Residual Functional Capacity Assessment

Medical Consultant Summary Dictation

CLAIMANT: MARY SMITH
SSN: 555-55-5555

This 22-year-old female alleges disability to 7/21/01 due to polymyalgia rheumatica, congestive heart failure, hypertension, arthritis, thyroid problems and sleep apnea.

Her ADL's completed 01/01/01 notes she lives alone, does her own personal care needs, prepares simple meals, does one load of laundry a day, drives short distances, can walk maybe one-half block, stand 5-10 minutes, climb no stairs, can sit one-half hour and then her back and hips hurt and she has to move around. Her symptoms are arthritic pain in the knees, feet, back, neck, shoulders, hands, shortness of breath, fatigue, high blood pressure, poor circulation. States that she "never feels good."

Medical evidence notes that claimant has had a left thyroid lobectomy for multinodular goiter. A thyroid uptake scan in October of '01 showed multinodular goiter on the right. She was seen in consultation but no surgery was recommended.

She underwent a cardiac catheterization in November of '01 which showed essentially negative findings. She did have a left ventricular ejection fraction of 70%.

She was hospitalized briefly in Midlands Hospital in December of '01 with hypertension and venous stasis which was felt secondary to her use of her Vioxx. Also found to have elevated blood sugar.

In March of '01 she was seen in the emergency room for dizziness. At that time EKG, chest x-ray, head CT and cardiac monitor were really noncontributory and she was diagnosed with vertigo and hypokalemia.

Follow-up at Nebraska Heart Institute on 01/01/01 noted that her weight was 999 lbs., her blood pressure 101/99. She had no murmur. She did have 1+ edema. The impression was that lower extremity edema is not likely cause from cardiac abnormalities.

She was hospitalized 01/01/01 to 01/01/01 at Any Hospital with near syncope. Chest x-ray was negative. Pulmonologist was consulted and felt that she had some element of sleep apnea and she was started on CPAP. An echo showed ejection fraction of 60%. The cardiologist felt that she had significant diastolic dysfunction which contributed to her edema. She was diagnosed with vasovagal syncope.

Follow-up on May 1 noted that she was not feeling better and gets shortness of breath with doing anything. Her weight was 999 lbs. She had regular S1 and S2 with no murmur or gallop and had only a trace to 1+ edema.

A sleep study in June of '01
diagnosed obstructive sleep apnea and periodic limb movements and CPAP was recommended.

She was hospitalized 01/01/01 to 01/01/01 at Anytown with an admitting diagnosis of probable acute MI, however, emergency cath showed no evidence of MI and her arteries were described as surprisingly normal. Her blood pressure was markedly elevated. Final diagnosis was noncardiac chest pain and severe hypertension.

Claimant underwent a CE by her primary care physician, Dr. Anydoc, on 01/01/01 with chief complaints severe fatigue, muscle and joint aches which have increased over the past year. It was noted that she had probable polymyalgia rheumatica and this had seemed to respond to low dose Prednisone. Also a history of hypertension, degenerative arthritis of the knees. States she can walk a half block then has to stop secondary to lack of energy. She complains of severe pain in the knees, right greater than left, as well as neck and low back pain, and has severe difficulty with bending, squatting, lifting, stooping or prolonged sitting. States that the range of motion of her neck, back, knees severely limited secondary to pain. On physical her height was 99 ½", weight was 999 lbs., blood pressure 101/99, neck had some tenderness over the anterolateral aspects. There were no murmurs. Lungs were clear. She had no edema. She did have increased muscle tone of the paralumbar musculature and had crepitace of both knees right greater than left. Her lumbar spine allowed forward flexion to 50 degrees, extension 20 degrees. Lateral flexion on the left 15 degrees. Knee flexion was 80 degrees on the right and 90 degrees on the left. Cervical flexion was 30 degrees, extension 20 degrees. Her gait was slow and wide based. She had no joint swelling. X-ray of the right knee showed tricompartmental degenerative changes especially in the medial compartment and the cervical spine showed some decreased joint space at C4-5.

Claimant has medically determinable impairments of 1. Degenerative arthritis of the right knee, 2. Obesity, 3. Hypertension, 4. History of congestive heart failure, 5. Diabetes, 6. Sleep apnea. The impairments appear severe but do not meet or equal a listing. The impairments can reasonably produce significant limitations in claimant's ability to stand or walk for prolonged periods or to do repetitive manipulations requiring flexion and extension of the right knee secondary to arthritis. She also would have limitations of kneeling, crouching and crawling. I do not find documented evidence supporting the diagnosis of polymyalgia rheumatica. I do not find significant limitations related to her diabetes or her thyroid multinodular goiter. She does have marked obesity. She does have significant hypertension and does have documented sleep apnea. Therefore her allegations appear partially credible, and she does appear limited as per RFC with EOD equaling AOD.

I affirm that the above transcription was made from the recorded voice of Dr. Doolittle.

NEBRASKA DEPARTMENT OF EDUCATION

Disability Determinations Section

Mailing Address: P.O Box 82530 - Lincoln Nebraska 68501-2530 - Phone (402) 471-2961
Fax # 402-471-3626
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

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.

NEBRASKA DEPARTMENT OF EDUCATION

Disability Determinations Section

Mailing Address: P.O Box 82530 - Lincoln Nebraska 68501-2530 - Phone (402) 471-2961
Fax # 402-471-3626
Determination For Social Security and Supplemental Security Income Disability

August 2, 2003

Dr. Psychologist
123 Circle Dr.
Anywhere, NE 12345

SSN: 555-55-5555
CLAIMANT: Jane 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.

Edna Examiner

1240/Job #3727

Transcribed Telephone Report
Dictated: August 2, 2003

DATE: August 2, 2008
SSN: 555-55-5555
CLAIMANT: Jane Doe
DOB: 01/01/1901
EXAMINER: Edna Examiner

Dr. Psychologist
123 Circle Dr.
Anywhere, NE 12345

PSYCHOLOGICAL REPORT

DATE OF EXAMINATION:

August 2, 2008

GENERAL OBSERVATIONS:

Jane Doe is a 48-year-old, married but separated, Caucasian female resident of Anytown, Nebraska, who drove herself unaccompanied to this interview from her home approximately 10 miles away. She arrived about 15 minutes late, apparently due to her watch being slow. She is about 5 feet 9 inches tall and weighs approximately 145 pounds, also reporting a 12-pound weight loss over the past 2 weeks. Hygiene and grooming were adequate. She was dressed in blue jeans and a sleeveless top. She was wearing a blue Denim visor over blonde hair. She has blue eyes. Her skin was relatively tanned. She reported having breaking out a rash in the last few days or so but showed me one small oval patch of irritation on her right shin line. She stated that she was feeling well but did not really know why other than having a rash. There were no adaptive devices in place. She was oriented in all spheres. She demonstrated an adequate understanding of the nature and purpose of the interview. She was cooperative with the interview process and attempted to answer questions freely and openly. The information in this evaluation is based on the clinical interview on administration of the mental status exam. There were no medical records provided.

PERSONAL AND FAMILY HISTORY:

SOCIAL HISTORY:

The claimant lives with her 2 children that include a 8-year-old daughter (Ashton) and a 1-1/2-year-old son

The claimant reported of having separated from her husband on April 15, 2003, after approximately 3 years of marriage. She described her husband as verbally abusive of her, and then reported that he had pushed her down and choked at her and threatened to kill her the night that she kicked him out of the house. Her 2 children are the products of a previous relationship.

The claimant grew up in Anywhere, Nebraska, the middle of 8 siblings. She has a brother aged 50 and a younger sister aged 27. She described her biological father as extremely violent and has having engaged in a great of physical abuse of her mother and the family. Essentially, she has had a family life "sucked." She was sexually abused in the 9th grade by a family friend. When she disclosed this to her parents, her father "stood by" the friend even though the same person had been previously convicted of sexual abuse of his own niece. She stated that her mother believed her and went to the police with this man's wife. The perpetrator was convicted of the charge and served one year. She reported that her father refused to speak to her for an extended period of time after that. She described him as never having been there for her and stated that he attributed lot of his behavior to abuse by his own parents. The claimant reported that the only time she had her father tell her that he loved to tell her that he loved her was after her daughter was born. However the relationship went back to "normal" after that.

The claimant reports that she has a couple of female friends who she described as essentially being like "sisters" to her. Otherwise, she appears to have some limited social support, although she apparently gets along relatively well with her landlord. She stated that she has preferred jobs in the past that did not involve working around people for the most part.

EDUCATIONAL/OCCUPATIONAL HISTORY:

The claimant states that she is a high school graduate who completed 1 year at Anywhere Community College. She was forced to quit her education when she became pregnant and was required to get a full-time job.

Her jobs have included working as a waitress and at McDonald's in the high school. She exhibits that she had very much enjoyed working in the bar for about 6 months and might have retained that job "if the same people were still there." As noted above, she has reported that most of the jobs are in places "where I don't have to be around people." Her most recent job was as a worker at a grocery store(Co-op), which she stated she was forced to quit when " they basically told me to choose between my children and the job." At present, she is employed a few hours a week, taking care of animals on a freelance basis.

MEDICAL HISTORY:

The claimant received medical care through John Doe, ARNP, of Anywher Community Service. She reports no current medical diagnosis or a history of acute medical illness or injury. She has had a couple of pregnancies. The other medications that she is taking at present include over-the-counter vitamins and "PMS pills."

PSYCHIATRIC HISTORY:

The claimant has had no formal psychiatric diagnosis or treatment but states that she is treated through Anywhere Community Services by her primary care provider for a bipolar disorder for which she was apparently prescribed Zoloft a year ago. She has had no formal diagnostic workup by a psychologist or a psychiatrist and has not been on a mood stabilizer. She is currently receiving no psychiatric treatments and is on no psychotropic medications. She stopped taking the Zoloft when she became pregnant. She stated that she now cannot afford the prescription but would otherwise take it at the present time. Her only extensive counseling was in marital counseling with John Smith, RN, HP, about 1-1/2 years ago. She and her husband had few sessions with her husband that the claimant told was initially hopeful in the marriage but the marriage ultimately ended in the aforementioned separation.

SUBSTANCE ABUSE HISTORY:

Abuse of alcohol and use of illegal substances, as well as abuse of prescription of non-prescription medications were denied.

LEGAL HISTORY:

The claimant reports that she is considering a lawsuit stemming from what she described as a false allegation or charge by a Anywhere Police Officer, of animal cruelty made against her. The claimant reports that she was "wrongly accused" by the officer because "he does not like me. He never has," stating that she had a number of testimonials from others, including her landlord regarding the current wrongful charge. Ms. Doe reported that she was working with a local veterinarian who was supporting her efforts to get her animals back. She stated that she had kept strays and other dogs that were unable or were in line to go to Humane Society. She reported that her van had been broken and she had been forced to stay at her mothers but was going to a home where the animals were, every other day, and was also taking care of her garden, the beauty and care of what she felt it is an example of evidence that she was actually there to care of the animals.

HISTORY OF PRESENT ILLNESS:

Of note, the claimant has no formal psychiatric or psychological diagnosis made but is being treated by her primary care practitioner who apparently made the diagnosis of bipolar a couple of years ago and began treating her with Zoloft. She has never taken a mood stabilizer and as noted above is not on any psychotropic medications at present. There have been no hospitalizations. It does appear that the claimant attributes her mood disorder symptoms to the difficulties she has had in maintaining employment. She states that she has been let go or fired from several jobs where she has had difficulties recently due to irritation and moodiness. She reports that she gets easily upset in private situations, but has not made any public scenes or been involved in any rancorous fights. She does report that her moods have gone up and down with

moods ranging from 2 to 8 on a scale of 1 low and 10 high over the past month. Her mood wanders as low as a 2 in response to her friends letting her know what her husband was doing with his current girlfriend and her discovery that he was introducing the girlfriend to their children. She also reported that she had become very upset upon finding out that her husband's "girlfriend is psycho, and she tried to take my daughter. That is the reason I cannot sleep at night." Ms. Doe has reported sleep disturbance including being unable to sleep more than 2 or 3 hours at a time and at times when she is not able to sleep. She reported being up for about 4 days with no more than 2 hours sleep over total after her husband left in April 2005. She reports loss of appetite with a 12-pound weight loss. She has reported that her energy level is very high and stated that last week "I cleaned my area from top to bottom in about 4 hours and what should have taken me about 4 months." She has reported some paranoid ideations, feeling as though "somebody is always watching me," but without particular reason, although she then later added she thought that her husband might be trying to take the children and she was extra alert as a result of that concern. She does report the concern as being having difficulty working out conflicts with others and some disrupted relationships on the job to which people in the community (such as with Police Officer she dealt earlier).

BEHAVIORAL OBSERVATIONS:

The claimant presented as described in the introductory session. She was open and cooperative. Intellectual capacity appears to be approximately in the average to low average range. Speech is clear and coherent, is somewhat pressured, was spontaneous and elaborated. Conversation was conjunctional at times but relatively goal directed and she tracked adequately in answering questions. Auditory and visual hallucinations were denied. There were no overt impairment indicative of a though disorder. There were no bizarre or unusual pre-occupations. Paranoid ideations appeared to be limited to choose specific conflicts and fears of her husband's abducting or otherwise taking her children from her. She described her mood at present as

5/6 on a scale of 1 low and 10 high. She denied history of suicidal ideation both past and present. She denied homicidal ideation. Generally speaking, she has no indications of intentions to harm herself or others or any self-mutilation behavior. Symptoms of an eating disorder were denied. She appeared to be struggling with some wide mood fluctuation and some anxiety or easy irritation, but did not subjectively identify any symptoms of panic attacks or pervasive anxiety.

MENTAL STATUS EXAMINATION:

She was oriented in all spheres. She was correct for 3 out of 3 objects, both on immediate and delayed recall. She was unable to calculate serial 7s essentially stating that she could not do it because she "hated math!" She was able to spell the word 'World' correctly backwards. She answered questions and judgment in reasoning adequately. She was able to adequately describe simple proverbs but tended to describe more complex proverbs somewhat concretely. She reported that she does not have a check-in account because she and her husband got into debts based on his mishandling of their finances and having overdrawn on accounts. She indicated she has had no problems with excessive spending or writing bad checks.

CURRENT ADAPTIVE FUNCTIONING (BASED ON _____):

The claimant states that she spends her typical day getting up in the morning, getting her children ready, and then going to turn out her horses. She reports doing some house work and taking care of her children, but reported that lately she had been refusing to help out her mother (with whom she is staying) on the basis that her 14-year-old sister "takes no responsibility and just sits around." Generally speaking, there does not appear to be any restrictions in terms of activities of daily living. She is able to perform her own hygiene tasks adequately.

Relative to social functioning, the claimant appears to have a number of difficulties in dealing with conflicts in social situations and is likely to be easily drawn into intense conflicts, rigid stances, and have difficulties in

making compromises that would lead to a resolution. She has reported having a couple of friends that she is very close to, and appears to have simple relationships with her landlord and several other people, but appears to be easily drawn into conflicts with others overall. She describes conflicts with the local Police Officer, an inability to resolve conflicts on the job with her employees and co-workers leading to her quitting, and appears to take a strong rigid stand with others (such as her description of her 85-year-old sister).

Relative to stress tolerance, the claimant indicates a certain amount of adaptive flexibility relative to handling day-to-day situations. She does, however, appear to live a crisis-oriented lifestyle with a great deal of disruption centering around loss of jobs, conflicts with authorities, family conflicts, and the aforementioned charge of animal cruelty which appeared to have been something that she may have otherwise resolved effectively if she were in a more stable frame of mind, and were more attentive to social cues.

The claimant's capacity for simple span of attention appears to be adequate but I predict that she would become disrupted by conflict or being presented with sudden problems that she is otherwise unprepared for. In no situation, she is likely to lose concentration and respond hastily and inefficiently.

The claimant can carry out short and simple instructions under ordinary supervision based on her ability to follow the 3-step directives in this evaluation, but similar to paragraph above, I believe that she may be unraveled when she is angry, upset, feels threatened, or is otherwise in a conflict.

Her ability to relate appropriately to co-workers, and supervisors is limited as already mentioned. She has a number of conflicts with others including conflicts on the job as mentioned earlier. It appears that many of these conflicts could be resolved adequately if she had better adaptive flexibility in working things out with people.

The claimant appears to have some resources for dealing with disappointments and loss in her life and making changes (such as moving out to her mother's house), but she, as noted earlier, appears to be crisis-oriented type of person who introduces and lives with a great deal of day-to-day chaos and disruption. She appears capable of finding better place to live and taking care of her children basically, but is likely to have difficulty making the adaptations needed to make a more careful and involved commitment through everyday relationships.

FORMULATION/PROGNOSIS:

This claimant does appear to have symptoms of a mood disorder but I am not finding episodes of a tweak of manic episodes. Her reaction to her husband leaving in April 2007 does sound somewhat hypomanic but is likely a function of a intense stress undergoing a sudden separation and the resulting emotional disruption and chaos. The claimant does have some mood irritability or inflexibility with others that suggest aspects of mood instability. It is possible that a likely diagnostic consideration is a bipolar type II disorder. She does not appear to be acutely depressed. To some degree, her reactions are situational and some from the case in which she is involved, but her mood disorder symptoms also contribute to the chaos and the other problems already mentioned in the first place. She reports mood fluctuation with a permanent irritability as well as sleep disturbance and episodes of high energy. For these reasons, I am considering a bipolar type II disorder. The claimant is not receiving any current psychiatric treatments and has not undergone a formal diagnosis. It would be most appropriate for her to undergo a full psychological or psychiatric evaluation to verify the diagnosis and make treatment recommendations specific to her symptoms on presentation. She also could use medication management and it appears that it would be most appropriate for her to see a psychiatrist for medication management consultation.

DIAGNOSTIC FORMULATION:

Axis I	Bipolar disorder, type II, rule out mood disorder, not otherwise specified.
Axis II	Deferred.
Axis III	No diagnosis.
Axis IV	High conflict marital separation, legal problems, problems with primary support group.
Axis V	Adaptive functioning of Global Assessment of Functioning score – 50.

ABILITY TO MANAGE FUNDS:

This claimant appears capable of managing her own funds.

_____
Sally Psychologist, Psy.D.
Licensed Psychologist

This transcription was made from a recording of the voice of Dr.Psychologist, Psy.D., on August 2, 2003.

1240/Job #3727

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

NEBRASKA DEPARTMENT OF EDUCATION

Disability Determinations Section

Mailing Address: P.O Box 82530 – Lincoln Nebraska 68501-2530 – Phone (402) 471-2961
Fax # 402-471-3626

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

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.

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

NEBRASKA DEPARTMENT OF EDUCATION

Disability Determinations Section

Mailing Address: P.O Box 82530 – Lincoln Nebraska 68501-2530 – Phone (402) 471-2961
Fax # 402-471-3626

Determination For Social Security and Supplemental Security Income Disability

August 2, 2003

Dr. Psychologist
123 Circle Dr.
Anywhere, NE 12345

SSN: 555-55-5555
CLAIMANT: Jane 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.

Edna Examiner

1240/Job #3727

Transcribed Telephone Report DATE: August 2, 2008
Dictated: August 2, 2003 SSN: 555-55-5555
CLAIMANT: Jane Doe
DOB: 01/01/1901
EXAMINER: Edna Examiner

Dr. Psychologist
123 Circle Dr.
Anywhere, NE 12345

PSYCHOLOGICAL REPORT

DATE OF EXAMINATION:

August 2, 2008

GENERAL OBSERVATIONS:

Jane Doe is a 48-year-old, married but separated, Caucasian female resident of Anytown, Nebraska, who drove herself unaccompanied to this interview from her home approximately 10 miles away. She arrived about 15 minutes late, apparently due to her watch being slow. She is about 5 feet 9 inches tall and weighs approximately 145 pounds, also reporting a 12-pound weight loss over the past 2 weeks. Hygiene and grooming were adequate. She was dressed in blue jeans and a sleeveless top. She was wearing a blue Denim visor over blonde hair. She has blue eyes. Her skin was relatively tanned. She reported having breaking out a rash in the last few days or so but showed me one small oval patch of irritation on her right shin line. She stated that she was feeling well but did not really know why other than having a rash. There were no adaptive devices in place. She was oriented in all spheres. She demonstrated an adequate understanding of the nature and purpose of the interview. She was cooperative with the interview process and attempted to answer questions freely and openly. The information in this evaluation is based on the clinical interview on administration of the mental status exam. There were no medical records provided.

PERSONAL AND FAMILY HISTORY:

SOCIAL HISTORY:

The claimant lives with her 2 children that include a 8-year-old daughter (Ashton) and a 1-1/2-year-old son

The claimant reported of having separated from her husband on April 15, 2003, after approximately 3 years of marriage. She described her husband as verbally abusive of her, and then reported that he had pushed her down and choked at her and threatened to kill her the night that she kicked him out of the house. Her 2 children are the products of a previous relationship.

The claimant grew up in Anywhere, Nebraska, the middle of 8 siblings. She has a brother aged 50 and a younger sister aged 27. She described her biological father as extremely violent and has having engaged in a great of physical abuse of her mother and the family. Essentially, she has had a family life “sucked.” She was sexually abused in the 9th grade by a family friend. When she disclosed this to her parents, her father “stood by” the friend even though the same person had been previously convicted of sexual abuse of his own niece. She stated that her mother believed her and went to the police with this man’s wife. The perpetrator was convicted of the charge and served one year. She reported that her father refused to speak to her for an extended period of time after that. She described him as never having been there for her and stated that he attributed lot of his behavior to abuse by his own parents. The claimant reported that the only time she had her father tell her that he loved to tell her that he loved her was after her daughter was born. However the relationship went back to “normal” after that.

The claimant reports that she has a couple of female friends who she described as essentially being like “sisters” to her. Otherwise, she appears to have some limited social support, although she apparently gets along relatively well with her landlord. She stated that she has preferred jobs in the past that did not involve working around people for the most part.

EDUCATIONAL/OCCUPATIONAL HISTORY:

The claimant states that she is a high school graduate who completed 1 year at Anywhere Community College. She was forced to quit her education when she became pregnant and was required to get a full-time job.

Her jobs have included working as a waitress and at McDonald's in the high school. She exhibits that she had very much enjoyed working in the bar for about 6 months and might have retained that job "if the same people were still there." As noted above, she has reported that most of the jobs are in places "where I don't have to be around people." Her most recent job was as a worker at a grocery store(Co-op), which she stated she was forced to quit when " they basically told me to choose between my children and the job." At present, she is employed a few hours a week, taking care of animals on a freelance basis.

MEDICAL HISTORY:

The claimant received medical care through John Doe, ARNP, of Anywher Community Service. She reports no current medical diagnosis or a history of acute medical illness or injury. She has had a couple of pregnancies. The other medications that she is taking at present include over-the-counter vitamins and "PMS pills."

PSYCHIATRIC HISTORY:

The claimant has had no formal psychiatric diagnosis or treatment but states that she is treated through Anywhere Community Services by her primary care provider for a bipolar disorder for which she was apparently prescribed Zoloft a year ago. She has had no formal diagnostic workup by a psychologist or a psychiatrist and has not been on a mood stabilizer. She is currently receiving no psychiatric treatments and is on no psychotropic medications. She stopped taking the Zoloft when she became pregnant. She stated that she now cannot afford the prescription but would otherwise take it at the present time. Her only extensive counseling was in marital counseling with John Smith, RN, HP, about 1-1/2 years ago. She and her husband had few sessions with her husband that the claimant told was initially hopeful in the marriage but the marriage ultimately ended in the aforementioned separation.

SUBSTANCE ABUSE HISTORY:

Abuse of alcohol and use of illegal substances, as well as abuse of prescription of non-prescription medications were denied.

LEGAL HISTORY:

The claimant reports that she is considering a lawsuit stemming from what she described as a false allegation or charge by a Anywhere Police Officer, of animal cruelty made against her. The claimant reports that she was “wrongly accused” by the officer because “he does not like me. He never has,” stating that she had a number of testimonials from others, including her landlord regarding the current wrongful charge. Ms. Doe reported that she was working with a local veterinarian who was supporting her efforts to get her animals back. She stated that she had kept strays and other dogs that were unable or were in line to go to Humane Society. She reported that her van had been broken and she had been forced to stay at her mothers but was going to a home where the animals were, every other day, and was also taking care of her garden, the beauty and care of what she felt it is an example of evidence that she was actually there to care of the animals.

HISTORY OF PRESENT ILLNESS:

Of note, the claimant has no formal psychiatric or psychological diagnosis made but is being treated by her primary care practitioner who apparently made the diagnosis of bipolar a couple of years ago and began treating her with Zoloft. She has never taken a mood stabilizer and as noted above is not on any psychotropic medications at present. There have been no hospitalizations. It does appear that the claimant attributes her mood disorder symptoms to the difficulties she has had in maintaining employment. She states that she has been let go or fired from several jobs where she has had difficulties recently due to irritation and moodiness. She reports that she gets easily upset in private situations, but has not made any public scenes or been involved in any rancorous fights. She does report that her moods have gone up and down with

moods ranging from 2 to 8 on a scale of 1 low and 10 high over the past month. Her mood wanders as low as a 2 in response to her friends letting her know what her husband was doing with his current girlfriend and her discovery that he was introducing the girlfriend to their children. She also reported that she had become very upset upon finding out that her husband's "girlfriend is psycho, and she tried to take my daughter. That is the reason I cannot sleep at night." Ms. Doe has reported sleep disturbance including being unable to sleep more than 2 or 3 hours at a time and at times when she is not able to sleep. She reported being up for about 4 days with no more than 2 hours sleep over total after her husband left in April 2005. She reports loss of appetite with a 12-pound weight loss. She has reported that her energy level is very high and stated that last week "I cleaned my area from top to bottom in about 4 hours and what should have taken me about 4 months." She has reported some paranoid ideations, feeling as though "somebody is always watching me," but without particular reason, although she then later added she thought that her husband might be trying to take the children and she was extra alert as a result of that concern. She does report the concern as being having difficulty working out conflicts with others and some disrupted relationships on the job to which people in the community (such as with Police Officer she dealt earlier).

BEHAVIORAL OBSERVATIONS:

The claimant presented as described in the introductory session. She was open and cooperative. Intellectual capacity appears to be approximately in the average to low average range. Speech is clear and coherent, is somewhat pressured, was spontaneous and elaborated. Conversation was conjunctional at times but relatively goal directed and she tracked adequately in answering questions. Auditory and visual hallucinations were denied. There were no overt impairment indicative of a though disorder. There were no bizarre or unusual pre-occupations. Paranoid ideations appeared to be limited to choose specific conflicts and fears of her husband's abducting or otherwise taking her children from her. She described her mood at present as

5/6 on a scale of 1 low and 10 high. She denied history of suicidal ideation both past and present. She denied homicidal ideation. Generally speaking, she has no indications of intentions to harm herself or others or any self-mutilation behavior. Symptoms of an eating disorder were denied. She appeared to be struggling with some wide mood fluctuation and some anxiety or easy irritation, but did not subjectively identify any symptoms of panic attacks or pervasive anxiety.

MENTAL STATUS EXAMINATION:

She was oriented in all spheres. She was correct for 3 out of 3 objects, both on immediate and delayed recall. She was unable to calculate serial 7s essentially stating that she could not do it because she “hated math!” She was able to spell the word ‘World’ correctly backwards. She answered questions and judgment in reasoning adequately. She was able to adequately describe simple proverbs but tended to describe more complex proverbs somewhat concretely. She reported that she does not have a check-in account because she and her husband got into debts based on his mishandling of their finances and having overdrawn on accounts. She indicated she has had no problems with excessive spending or writing bad checks.

CURRENT ADAPTIVE FUNCTIONING (BASED ON _____):

The claimant states that she spends her typical day getting up in the morning, getting her children ready, and then going to turn out her horses. She reports doing some house work and taking care of her children, but reported that lately she had been refusing to help out her mother (with whom she is staying) on the basis that her 14-year-old sister “takes no responsibility and just sits around.” Generally speaking, there does not appear to be any restrictions in terms of activities of daily living. She is able to perform her own hygiene tasks adequately.

Relative to social functioning, the claimant appears to have a number of difficulties in dealing with conflicts in social situations and is likely to be easily drawn into intense conflicts, rigid stances, and have difficulties in

making compromises that would lead to a resolution. She has reported having a couple of friends that she is very close to, and appears to have simple relationships with her landlord and several other people, but appears to be easily drawn into conflicts with others overall. She describes conflicts with the local Police Officer, an inability to resolve conflicts on the job with her employees and co-workers leading to her quitting, and appears to take a strong rigid stand with others (such as her description of her 85-year-old sister).

Relative to stress tolerance, the claimant indicates a certain amount of adaptive flexibility relative to handling day-to-day situations. She does, however, appear to live a crisis-oriented lifestyle with a great deal of disruption centering around loss of jobs, conflicts with authorities, family conflicts, and the aforementioned charge of animal cruelty which appeared to have been something that she may have otherwise resolved effectively if she were in a more stable frame of mind, and were more attentive to social cues.

The claimant’s capacity for simple span of attention appears to be adequate but I predict that she would become disrupted by conflict or being presented with sudden problems that she is otherwise unprepared for. In no situation, she is likely to lose concentration and respond hastily and inefficiently.

The claimant can carry out short and simple instructions under ordinary supervision based on her ability to follow the 3-step directives in this evaluation, but similar to paragraph above, I believe that she may be unraveled when she is angry, upset, feels threatened, or is otherwise in a conflict.

Her ability to relate appropriately to co-workers, and supervisors is limited as already mentioned. She has a number of conflicts with others including conflicts on the job as mentioned earlier. It appears that many of these conflicts could be resolved adequately if she had better adaptive flexibility in working things out with people.

The claimant appears to have some resources for dealing with disappointments and loss in her life and making changes (such as moving out to her mother's house), but she, as noted earlier, appears to be crisis-oriented type of person who introduces and lives with a great deal of day-to-day chaos and disruption. She appears capable of finding better place to live and taking care of her children basically, but is likely to have difficulty making the adaptations needed to make a more careful and involved commitment through everyday relationships.

FORMULATION/PROGNOSIS:

This claimant does appear to have symptoms of a mood disorder but I am not finding episodes of a tweak of manic episodes. Her reaction to her husband leaving in April 2007 does sound somewhat hypomanic but is likely a function of a intense stress undergoing a sudden separation and the resulting emotional disruption and chaos. The claimant does have some mood irritability or inflexibility with others that suggest aspects of mood instability. It is possible that a likely diagnostic consideration is a bipolar type II disorder. She does not appear to be acutely depressed. To some degree, her reactions are situational and some from the case in which she is involved, but her mood disorder symptoms also contribute to the chaos and the other problems already mentioned in the first place. She reports mood fluctuation with a permanent irritability as well as sleep disturbance and episodes of high energy. For these reasons, I am considering a bipolar type II disorder. The claimant is not receiving any current psychiatric treatments and has not undergone a formal diagnosis. It would be most appropriate for her to undergo a full psychological or psychiatric evaluation to verify the diagnosis and make treatment recommendations specific to her symptoms on presentation. She also could use medication management and it appears that it would be most appropriate for her to see a psychiatrist for medication management consultation.

DIAGNOSTIC FORMULATION:

Axis I	Bipolar disorder, type II, rule out mood disorder, not otherwise specified.
Axis II	Deferred.
Axis III	No diagnosis.
Axis IV	High conflict marital separation, legal problems, problems with primary support group.
Axis V	Adaptive functioning of Global Assessment of Functioning score – 50.

ABILITY TO MANAGE FUNDS:

This claimant appears capable of managing her own funds.

_____

Sally Psychologist, Psy.D.
Licensed Psychologist

This transcription was made from a recording of the voice of Dr.Psychologist, Psy.D., on August 2, 2003.

1240/Job #3727

Residual Functional Capacity Assessment

Medical Consultant Summary Dictation

CLAIMANT: MARY SMITH
SSN: 555-55-5555

This 22-year-old female alleges disability to 7/21/01 due to polymyalgia rheumatica, congestive heart failure, hypertension, arthritis, thyroid problems and sleep apnea.

Her ADL's completed 01/01/01 notes she lives alone, does her own personal care needs, prepares simple meals, does one load of laundry a day, drives short distances, can walk maybe one-half block, stand 5-10 minutes, climb no stairs, can sit one-half hour and then her back and hips hurt and she has to move around. Her symptoms are arthritic pain in the knees, feet, back, neck, shoulders, hands, shortness of breath, fatigue, high blood pressure, poor circulation. States that she "never feels good."

Medical evidence notes that claimant has had a left thyroid lobectomy for multinodular goiter. A thyroid uptake scan in October of '01 showed multinodular goiter on the right. She was seen in consultation but no surgery was recommended.

She underwent a cardiac catheterization in November of '01 which showed essentially negative findings. She did have a left ventricular ejection fraction of 70%.

She was hospitalized briefly in Midlands Hospital in December of '01 with hypertension and venous stasis which was felt secondary to her use of her Vioxx. Also found to have elevated blood sugar.

In March of '01 she was seen in the emergency room for dizziness. At that time EKG, chest x-ray, head CT and cardiac monitor were really noncontributory and she was diagnosed with vertigo and hypokalemia.

Follow-up at Nebraska Heart Institute on 01/01/01 noted that her weight was 999 lbs., her blood pressure 101/99. She had no murmur. She did have 1+ edema. The impression was that lower extremity edema is not likely cause from cardiac abnormalities.

She was hospitalized 01/01/01 to 01/01/01 at Any Hospital with near syncope. Chest x-ray was negative. Pulmonologist was consulted and felt that she had some element of sleep apnea and she was started on CPAP. An echo showed ejection fraction of 60%. The cardiologist felt that she had significant diastolic dysfunction which contributed to her edema. She was diagnosed with vasovagal syncope.

Follow-up on May 1 noted that she was not feeling better and gets shortness of breath with doing anything. Her weight was 999 lbs. She had regular S1 and S2 with no murmur or gallop and had only a trace to 1+ edema.

A sleep study in June of '01
diagnosed obstructive sleep apnea and periodic limb movements and CPAP was recommended.

She was hospitalized 01/01/01 to 01/01/01 at Anytown with an admitting diagnosis of probable acute MI, however, emergency cath showed no evidence of MI and her arteries were described as surprisingly normal. Her blood pressure was markedly elevated. Final diagnosis was noncardiac chest pain and severe hypertension.

Claimant underwent a CE by her primary care physician, Dr. Anydoc, on 01/01/01 with chief complaints severe fatigue, muscle and joint aches which have increased over the past year. It was noted that she had probable polymyalgia rheumatica and this had seemed to respond to low dose Prednisone. Also a history of hypertension, degenerative arthritis of the knees. States she can walk a half block then has to stop secondary to lack of energy. She complains of severe pain in the knees, right greater than left, as well as neck and low back pain, and has severe difficulty with bending, squatting, lifting, stooping or prolonged sitting. States that the range of motion of her neck, back, knees severely limited secondary to pain. On physical her height was 99 ½", weight was 999 lbs., blood pressure 101/99, neck had some tenderness over the anterolateral aspects. There were no murmurs. Lungs were clear. She had no edema. She did have increased muscle tone of the paralumbar musculature and had crepitace of both knees right greater than left. Her lumbar spine allowed forward flexion to 50 degrees, extension 20 degrees. Lateral flexion on the left 15 degrees. Knee flexion was 80 degrees on the right and 90 degrees on the left. Cervical flexion was 30 degrees, extension 20 degrees. Her gait was slow and wide based. She had no joint swelling. X-ray of the right knee showed tricompartmental degenerative changes especially in the medial compartment and the cervical spine showed some decreased joint space at C4-5.

Claimant has medically determinable impairments of 1. Degenerative arthritis of the right knee, 2. Obesity, 3. Hypertension, 4. History of congestive heart failure, 5. Diabetes, 6. Sleep apnea. The impairments appear severe but do not meet or equal a listing. The impairments can reasonably produce significant limitations in claimant's ability to stand or walk for prolonged periods or to do repetitive manipulations requiring flexion and extension of the right knee secondary to arthritis. She also would have limitations of kneeling, crouching and crawling. I do not find documented evidence supporting the diagnosis of polymyalgia rheumatica. I do not find significant limitations related to her diabetes or her thyroid multinodular goiter. She does have marked obesity. She does have significant hypertension and does have documented sleep apnea. Therefore her allegations appear partially credible, and she does appear limited as per RFC with EOD equaling AOD.

I affirm that the above transcription was made from the recorded voice of Dr. Doolittle.