

Office Visit-New

Brian Tilaro (MRN 08514700)

Visit and Patient Information			
<b>Patient Information</b>	<b>Patient Name</b>	<b>Sex</b>	<b>DOB</b>
	Tilaro, Brian	Male	11/5/1962

<b>Contact Information</b>	<b>Date &amp; Time</b>	<b>Provider</b>	<b>Department</b>	<b>Encounter #</b>	<b>Center</b>
	1/17/2007 1:00 PM	Richard K. Burt, MD, MD	Nmff Autoimmune Diseases	19289224	None

**Visit Summary**

**Reason for Visit** MULTIPLE SCLEROSIS

**Diagnoses** MS (Multiple Sclerosis) [340T] - Primary

**Allergies as of 01/17/2007** (Not on File)

<b>Vitals - Last Recorded</b>	<b>BP</b>	<b>Pulse</b>	<b>Temp</b>	<b>Resp</b>	<b>Ht</b>	<b>Wt</b>
	138/80	90	97.9 °F (36.6 °C)	18	5' 9" (1.753 m)	215 lb (97.52 kg)
	<b>SpO2</b>					
	98%					
	<u>Vitals History Recorded</u>					

**All Flowsheet Data (all recorded)**

AMBULATORY VITALS FLOWSHEET	
<b>Row Name</b>	<u>01/17/07</u> <u>1300</u>
<b>ENC VITALS</b>	
BP	138/80 mmHg -GR
Pulse	90 -GR
Resp	18 -GR
Temp	97.9 °F (36.6 °C) -GR
SpO2	98 % -GR
Wt - Scale	215 lb (97.52 kg) -GR
Height	5' 9" (1.753 m) -GR
<b>Initials</b>	<b>Name</b>
GR	Glides Ribero
	<b>User Key</b>
	(r) = User Recd, (t) = User Taken
	<b>Effective Dates</b>
	-

<b>BMI Data</b>	<b>Body Mass Index</b>	<b>Body Surface Area</b>
	31.75 (kg/m^2)	2.18 (m^2)

<b>Transcription</b>	<b>Type</b>	<b>Status</b>	<b>ID</b>	<b>Date &amp; Time</b>
	Progress Note	Authenticated	EMDAT14799204	1/17/2007 12:00 AM

**Authenticated by BURT, RICHARD K MD on 1/22/2007 at**  
**Document Text**

Patient: Tilaro, Brian ()  
DOB: 11/5/1962  
Date: 1/17/2007  
Attending: Richard Burt, MD

**HISTORY OF PRESENT ILLNESS:** Brian is a 44-year-old white male who is here from San Diego, California for consideration of a stem cell transplant for multiple sclerosis. He was diagnosed with multiple sclerosis in 2005 when he developed right eye optic neuritis and his MS was confirmed by an MRI. No lumbar puncture was done. He was

offered no treatment. After two months, his visual symptoms improved back to baseline. In January 2006, he was started on Betaseron and he has remained on Betaseron ever since that time. In February 2006, he began having extreme fatigue, insomnia, leg spasms, and in August 2006 the leg spasms were more acute with difficulty walking, dizzy, disoriented. He was treated with IV Solu-Medrol for five days and then two days of oral Solu-Medrol, with some improvement of his symptoms, which did not last long because he relapsed in November again with leg spasms, pain and weakness in his hands and arms and again had three days of IV Solu-Medrol, with improvement. Then, in December 2006, he had an MRI done, which showed a gadolinium enhancing lesion in the left frontal lobe. He reports that his current symptoms are numbness in his legs, face, and neck, spasms in his leg, urinary frequency but no incontinence, sexual dysfunction, no focal neurologic weakness, and currently no visual problems. He also has memory problems, especially with names and events, ringing or tinnitus in his left ear and buzzing in his right ear. He denies fever, chills, diplopia, blurred vision, jaundice, stiff neck, difficulty swallowing, pain in his mouth, shortness of breath, paroxysmal nocturnal dyspnea, orthopnea, dyspnea on exertion, palpitations, chest pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia, dysuria, dark urine, lymphadenopathy, pain or swollen or deformed joints, rashes, petechiae, skin ulceration or ecchymoses.

MEDICAL PROBLEMS: Multiple sclerosis.

ALLERGIES: None.

MEDICATIONS: Omeprazole 20 mg daily, Lioresal 10 mg 3 times a day, trazodone 50 mg once a day, ibuprofen 600 mg 3 times a day, temazepam 30 mg twice a week, B12 sublingual 4000 mcg once a day, multivitamins 1 a day, niacinamide 500 mg once a day, vitamin D 2000 IU once a day, B complex 2 tablets once a day, fish oil 2000 mg once a day, Betaseron every 2 days.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: He is married and has no children. His wife accompanied him to the visit. He is a claims adjuster for bodily injury and lives in San Diego. He is working full-time, does not smoke, does not drink alcohol. He has two sisters who are healthy, one older and one younger. Both parents are alive and healthy. The only MS in the family is a great-great-aunt who had MS.

PHYSICAL EXAMINATION: His temperature is 97.9, pulse 90, respirations 18, blood pressure 138/80. Weight 215 pounds, height 5 feet 9 inches. He wears glasses. His wife accompanied him. He is well-dressed, in good spirits. Skin has no rashes, ecchymoses, petechiae, ulcerations. Sclerae are white. Extraocular movements are intact. Sinuses are nontender. Neck is supple. Oropharynx has no lesions or exudates. The lungs are clear to auscultation and percussion. Heart: Regular rate and rhythm. The abdomen is soft. No hepatosplenomegaly, nontender, normal bowel sounds. The extremities have no joint swelling, pain, tenderness or deformity. There is no adenopathy. Muscle strength is 5/5 grossly throughout and reflexes in the lower extremities are grossly normal.

He had a formal neurologic exam by a neurologist at Rush today with an EDSS of 2.5. The MRI he brought with him from December 11, 2006 showed an enhancing lesion in the left frontal lobe. He left us a disc copy of the MRI.

IMPRESSION AND PLAN: This is a patient with multiple sclerosis with two acute attacks treated with IV Solu-Medrol in the last 12 months, despite Betaseron and at a time separate from those treatments, and an enhancing lesion on MRI obtained one month ago. He meets criteria for our MIST study. He was given consent and will be returning to San Diego in an attempt to obtain insurance approval for the procedure. Currently he came to this visit of his own will, since Kaiser Permanente refused to refer him for evaluation. He has also reported Kaiser Permanente difficulty with getting appointments to be

seen by neurologists or to receive medical care. He will continue, and we will try to help, him to obtain insurance approval for this procedure.

Electronically Signed by:  
Richard Burt, MD

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**Medications  
Orders**

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**Patient** None  
**Instructions**

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**Encounter Messages**

No Messages in this encounter

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**LOS Report** [Level of Service Report](#)

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**Encounter Status** Closed by Richard K. Burt, MD on 1/17/07 at 2:04 PM

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**Access Log** [User Access Log for Encounter](#)

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**Route History** [Routing History](#)

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**Document List** **Encounter Document List**

There is no document attached to this encounter.

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**Office Visit**

Brian Tilaro (MRN 08514700)

**Visit and Patient Information**

**Patient Information**  
**Patient Name** Tilaro, Brian  
**Sex** Male  
**DOB** 11/5/1962

**Contact Information**  
**Date & Time** 6/4/2007 11:00 AM  
**Provider** Richard K. Burt, MD, MD  
**Department** Nmff Autoimmune Diseases  
**Encounter #** 20442657  
**Center** None

**Visit Summary**

**Diagnoses** MS (Multiple Sclerosis) [340T] - Primary

**Allergies as of 06/04/2007** (Not on File)

**Vitals - Last Recorded**  
**BP** 146/80  
**Pulse** 86  
**Temp (Src)** 98.9 °F (37.2 °C) (Oral)  
**Resp** 20  
**Ht** 5' 9" (1.753 m)  
**Wt** 225 lb (102.06 kg)  
**SpO2** 97%

**All Flowsheet Data (all recorded)**

**AMBULATORY VITALS FLOWSHEET**

**Row Name** 06/04/07  
 1100  
**ENC VITALS**  
 BP 146/80 mmHg -CD  
 Pulse 86 -CD  
 Resp 20 -CD  
 Temp 98.9 °F (37.2 °C) -CD  
 Temp src Oral -CD  
 SpO2 97 % -CD  
 Wt - Scale 225 lb (102.06 kg) -CD  
 Height 5' 9" (1.753 m) -CD

**User Key** (r) = User Recd, (t) = User Taken  
**Effective Dates**

**Initials** CD  
**Name** Chintana Dawson Lpn

**BMI Data** **Body Mass Index**  
 33.23 (kg/m<sup>2</sup>)

**Body Surface Area**  
 2.23 (m<sup>2</sup>)

**Transcription**  
**Type** Progress Note  
**Status** Authenticated  
**ID** EMDAT16944885  
**Date & Time** 6/4/2007 12:00 AM

**Authenticated by BURT, RICHARD K MD on 6/6/2007 at**

**Document Text**

Patient: Tilaro, Brian ()  
 DOB: 11/5/1962  
 Date: 6/4/2007  
 Attending: Richard Burt, MD

**HISTORY OF PRESENT ILLNESS:** Mr. Tilaro is a 44-year-old white male from San Diego, California who was last evaluated at Northwestern Memorial Hospital on January 17, 2007 for relapsing MS despite interferons with enhancing lesions on MRI. He returns for another evaluation at this time. He reports that since January, 2007 he has improved slightly, which began about one month ago in that he was able to stop walking with a cane, although he still has spasticity

and after about four to five blocks he has trouble walking due to the spasticity and weakness. He reports that about three weeks ago his neurologist switched him from Betaseron, which did not appear to be working, to copaxone. His last IV corticosteroid treatment was in December, 2006 shortly before we had seen him at his first visit at NMH. He says that since his last evaluation here in January, 2007 he has had continued waxing and waning of symptoms, although not treated with IV corticosteroids. He continues to have buzzing in his right ear, ringing in his left ear, spasm and stiffness in his legs, which has improved, but does occur after about four to five blocks and if he stops using Baclofen it becomes incapacitating. He is having increasing numbness in his hands upon awakening in the morning and when trying to write. This is worse in his right hand and persists in his right thumb throughout the day. He says that his vision is getting worse. Since his optic neuritis in 2005 he has had to have several changes in eyeglasses for deteriorating visual acuity. He says, however, that the double vision is unchanged and that he has had nystagmus since childhood. He reports that he did develop some new symptoms in mid-April with problems with urinating for about three weeks. He would feel that he would have to urinate all of the time, but would only dribble; these symptoms have since slightly improved. He has had no urinary incontinence and no stool problems. He continues to have problems with balance where he will at times feel a little unsteady while walking, but is able to ambulate without assistance.

He denies fever, chills, jaundice, stiff neck, difficulty swallowing, pain in his mouth, shortness of breath, PND, orthopnea, dyspnea on exertion, palpitations, chest pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia, dysuria, dark urine, lymphadenopathy, pain or swollen or deformed joints, rashes, petechiae, skin ulcerations or ecchymosis.

Otherwise his medical conditions have not changed since his last evaluation in January, 2007 and he has had no hospitalizations since his last evaluation in January, 2007. He now returns for a workup for a stem cell transplant.

PHYSICAL EXAMINATION: Temperature is 98.9. Pulse 86. Respirations 20. Blood pressure 146/80. Weight 225 pounds. Height: 5 ft. 9 in. Oxygen saturation: 98% on room air. He is ambulating in no acute distress. He is able to ambulate without assistance. Skin has no rashes, lesions, exudates or ulcers. Oropharynx: clear without ulceration or exudates. Neck is supple. Sinuses are nontender. Lungs: clear to auscultation and percussion. Heart has regular rate and rhythm. Abdomen is soft with no hepatosplenomegaly. Extremities have no adenopathy, joint swelling, edema, tenderness or deformity. Strength is 5/5, except 5-, only slightly less with a barely appreciable decreased strength in his left thigh and left leg. His Romberg with eyes open and closed was fairly stable. He ambulated tandem gait heel to toe fairly well with only some loss of balance. He had trouble walking on heels with his balance, but had good strength and could walk fine on his toes. Cranial nerves II-XII were intact. Cognition was grossly normal.

An MRI was performed today, which showed two and possibly three enhancing lesions. The MRI was reviewed with the neuro-radiologist. A formal report is pending.

IMPRESSION/RECOMMENDATIONS: This is a patient with multiple sclerosis who returns for a final workup for stem cell transplant. We will compare his current evaluation with that performed in January, 2007 at Northwestern. He will return later today to be seen by the same neurologists at Rush who had evaluated him in January, 2007 to determine if he remains a candidate. His formal neurologic exam at Rush in January, 2007 was an EDSS of 2.5. In addition, his MRI today shows persistent enhancing lesions. I discussed with the patient that I would like to get all evaluations including the neurologist's evaluation and laboratory prior to discussing whether we would proceed with stem cell transplant and further discussed the risks of the procedure. He does have the consent and has read it and has no questions at this time.

Electronically Signed by:  
Richard Burt, MD

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**Medications  
Orders**

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**Patient** None  
**Instructions**

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**Encounter Messages**  
No Messages in this encounter

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**LOS Report** [Level of Service Report](#)

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**Encounter Status** Closed by Richard K. Burt, MD on 6/4/07 at 12:21 PM

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**Document List** [Encounter Document List](#)  
There is no document attached to this encounter.

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**Office Visit**

Brian Tilaro (MRN 08514700)

**Visit and Patient Information**

<b>Patient Information</b>	<b>Patient Name</b> Tilaro, Brian	<b>Sex</b> Male	<b>DOB</b> 11/5/1962
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<b>Contact Information</b>	<b>Date &amp; Time</b> 2/18/2008 4:00 PM	<b>Provider</b> Richard K. Burt, MD, MD	<b>Department</b> Nmff Autoimmune Diseases	<b>Encounter #</b> 21696573	<b>Center</b> None
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**Visit Summary**

**Reason for Visit** Follow Up Multiple Sclerosis

**Diagnoses** MS (Multiple Sclerosis) [340T] - Primary

**Allergies as of 02/18/2008** No Known Allergies  
Date Verified: 06/11/2007

**Visit Notes** Richard K. Burt, MD Fri Feb 22, 2008 4:21 PM  
Patient seen by neurologist.

9 hole Peg Test  
PASAT  
25 feet walk

Were completed. Results are in paper chart.

Per patient, he feels he is in remission.

Kim Yaung, RN

**Referring Provider** \*\*Return Visit

**Medications**

Outpatient Current Med (Prior to Today) 02/18/2008	Prescription	Disp	Refills	Start	End
	BACLOFEN 10 MG OR TABS Sig: 1 TABLET 3 TIMES DAILY	90	0/0	6/11/2007	
	PRILOSEC 40 MG OR CPDR Sig: 1 CAPSULE DAILY	56	0/0	6/11/2007	
	ATIVAN 2 MG OR TABS Sig: 1 TABLET DAILY	60	0/0	6/11/2007	
	WELLBUTRIN 75 MG OR TABS Sig: 1 TABLET DAILY	90	0/0	6/11/2007	

**Orders**

**Patient Instructions** None

**Encounter Messages**  
No Messages in this encounter

**LOS Report** Level of Service Report

**Encounter Status** Closed by Richard K. Burt, MD on 2/22/08 at 4:21 PM

**Office Visit**

**Brian Tilaro (MRN 08514700)**

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**Access Log** [User Access Log for Encounter](#)

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**Route History** [Routing History](#)

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**Document List** [Encounter Document List](#)

There is no document attached to this encounter.

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