kg

ID#: [redacted]
Room [redacted] Date: 21-AUG-92
Temp/Pres: 21 C / 764 mmHg
Physician [redacted]
Tested by [redacted]
Prev Study:
Medication:

Diagnosis:
Dyspnea: Yes How Long: 4 wks
Cough: Yes How Long: 4 wks
Smoker: No

Resting: No Exer: Yes
Productive: Yes Vol: mod

| | | PRED | PRE-RX BEST | PRE-RX %PRED | POST-RX BEST | POST-RX %PRED | %CHG |
|---|---|---|---|---|---|---|---|
| SPIROMETRY (BTPS) | | | | | | | |
| FVC | Liters | 5.07 | 4.33 | 85 | | | |
| FEV1 | Liters | 4.16 | 3.25 # | 78* | | | |
| FEV1/FVC | % | 82 | 75 | | | | |
| FEF25-75% | L/Sec | 4.30 | 2.81 | 65 | | | |
| IsoFEF25-75 | L/Sec | 4.30 | 2.81 | 65 | | | |
| FEF75-85% | L/Sec | | 0.60 | | | | |
| FEF50% | L/Sec | | 3.57 | | | | |
| PEF | L/Sec | | 4.92 | | | | |
| FET100% | Sec | | 11.7 | | | | |
| FIVC | Liters | 5.07 | 0.26 # | 5* | | | |
| PIF | L/Sec | | 1.00 | | | | |
| FEF50/FIF50 | Unitless | | 4.15 | | | | |
| Vol Extrap | Liters | | 0.16 | | | | |
| E Code | | | 10010 | | | | |

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# = OUTSIDE 95% CONFIDENCE INTERVAL * = OUTSIDE NORMAL RANGE

[redacted]

VITAL SIGNS FLOW SHEET

NAME [redacted]

9-1-92 11/19/93 RO needs

| DATE | 8/21/92 | ~~8-8-92~~ | 11/19/93 | | | |
|---|---|---|---|---|---|---|
| WT | 174.0 | 168.8 | – | | | |
| BP | 110/72 | 110/72 | 128/80 | | | |
| P | 74 | | 74 | | | |
| RR | 20 | | 20 | | | |
| T | – | | – | | | |
| Sa02 | 97% | | 97% | | | |

| DATE | | | | | | |
|---|---|---|---|---|---|---|
| WT | | | | | | |
| BP | | | | | | |
| P | | | | | | |
| RR | | | | | | |
| T | | | | | | |
| Sa02 | | | | | | |

| DATE | | | | | | |
|---|---|---|---|---|---|---|
| WT | | | | | | |
| BP | | | | | | |
| P | | | | | | |
| RR | | | | | | |
| T | | | | | | |
| Sa02 | | | | | | |

| DATE | | | | | | |
|---|---|---|---|---|---|---|
| WT | | | | | | |
| BP | | | | | | |
| P | | | | | | |
| RR | | | | | | |
| T | | | | | | |
| Sa02 | | | | | | |

Should not be drawn in gray tube

[redacted]

plasma hemolyzed

DRS [redacted]

PATIENT [redacted]

AGE _____ SEX M

_____ hr.p.p. # _____

☒ Blood Sugar (70 –110) 69 mg/dl

☐ Sodium (135 –145) _____ meq/l

☐ Potassium (3.5 – 5.3) _____ meq/l

☐ HgbA1C _____ [redacted]

10-15-96

DATE

[redacted]

[redacted]

000037

PATIENT NAME : [redacted]
PATIENT ID :
PATIENT PHONE:
HOSPITAL ID :
SEX: M AGE: 42 DOB: [redacted]
SS# [redacted] WARD: ROOM:

ACCESSION : [redacted]
REQUISITION:
REPORTED : 16-OCT-1996
RECEIVED : 16-OCT-1996
COLLECTED : 15-OCT-1996 09:04A
REASON :

PHYSICIAN : [redacted]
CLIENT NAME :

PHYS/UPIN#: [redacted]
CLIENT ID :
LOCATION :

TEST REQUEST : CORONARY RISK PROFILE I,PROSTATIC SPECIFIC ANTIGEN,

**ADDITIONAL INFORMATION:**
**FASTING: Y HEIGHT: WEIGHT:**

| TEST NAME | NORMAL RESULTS | ABNORMAL RESULTS | UNIT | REFERENCE RANGE |
|---|---|---|---|---|
| **CORONARY RISK PROFILE I:** | | | | |
| CHOLESTEROL | | **241 HIGH** | MG/DL | 100-199 |
| TRIGLYCERIDES | | **201 HIGH** | MG/DL | 0-199 |
| HDL-CHOLESTEROL | 43 | | MG/DL | 35-150 |
| CHOL/HDL RATIO | 5.6 | | | 4.2-5.6 |
| LDL (CALCULATED) | | **158 HIGH** | MG/DL | 0-130 |
| LDL/HDL RATIO | | **3.7 HIGH** | | < 3.1 |
| VLDL (CALCULATED) | | **40 HIGH** | MG/DL | 0-39 |
| RISK FACTOR | > 1 | | | =< 1 |

CHOLESTEROL/HDL RATIO

| CHD RISK FACTOR | MALE | FEMALE |
|---|---|---|
| 1/2 AVERAGE (LOW) | 3.4 | 3.3 |
| 1 X AVERAGE (NORMAL) | 5.0 | 4.4 |
| 2 X AVERAGE (MODERATE) | 9.6 | 7.1 |
| 3 X AVERAGE (HIGH) | 13.5 | 11.0 |

THE CHD RISK IS BASED ON THE T. CHOL/HDL RATIO. OTHER FACTORS AFFECT CHD RISK SUCH AS HYPERTENSION, SMOKING, DIABETES, SEVERE OBESITY, AND FAMILY HISTORY OF PREMATURE CHD.

**PROSTATIC SPECIFIC ANTIGEN:**

| | | | |
|---|---|---|---|
| PSA | 1.4 | [redacted] | 0.0-4.0 |

[redacted]