Case Review Form

Clinician: Myron Hardesty MH, PA-c **Case Number**: Patient Name / D.O.B. **Date**: March 8, 2012

Client Information

Gender: Female **Age**: 65 **Height**: 5' 4" **Weight**: 179 #s

Occupation: Grandmother (currently), Formerly: Clerical as Department Manager in retirement facility

Reason for visit: Sinus Congestion, Post-viral syndrome, Diminished immunity with multiple infectious illnesses, Domestic stressors. Also: Syncope/"blacked-out" (recent single episode), Hypertension, as determined at visit (BP: 170/98 HR: 74)

Primary Health Goal: Improved Immunity, resolution of post-infectious symptoms, stress reduction

Secondary Health Goals (if any): Negotiated: Reduced blood pressure, avoidance of recurrent syncopal episodes

Medical History

Drug History: **Current Drugs, Herbs and Supplements**: No history of prescription drug use other than occasional antibiotics for urinary tract (UTIs) and upper respiratory infections (URIs). No history of use of anti-hypertensive medications, statins, or proton pumps inhibitors. Occasional OTC Benadryl (not recent).

No Current medications other than acute, recent and current use of Congest Away (from Rainbow Light):

Clear Sinus & Lung Blend	356mg
-Xanthium 5:1 extract	
-Platycodon 4:1 extract	
-Peppermint essential oil	
Calming Relief Blend 4:1 extracts	682mg
-Yerba santa	
-Horehound	
-Mullein	
-Iceland moss	
-Chinese lovage	
-Chinese licorice	
Protective Blend	170mg
-Coptis 4:1 extract	
-Andrographis 5:1 extract	

Known Allergies to Drugs, Herbs, Foods, Etc.: No Known Drug, Herb or Food Allergies

Past Surgeries/Hospitalizations: Only for Child birth: February 1972 and April 1978. No Surgical History (Negative History of Gallbladder removal, Appendix removal, or Hysterectomy)

Family Health History: "Nothing remarkable," Father died of secondary complications one year after suffering a stroke. Mother with depressive disorder treated with anti-depressants, still living (assisted).

Maternal grandfather died of uncertain cause, possible heart attack. Paternal grandfather slow decline following heart attack. Patient as oldest of 8 Siblings, one brother with heart attack, still living with mild complications.

Women, Reproductive health/history: No History of contraceptive use ("catholic"). Two children. No abortions, No Hx of miscarriage or birth trauma. Status/post natural menopause, unremarkable transition without hormones or supplementation.

Personal History Overview: Long history of good health, robust constitution, and infrequent illness (until recently and likely associated with care of young grandchildren both as stressors and exposure).

Lifestyle Overview: "Married with Kids (+grandkids)" and "Is that all there is?" Non-vocational employment, merely occupational job x 20+ years "watching people pass on, mostly lonely experience". Anxious with worry however rather than boredom.

Diet Overview: Described as "general/standard" Breakfast: cereal in yogurt with added fresh fruit as berries or banana. Lunch: sandwiches, cottage cheese (as favorite), pizza, salads. Dinner: pasta, beef or chicken, and/or fried fish, with frozen vegetables. Snacks: nuts, popcorn, infrequent granola bar.

Elimination Habits: Regular urination and bowel movements every AM or every other AM. Infrequent to rare episodes of diarrhea until recently dealing with likely Viral Gastroenteritis secondary to grandchild care (and constituting original reason for visit as: "diminished immunity")

Alcohol/Drug/Cigarette Use History: Occasional glass of wine (1 x week) (father was alcoholic, so personally avoidant), "No Drugs!, No Smoking!"

Physical Activity/Exercise Overview: Walking approximately 2-3, miles usually 3-x week. Minimal exercise from clerical deskwork. Retirement didn't change that.

Rest, Play & Creativity Overview: Attempts something creative daily (not "artistic"), but prefers reading. More rest on weekends, denies extensive yard or garden work. Pleasurable (at times) grandchild care.

Stress Factors Summary: Particularly uninspired / un-inspiring spouse. Now compounded by issues with younger siblings since recent death of divorced father. Also divorced "widowed" mother (never remarried).

Observational Assessment

Constitution/Character: Measured movement: neither fast nor slow, but intentional. Pitta-Kapha constitution with broad shoulders, stocky body, well proportioned with slightly noticeable abdominal fat deposition.

Pulse: Slow, Pounding, Heart/Liver predominant

Tongue: Swollen, or rather full without scallop, erythematous, blue vascularization underside, red tip, reddish papillae appearing through thin white coat.

Face/complexion: "deer in headlights" (possibly acute) Otherwise full, round, without hard edges

Voice: Reserved, solid, direct/deliberate. As reflection of consciousness: non-imaginative, rather economic.

Skin: Thick, moist, well hydrated, warm

Hair: Dark, dry, full or dense, neither lustrous or dull

Teeth: N/A

Other Physical Observations: Unrelaxed, focused and intentional, slow to answer for sake of precision.

Eyes: Large, full and open, pupils normally dilated (with glasses removed)

Appetite: Diminished currently. Usually quite adequate, but never robust

Breathing: Shallow (circumstantial?) (Lungs were clear to auscultation on physical exam)

Nails: Crescent moon of nail bed negative for spooning, clubbing or cyanosis, no ridges.

Physical Exam (as necessitated by divulged recent history of Syncope): Blood Pressure: 175/101, Heart Rate: 74 bpm. Positive Tendon Reflexes of knees/elbows. Pupils normal and reactive to light. Left ear otoscopic evidence of otitis externa o/w negative (bilateral) to otitis media or pain on examination. Erythematous oropharaynx and upper palate. Negative skin turgor as adequate hydration, Positive capillary refill of digits. No swelling of lower extremities suggestive of water retention or lymphedema. Positive elicitation of discomfort to maxillary sinuses. No overt evidence of adenoid, cervical, supraclavicular or sub-mandibular lymphatic swelling. Negative for pain on sternal pressure. Negative CVA tenderness on palpation. Alert and oriented to person, place, and time. Non-expert exam of heart sounds: negative for gallops/rubs/or murmurs. Lungs (bilateral) Clear to Auscultation. Orthostatic measures of hypotension warranted but not attempted. Likewise electronic thermometer broken. Second blood pressure reading at 170/98.

Patient History (with particular regard to Acute Syncopal episode): Patient describes difficult recent winter months with repeated bouts of both upper respiratory infections and more recent episode of viral gastroenteritis secondary to caring for grandchildren after school as immediate parents were also sickened. One week prior to current visit patient had been suffering from residual sinus congestion and sore throat (treated with OTC "Congest Away" outlined above). 2-days prior to consult (i.e. 3/6/2012), patient awoke at 5 am, premature to usual 7am alarm, decided to take shower and proceeded to the bathroom, feeling dizzy beyond usual grogginess. Hot shower aggravated dizziness and prompted a bowel movement. Patient (apparently) "blacked out" (from defecation?), and woke up on the floor some short but undetermined amount of time later. Patient described "slight diarrhea" in retrospect, and denied blood in stool or evidence of hemorrhoids. Despite dizziness on waking and aggravation by hot shower, patient denied any prior episodes of dizziness in recent weeks as well as any prior episodes of syncope. Patient denied chest pain or heart palpitations at time of incident or any time in the weeks prior. Patient further denied nausea but admitted an abiding loss of appetite for a few days leading-up to incident and still present, not wanting to eat at all since episode. Patient complains of: sinus congestion, fullness and pressure behind itchy ears, "tongue feels thick", slight nearly inconsequential cough, and sore throat ("not terrible, but swallowing hurts"). Patient denies any other difficulty swallowing, denies any current loss of equilibrium, difficulty walking (ataxia) or memory loss or aphasia. Patient describes yesterday as feeling unusually cold and sleeping all day with extensive body aches and an abiding lightheadedness, but denies fever and chills. "Not shivery but rather cold-ache to the bones"