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CARDIOLOGY

History: Patient has been a smoker of two packs per day for 24 years and is known to be hypertensive since age 20. He has elevated cholesterol LDL and triglycerides in company with reduced HDL level.

Cardiac Evaluation: His heart rhythm is regular. An S4 gallop is heard along the LSB together with a blowing grade three holosystolic murmur. No S3 is found. A grade two bruit is noted over the left iliac artery. Both dorsalis pedis and posterior tibial pulses are absent in the nails and noted to be thickened. An echocardiogram was performed revealing a thickened left ventricular wall with a hypodynamic segment superiorly and anteriorly. The ejection fraction was 50%. The mitral valve is seen to prolapse and is associated with moderate regurgitation. No thrombi were seen in the atria although the left atrium is dilated. Right ventricle dynamics appeared normal.

Diagnosis: In summary this 55-year-old man with multiple risk factors presents with the clinical history and physical findings of coronary heart disease. He has modest mitral regurgitation as a consequence.

Plan: Recommend coronary arteriography to assess the status and potential for intervention by CABG. Preoperative carotid Doppler ultrasonography should be done.

CLINIC/OFFICE VISIT REPORT #1

History of Present Illness: 77 year-old, white lady with hypertension presents today for a blood pressure check. She feels well and has no complaints.

Medications: Atenolol 50 mg p.o.q.day and Pepcid 20 mg p.o. b.i.d.

Physical Examination:
Weight 205 lb., pulse 75, blood pressure 136/78.
Heart: regular rate and rhythm with no murmurs.
Lungs: clear to auscultation bilaterally.
Abdomen: soft, nontender, nondistended with normal bowel sounds.
Impression: hypertension, well-controlled.
Plan: Continue current medications. Return in three months for a complete physical examination.

Dictate medications as follows:
“fifty milligrams p o q day”
“twenty milligrams p o b i d”

Dictate numbers in PE as follows:
“weight two hundred five pounds comma pulse seventy-five comma blood pressure one hundred thirty-six over seventy-eight period”

Pronunciation: (capital letters = long vowel sounds;
‘ = primary stress; “ = secondary stress)

Atenolol [a – ‘ten – a – “lol]
auscultation [“os – kul – ‘tA – shun]

For additional information contact:

EXAQ, Inc.
www.exaq.com
support@exaq.com
Toll Free: (888) 548-8255

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CLINIC/OFFICE VISIT REPORT #2

History of Present Illness: The patient is a 31 year-old male, who presents with pain in the lumbar area since injuring his back three days ago. The patient has been very stiff in this area and has difficulty walking.

Medications: Tylenol.

Allergies: no known drug allergies.

Physical Examination: The lungs are clear. Cardiovascular exam shows a regular rate and rhythm. The spine is tender in the lumbar and thoracic area. Significant pain in the lumbar area with leg movements but no radicular pain in the lower extremities. Motor function is excellent in the lower extremities.

Assessment: lumbar strain after recent injury.

Plan: Lodine XL 500 mg. for pain. Physical therapy for flexibility and strength exercises.

Pronunciation: (capital letters = long vowel sounds;
‘ = primary stress; “ = secondary stress)
thoracic [tho – ‘ras – ik]
radicular [ra – ‘dik – yu – ler]
Lodine [‘lO – dEn] (Dictate: “Lodine XL five hundred milligrams for pain period”)

EMERGENCY MEDICINE NOTES

The patient is a 46-year-old white male who comes to the Emergency Department complaining of chest pain and some shortness of breath. The patient states that this came on about fifteen minutes prior to admission. The patient states that the pain gets worse with deep breathing and gets worse with a yawn, gets worse if he moves his left arm around. He states that the pain is an aching type and will last a few seconds and is fleeting.

73-year-old white male who states he has had substernal chest pain intermittently for the past few weeks. More frequently over the past few days. The chest pain is associated with diaphoresis. There is no shortness of breath but patient states he loses his breath when he bends forward. This morning patient developed pain across his anterior chest with throat tightness while holding his grandchild. His family insisted that he come to the emergency department. He denies nausea, vomiting, dizziness or palpations. PMH Myocardial infarction 1986 and stomach ulcer. Medications Corgard and nitroglycerin. No known allergies.

48-year-old white male with past medical history positive for noninsulin dependent diabetes and hypertension. He presents to the emergency department after two episodes of dull aching substernal chest pain with radiation to the left neck and left shoulder. This is associated with diaphoresis and palpitations. Each episode lasted approximately 15-20 minutes. The symptoms occur at rest and relieve spontaneously. He denies any shortness of breath, nausea or vomiting. No fever or cough. He denies any weakness or numbness. He denies any abdominal discomfort or back pain. No hematuria or dysuria. He denies any trauma. No past history of cardiac disease. Cardiac risk factors are positive for obesity hypertension diabetes and hypercholesterolemia. He denies any family history of smoking. The patient is asymptomatic at this time. No allergies. Medications include Dicloxacillin and Bactri.

Patient is a 50-year-old female with a history of gastritis in the past. Also has positive family history with mother, father and brother at 49-year-of-age with myocardial infarctions. She states that she has no known cardiac history. Today approximately 3:00 a.m developed epigastric

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discomfort and this was followed by substernal chest heaviness intermittently throughout the day. She states that she has had mild shortness of breath and some diaphoresis, nausea without vomiting. Denies any fever or chills. Denies any actual emesis. Denies any radiation of the pain except slight radiation to the back. The patient states the pain has been persistent throughout the day. She denies any actual abdominal pain. Denies blood in the stool or diarrhea. Denies fever or chills. Denies any previous history of chest pain. Denies any lower extremity pain or swelling. Denies history of thrombophlebitis or PE in the past.

HISTORY AND PHYSICAL

Chief Complaint: Fever.

History: The patient is a 4-year-old Hispanic female with a history of recurrent infections and a recent urinary tract infection. She has a history of gastroesophageal reflux in infancy. She was hospitalized November 2004 gastroenteritis and a white blood cell count of 34,000. She had negative blood cultures and urine cultures performed at that visit. She was also admitted in January 2001 for dehydration.

Allergies: The patient is lactose intolerant.

Physical Examination:
Vitals: Temperature 99.3, pulse 1.8, respiratory rate 24.
Eye exam: Her bilateral conjunctivae are injected.
Nose exam: She has some mild upper airway congestion.
Throat: Mucous membranes are moist and pink. Tonsils are 2+.
Lungs: Clear to auscultation bilaterally.
Cardiovascular: Regular rate and rhythm. No appreciable murmur.
Abdomen: Soft, nontender, nondistended with active bowel sounds.
Extremities: Warm and well perfused. There is no edema noted of her hands or feet.

Treatment: She was started on Rocephin 50 mg per dose intravenous q.24h. pending outcomes from her cultures.

Discharge Diagnosis
1. Fever.
2. Leukocytosis.
3. Bronchitis.
4. Conjunctivitis.

The patient shows some features of Kawasaki's disease.

Plan: Will discuss with pediatric infection disease doctors and request their input about possible atypical Kawasaki's disease. Will closely monitor her p.o. intake and will hold off on intravenous fluids currently.

MENTAL HEALTH

The patient was born in 1960. She is single and has two children. She graduated from high school regular classes. There is a family history of psychiatric problems.

History of Drug and Alcohol Abuse: The patient has history of cocaine use. She began drinking it in 1975 and used it three times a week. She quit and has had no history at present. She drank socially in the past but does not drink at present.

Mental Status Examination, General Appearance: The patient is a 46-year-old female who appears her stated age. There was no psychomotor retardation or agitation. They were no abnormal movements or posturing. She was sociable, maintained good eye contact and gave relevant answers to questions. She was cooperative throughout the interview.

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NEW PATIENT ENCOUNTER

Chief Complaint: Left knee injury.

The patient was playing basketball, running down the court and slipped on a wet floor. As he was falling he grabbed another player to try to stabilize himself and felt a pop in the knee.

Past History: The patient had surgery on his eye in 1998. He has a history of gastroesophageal reflux disease and hiatal hernia. He has also been treated for depression and anxiety.

Allergies: The patient is lactose intolerant. He is allergic to penicillin and aspirin. He is taking Allegra-D for seasonal allergies. No other medications at this time.

Family History: Positive for hypertension.

Physical Examination
General: Well-developed male in no acute distress.
Head: Benign.
Chest: Clear.
Heart: Regular rate and rhythm without murmur, gallops or rub.
Abdomen: Bowel sounds positive. Negative for masses. Negative for tenderness.
Extremities: There is no edema noted on his hands and feet. Swelling of the left knee.

OB/GYN (Neonatology)

I was asked by Dr. Smith to speak with mother to discuss issues regarding preterm delivery at 23 weeks gestation. I visited with the mother in her room for approximately 15 minutes, and discussed multiple issues regarding complications of premature delivery.

Mother was told that the infant was at risk for developing intraventricular hemorrhage, and that the gestational age and the infant's degree of illness would factor into the risk of bleeding. She was told that all premature infants have a higher risk of neurologic problems compared to term infants. Mother was also told about retinopathy of prematurity.

All of mother's questions at this time were answered, but she was told that we would be available to speak with her again anytime she would like.

Thank you very much for this consultation, and please call us if the mother would like to speak with Neonatology again about any of the issues that were discussed today.

ONCOLOGY #1

June 10, 2008

Clinical Summary: The patient is here for reevaluation of multiple myeloma. He is essentially asymptomatic.

Physical Examination: Examination shows no obvious evidence of disease. Performance status is 85 to 90, weight 160.5 pounds, blood pressure 136 over 84, temperature 97.9 degrees Fahrenheit.

Plan: Metastatic survey in about nine weeks. Return to the medical oncology and hematology office in ten weeks with serum and urine protein, serum cryoglobulins, chemical screening profile, electrolytes, CBC and platelets.

Comment: Laboratory studies from March 19, 2001 showed a B.U.N of 30, with an essentially normal SMA-12. cryoglobulins were negative. His white count was 4100, hemoglobin 12.6, hematocrit 36, platelets 186,000, and an unremarkable differential. The urine total protein

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was 470 milligrams in 24 hours. No protein was seen on urine protein electrophoresis or immunofixation.

X-rays from March 20, 2001 of the chest and right ribs showed an expansile posterolateral rib lesion at 7th and 8th ribs on the right. The patient states that he has been lifting his left leg with weights at the direction of Dr. Carter, and he has had considerable relief of pain in his right hip as a result.

ONCOLOGY #2

Chief Complaint: Mr. Jackson is a 73-year-old gentleman with a history of prostate cancer. He is receiving treatment with Depo injections and Zoladex, with known bone metastases. He had been on the intermittent androgen blockade protocol, but had a suboptimal PSA response. Currently he is receiving ketoconazole at a dose of 200 milligrams t.i.d. He has had a PSA response to the ketoconazole with a drop in the PSA from 48 to a most recent value of 12.7. He tolerates the ketoconazole better now than he did initially without symptoms of nausea.

Mr. Jackson does complain of diminished energy and fatigue. He has no complaints of pain. He does suffer from some urinary urgency and nocturia times 1.

Physical Examination: His weight is 170, blood pressure 142 over 80. There is no spinal tenderness to percussion. Lungs were clear. Heart is regular with normal S1 and S2. He does have a systolic ejection murmur heard best at the right upper sternal border.

PSA is pending from today. CBC shows a hematocrit of 37.4, white count 7.2, platelet count 351, liver function tests are normal.

Impression: Mr. Jackson is clinically stable on treatment with Zoladex and ketoconazole. I will continue with treatment pending today's PSA. Assuming the PSA is stable, I will see him back again in three months with repeat blood work at that time.

ONCOLOGY #3

Mrs. Johnson is a 62-year-old woman with a history of a left-sided infiltrating ductal carcinoma. She was diagnosed in July of this year. She underwent lumpectomy, sentinel node procedure, radiation, and has been on tamoxifen for the past 3 months. She finished radiation therapy approximately 5 weeks ago.

She has been doing quite well. She tolerated radiation without adverse effects other than some fatigue. She tolerates tamoxifen without adverse effects. She has occasional hot flashes but no gynecologic symptoms and no lower extremity swelling.

Physical Examination: Her weight is 230. Blood pressure: 140 over 80. There is no cervical or supraclavicular lymphadenopathy. There is no scleral icterus. Lungs are clear bilaterally. Heart is regular with normal S1 and S2. Abdomen is soft and nontender without hepatosplenomegaly. Left breast shows the lateral incision. There is no evidence of local or regional recurrence. Right breast and axilla are negative.

In summary, Mrs. Johnson is doing well on followup for left-sided breast cancer. She will continue with tamoxifen and I will see her back again in six months. She is due for a six-month interval left-sided mammogram in January of 2003, and she will resume bilateral yearly mammograms in July of next year.

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OPHTHALMOLOGY

The patient is a 74-year-old male sent for evaluation of distorted vision in the left eye over the past two weeks. There was concern about some edema or cysts in the papillomacular bundle by Dr. Becker, the referring physician. Medical history is unremarkable for Meniere's disease and he is currently taking Motrin.

Fundus photo prints show the posterior pole of each eye as described. An angiogram was done with the transit OS and late transit OD. There is a focal leak within the papillomacular bundle which progresses to an area of serious subretinal fluid in the later frames. This does not include the macula. The right eye frames show a few RPE changes temporal to the macular but no leakage.

The patient does have central serious retinopathy with an active leak OS. Observation is indicated at this time and I have asked him to return to see me in one month. The leak is in a treatable location and if things become worse or if the distortion is really a problem for him, I'll discuss laser photocoagulation treatment with him.

ORTHOPEDICS (Short Version)

Personal History: He is seen today to evaluate a painful right knee. Onset three months ago of increasing pain associated with activity such as walking, climbing and also occurring at rest. Most notable is the swelling, limited motion and fullness and sensitivity in the posterior compartment.

Physical Findings: Deep tendon reflexes, motor and sensory is intact with sensitivity in the sciatic notch and paraspinal muscles in the lower back area. He has sensitivity and fullness in the posterior medial compartment of his knee.

Impression: Degenerative osteoarthritis, right knee. A trial of anti-inflammatories, continued physical therapeutic measures and structuring aquatic therapy. A trial of Lodine 500 XL has been dispensed.

ORTHOPEDICS (Long Version)

Personal History: He is seen today to evaluate a painful limb, right knee. Onset three months ago of increasing pain posterior compartment and medial compartment with weight-bearing activities. He is status post high tibial osteotomy some five years ago left knee, with a good outcome. His right knee however, became increasingly debilitating the painful with weight-bearing activities with pain associated with activity such as walking, climbing and also occurring at rest. Most notable is the swelling, limited motion and fullness and sensitivity in the posterior compartment.

He underwent arthroscopy with debridement for osteoarthritis and medial meniscus tear and a small radial tear of the lateral meniscus. Postoperatively he continued to have discomfort. Through the course of his rehab, flexibility and training a conditioning activities have resulted in mild lobe back discomfort, but increasing right leg radicular pain involving the sciatic notch, groin and radiating pain along lateral and dorsal aspect of his foot.

Physical Findings: Show supple range of motion of the hips, negative straight leg raise with only mild groin and back discomfort line flat and with hip rotatory maneuvers. Deep tendon reflexes, motor and sensory is intact with sensitivity in the sciatic notch and paraspinal muscles in the low back area. He has sensitivity and fullness in the posterior medial compartment of his knee.

Impression: Degenerative osteoarthritis, right knee, varus aligned knee, radiculopathy, right leg and discogenic facet degenerative changes. A trial of anti-inflammatories,

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Sample Medical Reports

continued physical therapeutic measures and structuring aquatic therapy. A trial of Lodine 500 XL has been dispensed.

RADIATION ONCOLOGY NOTE

Mrs. Jones completed a planned course of radiation therapy given for carcinoma of the large bowel back on the 2nd of December. She had problems during the course of treatment with dehydration and diarrhea.

Since she finished therapy, she has done quite well. She is over all of her acute symptoms.

On examination today, she looks quite well. There are no neck nodes palpable. There was good air entry bilaterally in the chest. Abdominal examination failed to reveal masses. There is no evidence of perineal recurrence.

This patient has done well since finishing radiation. She is now back on her second to last cycle of chemotherapy. I will see her in four months' time.

REFERRAL LETTER

Dear Dr. Taylor,

I had the pleasure of seeing Robert May in my office today. The patient was admitted to the hospital in early November with decompensated congestive heart failure, which was precipitated by recurrent atrial fibrillation.

Since discharge he has been feeling better without significant dyspnea on exertion, but does have fatigue. The symptoms have substantially improved since prior to hospitalization. He has had no edema, orthopnea or PND.

Other problems include COPD and he did have mild respiratory wheeze on evaluation today. He remains on inhalation therapy. I will see him in six months. He will follow up with his family doctor in the next month, and with his electrophyisiologist who will plan placement of an ICD for sudden death prophylaxis.

Please do not hesitate to contact my office as needed. I certainly appreciate participating in Mr. May's care.

Sincerely,

SOAP NOTE

S—Patient states that she has always been overweight. She is very frustrated with trying to diet. Her 20 year class reunion is next year and she would like to begin working toward a weight loss goal that is realistic. NKDA.

O—Weight = 210 lbs, Height = 60", Cholesterol = 255, BP = 120/75

A—Obese at 183% IBW, hypercholesterolemia

P—Long Term Goal: Change lifestyle habits to lose at least 70 pounds over a 12 month period. Short Term Goal: Client to begin a 1500 Calorie diet with walking 20 minutes per day. Instructed patient on lower fat food choices and smaller food portions. Patient will keep a daily food and mood record to review next session. Follow-up in one week.

For additional information contact:

EXAQ, Inc.
www.exaq.com
support@exaq.com
Toll Free: (888) 548-8255