CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 11/06/2015

Chakey, Jennifer T

61 Y old Female, DOB: 10/17/1954
Account Number: 19500
30 West 72nd Street, Apt. 1B, New York, NY-10023
Home: 917-833-7000
Guarantor: Chakey, Jennifer T Insurance: Medicare
Appointment Facility: N.Y.N.A. Upper West Side

11/06/2015 **Gary Starkman, MD**

Current Medications

Taking

- Premarin
- Neurontin
- Vicodin
- Xanax XR 0.5 mg QD
- PROzac
- Ambien
- raNITIdine
- Zanaflex
- metoprolol
- aspirin 81 mg tablet, chewable 1 tab (s) orally once a day

Past Medical History

Lyme disease.
Arthritis and HNP's.
Anxiety/Depression/Agoraphobia.

Review of Systems

Opiod Management:
no Myoclonus.
no Nausea/Vomiting. no Itching, Rash. no Constipation. no Sedation. no Diaphoresis. no Edema. no Dry Mouth. no Blurred Vision. no Hallucinations, wierd dreams. no Headaches. no Recreational Drugs. Pain Relief yes. no Respiratory Difficulty. no Stomach Pain. no Other.
Follow Up ROS:
no General:. no Psych:. Neuro: yes. no Cardio:. no Pulmon:. no GI:. no Endo:.

Reason for Appointment

1. No new complaints

History of Present Illness

:

Pt's coming in today for f/u visit for multiple Sx's (same since last visit but had a difficult month due to stress & pain fluctuates) & Rx renewals. She has no new complaints. Bowel/bladder are intact.

Pain involves multiple regions including hands/wrists, feet, knees, hips, UE's/LE's, spine (neck & entire back- includes upper back involving LB exacerbations unilaterally due to stress resulting in small pimple like scab breakouts), and bladder (involves abdomen & has urinary frequency). Burning sensation in hands/UE's continues w/o changes. Pain fluctuates- has been 9/10 in severity with Tx the past month due to stress/weather changes, L>R sides, constant, neck pain radiates to R>L scalp intermittently, wrist pain radiates up UE's & to hands, knee pain involves region of LE inferiorly/posteriorly, has swelling in L>R knees/distal LE's/ankles- fluctuates & has been aware of it in L>R LE's consistently for a few days (had them elevated & veins were hurting), painful/restricted ROM, worse with weather changes/activity/night time, affect sleep/gait/balance/ADL's, & otherwise same characteristics as prior visits. Cramps in LE's (calves/thighs) haven't reoccurred since last visit. N/T sensations in B/L feet & forearms/hands continue w/o changes aside from being more frequent in hands: intermittent but daily in hands, affect sleep/ADL's, & notes reduced sensation. Odd LE sensation continues to occur infrequently w/o changes: gets up & feels as though she can't feel her LE's & affects gait-wobbly. She denies having muscle weakness.

Imbalance continues daily w/o changes: stumbles frequently, affects gait, and had no falls since last visit. Dizziness continues w/o changes: positional, sensation of room spinning, daily, short lived, & affects ADL's. She hasn't had any severe episodes since last visit & denies LOC. Tinnitus/pressure in B/L ears (intermittent, high pitched ringing, affects sleep, & notes changes in hearing) continues w/o changes. Tremors in B/L hands with intention continue intermittently w/o changes. Twitching in multiple extremities continues w/o changes: infrequent, short lived, & affect ADL's/sleep. RLS Sx's continue w/o changes: worse with stress, B/L sides, nightly,

occurs with lying/relaxing, & affect sleep.

Headaches improved since last visit: 7/10 in severity (worse since last visit), R>L sides, begin at the center of brow and radiate to right forehead but lately are more on top of scalp, short lived in duration, intermittent, affect sleep/ADL's, & otherwise same characteristics as prior visits. She may have associated N/V/photophobia/R>L dry eyes. Ophthalmologist f/u is pending.

Agoraphobia, anxiety, and depression Sx's fluctuate: daily, cries frequently, affected by pain/stress, and affect sleep/ADL's. She denies having SI. PCP is addressing this currently.

Pain is under adequate control with regimen but notes less relief at night. She tolerates meds well with no ADR's aside from having possible dry mouth (uses Biotin & smart mouthwash with relief-declines evaluation/counteraction or med adjustment due to this)/drowsiness (manageable & doesn't affect ADL's)/constipation, seems compliant, no aberrant behavior noted, ADL's are adequate/improved, took meds yesterday/today- has a few tabs of each med remaining, takes meds daily as directed w/o going over MDD but uses gel PRN, and provide some (mild recently) relief for majority of day. Constipation is stable: BM's are every 2 days up to BID, hasn't strained, probiotics help, & MiraLax provides relief. She would like better relief- MS Contin isn't helping. She had Botox injections done recently- Sx's improve with Tx. PTx for Sx's is pending to begin. Some tests are pending. ENT referral is pending. Cardiac f/u is pending, & has been referred to cardiovascular specialist for LE swelling. Orthopedic consultation for knee pain is pending. She declines to arrange any other procedures or PTx referrals for Sx's.

Examination

General Examination:

General appearance: pleasant;
NAD. HEENT: NC/AT. Neck: painful/restricted ROM appreciated in the C-spine with lateral movement/rotation R>L sides and extension>flexion. Lungs: mild tenderness appreciated upon palpation of the sternum. Extremities: edema appreciated in the L>R knees posteriorly and inferior to the knees as well as the L>R ankles laterally>medially; painful/restricted ROM appreciated in B/L wrists along all aspects, L>R ankles inversion>eversion, and L>R knees extension. Skin: no rashes appreciated; multiple regions of vitiligo appreciated along the U+L extremities B/L sides; Addendum: no bruising appreciated. Neurological: antalgic gait; negative Romberg test; thenar/snuffbox atrophy appreciated in the hands R>L sides; left UE & LE are thinner in appearance compared to the right side; minimal intentional tremors appreciated in the R>L hands; no changes since last examination; Addendum: non-focal examination. Back: painful/restricted ROM appreciated in the L-S spine with extension>flexion and rotation/lateral movement R>L sides.

Assessments

1. Numbness - 782.0 (Primary)
2. HEADACHE - 784.0

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 11/06/2015

3. PAIN IN LIMB - 729.5
4. Anxiety disorder NOS - 300.00
5. Joint pain, other specified sites NEC - 719.48
6. Dizziness - 780.4
7. Chronic pain syndrome - G89.4
8. Cervicalgia - M54.2
9. Dorsalgia, unspecified - M54.9

Treatment

1. Numbness
Increase Neurontin tablet, 600 mg, 1 tab(s), orally, BID, 30 day(s), 60 Tablet
Notes: Hold Neurontin 400 mg BID- received Rx on 8/14/15 for a month supply with 5 refills but will try a stronger dose. Due to odd LE sensation, f/u MRI of the L-S spine to r/o HNP with nerve impingement and may consider EMG/NCS LE's f/u sooner to r/o radiculopathy..

2. HEADACHE
Notes: Instructed patient to repeat Botox every 3-4 months- has appt for 12/9/15 and has buy & bill. She declines to try any other oral prophylactic medications for the headaches currently..

3. PAIN IN LIMB
Continue Norco tablet, 325 mg-10 mg, 1 tablet, orally, QID PRN, 30 days, 120
Start Opana ER tablet, extended release, 20 mg, 1 tab(s), orally, every 8 hours, 30 day(s), 90 Tablet
Notes: Hold MS Contin 30 mg- will put aside any left over as she tries something else. Pt is to take Norco TID-QID. Continue Zanaflex 4 mg QHS & VG QID PRN- received Rx's on 8/14/15 for a month supply with 5 refills. Hold Celebrex 200 mg BID due to cardiac issues, and has yet to discuss it with the cardiologist. Instructed her on how to take her medications, and not to go over her MDD. Start PTx for the neck & LB pain: has the referral as well as one for her knees/hips from use but also has a referral from an orthopedist for the knees. She declines to arrange any interventional procedures for any of her symptoms currently. Follow up in 1 Month- is to call and come in sooner with any new/worsening symptoms. NYSDOH PMP database was checked and verified Rx's. Any incompliancy with OMTx may result in d/c of medications, d/c from the practice, and referral for substance abuse evaluation. UT was done today to check for compliance with medications with confirmatory report to follow. Recommended her to try tonic water for the cramps, and instructed her to remain hydrated. Instructed her to increase water/fiber intake as well as retry Metamucil OTC for constipation. Avoid laxative (MiraLax) use and try a stool softener such as Colace/Metamucil OTC instead for her BM's. Referral to an orthopedist for knee and hip pains are pending. B/w to check for CBC, electrolytes, and LFT's is pending..

4. Anxiety disorder NOS

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Notes: She was seeing a psychopharmacologist for depression/anxiety- Dr. Andrew Slaby. Instructed her to see a psychiatrist ASAP- her previous psychiatrist doesn't take her insurance coverage and has a list names..

5. Joint pain, other specified sites NEC
Notes: Hold off on completing the B/L Synvisc knee injections- she will be following up with an orthopedist/orthopedic surgeon for this matter..

6. Dizziness
Notes: Dizziness may be cardiac/medication related currently. She is undergoing cardiac testing and had VNG testing done (requested for the results to be sent to our office when they are ready). She sees Dr. Assadi (212-315-3322). Instructed her to see an ENT specialist as well for her dizziness & tinnitus- has the referral..

7. Chronic pain syndrome
Notes: Addendum: Arrange MRI C-spine to r/o HNP..

8. Others
Notes: Observe RLS for the time being and declines Tx currently. She has been encouraged to exercise. She plans to go to a sleep study specialist. Referral to a GI specialist for N/V & Acid Reflux is pending. She declines to arrange any other imaging/testing currently. Instructed her to see her PCP/urologist due to the bladder/abdominal pain. Steroidal interventional procedures are not recommended to be done until cardiac matters are under control. Instructed her to see a cardiologist ASAP and even to go to the ER due to having cardiac symptoms. Pt has been incompliant with keeping her referrals. Addendum: Instructed her to go to the ER with any worsening Sx's..

Diagnostic Imaging

Imaging: MRI L Spine Without Contrast
Imaging: MRI C spine Without Contrast

Labs

Lab: LFTs
Lab: CBC with diff
Lab: SMA 12

Follow Up

with test results; 1 Month or PRN sooner for medication f/u; Refer pt to a cardiologist

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 11/06/2015

Electronically signed by Gary Starkman M.D. on 10/19/2023 at 04:26 PM EDT

Sign off status: Pending

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Progress Note: Gary Starkman, MD 11/06/2015

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CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 11/05/2014

Chakey, Jennifer T

60 Y old Female, DOB: 10/17/1954
Account Number: 19500
30 West 72nd Street, Apt. 1B, New York, NY-10023
Home: 917-833-7000
Guarantor: Chakey, Jennifer T Insurance: Medicare
Appointment Facility: N.Y.N.A. Upper East Side

11/05/2014 **Progress Note: Gary Starkman, MD**

Current Medications

Taking

- Premarin
- Ambien
- Neurontin
- Vicodin
- Klonopin
- Cymbalta

Past Medical History

Lyme disease.

Review of Systems

Follow Up ROS:
no General:. no Psych:.
Neuro: yes. no Cardio:. no Pulmon:.
no GI:. no Endo:.

Reason for Appointment

1. No new complaints

History of Present Illness

:

Feels the same, no changes in pt's status, f/u for Tx with Botox.

Examination

General Examination:

Neurological: no changes since last exam.

Assessments

1. HEADACHE - 784.0 (Primary)
2. Anxiety disorder NOS - 300.00
3. Arthritis - 719.48

cervical dystonia.

Treatment

1. Arthritis

Continue Norco tablet, 325 mg-10 mg, 1 tab(s), orally, every 6 hours prn, 150
Notes: PMP was checked..

2. Others

Notes: 400 U of Botox was injected in selected cranial and cervical mm by protocol for cervical dystonia with H/A without complications.
.

Follow Up

1 Month for meds and 3 months for Botox

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 11/05/2014

Electronically signed by Gary Starkman M.D. on 10/19/2023 at 04:26 PM EDT

Sign off status: Pending

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Progress Note: Gary Starkman, MD 11/05/2014

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 05/30/2012

Chakey, Jennifer T

57 Y old Female, DOB: 10/17/1954
Account Number: 19500
30 West 72nd Street, Apt. 1B, New York, NY-10023
Home: 917-833-7000
Guarantor: Chakey, Jennifer T Insurance: Medicare
Appointment Facility: N.Y.N.A. Upper East Side

05/30/2012 **Progress Notes: Risa Ravitz, MD**

Current Medications

Taking

- Premarin
- Ambien
- Neurontin
- Vicodin

Past Medical History

Lyme disease.

Surgical History

Hysterectomy 2000
Appendix 1972

Family History

Father: deceased, Stroke, MI
Mother: alive, CABG
1 sister(s) .

Social History

Marital status: married.
Working: yes, Self employed, wine bar, and opening up another restaurant.
no Smoking.
Alcohol: yes, Frequency: occasional.
no Drugs.

Hospitalization/Major Diagnostic Procedure

Constipation 2008

Review of Systems

Constitutional:
no Weight change. no Loss of appetite. no Fever. no Fatigue. no Night sweats.
Cardiology:
no Chest pain. Palpitations yes. no Shortness of breath.
Gastroenterology:
no Nausea. no Vomiting blood. Blood in stool yes.
Genitourinary female:

Reason for Appointment

1. Headaches
2. Anxiety
3. Numbness and tingling
4. Pain in wrist

History of Present Illness

:

57 year old right handed female no pmh complaining of joint pain and headaches that began in 2007. She was diagnosed with Lyme disease and was put on Doxycycline for a year and a half. Currently she complains of numbness in her hands and feet, intermittent in nature and can radiate up to her elbows. This progressed over two years. The symptoms are worse at night and in the morning. She can be wobbly in the morning. She also complains of cramping and charlie horses in her feet. She has a 2-3 year history of agoraphobia and anxiety that has gotten worse. She complains of intermittent pain in her teeth, toes, calves or arms. The pain is quick and sharp. She has a constant aching pain in her wrist, hands and up to her forearms. The pain occurs a few times a day and can sometimes occur up to 5-6 times/day. The pain is severe, she will have to wrap her hands, it can make her cry, and can reach a 10/10. She recently started Neurontin 2-3 months TID and it is not helping. She takes Vicodin 1/2 tablet BID which helps. She has lost strength in her hands and is dropping glasses on a regular basis.

She complains of headaches on the right side of her head. The pain is moderate in nature, 4-6/10, and can't describe any aggravating or alleviating symptoms. This problem began about 2 months ago without and inciting event. She does not know how often the pain occurs.

She brought records (attached). MRI brain from 2007 showed 2 punctate foci of T2 intensity and SPECT scan showed mild to moderate hypoperfusion in the cerebrum of the occipital lobes.

She has been crying a lot. Her sleep is interrupted. She does not like to go out like she used to. She will go out of the house often. She had seen a psychiatrist in the past and was put on Lexapro and Prozac and didn't tolerate it.

Vital Signs

Ht: 68, Wt: 130, BMI: 19.76, BP: 119/65, HR: 79, RR: 12.

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 05/30/2012

Blood in urine yes, Worked up.
Psychology:
Tension/stress yes. Anxiety yes.

Examination

General Examination:

General appearance: pleasant. HEENT: EOM are full, without nystagmus PERRLA, discs sharp bilaterally. Neck: no carotid bruit, no tender points. Lungs: no chest wall tenderness, no wheezing. Heart: normal. Abdomen: soft, NT/ND, BS present. Extremities: no edema.

Physical Examination

Neurological:

Mental status exam: normal, alert and oriented x 3. Cranial nerves: II-XII. Normal bilaterally. Motor: V/V bilaterally. Sensory: no abnormalities to touch, PP, temperature and vibration. Reflexes: bilaterally symmetrical, babinski negative. Upper motor neuron signs: equivocal. Cerebellar signs: absent. Tremors: absent. Coordination: finger-to-nose and rapid alternating movements were intact. Gait: normal.

Assessments

1. Numbness - 782.0 (Primary)
2. HEADACHE - 784.0
3. PAIN IN LIMB - 729.5
4. Anxiety disorder NOS - 300.00

Treatment

1. Numbness

Start Lyrica capsule, 50 mg, 1 cap(s), orally, 2 times a day, 30 day(s), 60
Notes: Schedule MRI brain +/- to rule out demylination, report to follow. MRI C-spine to rule out demyelination in setting of numbness and tingling. EMG Upper Extremities done today to rule out neuropathy, report to follow. Start Lyrica. Appropriate bloodwork sent, report to follow. Discussed likely multifaceted approach to pain management.

2. HEADACHE

Notes: MRI brain pending. EEG to rule out sz in setting of headache and numbness performed today, report to follow. CCD/TCD to rule out vascular dissection in setting of headache performed today, report to follow.

3. PAIN IN LIMB

Start Vicodin tablet, 500 mg-5 mg, 1 tab(s), orally, every 6 hours as needed for pain, 30, 60, Refills 0
Notes: Start Vicodin prn pain.

4. Anxiety disorder NOS

Notes: Discussed and recommended that pt follow up with a psychiatrist. She will do so.

Diagnostic Imaging

CHAKEY, Jennifer T **DOB:** 10/17/1954 (69 yo F) **Acc No.** 19500 **DOS:** 05/30/2012

Imaging: MRI C spine Without Contrast
Imaging: MRI Brain with and without contrast

Labs

Lab: RPR
Lab: Chem 7
Lab: B12 level
Lab: Rheumatoid factor
Lab: ANA
Lab: Folate
Lab: TSH
Lab: CBC with diff
Lab: ESR
Lab: thiamine
Lab: ck

Follow Up

with MRI

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Sign off status: Pending

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Progress Note: Risa Ravitz, MD 05/30/2012

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