CHRONOLOGICAL MEDICAL SUMMARY

Patient Name

SSN	XXX-XX-XXXX
Date of Birth	MM/DD/YY
Date of Injury	MM/DD/YY
Method of Injury	MVA
Injured Body Parts	Head, neck, back and legs

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XYZ Patient Care Report Breanna, EMT	08/15/15	16-18	**MOI:** On 08/15/15, patient involved in a MVA and had head, neck, back and left leg pain. **Chief Complaint:** Acute onset, neck pain. **Past Medical History:** Asthma, hyperlipidemia, hypertension, hypothyroid, hysterectomy, kidney stones. **Allergies:** Augmentin. **Medications:** Theophylline, Cardura, Cardizem, Levothyroxine Sodium, Singulair, Premarin, Lortab. **Primary Impression:** Trauma - soft tissue. **Secondary Impression:** Pain - neck. **Narrative:** Patient complains of neck pain. Patient was a restrained driver of a sedan who was rear ended. She was travelling about 50 mph and she thinks the car that hit her was travelling about 70 mph. Patient has 9-12 inches of damage into the trunk compartment patient has not passenger compartment intrusion. No airbag deployment. Patient denies LOC, patient has a GCS of 15 and was ambulatory on scene patient is complains of neck pain, head pain, lower back pain, left arm pain, bilateral knee pain. Patient does not have any deformities and no visible swelling. The pain patient has feels throbbing in her head and neck. 7/10. Patient denies chest pain N/V/D dizziness weakness, syncope, shortness of breath. **Transports To:** XXX Medical Center.
XXX Medical Center Emergency Department Physician Notes Garrett Emery, MD	08/15/15	40-43	**MOI:** On 08/15/15, patient involved in a MVA and had head, neck, back and left leg pain. **History of Present Illness:** The patient presents following motor vehicle collision. The onset was just prior to arrival. The collision was rear impact. The patient was the driver. There were safety mechanisms including seat belt, no airbag. Location: Neck, back, bilateral knee and left shoulder. The degree of pain is moderate. The degree of bleeding is none. Associated symptoms: Back pain, denies chest pain, denies abdominal pain, denies nausea and denies loss of consciousness. Patient was ambulatory on scene. **Allergies:** Mysoline - hypersensitive even small doses,

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			Augmentin. **Medications:** Aspirin 81mg, Advair Diskus 500mcg-50mcg, Cardizem LA 300mg, Cardura 2mg, Cardura 4mg, Lortab 500, Nexium 40mg, Singulair 10mg, Soma 500mg, Sudafed 60mg, Vitamin C 1000mg. **Past Medical History:** Resolved: Asthma, back pain, GERD, hypertension. **Surgical History:** Sinus, lithotripsy, knee. **Social History:** Alcohol use: occasionally. Denies tobacco use and drug use. **Diagnosis:** **1.** MVA. **2.** Cervical strain. **3.** Lumbar strain. **Plan:** **1.** Condition: Stable. **2.** Disposition: Discharged to home. **3.** Prescriptions: Tylenol with Codeine #3 (300/30) 1 tab p.o. q.6 hours 20 tab p.r.n. pain. **4.** Follow-up in 1 to 3 days, call for follow-up appointment. **5.** Return to ED if symptoms worsen. **6.** Take all medications as prescribed.
Rad Center Radiology Report John Jensen, MD	08/15/15	19-20	**Reason for History:** MVA. **Exam:** CT cervical spine without contrast. **Impression:** Mild degenerative changes. No acute fractures.
Rad Center Radiology Report John Jensen, MD	08/15/15	27	**Reason for History:** MVA. **Exam:** CT brain without contrast. **Impression:** No acute intracranial process.
Follow-up Report Jeffrey, DO	08/21/15	32	**Subjective:** The patient returns for follow-up and reports that she is still very stiff and sore.

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			Assessment: Multiple post traumatic soft tissues injuries, as previously described. **Plan:** Drs. treated her with EMS/hot packs and OMT to the cervical, thoracic, lumbar, sacral and pelvic regions, with OMT to the occipital and rib cage regions. Dr. will see her Monday. Drs. will decide on Monday whether or not she can try to go back to work.
McKenna, Ruggeroli and Helmi Pain Specialists Consultation Report McKenna, MD	12/29/15	51-57	**History of Present Illness:** Reason for visit: New injury/problem. Patient involved in motor vehicle accident on 08/15/15, resulting in new low back pain, exacerbated cervical pain/upper back pain. She had pre-existing pain complaints in neck and upper back. She was receiving treatment by Dr. Ziegler and underwent IM injections. Patient has received chiropractic therapy and analgesics. She had motor vehicle accidents in 1983, 1984, 1985. Patient had 2-3/10 in cervical/upper back region. After the accident, 4-5/10. Lower back pain is 6/10. Patient states that her lower back issues are new. She did have transient lower back pain in 2013. MRI at that time with mild disc bulges and mild right L3-4 foraminal stenosis. Patient has taken Hydrocodone/Acetaminophen and Carisoprodol for several years. MRI's reviewed: Cervical: Multilevel cervical discopathy and spondylosis, most severe C5-6 with bilateral foraminal stenosis, no central canal stenosis. Lumbar: L3-4-L5-S1 disc protrusions, mild right foraminal stenosis L3-4, no significant change from 2013 motor vehicle accident. The pain is described as occasional, aching, burning, exhausting, gnawing, numb, sharp, stabbing, tender, tiring, unbearable and is worse in the morning, in the evening, at night time. On average, the pain is rated a 4 on a 0-10 scale (0 being no pain). At this time, the pain is rated a 4 on a 0-10 scale (0 being no pain). Pain is made better by exercise, heat, ice, message, medication, walking. Pain is made worse by weather, sitting for long periods of time, standing for long periods of time. **Current Medications:** Excedrin Back and Body Tabs (Acetaminophen-Aspirin Buffered), Cardura 4mg (Doxazosin Mesylate), Est Estrogens-Methyltest Tabs, Levothyroxine Sodium 112mcg, Albuterol Sulfate Nebulizer, Singulair 10mg, Theophylline ER 200mg, Soma 500mg, Norco 7.5-325mg.

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			New Problems Added: 1. Disc displacement, lumbar region without myelopathy. 2. Disc displacement, cervical mid region without myelopathy. 3. Sprain/strain lumbar. 4. Sprain/strain cervical. 5. Elevated BMI. 6. Hypertension. New problems assessed today: Patient with history of cervical pain and new, severe lower back status post trauma that has failed to resolve with time and conservation care. **Plan:** Z-joint intraartic injection, left. Bilateral L5-S1, ? Bilateral Zygapophysial joint injections. **New Medications:** Cardizem CD 300mg, Soma 500mg (Carisoprodol). **Medication List upon Discharge Today:** Cardizem CD 300mg (Diltiazem HCl Coated Beads), Excedrin Back and Body Tabs (Acetaminophen-Aspirin Buffered), Cardura 4mg (Doxazosin Mesylate), Est Estrogens-Methyltest Tabs, Levothyroxine Sodium 112mcg, Albuterol Sulfate Nebulizer, Singulair 10mg, Theophylline ER 200mg, Soma 500mg, Norco 7.5-325mg.
Surgical Medical Center Operative Report McKenna, MD	01/07/16	12-15	**Indication:** The patient understood that this was a diagnostic injection and that minimal sedation would be used and that it is important that cognitive function be maintained in order to properly assess the effect of the procedure. The transient weakness may result and that the operation of a motor vehicle or heavy equipment is contraindicated for twelve hours after the procedure. No steroid was used. **Pre and Postoperative Diagnosis:** Spondylosis without myelopathy or radiculopathy, lumbar. **Procedures:** 1. Intraarticular lumbar zygapophysial (facet) joint injection (diagnostic, staged procedure) - Bilateral L5-S1, bilateral L4-5. 2. Fluoroscopy.