

EXECUTIVE PLUS

CONTINUING CARE DOCUMENT

Cornelius Brown

Name: External ID:

DOB: Sex: Male

S.S.: License/ID:

Marital Status:

MEDICAL HISTORY

No fam h/o colon ca. No blood in the stool. No diarrhea. No abd pain or distension. 3 lbs weight loss in the last 3 months. No anorexia. No nausea or vomiting. No smoking, alcohol or substance abuse. No hospitalization or surgeries. No known allergies. H/O HTN. Only one medication. H/O HTN x 15 yrs with poor compliance. Denies heart disease, chest pain SOB or palpitations.

Weight Change: NO
Weakness: NO
Fatigue: NO
Anorexia: NO
Chills: NO
Night Sweats: NO
Insomnia: NO
Heat Or Cold: NO
Intolerance: NO

Change In Vision: NO Glaucoma Family History: NO

Eye Pain: NO
Eye Redness: NO
Double Vision: NO
Blind Spots: NO
Blind Spots: NO

Photophobia: NO
ENT Discharge: NO
Vertigo: NO
Frequent Colds: NO
Sinus Problems: NO
Hearing Loss: NO
ENT Pain: NO
Tinnitus: NO
Sore Throat: NO
Post Nasal Drip: YES

Nosebleed: NO Snoring: NO
Apnea: NO Breast Mass: NO
Breast Discharge: NO Breast Biopsy: NO

Cough: NO

Sputum: NO Shortness Of Breath: NO

Wheezing: NO
Asthma: NO
COPD: NO
Chest Pain: NO
Syncope: NO
DOE: NO
Peripheral: NO
Hemoptysis: NO
COPD: NO
Palpitation: NO
PND: NO
Orthopnea: NO
Edema: NO

Leg Pain/Cramping: NO
Arrythmia: NO
Dysphagia: NO
Bloating: NO
Flatulence: NO
History Murmur: NO
Heart Problem: NO
Heartburn: NO
Belching: NO
Nausea: NO

Vomiting: NO Hematemesis: NO

Gastro Pain: NO Food Intolerance: NO

Hepatitis: NO Jaundice: NO

Hematochezia: NO

Diarrhea: NO

Polyuria: NO

Dysuria: NO

Urine Frequency: NO

Incontinence: NO

Constipation: NO

Polydypsia: NO

Hematuria: NO

Urine Urgency: NO

Renal Stones: NO

UTIs: NO

VITAL SIGNS

Blood Pressure: 168/100 Weight: 183.00 lb (83.01 kg) Height: 66.00 in (167.64 cm) Temperature: 97.80 F (36.56 C)

Temp Method: Axillary Pulse: 68 per min Respiration: 20 per min BMI: 30 kg/m^2

BMI Status: Overweight Waist Circ: 36.00 in (91.44 cm)

Oxygen Saturation: 98 %

PHYSICAL EXAMNIATION

WNL GEN Appearance

WNL EYE Conjunctiva, pupils
WNL ENT TMs/EAMs/EE, ext nose

WNL Nasal mucosa pink, septum midline WNL Oral mucosa pink, throat clear

WNL Neck supple
WNL Thyroid normal
WNL CV RRR without MOR
WNL No thrills or heaves

WNL Carotid pulsations nl, pedal pulses nl

WNL No peripheral edema

WNL CHEST No skin dimpling or breast nodules

WNL RESP Chest CTAB

WNL Respirator effort unlabored WNL GI No masses, tenderness WNL No organomegaly

WNL No hernia

WNL Anus nl, no rectal tenderness/mass

WNL GU Nl ext genitalia,

WNL LYMPH No adenopathy (2 areas required)

WNL MUSC Strength

WNL ROM Normal

WNL Stability

WNL In	spection	Normal muscle mass
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WNL NEURO CN2-12 intact
WNL Reflexes normal
WNL Sensory exam normal

WNL PSYCH Orientated x 3 WNL Affect normal

WNL SKIN No rash or abnormal lesions

MEDICATIONS

Amlodipine 5 mg orally daily - partially compliant



BIOMEDICAL

CALEDONIA MEDICAL LABORATORY LTD.

8A Caledonia Ave., Kingston 5, Tel: 926-4191, 929-3717, 926-7479



Name: -

Birthdate: Sex: Male

24/07/1959

Age: 56 yrs

Lab Nº:02 / 0000058251

Patient ID:

Received: 25/01/2016

Branch: Tangerine Place

Client Nº: 798228

Reported: 27/01/2016

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DR. SEWELL, CLINTON 17 TANGERINE PL., KINGSTON 10

Agent:

TEST(S)

IN RANGE OUT OF RANGE REFERENCE VALUES

GLUCOSE FASTING

5.0

2.8-6.1 mmol/L

BUN

4.3

CREATININE

60

64-111 umol/L

ESTIMATED GFR

>60

DIVIDE RESULT BY 1.212 IF PATIENT IS NOT OF AFRICAN DESCENT Reference Range \$\geq 60mL/min/1.73m^2\$

ELECTROLYTES

SODIUM POTASSIUM CHLORIDE CO2	138 106 26	6.2	135-145 mmol/L 3.5-5.5 mmol/L 98-107 mmol/L 22-32 mmol/L	
SERUM PROTEINS				
TOTAL PROTEIN ALBUMIN GLOBULIN	67 43 24		65-80 g/L 35-55 g/L 20-35 g/L	
BILIRUBIN TOTAL	10		0-25 umol/L	
ALKALINE PHOSPHATASE	77		40-150 IU/L	
SGOT	21		5-34 IU/L	•
SGPT	25	Polhola	- 0-55 IU/L	



DR. SEWELL, CLINTON 17 TANGERINE PL., KINGSTON 10

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	Agent:		
TEST(S)	IN RANGE	OUT OF RANGE	REFERENCE VALUES
CHOLESTEROL TOTAL		5.6	3.9-5.2 mmol/L
TRIGLYCERIDE	1.73		0.56-2.00 mmol/L
CALCIUM TOTAL SERUM	2.26		2.11-2.62 mmol/L
CEA	3.5		0.0-5.0 ng/ml
PSA TOTAL		5.94	0.00-4.00 ng/ml
COMPLETE BLOOD COUNT			
HB PCV MCHC MCH MCV RBC WBC SEGMENTED NEUTROPHILS % EOSINOPHILS % BASOPHILS % LYMPHOCYTES %	33 29 87 6.00 9.7 58 1 2 34	17.2	13.5-17.0 g/dL 0.40-0.50 L/L 31-35 g/dL 27-32 pg 80-96 fL 4.50-6.50 x10 ¹² /L 3.3-9.7 x10^9/L 40-75 % 0-6 % 0-2 % 20-45 % 0-10 %
SEGMENTED NEUTROPHILS ABSOLUTE COSINOPHILS ABSOLUTE BASOPHILS ABSOLUTE LYMPHOCYTES ABSOLUTE MONOCYTES ABSOLUTE RBC MORPHOLOGY NO	5.6 0.1 0.2 3.3 0.5 RMAL	OR	1.6-6.1 x10^9/L 0.0-0.6 x10^9/L 0.0-0.2 x10^9/L 1.5-4.5 x10^9/L 0.0-1.0 x10^9/L
PLATELETS	231	78/1/holh	150-400 x10^9/L



DR. SEWELL, CLINTON 17 TANGERINE PL., KINGSTON 10

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Patient ID:

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Branch: Tangerine Place

Client Nº: 798228

Reported:

27/01/2016

TEST(S)

VDRL

COMMENT

Agent:

1.010

NONE

NONE

NONE

NONE

NONE

NONE

NONE

1

0

IN RANGE

OUT OF RANGE

NON REACTIVE

REFERENCE VALUES

NON REACTIVE

URINALYSIS

APPEARANCE COLOUR PH SPECIFIC GRAVITY PROTEINS BLOOD GLUCOSE KETONES BILIRUBIN UROBILINOGEN NITRITE WBC (HPF) RBC (HPF) EPITHELIAL CELLS (HPF) BACTERIA (HPF) CRYSTALS CASTS (LPF) YEAST CELLS TRICHOMONAS AMORPHOUS DEPOSITS MUCOUS THREADS

PALE YELLOW

8.0

CLOUDY

4.8-7.5

1.000-1.030

NONE

CLEAR

NONE NONE

NONE NONE

NONE NONE

0-5 HPF 0-2 HPF

OCCASIONAL OCCASIONAL

NONE

NONE

NONE NONE

NONE

NONE

NONE

NONE

HELICOBACTER PYLORI ANTIBODY (IGG):

PENDING.

Authorized Signature:





CALEDONIA | 8A Caledonia Ave., Kir

Age: 56 yrs

AL LABORATORY LTD. 26-4191, 929-3717, 926-7479



Name:

Birthdate:

24/07/1959

Sex: Male

DR. SEWELL, CLINTON 17 TANGERINE PL., KINGSTON 10

TEST(S)

H. PYLORI AB IgG

Lab Nº.02 / 0000058251

Patient ID:

Received: 25/01/2016

Branch: Tangerine Place

Client Nº: 798228

Reported: 01/02/2016

IN RANGE

Agent:

OUT OF RANGE

REFERENCE VALUES

NEGATIVE

NEGATIVE.

Authorized Signature:

3/2/1/2/10

1111

MEDICAL X-RAY INSTITUTE LIMITED 18 Tangerine Place Kingston 10

Tel: 926-0476

XRAY REPORT

Name:

DOB: 24.07.1959 AGE: 56 yrs Film No.471 -16

Date Taken: 22 Jan.'16

Date Reported: 22 Jan.'16

Type of Examination: CHEST

Doctor: Clinton J. Sewell

Clinical details: Chronic Bronchitis

REPORT:

No previous chest radiograph available for review/comparison.

PA film performed. The patient is minimally rotated.

The lungs and pleural recesses appear generally clear.

No masses or dense areas of consolidation seen.

There is slight prominence of the right ileum, but this could be due to the degree of rotation.

Previous films would be helpful for review.

The heart is within normal limits for size.

The bony thorax is unremarkable.

N SUTHERLAND

B.\$c. (Hons) M.B., B.S, D.M. (Rad) CONSULTANT RADIOLOGIST

NS/tm

CARDIOLOGY DIAGNOSTICS ASSOCIATES



15 Tangerine Place, Kingston 10. (876)631-8331

Clinton J Sewell, MD - Consultant Physician - Cardiology

ELECTROCARDIOGRAM REPORT

PATIENT'S NAME:

AGE: 56 yrs **Date:** 22/1/2016

REFERRING DIAGNOSIS: HTN, screening. **REFERRING DOCTOR:** Dr. C.J. Sewell.

Findings: Normal sinus rhythm, normal electrical axis, frequent unifocal PVCs.

Impression: Intrinsic or ischaemic heart disease.

Recommend: Treadmill stress test, echocardiogram.

Clinton J Sewell, MD

Consultant Physician – Diagnostic Cardiology

CARDIOLOGY DIAGNOSTICS ASSOCIATES



15 Tangerine Place, Kingston 10. (876)631-8331, Fax: (876)631-8320

Clinton J Sewell, MD - Consultant Physician - Cardiology

TREADMILL STRESS TEST REPORT

NAME: ADDRESS: AGE: 56 yrs

DATE: 22/1/2016

INDICATION: Abnormal ECG.

REFERRING PHYSICIAN: Dr. C. Sewell.

PROTOCOL: Bruce

Findings:

<u>Baseline</u>: The baseline ECG revealed normal sinus rhythm, normal electrical axis, frequent unifocal PVCs.

<u>Exercise</u>: The patient achieved the target heart rate. There were no cardiac related symptoms during exercise, but there were frequent unifocal PVCs and ST segment depressions in leads II, III, aVF, V5 and V6 commencing in Stage 2 and persisting throughout exercise.

<u>Recovery</u>: The patient was monitored for >10 minutes. There were no cardiac related symptoms for the duration of the monitored period, but frequent PVCs persisted. The ST segment depressions returned to baseline in the 7th minut of recovery.

The return of blood pressure and heart rate to baseline were delayed.

Impression: Abnormal treadmill stress test.

Recommend: 24 hour Holter monitor, echocardiogram, cardiology evaluation.

Clinton J Sewell, MD

Consultant Physician – Diagnostic Cardiology.

CARDIOLOGY DIAGNOSTICS ASSOCIATES



15 Tangerine Place, Kingston 10.

(876)631-8331, Fax: (876)631-8320

2-D & M-Mode ECHOCARDIOGRAM REPORT COLOR FLOW DOPPLER REPORT

Patient Name: Sonographer: CJS Height: Weight:

Indication: Abnl. ECG Date: 29/1/2016 BP:

Date of Birth: 24/7/1959 Gender: Male Referring Physician: Dr C. Sewell

DIMENSIONS	In cm	NORMALS	DIMENSIONS	In cm	NORMAL
Aortic Root (ED)	3.94	2.0-3.7 cm	Left Atrium (ES)	2.97	1.9-4.0 cm
Left Ventricle			Right Ventricle		
Diastole	4.90	3.7-5.6 cm	Diastole	2.84	0.7-2.3 cm
Systole	3.55	1.8-4.2 cm	RV wall thekness	0.56	< 0.6 cm
LVPW (D)	1.03	0.6-1.1 cm	IVS (D)	0.84	0.6-1.1 cm
LVPW (S)	1.74	0.8-2.0	IVS (S)	1.42	0.8-2.0
LVEF (est)	49%	>50%			

The aortic root is mildly dilated.

Aortic valve is normal. The valve is tricuspid. There is normal mobility. No vegetations are seen.

Mitral valve is normal in mobility and thickness.

There was no mitral annular calcification.

Tricuspid valve is well visualized and is normal.

Pulmonic valve is well visualized and is normal.

Left ventricular dimensions show normal chamber size. LV wall thickness is normal.

There is mildly reduced left ventricular systolic contractility. There is no wall motion abnormality or diastolic dysfunction.

Right ventricular dimensions show mildly increased chamber size. RV wall thickness is normal.

There is normal right ventricular contractility.

Left atrial size is normal.

Right atrial size is normal.

There is no pericardial effusion. IVC was normal with respiratory variation.

COLOR FLOW AND DOPPLER WAVEFORM ANALYSIS

Aortic systolic flow pattern was normal and there was mild regurgitation noted.

Mitral diastolic flow pattern was normal and there was mild regurgitation noted.

Tricuspid diastolic flow pattern was normal and there was mild regurgitation noted.

Pulmonic systolic flow pattern was normal and there was no regurgitation noted.

IMPRESSION: Dilated aortic root with mild aortic regurgitation, mild mitral regurgitation and mildly reduced left ventricular systolic function.

Clinton J Sewell, MD

Consultant Physician - Diagnostic Cardiology.

ABDOMINAL/PELVIC SONOGRAM REPORT

Patient's Name:

Age: 56 yrs.

Date of Service: 4/3/2015

Referring Physician:.

Referring Diagnosis: Health Assurance Package.

ABDOMINAL

The liver is normal sized with normal echotexture and a span of 9.24 cm.

The gallbladder is normal sized with normal wall thickness. There are no internal echoes.

The common bile duct measures 3.2 mm.

The pancreas was not well visualized due to overlying bowel gas shadowing.

The right kidney measures 10.2 cm x 3.62 cm x 5.24 cm, and is of normal contours and echotexture.

The left kidney measures 10.2 cm x 5.97 cm x 5.12 cm, and there is a 2.53 cm mid-pole, homogeneous, circular, benign-appearing lesion in the outer aspect.

The spleen has a span of 9.53 cm in the vertical axis.

Impression: Benign left renal lesion.

Recommend: Repeat abdominal sonogram in 6 months.

Clinton J Sewell, MD

Consultant Physician.

Island Endoscopy

15 Tangerine Place,Kingston 10.(876) 631-8331

Patient Name:

Age: 56 yrs

Referring Physician:

Referring Diagnosis: Screening.

Date: 28/1/2015

Colonoscopy Report

The patient was sedated with Dormicum 3.0 mg IV and received Pethidine 25 mg IV and Ketamine 25 mg IV in titrated amounts for analgesia. The patient was placed in the left lateral position and the Pentax EC-3830TL video colonoscope passed without difficulty to the caecum. The bowel preparation was fair.

Findings:

The visualized colonic mucosa was normal.

The scope was retroflexed in the rectum revealing normal anorectal mucosa.

The patient tolerated the procedure well. There was no bloating post procedure.

Impression: Normal colonoscopy.

Clinton J Sewell, MD

Consultant Physician - Gastrointestinal Endoscopy

- Diagnostic Cardiology

SUMMARY

A middle-aged, mildly overweight male with uncontrolled hypertension and poor medication compliance. Laboratory reports revealed hyperkalaemia, hyperlipidemia, and elevated PSA. ECG was abnormal. Treadmill stress test was abnormal. Echocardiogram revealed dilated aortic root with mild aortic regurgitation, mild mitral regurgitation and mildly reduced left ventricular systolic function.

MEDICAL PROBLEMS

- 1. Overweight middle aged male
- 2. Hypertension, uncontrolled
- 3. Electrolyte disturbance
- 4. Hyperlipidemia
- 5. Significant cardiac disease
- 6. Prostatitis/occult prostate cancer
- 7. Benign left renal lesion

HEALTH RISK ASSESSMENT (HLA Index)

Without treatment

Health (5 year):

<u>Cardiovascular</u>: Progression of cardiovascular disease and progressive decline in function of the target organs (heart, kidneys and brain), with decrease in exercise tolerance, exertional chest pain or discomfort, palpitations, leg swelling, decline in mental capacity, fainting or stroke, including sudden death.

<u>Cancer</u>: If occult prostate cancer, progression to late stage cancer with weight loss, bone pain, and other organ involvement.

Life (5 year):

Moderate risk of death.

With treatment

Health (5 year):

<u>Cardiovascular</u>: Halt in progression of cardiovascular disease.

Cancer: No illness

Life (5 year):

Minimal to zero risk of death.

Health & Life Assurance (HLA-5) IndexTM: 6

CONTINUING CARE RECOMMENDATIONS

- 1. Evaluation and treatment of elevated potassium
- 2. Education and counselling regarding lifestyle and dietary changes, exercise (only moderate initially) and compliance with medical regimen
- 3. Immediate medical management of ischaemic heart disease and hyperlipidemia
- 4. Intensification of antihypertensive treatment regimen
- 5. Cardiology consultation for coronary angiography and possible angioplasty
- 6. Urology consultation for possible biopsy of the prostate to exclude cancer
- 7. Repeat renal ultrasound examination in 6 months, as recommended.

Re-Assessment

A comprehensive medical re-evaluation and HLA risk assessment (**MedeSure Executive Health Package**) is recommended in 2-3 years.