1 Patient Identification

Name:	Frederick J. Alderman
DOB / Age:	11/03/1953 / 71 years
Sex:	Male
MRN:	MRN-4829174
Date of Visit:	April 27, 2025
Referring Provider:	Dr. Carolyn Hayes, MD (Primary Care, Chapel Hill, NC)
Neurologist / Movement Disorder Specialist:	Dr. Rajesh V. Patel, MD, PhD — UNC Movement Disorders Center
Accompanied by:	Wife, Eleanor Alderman (primary caregiver, married 44 years)

S Subjective

2 CHIEF COMPLAINT

Primary concern (tremor, slowness, stiffness, gait, wearing-off):	Worsening motor fluctuations — increased 'off' periods lasting 3–4 hours in the afternoon, worsening gait freezing, and new mild cognitive complaints
Duration:	Parkinson's disease diagnosed 6 years ago. Current motor fluctuations worsening over past 4 months.

3 HISTORY OF PRESENT ILLNESS

ONSET & PROGRESSION

Onset (unilateral / bilateral):	Unilateral onset — right-sided resting tremor and bradykinesia at diagnosis in 2019. Now bilateral with right side predominating.
Duration and progression:	Gradual progression over 6 years. Initially right-sided rest tremor, evolved to include bilateral involvement, gait disturbance, and now motor fluctuations with wearing-off.
Symmetry of symptoms:	Asymmetric — right side significantly more affected. Right hand tremor more prominent, right arm reduced swing more severe.

MOTOR SYMPTOMS

Resting tremor:	Right hand pill-rolling tremor present at rest, 4–5 Hz, suppressed with voluntary movement. Left hand mild resting tremor emerged 2 years ago.
Bradykinesia:	Moderate bilateral bradykinesia. Slow hand movements, difficulty with fine motor tasks (buttoning, writing). Significantly worse during 'off' periods.
Rigidity:	Moderate cogwheel rigidity bilaterally, right greater than left. Lead-pipe rigidity of right arm during 'off' states.
Postural instability:	

	Present — Pull test positive, requires 2 steps to recover. History of 3 falls in past 6 months.
Micrographia:	Significant micrographia — handwriting has become illegible. Uses computer for correspondence. Cannot sign checks.
Masked facies:	Moderate hypomimia — decreased facial expression noted by wife and children. Difficulty expressing emotion.
Reduced arm swing:	Bilateral reduced arm swing, right more than left. Right arm hangs stationary during ambulation.
GAIT & BALANCE	
Shuffling gait:	Moderate shuffling gait pattern with reduced step length. Festination occasionally noted on long corridors.
Freezing of gait:	Freezing episodes at doorways and when turning — occurring 4–6 times daily. Duration 10–30 seconds. Improved with visual cues (floor lines).
Difficulty initiating walking:	Present — start hesitation requiring 2–3 seconds before first step. More pronounced during 'off' periods.
Falls (frequency, triggers):	3 falls in past 6 months. Triggers: turning, doorways during 'off' periods. No loss of consciousness with falls. One fall resulted in bruised right shoulder.
MOTOR FLUCTUATIONS	
On periods:	Approximately 5–6 hours of good 'on' time after morning carbidopa-levodopa dose. Diminished mobility and tremor well-controlled when 'on'.
Off periods:	Predictable 'off' periods emerging 3–3.5 hours after each dose. Afternoons most problematic (2–5 PM). Duration of 'off' 3–4 hours.
Dyskinesias:	Mild peak-dose dyskinesias — choreiform movements of neck and right arm occurring 60–90 minutes after morning dose. Not functionally disabling but distressing to patient.
Wearing-off:	Consistent wearing-off before next levodopa dose. Wife notes morning akinesia before first pill — patient rigid and slow until carbidopa-levodopa takes effect (onset 35–45 min).
RESPONSE TO MEDICATION	
Response to Levodopa:	Good levodopa response established — clear 'on/off' pattern confirms idiopathic PD. Approximately 60% motor improvement when 'on'.
Side effects:	Peak-dose dyskinesias (mild, neck and right arm). Nausea with morning dose — takes with crackers. Orthostatic hypotension — dizziness on standing.
NON-MOTOR — NEUROPSYCHIATRIC	
Depression / anxiety:	PHQ-9: 14 (moderate depression). GAD-7: 8. Reports anhedonia, reduced engagement with former hobbies (woodworking). On sertraline 100mg.
Hallucinations:	Visual hallucinations — reports seeing small figures or animals in peripheral vision, particularly in the evening. Non-threatening. Occurred 3 times in past month. New symptom.
Cognitive decline:	MoCA score 22/30 at today's visit (23/30 at last visit 6 months ago). Difficulties with visuospatial tasks and word fluency. Wife confirms forgetfulness, repetitive questioning.
NON-MOTOR — AUTONOMIC	
Orthostatic symptoms:	

	Symptomatic orthostatic hypotension — lightheadedness on standing, BP drops 22 mmHg systolic. Occurred daily. Has caused one pre-syncopal episode.
Constipation:	Chronic constipation — bowel movements every 3–4 days despite fiber supplementation and MiraLax. Pre-dates PD diagnosis by 8 years.
Urinary symptoms:	Urinary urgency and nocturia x3. No urinary tract infections. Seen by urology last year — neurogenic bladder on urodynamics.
Sexual dysfunction:	Decreased libido and erectile dysfunction, present for 3 years. Not currently on treatment. Discussed with wife present.

NON-MOTOR — SLEEP

Insomnia:	Difficulty maintaining sleep. Awakens 3–4 times nightly. Morning akinesia contributes to poor sleep quality.
REM sleep behavior disorder:	Confirmed on prior sleep study — RBD present. Wife reports patient acting out dreams, shouting and moving arms during sleep. Pre-dates PD diagnosis by 4 years.
Daytime sleepiness:	Epworth Sleepiness Scale: 13/24. Sleep attacks noted — patient has fallen asleep at dinner table twice.

NON-MOTOR — SENSORY

Anosmia:	Complete loss of smell for 9 years — pre-dated motor symptoms. Confirmed on UPSIT testing (score 12/40).
Pain:	Right shoulder pain — likely off-period dystonia. Morning clenching of right hand causing pain. Also osteoarthritis of lumbar spine contributing to back pain.

FUNCTIONAL STATUS

Basic ADLs:	Requires assistance with dressing (buttons, shoes) and grooming during 'off' periods. Independent when 'on'. Bathing with grab bars — independent.
Instrumental ADLs:	No longer drives — voluntarily surrendered license 2 years ago. Cannot manage finances independently (micrographia, cognitive changes). Wife manages household.
Work and independence impact:	Retired electrical engineer — stopped working at age 68 due to motor symptoms. Woodworking hobby no longer possible. Dependent on wife for most errands.

RED FLAG SYMPTOMS

Early falls / rapid progression:	3 falls in 6 months — concerning but preceded by identifiable triggers. Progression moderate and consistent with idiopathic PD timeline.
Poor levodopa response:	No — clear and substantial levodopa response confirms idiopathic PD diagnosis. Rules out MSA and PSP.
Early autonomic failure / vertical gaze palsy:	No vertical gaze palsy. Mild autonomic dysfunction (orthostatic hypotension, constipation) — present but not disproportionate. No early-onset autonomic failure.

PRIOR EVALUATION & TREATMENT

Previous diagnosis:	Parkinson's disease, idiopathic — diagnosed October 2019 by Dr. Patel at UNC. Confirmed with clinical criteria and DaTscan.
Imaging / tests:	DaTscan (2019): reduced dopamine transporter uptake bilateral putamen and caudate, asymmetric right > left. MRI brain (2022): mild cortical atrophy, no structural lesions, no hydrocephalus.

Prior medications / therapies:	Started carbidopa-levodopa 25/100 TID in 2019. Added ropinirole 2021 (discontinued — ankle edema). Added entacapone 2022. Physical therapy (2020, 2023). Occupational therapy (2022).

4 PAST MEDICAL HISTORY

1. Parkinson's disease, idiopathic — diagnosed 2019
2. Major depressive disorder — on sertraline 100mg
3. REM sleep behavior disorder — confirmed PSG 2018
4. Orthostatic hypotension — related to PD autonomic dysfunction
5. Neurogenic bladder — confirmed urodynamics 2024
6. Osteoarthritis, lumbar spine — on acetaminophen PRN
7. Hypertension — well-controlled on amlodipine
8. Hyperlipidemia — on rosuvastatin

5 PAST SURGICAL HISTORY

1. Right inguinal hernia repair — 2004, uncomplicated
2. Right knee arthroscopy — 2008
3. Cataract extraction, left eye — 2021

No neurosurgical procedures. Not yet a DBS candidate (undergoing evaluation).

6 MEDICATIONS

1. Carbidopa-Levodopa 25/100mg — 1 tablet every 3.5 hours (6 AM, 9:30 AM, 1 PM, 4:30 PM, 8 PM)
2. Entacapone 200mg — with each carbidopa-levodopa dose
3. Sertraline 100mg — once daily (depression)
4. Amlodipine 5mg — once daily (HTN)
5. Rosuvastatin 20mg — nightly
6. MiraLax 17g — daily (constipation)
7. Midodrine 5mg — TID (orthostatic hypotension)
8. Melatonin 3mg — nightly (RBD and sleep)

7 ALLERGIES

Sulfa drugs — Stevens-Johnson syndrome (severe — documented in EMR)
NSAIDs — GI bleed (2015)
No food allergies

8 SOCIAL HISTORY

Occupation:	Retired electrical engineer (retired 2022). Previously managed complex engineering projects. Now home-based.
Living situation:	Lives with wife in single-story home in Cary, NC. Home safety evaluation performed in 2023 — grab bars installed, throw rugs removed.
Exercise:	Supervised walking program 3x/week with wife, 20 minutes. Rock Steady Boxing (PD-specific program) 2x/week. Significant benefit noted.
Substance use:	Occasional red wine (1 glass, 1–2 times per week). Non-smoker. No illicit substances.
Caregiver support:	Wife Eleanor is primary caregiver — present and engaged at all visits. Attends PD caregiver support group. Adult daughter assists on weekends. No paid caregivers currently.

9 FAMILY HISTORY

Father: Essential tremor (not PD)
Mother: Alzheimer's dementia, onset age 78, deceased age 85
No siblings with PD
No known LRRK2 or SNCA mutations — genetic testing not performed
Family history of dementia on maternal side of concern given current cognitive symptoms

10 REVIEW OF SYSTEMS

Neurological:	Motor fluctuations (wearing-off, dyskinesias), gait freezing, falls, RBD, cognitive changes (MoCA 22), new visual hallucinations
Psychiatric:	Moderate depression (PHQ-9: 14), mild anxiety, anhedonia. On sertraline. New visual hallucinations require evaluation.
Autonomic:	Symptomatic orthostatic hypotension (drop 22 mmHg systolic), constipation, neurogenic bladder, erectile dysfunction
Sleep:	REM sleep behavior disorder (confirmed), insomnia, nocturia x3, daytime somnolence (ESS 13)

O Objective

11 VITAL SIGNS

BP:	Supine: 138/82 mmHg | Standing at 1 min: 116/74 mmHg (drop of 22 mmHg systolic — symptomatic)	**RR:**	14 breaths per minute	**SpO2:**	97% on room air
HR:	72 bpm, regular — heart rate does not appropriately increase with standing (autonomic dysfunction)	**Temp:**	97.8°F (36.6°C)		

12 GENERAL EXAMINATION

Facial expression:	Moderate hypomimia — reduced spontaneous facial movement, infrequent blinking (approximately 8 blinks/minute), fixed gaze appearance.
Posture:	Stooped posture — flexed neck, rounded shoulders, slight forward trunk lean. Camptocormia not present.
Spontaneous movements:	Reduced spontaneous movements overall. Pill-rolling tremor visible at rest in right hand. Patient self-aware of tremor and attempts to suppress.

13 NEUROLOGICAL EXAMINATION

MENTAL STATUS

Orientation / Memory / Attention:	Oriented to person, place, time, and situation. Serial 7s: errors at 3 subtractions. Immediate recall 3/3; delayed recall 1/3 at 5 minutes.
Cognitive screening:	MoCA: 22/30 (decline from 23/30 six months ago). Deficits in visuospatial (2/5 clock drawing), language fluency (8 F-words/minute), and delayed recall (1/3).

CRANIAL NERVES

Facial movement / speech (hypophonia):	Hypophonia present — voice volume low, requiring patient to repeat statements twice during interview. Monotone speech. Dysarthria mild.
Swallowing / eye movements:	Mild dysphagia — reports occasional coughing with thin liquids. Smooth pursuit eye movements intact. No saccadic intrusions. No vertical gaze abnormality.

MOTOR EXAMINATION

Strength:	5/5 in all major muscle groups bilaterally. Strength preserved — weakness not a prominent feature.
Tone (rigidity):	Cogwheel rigidity: right arm 3+/4, left arm 2+/4, bilateral lower extremities 2/4. Lead-pipe rigidity during 'off' assessment.
Tremor:	Right hand rest tremor 4–5 Hz, amplitude 2 cm — present. Left hand rest tremor 4–5 Hz, amplitude 0.5 cm — mild. No postural or kinetic tremor.
Bradykinesia exam:	Finger taps: right hand — irregular, decremental amplitude (score 3/4 UPDRS). Left hand — mild slowing (score 2/4). Heel taps bilateral — reduced amplitude and speed.

COORDINATION & GAIT

Gait pattern / turning:	Shuffling gait, reduced step length bilaterally. Turning: requires 4–5 small steps (en-bloc turning). Freezing demonstrated at clinic doorway — resolved with auditory cueing.
Postural stability / fall risk:	Pull test positive — 2 steps to recover, requires support. UPDRS postural instability score 2/4. Fall risk HIGH. Referred for PT gait analysis.

14 RATING SCALES

UPDRS score:	MDS-UPDRS Total: 68 (Part II — Motor Experiences: 22; Part III — Motor Examination: 46). Previous score 6 months ago: 58. Progression confirmed.
Hoehn and Yahr scale:	Stage 3 — bilateral involvement with postural instability, independent but with significant limitations

15 DIAGNOSTIC STUDIES

MRI brain:	MRI Brain (2022): Mild global cortical atrophy, white matter changes (Fazekas grade 1), no structural lesions, no hydrocephalus. No findings suggesting atypical parkinsonism.
DaTscan:	DaTscan (2019): Significantly reduced dopamine transporter binding bilateral putamen (right > left) and caudate nuclei, consistent with nigrostriatal degeneration. Pattern consistent with PD.
Labs:	CBC: WBC 6.2, Hgb 13.8, Plt 198; CMP: Na 138, K 4.0, Cr 1.0, eGFR 72; Thyroid: TSH 2.4 mIU/L; Vitamin B12: 312 pg/mL; RPR: nonreactive

Neuropsychological testing:	Formal neuropsychological testing (2024): mild cognitive impairment — executive function and visuospatial processing most affected. Memory relatively preserved. Pattern consistent with PD-MCI.

A Assessment

16 PRIMARY DIAGNOSIS

Diagnosis:	Parkinson's Disease, idiopathic — with motor fluctuations, wearing-off, mild peak-dose dyskinesias, mild cognitive impairment, and new visual hallucinations
ICD-10 Code:	G20 (Parkinson's disease); F06.70 (Mild neurocognitive disorder due to PD); F32.1 (Moderate depressive episode)

17 DISEASE SEVERITY / STAGE

Hoehn & Yahr stage:	Stage 3 — bilateral disease, postural instability, functionally independent with limitations
UPDRS score assessment:	MDS-UPDRS Motor Score (Part III): 46 — moderate motor impairment. Total UPDRS: 68 — 10-point increase from 6 months ago indicating disease progression.

18 DIFFERENTIAL DIAGNOSIS

Essential tremor:	Excluded — tremor is resting, not postural or kinetic; DaTscan abnormal; clear levodopa response
Drug-induced parkinsonism:	Excluded — no exposure to dopamine-blocking agents; DaTscan abnormal
Atypical parkinsonism:	MSA excluded (no cerebellar findings, no severe early autonomic failure disproportionate to PD stage); PSP excluded (no vertical gaze palsy, no early falls at onset, no axial rigidity predominance)

19 ASSOCIATED CONDITIONS

Mood disorders:	Moderate depression — PHQ-9: 14. On sertraline 100mg. Considering dose increase. New visual hallucinations may be related to dopaminergic therapy.
Cognitive impairment:	PD-MCI confirmed — MoCA 22/30, decline from 23 six months ago. Executive and visuospatial deficits. At risk for PD dementia. Rivastigmine to be considered.
Sleep disorders:	REM sleep behavior disorder (confirmed PSG), insomnia, and daytime somnolence (ESS 13). Melatonin 3mg continued. Sleep study repeat not planned unless symptoms worsen.
Autonomic dysfunction:	Symptomatic orthostatic hypotension (22 mmHg systolic drop), constipation, neurogenic bladder, erectile dysfunction — consistent with PD autonomic involvement.

20 RED FLAGS & PROGNOSIS

Red flag features (if present):	Visual hallucinations — new, require monitoring for dopaminergic psychosis. Monitor for dementia conversion. Dysphagia with thin liquids — aspiration risk.

Disease progression / functional outlook:	Disease progressing at expected rate for 6-year PD duration. Motor fluctuations will likely worsen. DBS evaluation appropriate given motor fluctuations, good levodopa response, and no major cognitive contraindication.

P Plan

21 MEDICAL MANAGEMENT

1. ADJUST levodopa schedule — decrease dosing interval from 3.5 to 3 hours to reduce 'off' time: C/L 25/100mg at 6 AM, 9 AM, 12 PM, 3 PM, 6 PM, 9 PM
2. ADD amantadine 100mg BID for peak-dose dyskinesia management
3. REDUCE dopaminergic stimulation in evening — advance last dose to 9 PM, avoid nighttime dosing that may worsen hallucinations
4. HOLD visual hallucination evaluation — may be levodopa-related. Reduce total dopaminergic burden if hallucinations worsen. Avoid antipsychotics (except quetiapine or pimavanserin if needed)
5. CONTINUE sertraline 100mg for depression. Consider increasing to 150mg at next visit.
6. CONTINUE midodrine 5mg TID for OH. Add increased fluid/salt intake and compression stockings.
7. REFER for rivastigmine discussion — PD-MCI with decline, candidate for cholinesterase inhibitor

22 REHABILITATION

Physical therapy:	Ongoing PT with LSVT BIG program — 4 sessions remaining. Emphasis on gait training, freezing strategies, and fall prevention. Nordic walking poles recommended.
Occupational therapy:	OT referral for adaptive equipment assessment — weighted utensils, button hooks, voice-activated devices for home management.
Speech therapy:	LSVT LOUD program referral for hypophonia — 16-session intensive program. Dysphagia evaluation recommended given reported coughing with thin liquids — modified barium swallow study ordered.

23 ADVANCED THERAPY

Deep Brain Stimulation evaluation:	DBS evaluation initiated — patient meets preliminary criteria: >4 years PD, clear levodopa response, motor fluctuations, no major dementia (MoCA 22). Referred to UNC DBS team for neuropsychological clearance, psychiatric clearance, and surgical consultation.

24 REFERRALS

Neurology / movement disorder specialist:	Continuing care with Dr. Patel at UNC Movement Disorders Center. Next visit in 3 months.
Psychiatry:	Geriatric psychiatry referral placed — for management of visual hallucinations, moderate depression, and PD-MCI. Urgent evaluation requested.
Rehabilitation services:	LSVT BIG (PT) and LSVT LOUD (SLP) in progress. Rock Steady Boxing to continue. Home PT evaluation for fall prevention.

25 MONITORING

ON / OFF fluctuations / dyskinesias:	Patient to complete ON/OFF diary — tracking 'on' and 'off' times, dyskinesia severity hourly for 3 days. Review at next visit.
Falls / cognition:	

	Fall diary requested — document each fall (time, activity, 'on'/'off' state). MoCA repeated at each visit. Family to alert clinic if rapid cognitive decline.
Medication side effects:	Monitor for worsening hallucinations — patient instructed to call clinic immediately if hallucinations become threatening or disturbing. Monitor for excessive daytime sleepiness (amantadine).

26 PATIENT & CAREGIVER EDUCATION

1. Motor fluctuations explained — relationship between levodopa timing and 'on/off' periods. New dosing schedule reviewed with written instructions.
2. DBS evaluation discussed — what to expect, timeline (3–6 months), risks and potential benefits explained.
3. Fall prevention reinforced — home safety, grab bars, avoiding high-risk activities during 'off' periods.
4. Visual hallucinations discussed — patient and wife instructed to call clinic if hallucinations become threatening or increase in frequency.
5. Dysphagia precautions — chin tuck with thin liquids, small bites, eat while 'on.'
6. Caregiver burden addressed — Eleanor referred to PD caregiver support group and respite care program.

27 FOLLOW-UP

Routine follow-up:	3 months — review levodopa adjustment, ON/OFF diary, DBS evaluation status, swallowing study results, and amantadine tolerance.
Early review if:	Worsening or threatening hallucinations, new fall with injury, inability to swallow medications, severe 'off' periods unresponsive to levodopa, rapid cognitive decline.

28 TIME / BILLING

Total time (minutes):	75 minutes
Counseling time:	35 minutes (DBS discussion, medication changes, caregiver education, fall prevention, hallucination counseling)
Complexity:	High complexity MDM — multiple chronic conditions with exacerbation, prescription drug management, new problem (hallucinations), DBS referral initiation

Provider name & credentials:	Dr. Rajesh V. Patel, MD, PhD — Movement Disorders Neurology
Signature:	R.V. Patel, MD, PhD
NPI:	1728394056
Date / Time:	April 27, 2025 — 11:00 AM
Facility:	UNC Movement Disorders Center, 170 Manning Drive, Chapel Hill, NC 27599
Visit type:	Office Visit — Established Patient (99215, High Complexity MDM)