

NEBRASKA DEPARTMENT OF EDUCATION

Disability Determinations Section

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Determination For Social Security and Supplemental Security Income Disability

August 2, 2003

John Smith, M.D.
123 Any Street
Anytown, NE 55555

SSN: 555-55-5555
CLAIMANT: John Doe

Thank you for your telephone report which is included as evidence in the file of the above claimant.

Two copies are enclosed for your review.

PLEASE SIGN, REVIEW, AND RETURN A COPY OF THE REPORT

Thank you for your support.

Jane Jones

1240/Job #3756

Transcribed Telephone Report

DATE: August 2, 2009
Dictated: August 2, 2009
SSN: 555-55-5555
CLAIMANT: John Doe

EXAMINER: Mary Mary

John Smith, M.D.
123 Any Street
Anytown, NE 55555

MEDICAL REPORT

DATE OF EXAMINATION:

August 2, 2009

CHIEF COMPLAINT:

Stroke, resulting in memory problems.

HISTORY OF PRESENT ILLNESS:

This is a 30-year-old white male who presents today for disability examination. He reports that he has had a rather complicated past medical history which involved having a stroke in January 2009. He reports that since having his stroke, he has had a number of difficulties including memory problems, depression, and not being able to see well at night. In talking with him, it was very difficult to extract what problems he was having currently versus all the problems that he had in the past. In talking with him now, he finds it very hard to concentrate and has difficulty with his memory. This seems to have been present primarily since he had a stroke. He also indicates he cannot see well at night. In fact, he does not drive at night any longer. He also reports that occasionally he does get short of breath but he has a past history of asthma. He denies any cough associated with shortness of breath. He denies any chest pain or palpitations. He does have a fairly extensive past medical history which is contributed to him having a stroke.

PAST MEDICAL HISTORY:

He apparently had a DVT approximately 15 years ago in 1999. This PE occurred in June 1999. Shortly thereafter, he ended up with an abscess and pulmonary embolism which lead to partial lung resection in September 1988. He also had a single seizure in May 1988 and had a recurrent seizure in

CLAIMANT: John Doe

July 1999. He apparently then suffered some sort of condition with his right testicle which involved a "clotting problem." He was initially worked up and was negative but then subsequently he was diagnosed sometime later with protein C deficiency. He did have a stroke in January 2009 and was hospitalized at East, and this left him with some of the above symptoms described. In addition to these, he also has history of sleep apnea, asthma, hypertension, hyperlipidemia, and depression.

SURGICAL HISTORY:

He has had bilateral carpal tunnel surgery. He also has had surgery for cervical spinal stenosis.

MEDICATIONS:

1. Neurontin.
2. Prozac.
3. Coumadin.
4. Pravachol.
5. Lopid.

He does not recall the specific doses of his medications.

FAMILY HISTORY:

He apparently has an uncle and a cousin along with his mother who have a clotting disorder. This clotting disorder on the claimant has never have been identified.

SOCIAL HISTORY:

He had been working for Jones most recently; however, he had some difficulty working due to the memory problems and some difficulty driving following his recent stroke. He did fail his CDL and apparently had an accident with the stroke. Now, he indicates he has passed his CDL. He has now been working as a driver. He used to smoke but he has quit smoking at this time. He, as stated above, does have a history of alcohol abuse and has been through alcohol treatments.

REVIEW OF SYSTEMS:

GENERAL:

The claimant denied any fever, chills, night sweats, weight gain or weight loss.

HEENT:

He denied any headaches, blurred vision or double vision. He does report visual complaints at night which consists of difficulty seeing and somewhat blurred vision. He does report some hearing loss and has been followed by ENT. He denies any sore throat or congestion.

CARDIOVASCULAR:

He denies any chest pain or palpitations. He also denies any orthopnea or PND.

PULMONARY:

He has had some shortness of breath which he relates to his asthma. He has not had any cough.

ABDOMEN:

He denies any abdominal pain, nausea, vomiting, diarrhea, or constipation.

GENITOURINARY:

He denies any urinary symptoms.

NEUROLOGICAL:

He does report some difficulty with his hands in terms of sensation and some generalized weakness in the hands.

PHYSICAL EXAMINATION:

GENERAL:

This is a middle aged black male who is somewhat obese, who appears much older than his stated age. He has hazel eyes and brown hair. He appeared to be in no acute distress. He is alert and oriented to person, place, and time.

VITAL SIGNS:

His blood pressure was 116/60, pulse 60, respirations 16, height was 99 inches, and weight was 999 pounds.

HEENT:

HEAD:

Atraumatic and normocephalic.

EYES:

Pupils were equally round and reactive. Extraocular muscles were intact. There was no nystagmus.

EARS:

TMs were clear bilaterally.

THROAT:

Clear.

NECK:

Supple. I did not appreciate any lymphadenopathy. There is no thyromegaly. Carotid upstrokes were 2+. I did not appreciate any bruits.

CHEST/LUNGS:

Lungs revealed diminished breath sounds throughout, but there were no wheezes or rales heard.

HEART/CARDIOVASCULAR:

Regular rate and rhythm.

ABDOMEN:

Soft. Obese. It seemed to be nontender and nondistended with normal bowel sounds. It was difficult for asses for any masses though due to the obesity.

EXTREMITIES:

Revealed some trace edema. Homan sign was negative bilaterally.

Range of motion of the spine was noted as documented on the range of motion sheet.

NEUROLOGIC:

Cranial nerves were intact. His grip strength was equal bilaterally and seen to be quite normal. Strength in the upper and lower extremities was symmetric and grossly normal. Sensation in his extremities seemed normal. His gait appeared to be steady. Romberg was negative.

ASSESSMENT:

1. Complex history of cerebrovascular accident resulting from protein C deficiency.
2. History of deep venous thrombosis and pulmonary embolism.
3. History of seizure disorder.
4. History of sleep apnea.
5. Asthma.
6. History or alcohol abuse.

CLAIMANT: John Doe

DISCUSSION:

This gentleman, as stated, did present for his disability examination. At this time, he seems to have some mild memory problems related to his stroke but he has successfully passed CDL by his history. He seems to be driving without significant difficulties during the day, time, although there is his past history, that shortly after stroke had some problems, but currently that has improved. I do think this gentleman has capability to go through vocational rehab and be trained for other work if he does not feel he can drive. Certainly if he has passed his CDL and CDL physical, he does not appear to have any deficits that would prevent him from driving a truck as long as it is during the day time. I think he does have a very complicated past medical history and there is a need for close medical followup and lifelong anticoagulation therapy. He also needs aggressive management of his risk factors which at time I am uncertain if being done, as I do not have that information available to me. Certainly his blood pressure looks like it is under good control based on the reading we had today.

John Smith, M.D.

This transcription was made from a recording of the voice of John Smith, M.D., on August 2, 2009.

1240/Job #3756