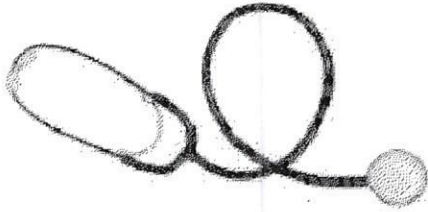




F A X S H E E T

Date: 02/10/2025 10:06:57 AM
To: LINDSEY BARTON
Subject: Progress Notes
Fax Number: 334-244-3396
To Company:
From Name: WILSON,TAYLOR
From Company: Dysautonomia MVP Center LLC
From Facility: Dysautonomia MVP Center LLC
Support Contact: 205-286-3200
Number of Pages(s): 5

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RAYBORN, MEREDITH

50 Y old Female, DOB: 06/27/1974

Account Number: 35922

6220 BELL GABLES, MONTGOMERY, AL-36117-4376

Home: 334-320-5855

Guarantor: RAYBORN, MEREDITH Insurance: BLUE

CROSS AND BLUE SHIELD Payer ID: 00580

Referring: LINDSEY BARTON

Appointment Facility: Dysautonomia MVP Center LLC

02/06/2025

Progress Notes: GINGER HITCHLER, CRNP

Current Medications

Taking

- Estradiol 0.025 MG/24HR Patch Twice Weekly 1 patch to skin Transdermal Two times a Week
 - Fluticasone Propionate 50 MCG/ACT Suspension 1 spray in each nostril Nasally Twice a day
 - Cetirizine HCl 10 MG Tablet 1 tablet Orally Once a day
- Medication List reviewed and reconciled with the patient

Past Medical History

MVP.
Migraines.
Seasonal Allergies.
Anemia.
COVID-19.

Surgical History

Ear Tubes 1976
Wisdom Teeth removal and tongue frenulum clipped 1993
Nephrostomy 1997
Colonoscopy and Endoscopy 2011
Radical Hystorectomy 2023

Family History

Father: deceased
Mother: deceased
Father- A-Fib and Neurocardiogenic syncope, Brain tumor
Mother- Cancer, non-hodgkins Lymphoma, uterine cancer, melanoma metastasized into brain tumor- died of brain bleed.

Social History

SOCIAL HISTORY:

Marital status: Divorced.
Children: None.
Smoking status: Non-smoker.
Alcohol consumption: rarely.
Caffeine intake: no coffee- 2 cups of tea.
Fluid intake: 120oz.
Exercise history: Does not exercise.
Allergy shots: No.
Asthma: No.
Occupation: Student Success Advisor.

Allergies

N.K.D.A.

Hospitalization/Major Diagnostic Procedure

See surgical history

Review of Systems

Reason for Appointment

1. Racy heart*

History of Present Illness

Anxiety Screening:

GAD-7

Feeling nervous, anxious, or on edge *Several days*

Not being able to stop or control worrying *Several days*

Worrying too much about different things *Several Days*

Trouble relaxing *Several days*

Being so restless that it is hard to sit still *Not at all*

Becoming easily annoyed or irritable *Several days*

Feeling afraid as if something awful might happen *Not at all*

How difficult have these issues made it for you to do your work, take care of things at home, or get along with other people?

Somewhat difficult

Depression Screening:

PHQ-9

Little interest and pleasure in doing things? *Several days*

Feel down, depressed, or hopeless? *Several Days*

Have trouble falling or staying asleep or sleeping too much?

More than 1/2 the days

Feel tired or have little to no energy? *More than 1/2 the*

days

Feel bad about yourself, feel like a failure or that you have let yourself or your family down? *Almost every day*

Have trouble concentrating, like when reading or watching

TV? *Not at all*

Move or speak so slowly people notice, or being fidgety or restless? *Not at all*

Have thoughts that you would be better off hurting yourself?

Not at all

Isolation Precautions:

Respiratory Illness Screening

1. Is fever present / reported? *No*

2. Are respiratory illness symptom(s) present / reported? *No*

7. Did travel or close contact (if applicable) occur within 14

days of symptom onset? *No*

*** Other ***:

50yo female presents today for evaluation of dizziness. She was referred by Lindsey Barton. Records that are available were reviewed prior to visit today. Patient carried PMH of POTS. She had TTT and was diagnosed in Florida in 2007. She has had recent cardiology and neurology work-up.

Recent testing:

Brain CT July 2024: normal

General/Constitutional:

Allergies **admits**. Insomnia **admits**.
Sleep apnea denies. Narcolepsy denies.
Cataplexy denies. Excessive
sleepiness denies. Personal History of
Cancer denies. Fatigue **admits**. Weight
loss denies.

ENT:

Vertigo **admits**. Hearing loss denies.
Ringing in the Ears denies. Dry
Mouth denies.

Endocrine:

Goiter denies. Hypothyroidism denies.
Hyperthyroidism denies. Diabetes denies.
Excessive sweating denies. Lack of
Sweating denies. Flushing of
Skin **admits**.

Ophthalmologic:

Blurred vision denies. Dry
eyes **admits**. Floaters in the visual
field **admits**. Sensitivity to Bright
Light denies.

Cardiovascular:

Syncope **admits**.
Lightheadedness **admits**.
Tachycardia denies. Palpitations **admits**.
Heart Attack denies.
Hypercholesterolemia denies. Chest
pain denies. High blood pressure denies.
Shortness of breath **admits**.

Gastrointestinal:

Abdominal Pain **admits**. Abdominal
Bloating **admits**. IBS denies.
Constipation denies. Diarrhea denies.
Heartburn/Reflux **admits**.
Nausea **admits**. Vomiting **admits**. Early
Satiety denies.

Musculoskeletal:

Arthralgias denies. Myalgias denies.
Fibromyalgia denies. Ehlers-Danlos
Syndrome denies. Arthritis denies.
Hypermobility Joints (No Dx of
EDS) denies.

Neurologic:

Migraines **admits**.
Headaches **admits**. Dizziness **admits**.
Tingling/Numbness **admits**. Burning Pain
in Hands and/or Feet denies. Difficulty
Concentrating denies. Lack of
Coordination/Unsteadiness denies.

Psychiatric:

Anxiety denies. Depressed
mood denies. Bipolar Disorder denies.

Respiratory:

Asthma **admits**. Cough denies.
Wheezing denies.

Skin:

Hives **admits**. Discoloration (When
Cold) **admits**. Discoloration of Legs (w/
Standing) **admits**.



Brain CT July 2024. Normal

Brain MRI: November 2024, was normal per patient

EEG: November 2024, normal per patient

TTE: had this in November 2024. She says it was
"unremarkable" and asked her f/u in 3-6 months.

She has PMH significant for MVP as a teenager, hormonal
migraines, IDA correct since hysterectomy 2023, GERD, POTS,
ANXIETY.

Today has complaints that include:

DIZZINESS: Not daily, a few times a week. Has not been
checking BP at home. Says her BP can range from 90/60 to
160/90. Can get higher with stress. The last 3 months she has
been at doctor many times and it has been normal.

SYNCOPE: 4 episodes in the last 6 months. She had one in
November that scared her bc she passed out while sitting in her
chair at work. She was out for about 1-2 minutes. She felt really
nauseous.

TACHYCARDIA: HR is usually around 50bpm at rest. Usually
ranges from 50-80bpm. She has seen 100bpm when stressed.

PALPITATIONS: occasional, worse with stress.

PARESTHESIA: pins and needles in hands if she holds her
phone or bf's hands

GI S/SX: GERD, PPI daily and Pepcid PRN, says she has
trouble swallowing. Says something is stuck. Has had EGD in
2017.

HEADACHES/MIGRAINES: occasional headaches, better
with OTC meds. Migraines less frequent since hysterectomy 2023.

ANXIETY/MOOD: says she has anxiety and is a 'worry wart'

SLEEP: doesn't sleep well, has trouble falling sleep and then
wakes in the middle of the night and has trouble going back to
sleep. She does snore.

FATIGUE: she is tired during the day, lies down most days
after work.

JOINT PAIN: occasionally in fingers

Drinks 3 caffeine drinks a day, breakfast, lunch and dinner.
Drinks about 80 ounces of water a day.

Has seen new PCP recently and did not have a good
experience and won't be going back.

Vital Signs

Standing HR: **74** /min, Standing BP: **133/84** mm Hg, Sitting HR: **77**
/min, Sitting BP: **139/83** mm Hg, Wt: **253.4** lbs, BMI: **36.36** Index,
Ht: 70 in.

Examination

General Examination:

GENERAL APPEARANCE: Generally well nourished, well
developed patient in no acute distress, appearing stated age.

HEAD: normocephalic, atraumatic, no scalp lesions.

EYES: normal, extraocular movement full and smooth, pupils
equal, round, reactive to light and accommodation, sclera
anicteric.

EARS: hearing intact to whispered voice, external appearance
of the ears and nose normal.

NECK/THYROID: neck supple without masses, trachea
midline, full range of motion, no thyromegaly.

SKIN: good turgor, normal texture, warm and dry, no lesions,
rashes.

HEART: Normal PMI, regular rate and rhythm. No murmur,

gallop or rub. Carotid arteries 2+ bilaterally without bruit. Peripheral pulses are full and equal bilaterally. No lower extremity edema.

LUNGS: normal respiratory effort, equal expansion, clear to auscultation in all fields. No wheezes, rales, or rhonchi.

BACK: Symmetrical. No kyphosis or scoliosis.

MUSCULOSKELETAL: Normal station and gait. Normal nails. No clubbing, cyanosis, clubbing or edema. Normal muscle tone and strength.

NEUROLOGIC: cranial nerves 2-12 grossly intact. Motor and sensory functions normal., cooperative with exam, no tremor.

PSYCH: alert, oriented, cognitive function intact, cooperative with exam. Normal affect, appropriate mood, no suicidal ideations.



Assessments

1. Syncope and collapse - R55 (Primary)
2. Tachycardia, unspecified - R00.0
3. Dizziness and giddiness - R42
4. Paresthesia of skin - R20.2
5. Palpitations - R00.2
6. Elevated blood-pressure reading, without diagnosis of hypertension - R03.0
7. Snoring - R06.83
8. Insufficient sleep syndrome - F51.12
9. Generalized anxiety disorder - F41.1
10. Morbid (severe) obesity due to excess calories - E66.01

Bc of dizziness and palpitations, I will check with GXT and TTT. Bc of paresthesia, I will check SSR.

I was a pleasure meeting Meredith today. After interviewing her, performing an exam and reviewing the test results, I feel like the patient does NOT have POTS/Dysautonomia. I do think that many of Meredith's symptoms are exacerbated by anxiety and lack of sleep. She will get with PCP regarding sleep study. I think it would help to decrease caffeine from 3-4 servings a day to 1 or less and add exercise regimen with clean diet. I will have her implement these things, f/u with cardiology and PCP. She can return to office PRN.

****TILT: NO SIGNIFICANT SYMPTOMS OCCURRED WITH TILT. THERE WAS A NORMAL HR AND BP RESPONSE TO TILT. NORMAL TILT****

****SUDOMOTOR SYMPATHETIC RESPONSE (SSR): NORMAL SKIN CONDUCTANCE C/W NORMAL PERIPHERAL AUTONOMIC FUNCTION****

**** GXT SHOWS A BELOW AVERAGE EXERCISE TIME. THE TEST WAS STOPPED DUE TO SOB, DIZZINESS, NAUSEA, CEST TIGHTNESS. THERE WAS AN EXCESSIVE HR RESPONSE AND A NORMAL BP RESPONSE TO EXERCISE. THERE WERE NO ARRHYTHMIAS OR SIGNIFICANT ST CHANGES WITH TESTING. POOR CONDITIONING. NORMAL HEMODYNAMICS. NONDIAGNOSTIC GXT. PDM****

****I HAVE REVIEWED THIS OFFICE VISIT AND INTERPRETED THE TESTING. I AGREE WITH THE ASSESSMENT AND PLAN. PAULA D. MOORE M.D.****

Treatment

1. Tachycardia, unspecified

PROCEDURE: GXT

2. Dizziness and giddiness

PROCEDURE: TILT TABLE EVALUATION

3. Paresthesia of skin

PROCEDURE: SUDOMOTOR TESTING

4. Palpitations

PROCEDURE: GXT

5. Others

Clinical Notes: DETAILED COUNSELING: Aerobic exercise appropriate for patient's BMI, level of conditioning and physical abilities was discussed and the patient voiced understanding of the exercise plan to their overall treatment plan. Caffeine restriction was discussed. A minimum of 64 oz of fluid per day, mostly as water or low-sugar electrolyte drink, was recommended to the patient.

Procedure Codes

95923 SUDOMOTOR-SYP SKIN RESPONSE, Modifiers: 59

93660 TILT TABLE EVALUATION

93015 CARDIOVASCULAR STRESS TEST

Follow Up

PRN

Paula Moore M.D.

Electronically signed by PAULA MOORE , M. D. on 02/10/2025
at 08:19 AM CST

Sign off status: Completed

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Progress Note: GINGER HITCHLER, CRNP 02/06/2025

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*2/11/25
Shanton
CRNP*