814 Porte Avenue • Valparaiso, Indi 46383
Telephone (219) 465-4600

RECORD COPY

January 31, 1989

At the patient's request, the following memo is to be kept in the medical file of Robert W. Jeffords:

Mr. Jeffords states he has a medical history of wheezing, random choking, and an inability to catch his breath which results in muscle soreness and severe sore throat pain. Mr. Jeffords stated he suffered from these phenomenon after surgery in January 1989.

If at any time in the future Mr. Jeffords requires surgery or anesthesia, he would like those physicians involved to be aware of his history.

Sincerely,

Leslie O'Toole

Leslie O'Toole, R.N.
Unit Director, M.S.C. Surgery Dept.

LO/bsc
cc: Mr. Jeffords
Dr. Brown ✓
Dr. C. Leland
Medical Records Dept.
file

Thomas R. Hall, M.D.

Robert Jeffords
10-16-79

ID The patient is a 51 year old male referred by Dr. Moayad because of respiratory problems.

HPI Patient reports that for the last 8 years or so he has had problems with intermittent dyspnea. He has been treated with Quadrinal and an allergy medicine. When he is on these medicines he is relatively asymptomatic. He reports that on one occasion he tried to get along without the medicine and had an exacerbation of his symptoms. A second time he inadvertantly ran out and promptly redeveloped symptoms. The patient works as a carpenter. He reports that he formerely smoked 3½ packs of cigarettes a day, but quit 18 years ago.

PMH Surgeries: T & A, age 20.
Hospitalizations: Age 44 for a kidney stone and again for an episode of dyspnea.
Medical Illnesses: The patient has been told that he has had high blood pressure. He currently is on no medication for this. Patient also has gout for which he regularly takes Col Benemid.
Medications: Forhistal, Etrafon, and Quadrinal.
Allergies: The patient states that he has been told that he is allergic, but he does not know to what.

ROS Head: No headaches.
Eyes & Ears: Occasional spots in front of the eyes when the patient stands up too quickly. No change in acuity no pain and no discharge.
Nose & Throat: Patient notes some increasing difficulty recognizing common odors.
Cardioresp: As above.
GI: No nausea, vomiting, pain, diarrhea or constipation.
GU: Patient states he has always had a weak bladder having to urinate more frequently than most people. He has nocturia times 3. He also has some mild difficulty starting and stopping his urinary stream.
Musculo-skeletal: Intermittent low back pain. This has been attributed to a degenerated third lumbar vertabrae. Surgery was offered, but the patient opted for a back brace instead.

EXAM Physical exam reveals a 51 year old male who looks his stated age. BP is 140/90. Pulse is 68 and regular.
Head: Normocephalic.
Eyes: Pupils equal, round, reactive to light. Disk margins sharp. No hemorrhages or exudates.
Ears: Both TM's dull gray and somewhat retracted.
Nose: Mucosa mildly erythematous. A moderate amount of watery discharge present.

Throat:	No erythema. Dental plates in place.
Lungs:	Clear. No rales. No wheezing.
Heart:	Regular rhythm. No S3,4 or murmurs.
Abdomen:	Soft. Liver and spleen not palpable. No masses. No tenderness.

Complete pulmonary fundtion tests were normal.

IMPRESSIONS — Chronic obstructive pulmonary disease, mild. Well controlled with the present medication program.

PLANS — No change in therapy

G. David Beiser, M.D.
McKindra Fletcher, Jr., M.D.
George J. Grcevich, M.D.
Fred J. Harris, M.D.
Michael L. Wheat, M.D.

CARDIOVASCULAR ASSOCIATES, INC.

2102 East Evans Avenue
Valparaiso, IN 46383
(219) 465-0808
1-800-727-6337

STRESS TEST EVALUATION

NAME: JEFFORDS, ROBERT W. **AGE:** 63 **SEX:** Ma **WT.:** **DATE:** 2/28/92

REFERRING PHYSICIAN: Thomas R. Hall, M.D. **TECH:** Gwenlyn L. Smith, R.C.T.

MEDICATIONS: Cardura and Allopurinol.

LOCATION: CVA Valparaiso office.

INDICATIONS: Chest pain.

RESTING ECG

Rate Shows a normal sinus rhythm at a rate of 68.

Arrhythmias None.

QRS Complexes Normal.

ST-T Waves Normal.

HYPERVENTILATION Not done.

EXERCISE

Rate Achieved 139 bpm (90% predicted maximum for age and sex)

Exercise Duration The patient exercised for 6 minutes, 15 seconds on a standard Bruce protocol and achieved 90% of his maximum predicted heart rate. The patient achieved a heart rate of 139 beats per minute. His resting blood pressure was 140/84 and rose with exercise to 194/80.

Arrhythmias A few PAC's occurred during the test.

QRS Changes None.

ST-T Wave Changes Negative for ischemia.

Symptoms The patient denied any symptoms of chest pain with the exercise stress test. The test was terminated due to shortness of breath and general body fatigue.

INTERPRETATION:

1. Negative maximal stress EKG's for ischemia.
2. No significant arrhythmias with exercise.

Michael Wheat MD

Signed_____, M.D.
Michael L. Wheat, M.D.

MLW/dml

PREADMIT:

PORTER MEMORIAL HOSPITAL
VALPARAISO, INDIANA 46383

HISTORY & PHYSICAL

NAME JEFFORDS, ROBERT ROOM # _____ HOSPITAL # _____

ATTENDING PHYSICIAN W. KILMER,M.D. ADM. DATE 1-7-80

PI: This 51 year old white male is being admitted to the hospital for a left inguinal hernia repair. He states he is a carpente and this hernia gives him considerable distress when he has to lift.

PH: He gives a history that he takes three medications.He needs the medications to prevent tracheal spasm. He takes Quadrinal 1 tab tid, Etrofon 2-10 one tid, Forhistal 2.5 mg one at bedtime. He has had a T&A many years ago, otherwise, no serious health problems.

PHYSICAL EXAMINATION

GA: Reveals the previously described white male appearing his stated age of 51. He is quite tall, is somewhat overly WN. Wt is 250½ lbs.

HEAD: Symmetrical. Scalp is clear.
EYES: EOM are intact. Pupils are round, equal and react to light.
NTM: Clear.
NECK: Supple. Trachea in midline. Thyroid not hypertrophied. No cervical adenopathy.
SPINE: Unremarkable.
CHEST: Hemithorases move with equal excursion. Lungs clear to A.
HEART: No murmurs or cardiomegaly. BP: 170/88
ABDOMEN: Soft, nontender. No abnormal masses except a large left inguinal hernia.
EXTREMITIES: No abnormality.

DIAGNOSIS: Large left inguinal hernia and allergy causing tracheal distress, possibly laryngeal edema.

mem 1-7-80
1-7-80

Signature _____ M.D.

B16/45

W. KILMER,M.D.

P O R T E R M E M O R I A L H O S P I T A L
VALPARAISO, INDIANA 46383

CONSULTATION REPORT

NAME: JEFFORDS, ROBERT ROOM #: 347-2 HOSPITAL #: 82-10809

ATTENDING M.D.: W. KILMER CONSULTING M.D.: A. ABEY

FINDINGS, DIAGNOSIS & RECOMMENDATIONS:

PAGE 2.

EXTREMITIES: Unremarkable.

LABORATORY WORK:

CBC showed leukocytosis with a left shift. Hgb. is 14.6. Platelet count is normal. Coagulation studies were WNL. EKG reveals questionable RBBB, otherwise unremarkable.

DIAGNOSTIC IMPRESSION:
#1 ACUTE CHOLECYSTITIS
#2 MILD HYPERTENSION
#3 BRONCHIAL ASTHMA
#4 GOUT BY HISTORY

Patient appears medically stable at the present time. I would suggest a recheck, a liver profile prior to surgery. Otherwise the patient is in stable condition for the planned surgery. I will continue to follow the patient with you medically.

8-10-82 pat

A. ABEY, M.D.

SPECIALTY LABORATORIES, INC.
OncQuest
2211 MICHIGAN AVENUE
SANTA MONICA, CA 90404-3900
(310) 828-6543 (800) 421-4449

COUNT NUMBER	S.L.I. ACCESSION NUMBER
6290	5519264

PATIENT NAME: JEZZORDS, ROBERT W

REFERRING PHYSICIAN: PORTER MEMORIAL HOSPITAL

NOTES:

PORTER MEMORIAL HOSPITAL
ATTN: LABORATORY
814 LA PORTE AVE
VALPARAISO, IN 46383-5898

PATIENT I.D. NUMBER	DRAWN
145601	

RECEIVED	REPORTED
08/29/95 15:29	09/01/95 01:43

AGE: 66Y SEX: M

conditions with myelin breakdown; MBP concentrations of 1-3 ng/mL suggest a slower rate of myelin degradation or recovery from an acute flare of demyelination and can also be observed in patients with chronic active MS or other CNS disease. (508)

594

James RoPeter, M.D. Ph.D.

PATIENT: Jeffords, Robert (43) ADDRESS: Portage, Indiana EXAM: #1990 Chest, L. Lat.

PA and lateral views. The heart size appears normal. The trachea is in the midline. Prominent peri hilar calcifications are noted mainly on the right. I see no active infiltrations or congestion. No pneumothorax or atelectasis. The visualized bony structures appear unremarkable.

IMPRESSION: NO ACTIVE PATHOLOGIC PROCESS NOTED.

SURJIT S. PATHEJA, M.D.

SSP/mld

B. F. PORACKY, M. D., Radiologist

DOCTOR: W.L. Kilmer DATE: 4-28-72

JEFFORDS, ROBERT W	AGE 56	11-13-84	VALPARAISO, INDIANA
02-31-19	PCC	DR. KILMER DR. CRISE	X-RAY DEPARTMENT

CERVICAL SPINE WITH FLEXION & EXTENSION VIEWS:

There is narrowing of disc space at C-5 C-6 with posterior and anterior osteophytes at the juxta-articular vertebral bodies. The vertebral body heights are normally maintained. The curvature is normally maintained. Prevertebral soft tissue space, odontoid process and atlanto-axial articulation are normal.

CONCLUSION: PROMINENT ANTERIOR AND POSTERIOR OSTEOPHYTES AT C-5 C-6 WITH NARROWING OF DISC SPACE OF C-5 C6. OBLIQUE VIEWS WOULD BE OF VALUE TO RULE OUT NEURAL FORAMINA ENCROACHMENT.

LEFT SHOULDER

Bones are in normal position and show normal textures. The regional soft tissue is unremarkable.

CHEST PA & LATERAL

The heart is borderline in size. Prominent pericardial fat pad is seen at the left cardiophrenic angle. Compared to 8-10-82, minimal residual fibrotic scarring in the left cardiophrenic angle. The remainder of lung fields are clear. Hilar calcifications are noted. Bony thorax is unremarkable.

CONCLUSION: BORDERLINE CARDIAC SIZE. MINIMAL FIBROTIC SCARRING IN THE LEFT LUNG BASE. NO DEFINITE ACTIVE RECENT PARENCHYMAL INFILTRATES.

CHUNG JA KIM, M.D.
linda
11-13-84

PORTER MEMORIAL HOSPITAL

OPERATIVE REPORT

NAME JEFFORDS, ROBERT HOSP. NO. 72- 5192

ROOM NO. DATE 4/29/72

PREOPERATIVE DIAGNOSIS:

R.O. Tracheo-bronchial compression

POSTOPERATIVE DIAGNOSIS:

Trachea and bronchi appeard normal
a laryngeo edema is quite marked.

PROCEDURE:

Under general anesthesia, a 7 x 40 Bronchoscope was introduced. A trachea and bronchi were inspected. Each bronchus was irrigated separately with Saline and aspirated for cytology, both of which have been reported as normal.
Bronchoscope was then removed and the patient was allowed to recover. During the recovrey period, he had lots of respiratory distress and was watched carefully and no cyanosis developed. It is felt that the patient suffers from probably allergic laryngeo edema and is being referred for allergy consultation.

5/9/72
5/16/72
cb

----------M.D.
(Signature of Physician)
W. KILMER M.D.

MINOR HISTORY

(To be used in short stay cases only)

Family Name JEFFORDS, ROBRET	First Name	Attending Physician KILMER	Room No.	Hosp. 72- 5192

Date _____ Age _____ Sex _____ S. M. W. D. Race _____ Occupation _____

Diagnosis—Working _____

Final _____

Complications _____

Family History _____

Personal History This 43 year old white male admitted to the hospital for respiratory distress. The patient was in the hospital from March 20, through March 23, because of probable ureteral stone. He complains of awakening in the night, sometimes with a severe chocking sensation. Otherwise, no serious health problems. This has gone on for some time.

Present Illness—Onset—History—Complaint—Physical Examination Physical examiantion reveals a WD,WN, white male, in no acute distress.

HEAD:	Symmetrical Scalp is clear
EYES:	EOM's intact. Pupils round, equal, react to light
NTM:	Clear
NECK:	Supple. Trachea midline, thyroid not hypertrophied No cervical adenopathy
SPINE:	Straight and supple
CHEST:	Hemothoraces move with equal excursion. Lungs clear to auscultation
HEART:	No murmurs or cardiomegaly. BP 120/70. Pulse 80, regular
ABDOMEN:	Soft, non-tender. No abnormal masses. No hernias noted. Both testes in scrotum
EXTREMITIES:	No abnormalities. REflexes physiologic.

Progress Notes

The patient had a chest x-ray in the office, which shows paratracheal nodes which are calcified and gives the impression a distal trachea may be narrowed.

IMPRESSION: R.O. Tracheo-bronchial compression.

Condition on Discharge _____

5/9/72
5/16/72
cb

Intern _____ Signature _____ M.D.

PORTER MEMORIAL HOSPITAL
VALPARAISO, INDIANA
X-RAY DEPARTMENT

JEFFORDS, ROBERT AGE 52 8-10-82

02-31-19 ER DOCTOR KILMER
EMERGENCY ROOM

CHEST PA & LATERAL:

Compared with the study of 9-3-80, no change is evident in the heart, great vessels, or mediastinum from that seen previously. Hilar and parenchymal calcifications are again visualized. The markings in both bases appear to be more heavy with irregularity also evident adjacent to the diaphragm. Discoid atelectasis is present on the left. The diaphragm is outlined. The bony thorax is unchanged.

IMPRESSION: THE HEART AND AORTA ARE UNCHANGED.

HEAVIER MARKINGS WITH SOME PARENCHYMAL IRREGULARITY IN BOTH BASES SUSPICIOUS OF PNEUMONITIS. SOME BASILAR SCARRING, OR DISCOID ATELECTASIS ON THE LEFT IS ALSO PRESENT.

BERNARD F. PORACKY, M.D.
ls

PORTER MEMORIAL HOSPITAL

VALPARAISO, INDIANA

X-RAY DEPARTMENT

JEFFORD, ROBERT AGE 51 1-2-80

80-208 PREADMIT ~~DR.~~ KILMER

CHEST PA AND LATERAL
Heart size ismormal. TRachea isin the midline. FEw perihilar calcificati are demonstarted. There is minimal insignificant fibrosis at the left base. Lung fields are well expanded and the bones appear nnremarkable.

IMPRESSION: NO ACTIVE PULMONARY DISEASE.

RIGHT HIP AND FEMUR
AP frog leg views of the right hip and AP and lateral of the distal thirds of the shaft of the femur demonstrate the bones to be in good position and alignment. TExture and density is normal.

IMPRSSION : NO EVIDENCE OF FRACTURE.

SURJIT S. PATHEJA,M.D.
cc

PLAN AND RECOMMENDATIONS:

1) The patient should be able to tolerate the above surgery with only a moderate increase in risk.
2) Consider pulmonary treatment as needed as the patient has history of asthmatic bronchitis and bronchospasm and may need bronchodilators.
3) Continue Cordarone and Altace through the perioperative period to control the patient's atrial fibrillation and blood pressure.

Thank you, Dr. Zelaya, for allowing us to assist in the care of this gentleman. I will be happy to follow on a prn basis.

F. HARRIS, MD

\: sms
/: 213
DD: 08/23/95
DT: 08/23/95
ID: 00007659
JOB: 0163
cc: A. ZELAYA, MD
F. HARRIS, MD
K. BLACK, MD

PORTER MEMORIAL HOSPITAL
Valparaiso, Indiana

C O P Y

CONSULTATION

NAME: JEFFORDS, ROBERT W
ATTENDING: K. BLACK, MD
CONSULTING: V. DIBIASE, MD
DOB: 10/08/28
PT TYPE: I

ROOM NO: 2N-0264-1
MR#: 145601
ACCT#: 1430147
ADM DATE: 08/21/95
DATE: 08/27/95
DIS DATE: 00/00/00

NEUROLOGY

FINDINGS, DIAGNOSIS & RECOMMENDATIONS:

Thank you for asking me to see Robert.

This is a 66 year old white gentleman with a history significant for hypertension, paroxysmal nocturnal dyspnea, and atrial fibrillation controlled on Amiodarone, chronic obstructive pulmonary disease, benign prostatic hypertrophy, mild diverticulosis, who is admitted with back pain and left leg pain and weakness. He was found to have significant L2-3 spinal stenosis by MRI and lumbar myelogram. He was evaluated by Dr. Zelaya and on 8/23/95 had bilateral foraminotomies at L2-3 but mainly on the left. It appears that postoperatively he developed some disorientation and confusion which escalated over several days and he was not sleeping at all. He is quite sleep deprived. He has received a total of 8 mg of Haldol since 8/25 and a total of 2 mg of Xanax since 8/26. He had received only a few doses of Vicodin on 8/24.

This morning he was found to be extremely lethargic and sleepy and neurological consultation was requested.

His family gives no prior history of dementia or encephalopathy or other central nervous system symptomatology.

PRESENT MEDICATIONS: Naprosyn, Cardarone, Allopurinol, Altace, Azactam, Kefzol.

PERSONAL HISTORY: He is not a smoker. He is not a drinker.

PHYSICAL EXAMINATION:

VITAL SIGNS: He is currently afebrile although he had a temperature maximum of 100 on 8/26. Blood pressure 130/70. Respiration is 20 with a heart rate of 74.

NECK: He has no carotid or extra cranial bruits.

NEUROLOGICAL:

1972

MINOR HISTORY

(To be used in stay cases only)

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1972

Condition on Discharge _____

5/9/72
5/16/72
cb

Intern _____ Signature _____ M.D.

Thomas R. Hall, M.D.

1979

Robert Jeffords
10-16-79

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1979

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IMPRESSIONS — Chronic obstructive pulmonary disease, mild. Well controlled with the present medication program.

PLANS — No change in therapy

1979

VALPARAISO, INDIANA

X-RAY DEPARTMENT

JEFFORDS, ROBERT | AGE 52 | 8-10-82

02-31-19 | ER | DOCTOR KILMER
EMERGENCY ROOM

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[redacted], M.D.
lg

1982

JEFFORDS, ROBERT W | AGE 56 | 11-13-84

02-31-19 | PCC | DR. KILMER
DR. CRISE

VALPARAISO, INDIANA

X-RAY DEPARTMENT

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CHUNG JA KIM, M.D.
linda
11-13-84

1984

PORTER MEMORIAL HOSPITAL
VALPARAISO, INDIANA

1991

CONSULTATION REPORT

NAME: JEFFORDS, ROBERT ROOM #: 1W HOSPITAL # 1833964

ATTENDING M.D.: J. HULL, M.D. CONSULTING M.D.: MICHAEL WHEAT, M.D.

DATE 3-22-91

FINDINGS, DIAGNOSIS & RECOMMENDATIONS:

INDICATIONS FOR CONSULTATION
NEW ONSET ATRIAL FIBRILLATION

HPI Mr. Jeffords is a pleasant 62-year-old white male who has a long, greater than 20-year history of hypertension for which he has been taking hypressor. He has had no prior cardiac history. Yesterday while working in his yard cutting up a tree, he noted the acute onset of some mild diaphoresis and general body fatigue. The patient felt nauseated and some dyspneic and had what he called a sick headache. This lasted for approximately 4 hours. This feeling subsided and the patient had presented to the Convenience Center for earwax removal. At this point he was found in atrial fibrillation and was told to call his doctor in the morning. He currently feels fine. Denies any symptoms of chest heaviness, pressure, shortness of breath or dizziness. There is no history of exertional angina nor other chest discomfort. There is no history of syncope, near syncope, paroxysmal nocturnal dyspnea, orthopnea or pedal edema. The patient has never had a myocardial infarction.

The patient's cardiac risk factors include 1) positive history of tobacco abuse although he quit 28 years ago, 2) hypertension is positive for a 20-year history, 3) diabetes is negative. Family history is positive in a brother who had a myocardial infarction. Cholesterol status is unknown to me at this point in time.

PMH There is a history of chronic bronchitis. There is a history of severe ALLERGIC REACTIONS TO GENERAL ANESTHETICS WHICH SOUNDS like BRONCHOSPASM. The patient in 1981 had left hernia repair, in 1983 had cholecystectomy, had removal of polyps 3 years ago and had a procto Monday by Dr. Paul, the results are currently pending. In 1982 he had a renal caculi removed. The patient does have a history of gout.

MEDS Lopressor 50 mg bid and Allopurinol 1 per day.

PORTER MEMORIAL HOSPITAL
Valparaiso, Indiana

COPY

CONSULTATION

NAME: JEFFORDS, ROBERT W
ATTENDING: K. BLACK, MD
CONSULTING: V. DIBIASE, MD
DOB: 10/08/28
PT TYPE: I

ROOM NO: 2N-0264-1
MR#: 145601
ACCT#: 1430147
ADM DATE: 08/21/95
DATE: 08/27/95
DIS DATE: 00/00/00

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NEUROLOGICAL:

PORTER MEMORIAL HOSPITAL
Valpa iso, Indiana

C O P Y

HISTORY AND PHYSICAL

NAME:	JEFFORDS, ROBERT W	ROOM#:	2N-0261-1
ADM DATE:	08/21/95	MR#:	145601
ATTENDING:	K. BLACK, MD	ACCT#:	1430147
DOB:	10/08/28	PT TYPE:	I
DIS DATE:	00/00/00		

HISTORY OF PRESENT ILLNESS: This 66 year old white male is admitted to the hospital due to severe leg, hip, and back pain incapacitating to the extent that the gentleman had been crawling around the house for the last four days. He was not able to stand enough to function. He was scheduled on this day of admission for colonoscopy. He had _____ to prep and wanted to complete the colonoscopy. Xrays of the lower back showed some degeneration of L5-S1. Straight leg raising test was positive at 20 degrees bilaterally. Reflexes were equal. The patient has worked construction and has had the pain off and on for 35 years but he has toughed it out in the past. This time he did not feel this was possible. The patient has a history of apparent arrhythmia and has been on Cordarone as well as Naprosyn for arthritis as well as Allopurinol for gout and _____.

ALLERGIES: None

SOCIAL HISTORY: He used to be a smoker but has stopped. Alcohol use [illegible].

FAMILY HISTORY: Positive for leukemia and coronary artery disease.

PAST MEDICAL HISTORY: Cholecystectomy, hernia, and arthritis as well as the coronary problems. He has also had some problems with chronic obstructive pulmonary disease. He is retired. Patient has a history of prostatism and had had a transurethral resection of the prostate. He still gets up three times per night and during the day he goes approximately every hour. He has had a transurethral resection of the prostate again recommended by has abstained from same.

PHYSICAL EXAMINATION:

GENERAL ASSESSMENT: Examination presents an ill-appearing male.

VITAL SIGNS: Blood pressure 130/74, pulse 80, respiration 16.

HEENT: Benign. Dentures.

NECK: No masses or thyromegaly.

CARDIAC: I could appreciate no murmurs or gallops.

[illegible]: Soft. Old surgical scar present.

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PORTER MEMORIAL HOSPITAL
Valpa[illegible]so, Indiana

C O P Y

CONSULTATION

NAME: JEFFORDS, ROBERT W
ATTENDING: K. BLACK, MD
CONSULTING: V. DIBIASE, MD
DOB: 10/08/28
PT TYPE: I

ROOM NO: 2N-0264-1
MR#: 145601
ACCT#: 1430147
ADM DATE: 08/21/95
DATE: 08/27/95
DIS DATE: 00/00/00

NEUROLOGY

FINDINGS, DIAGNOSIS & RECOMMENDATIONS:

Thank you for asking me to see Robert.

This is a 66 year old white gentleman with a history significant for hypertension, paroxysmal nocturnal dyspnea, and atrial fibrillation controlled on Amiodarone, chronic obstructive pulmonary disease, benign prostatic hypertrophy, mild diverticulosis, who is admitted with back pain and left leg pain and weakness. He was found to have significant L2-3 spinal stenosis by MRI and lumbar myelogram. He was evaluated by Dr. Zelaya and on 8/23/95 had bilateral foraminotomies at L2-3 but mainly on the left. It appears that postoperatively he developed some disorientation and confusion which escalated over several days and he was not sleeping at all. He is quite sleep deprived. He has received a total of 8 mg of Haldol since 8/25 and a total of 2 mg of Xanax since 8/26. He had received only a few doses of Vicodin on 8/24.

This morning he was found to be extremely lethargic and sleepy and neurological consultation was requested.

His family gives no prior history of dementia or encephalopathy or other central nervous system symptomatology.

PRESENT MEDICATIONS: Naprosyn, Cardarone, Allopurinol, Altace, Azactam, Kefzol.

PERSONAL HISTORY: He is not a smoker. He is not a drinker.

PHYSICAL EXAMINATION:

VITAL SIGNS: He is currently afebrile although he had a temperature maximum of 100 on 8/26. Blood pressure 130/70. Respiration is 20 with a heart rate of 74.

NECK: He has no carotid or extra cranial bruits.

NEUROLOGICAL:

PORTER MEMORIAL HOSPITAL
Valparaiso, Indiana

1995

COP

CONSULTATION

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ATTENDING: K. BLACK, MD
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