MARVIX AI

# SAMPLE LIFESTYLE MEDICINE SOAP NOTE

PREDIABETES & HYPERTENSION — NIGHT-SHIFT WORKER

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## 1 PATIENT INFORMATION

### 1 PATIENT DETAILS

| | |
|---|---|
| NAME | Marcus D. Whitfield |
| DOB | 03/14/1968 |
| AGE / SEX | 58 yrs / Male |
| MRN / PATIENT ID | LM-40218 |
| DATE OF SERVICE | 08/14/2026 |
| PROVIDER | Dana R. Osei, MD |
| CREDENTIALS | MD, Dipl. ABLM |
| PRIMARY CARE PROVIDER | Ellen Vargas, MD |

VISIT TYPE

Lifestyle Medicine Consultation — initial, chronic disease lifestyle management

CARE SETTING

Outpatient Lifestyle Medicine Clinic (hospital-affiliated), in person

| | |
|---|---|
| REFERRAL SOURCE | INTERPRETER USED |
| Primary care — rising HbA1c and uncontrolled BP | None required |

## CC CHIEF COMPLAINT

### 2 PRIMARY LIFESTYLE MEDICINE CONCERN

> "My sugar is creeping up and my doctor says I'm headed for diabetes. I'm tired all the time and I've put on thirty pounds since I went to nights. I want to fix this without starting more pills."

## S SUBJECTIVE

### 3 PATIENT-REPORTED GOALS, HABITS & BEHAVIOR-CHANGE CONTEXT

#### 3a REASON FOR EVALUATION & HEALTH GOALS

**Reason for Lifestyle Medicine Evaluation**

Initial consultation for diabetes prevention and cardiometabolic risk reduction in a patient with prediabetes, stage 2 hypertension, obesity, hepatic steatosis, and untreated dyslipidemia. Referred after HbA1c rose from 5.9% to 6.4% over 18 months. Also requesting help with fatigue and shift-work sleep disruption.

### Patient Health Goals

Patient-stated, in priority order: (1) avoid starting a diabetes medication, (2) lose 25–30 lb, (3) “have energy left over” to take his two grandchildren to the park on weekends, (4) stop vaping. Willing to change breakfast and lunch first; describes dinner as “family territory” and less negotiable.

### Current Health Status and Chronic Conditions

Prediabetes (HbA1c 6.4%), essential hypertension on monotherapy, class I obesity (BMI 34.6), hepatic steatosis on ultrasound 2024 with ALT 62, hyperlipidemia (LDL 152, untreated — declined statin in 2024), chronic low back pain, high sleep apnea risk. No known cardiovascular disease. Metabolic syndrome criteria met on waist, BP, glucose, triglycerides, and HDL.

## 3b NUTRITION, ACTIVITY & SLEEP

### Nutrition Pattern

Rail-yard dispatcher on a rotating 6p–6a schedule, 4 nights on / 3 off. Eats from yard vending machines and a 24-hour drive-through most shifts: breakfast sandwich and 24 oz sweetened iced coffee at 2000, fried chicken or burger with fries around 0100, cereal on arriving home at 0700. Two to three 20 oz regular sodas plus 2–3 energy drinks per shift. Vegetables 2–3 servings per week; no legumes; fiber estimated under 12 g/day. Sodium high (canned soup, fast food, seasoning salt). Alcohol 4–6 beers on each off-night. On days off wife Renata cooks Southern-style meals with rice, cornbread, and stewed greens with smoked turkey.

### Eating Behaviors

Eats alone in the dispatch tower while watching monitors; describes eating “fast and without noticing.” Strong 0200–0400 cravings for salty and sweet foods, attributed to boredom and fatigue. No binge episodes or compensatory behaviors; no purging, no laxative use. Never plans meals in advance; grocery shops once monthly. Can cook simple foods and is willing to batch-prep on off-days if shown how.

### Physical Activity

No structured exercise for approximately 6 years. Occupational activity minimal — seated 9–10 h per shift with two short walks across the yard. Estimated 2,800 steps/day by phone. No resistance training. Sedentary time approximately 13 h/day including off-days. Reports right-sided low back pain at 4/10 after 15 minutes of walking, worse on concrete. Prefers walking and “something I can do with my grandkids”; dislikes gyms.

### Sleep

Sleeps 0730–1300 on work days (5–5.5 h, fragmented by household noise and daylight); shifts to 2300–0630 on off-days. Loud habitual snoring witnessed by wife with two observed breathing pauses; wakes unrefreshed with dry mouth and morning headaches 3–4 days per week. Epworth 12. Falls asleep watching TV daily and reports one near-miss drowsy-driving episode on the interstate 3 months ago. Energy drinks consumed as late as 0400. No blackout curtains; phone in bed.

## 3c STRESS, SUBSTANCES & SUPPORT

### Stress and Emotional Well-Being

Stress 7/10, driven by mandatory overtime, a supervisor conflict, and finances after his adult daughter and grandchildren moved in. Coping is passive — television, phone scrolling, food. PHQ-9 8 (mild; low energy, sleep, and appetite items driving the score) with no anhedonia and no suicidal ideation. GAD-7 6. No prior therapy; declines medication but open to a group class and to breathing exercises. Identifies his faith community as a strength.

### Substance Use

Cigarettes 1.5 ppd for 22 years, quit 2011 (15 pack-years). Currently vaping nicotine 12 mg/mL, approximately one pod every 2 days for 4 years; wants to stop and has never used NRT. Alcohol 4–6 beers per off-night, roughly 15–18 drinks/week; AUDIT-C 5 (positive). Denies cannabis, stimulants, opioids, sedatives. DAST 0. Readiness to change vaping 8/10; readiness to reduce alcohol 4/10 — describes it as his only relaxation.

### Social Connection and Support

Married 31 years; wife is supportive, manages household cooking, and has offered to walk with him. Daughter and two grandchildren (ages 4 and 7) living in the home; he is a part-time caregiver on off-days. Active in a church men’s group.

No loneliness reported. Night schedule limits social contact and overlaps poorly with family meals — a barrier he names himself.

### 3d WEIGHT, READINESS, MEDICATIONS & CONTEXT

#### Weight and Metabolic History

Current 238 lb; highest 241 lb (2025); lowest adult weight 178 lb (age 30). Gained approximately 32 lb since transferring to nights in 2019. Prior attempts: commercial shake program 2021 (lost 14 lb, regained within 5 months), intermittent fasting 2023 (abandoned — incompatible with shift schedule). No anti-obesity pharmacotherapy or bariatric surgery. Waist 44 in. Appetite high, cravings nocturnal. Names shift schedule and food environment as his main barriers.

#### Behavior Change Readiness

Readiness 8/10, confidence 5/10, importance 9/10. Prior successful change: smoking cessation in 2011, cold turkey and sustained, which he cites as evidence he "can do hard things." Patient-selected first steps: eliminate regular soda on shift, and pack food from home for two of four shifts per week. Anticipated barriers: overtime, vending-only access at 0200, fatigue. Requests written goals and a wife-inclusive plan.

#### Medication and Supplement History

Lisinopril 10 mg daily (adherent, 5 years). Ibuprofen 600 mg PRN back pain, 3–4 doses/week. Cetirizine 10 mg PRN. No supplements other than an occasional multivitamin. Declined atorvastatin in 2024 due to fear of muscle side effects after a coworker's experience. No glucose-lowering medication. No weight-promoting agents identified. Insurance covers generics; no access barriers.

#### Family History

Father: type 2 diabetes at 52, myocardial infarction at 61, deceased at 68. Mother: hypertension, obesity, living at 82. Brother: type 2 diabetes on insulin at 49, obstructive sleep apnea on CPAP. Maternal grandmother: stroke. No known familial hyperlipidemia. No family history of substance use disorder disclosed.

#### Social Determinants of Health

Stable housing (owns home), reliable vehicle. No food insecurity, but food access at work is vending and drive-through only between 1800 and 0600 — a structural barrier. Financial strain moderate since the household grew. Health literacy adequate; prefers printed materials. Neighborhood walkable in daylight; not comfortable walking after dark. No gym membership. Cultural food preferences important to the household and incorporated into the plan.

#### Pertinent Negatives

Denies chest pain, exertional dyspnea, palpitations, syncope, and claudication. No focal neurologic deficit. No suicidal ideation, no eating disorder red flags, no rapid unexplained weight loss. No exercise-related chest or presyncopal symptoms. Denies polyuria, polydipsia, and blurred vision.

## ROS LIFESTYLE MEDICINE REVIEW OF SYSTEMS

### 4 PERTINENT POSITIVES & NEGATIVES

| | |
|---|---|
| Fatigue, weight change, appetite, energy, exercise intolerance | **Positive: daily fatigue, +32 lb since 2019, high appetite, low energy. Negative for exercise intolerance beyond deconditioning.** |
| Cardiovascular | **Negative for chest pain, palpitations, dyspnea, edema, dizziness, syncope.** |
| Sleep | **Positive: loud snoring, 2 witnessed apneas, non-restorative sleep, daytime sleepiness (Epworth 12), morning headache, one drowsy-driving near-miss.** |
| Gastrointestinal | **Positive: intermittent reflux 2–3 nights/week after late** |

| | |
|---|---|
| | meals. Negative for constipation, diarrhea, dysphagia. |
| Musculoskeletal | Positive: chronic right lumbar pain 4/10 with prolonged standing or walking. Negative for joint swelling or radicular symptoms. |
| Psychiatric | Positive: stress 7/10, boredom eating, sleep disturbance. PHQ-9 8, GAD-7 6. Negative for suicidal ideation. |
| Substance use | Positive: nicotine vaping, AUDIT-C 5. Negative for cannabis, stimulants, opioids, sedatives. |
| Medication / treatment barriers | Positive: statin refusal, frequent NSAID use with hypertension. Negative for adherence problems with lisinopril. |

## O OBJECTIVE

### 5 OBSERVED FINDINGS

### V VITALS

**TEMPERATURE**
98.2 °F

**BLOOD PRESSURE**
148/92 mmHg (repeat 146/90, large cuff)

**HEART RATE**
84 bpm, regular

**RESPIRATORY RATE**
16/min

**OXYGEN SATURATION**
97% on room air

**HEIGHT**
5′ 10″ (178 cm)

**WEIGHT**
238 lb (108.0 kg)

**BMI**
34.6 kg/m²

**WAIST CIRCUMFERENCE**
44 in (112 cm)

**PAIN SCORE**
3/10 lumbar at rest

### 5a FOCUSED EXAMINATION

**General Appearance**

Alert, well-groomed, no distress. Central adiposity with android habitus. Ambulates independently with mildly guarded lumbar posture. Appears fatigued; yawned twice during the visit.

**Cardiovascular**

Rate and rhythm regular, S1/S2 normal, no murmur, rub, or gallop. Radial and pedal pulses 2+ and symmetric. Capillary refill under 2 seconds. Trace bilateral ankle edema, non-pitting. No carotid bruits, no JVD.

**Pulmonary**

Normal effort, no accessory muscle use. Clear to auscultation bilaterally, no wheeze or crackles. Room air. Mildly short of breath climbing one flight during hallway walk test, recovered within 60 seconds.

**Abdomen**

Soft, obese with prominent central adiposity. Non-tender, no guarding. Liver edge not clearly palpable beneath adipose tissue; no appreciable hepatomegaly. No masses, no surgical scars.

### Musculoskeletal

Gait steady with mildly reduced stride length. Lumbar flexion limited to approximately 60° with reproducible right paraspinal tenderness at L4–L5. Straight leg raise negative bilaterally. Strength 5/5 throughout. Single-leg stance 12 seconds bilaterally. Full shoulder and hip range of motion.

### Skin

Acanthosis nigricans at the posterior neck and both axillae. No xanthomas or xanthelasma. No rashes, wounds, or ulcers. Turgor normal, no bruising.

### Neurologic

Alert and oriented ×3. Cranial nerves II–XII intact. No focal motor or sensory deficit. Monofilament sensation intact at all 10 plantar sites bilaterally. Vibration intact. Romberg negative.

### Psychiatric

Mood mildly frustrated, affect congruent and reactive. Cooperative and engaged; visibly discouraged when discussing prior weight-loss attempts. Insight and judgment good. No safety concerns.

## LV LIFESTYLE VITAL SIGNS / HEALTH BEHAVIOR ASSESSMENT

### 6 LIFESTYLE DOMAINS ASSESSED

| | |
|---|---|
| Nutrition quality and eating pattern | **Low fiber (under 12 g/day), high sodium, high added sugar (~110 g/day from beverages alone), 2–3 vegetable servings/week, predominantly ultra-processed and drive-through sourced.** |
| Physical activity minutes per week | **Approximately 20 min of intentional activity per week; ~2,800 steps/day.** |
| Resistance training frequency | **None.** |
| Sedentary time | **Approximately 13 h/day, largely uninterrupted seated dispatch work.** |
| Sleep duration and quality | **5–5.5 h on work days, fragmented and non-restorative; 7 h on off-days. High apnea risk.** |
| Stress level and coping strategies | **7/10; passive coping (screens, food). No active relaxation practice.** |
| Tobacco / nicotine use | **Former smoker (15 pack-years, quit 2011); current nicotine vaping 12 mg/mL, ~1 pod every 2 days.** |
| Alcohol and substance use | **15–18 standard drinks/week concentrated on off-nights; AUDIT-C 5. No other substances.** |
| Social connection and support | **Strong — supportive spouse, multigenerational household, active faith community.** |
| Readiness for change | **8/10 overall; 8/10 vaping, 7/10 nutrition, 4/10 alcohol reduction.** |
| Confidence level | **5/10 at intake, 7/10 after collaborative goal-setting.** |
| Patient-selected SMART goals | **(1) Zero regular soda or energy drinks on shift, replaced with water and unsweetened tea, starting 08/17. (2) Food from home for 2 of 4 shifts per week. (3) Walk 15 minutes** |

| | |
|---|---|
| | **on off-days, 3 days/week, with wife.** |

## ST SCREENING / ASSESSMENT TOOLS

### 7 STANDARDIZED TOOLS & INTERPRETATION

| | |
|---|---|
| PHQ-9 | **8 — mild depressive symptoms, somatic items predominant. Prior 08/2025: 6. Item 9 = 0.** |
| GAD-7 | **6 — mild anxiety, situational (work conflict, finances).** |
| AUDIT-C | **5 — positive screen for unhealthy alcohol use in men. Brief intervention delivered this visit.** |
| DAST | **0 — negative.** |
| STOP-Bang | **5 — high risk (snoring, tiredness, observed apnea, BP, age, neck 17.5 in, male sex).** |
| Epworth Sleepiness Scale | **12 — excessive daytime sleepiness; confounded by chronic shift-work sleep restriction.** |
| ASCVD 10-year risk | **14.8% — intermediate-to-high. Was 11.2% in 2024; recalculated with current lipids and BP.** |
| Diabetes risk assessment | **HbA1c 6.4%, BMI 34.6, first-degree family history — very high risk of progression; National DPP eligible.** |
| Food frequency questionnaire | **Fiber ~11 g/day, added sugar ~110 g/day, sodium ~4,800 mg/day, 2–3 vegetable servings/week.** |
| Physical activity questionnaire | **~20 min/week moderate activity, 0 resistance sessions — well below the 150 min/week guideline.** |
| Readiness-to-change scale | **Readiness 8/10, confidence 5/10, importance 9/10.** |
| Social determinants of health screening | **Negative for food and housing insecurity; positive for financial strain and work-schedule barriers.** |
| Pain / functional scale | **Lumbar pain 3/10 at rest, 4–5/10 after 15 min walking — shapes exercise progression.** |

## L LABORATORY AND DIAGNOSTIC RESULTS

### 8 RESULTS REVIEWED OR ORDERED

**Cardiometabolic Labs (08/08/2026)**

HbA1c 6.4% (5.9% in 02/2025, 6.1% in 12/2025 — rising). Fasting glucose 116 mg/dL. Total cholesterol 238, LDL-C 152, HDL-C 36, triglycerides 248, non-HDL 202 mg/dL. CMP: sodium 139, potassium 4.1, creatinine 1.02 (eGFR 84), ALT 62, AST 44, alkaline phosphatase 91. Urine albumin/creatinine ratio 22 mg/g (mildly elevated). hs-CRP 4.6 mg/L.

**Nutrition / Deficiency Labs**

CBC normal (Hgb 15.1, MCV 89). Ferritin 128. Vitamin D 19 ng/mL (deficient). B12 402, folate normal, magnesium 1.9. TSH 2.1 with normal free T4 — thyroid not contributing to fatigue or weight.

### Weight / Metabolic Testing

Waist 44 in. Bioimpedance: 36.2% body fat, ~68 lb fat mass. Abdominal ultrasound 06/2024: increased hepatic echogenicity consistent with steatosis, no focal lesion. EKG today: normal sinus rhythm at 84, no ischemic changes, no LVH by voltage criteria. Coronary calcium score ordered.

### Preventive Screening Results

Home BP log (2 weeks): average 147/91, all readings above 140/90. Colonoscopy 2019 normal, next due 2029. Tdap 2021; influenza due; COVID-19 booster due; shingles series not started (eligible). No DEXA indicated.

### Prior Records Reviewed

Primary care notes 2024–2026 (statin refusal documented twice, BP escalation), 2024 abdominal ultrasound report, occupational health screening, pharmacy fill history (lisinopril adherence 96%, no statin fills), patient-provided 7-day food and beverage log, and phone step data.

## A ASSESSMENT

### 9 LIFESTYLE MEDICINE CLINICAL INTERPRETATION

- **Prediabetes at high risk of progression** — HbA1c 6.4%, up 0.5 points over 18 months, with class I obesity, hepatic steatosis, and a first-degree family history of insulin-requiring type 2 diabetes. Metabolic syndrome criteria met on all five components.
- **Cardiometabolic risk intermediate-to-high** — ASCVD 10-year risk 14.8%, LDL-C 152 untreated, hs-CRP 4.6, albuminuria 22 mg/g, and uncontrolled stage 2 hypertension on lisinopril monotherapy. Frequent NSAID use is likely contributing to BP resistance.
- **Nutrition is the highest-yield target** — dominant drivers are roughly 110 g/day of liquid added sugar, 4,800 mg sodium, and near-absent fiber within a work food environment offering only vending and drive-through options between 1800 and 0600. The household dinner pattern is culturally important and is best modified rather than replaced.
- **Physical activity severely limited** (~20 min/week, 13 h sedentary/day) and further constrained by mechanical low back pain, which should shape progression rather than exclude activity.
- **High probability of obstructive sleep apnea** — STOP-Bang 5, witnessed apneas, morning headaches, Epworth 12, layered on shift-work sleep restriction. Untreated apnea plausibly contributes to hypertension, insulin resistance, weight gain, and fatigue; the drowsy-driving near-miss is an immediate safety issue.
- **Mild depressive and anxiety symptoms with passive coping** (PHQ-9 8, GAD-7 6) reinforce nocturnal eating and inactivity; no pharmacotherapy indicated and no safety risk.
- **Nicotine vaping and unhealthy alcohol use** (AUDIT-C 5) both contribute to cardiometabolic risk and sleep fragmentation. Readiness is high for vaping and low for alcohol, so interventions are sequenced accordingly.
- **Weight trajectory upward** (+32 lb since night-shift transfer) with prior regain after restrictive commercial and fasting approaches — a schedule-compatible, non-restrictive pattern is more likely to hold.
- **Medication factors:** untreated dyslipidemia by patient choice, NSAID-related BP elevation, vitamin D deficiency, and no glucose-lowering therapy. Metformin is a reasonable adjunct if HbA1c does not respond.
- **Readiness favorable** (8/10) with a proven prior success in smoking cessation and strong spousal support; confidence (5/10) is the modifiable limiter. Lifestyle prescription, sleep study, statin reconsideration, and DPP referral indicated. No red flags requiring urgent or higher-level care.

## P PLAN

### 10 MANAGEMENT BY LIFESTYLE DOMAIN

- **Nutrition.** Whole-food, Mediterranean-style pattern adapted to household cooking. Immediate: eliminate regular soda and energy drinks on shift, replacing with water, unsweetened iced tea, and sparkling water. Fiber goal 30 g/day built through beans added to household greens and rice, oats at wake-up, and fruit; protein 25–30 g per main meal. Sodium target under 2,300 mg — salt-free seasoning blends, limit canned soup. Batch-prep two shift meals on off-days. Registered dietitian referral placed for two visits, spouse invited.
- **Physical activity.** Begin 15 min walking on off-days three times weekly, progressing 5 min every 2 weeks toward 150 min/week. Add two band-resistance sessions per week (8 exercises, 1–2 sets of 10–12), demonstrated today. Interrupt sedentary time with a 3-minute stand-and-walk each hour of the dispatch shift, timer set with patient. Back-pain adaptations: cushioned footwear, walk on track or grass rather than concrete, hip-hinge and core drills, stop if pain exceeds 5/10.
- **Sleep.** Anchor sleep 0800–1400 on all work days with blackout curtains, white noise, phone out of the bedroom, and a household do-not-disturb agreement. No caffeine after 0200. **Home sleep apnea test ordered** for STOP-Bang 5 with witnessed apneas. Drowsy-driving safety counseling: pull over and nap before the commute, report any further near-miss. Sleep medicine referral if the study is positive or symptoms persist.
- **Stress management.** Twice-daily 4-7-8 breathing for 2 minutes, anchored to shift start and shift end. One outdoor activity per off-day with grandchildren, counted as both activity and stress care. Continue church men's group. Behavioral health group referral accepted; individual therapy and medication declined. Re-screen PHQ-9 and GAD-7 at 6 weeks.
- **Substance use.** Vaping cessation with quit date 08/24/2026: nicotine patch 14 mg daily for 6 weeks with 7 mg taper, plus lozenge PRN, prescribed today; quitline and text-support enrollment provided. Alcohol: brief intervention delivered for AUDIT-C 5; interim limit agreed at 2 drinks per occasion and no more than 8 drinks/week with a written log. Alcohol goal revisited at 6 weeks; readiness is 4/10 and is not being forced.
- **Weight management.** Target 5–7% loss (12–17 lb) over 6 months, the DPP threshold associated with reduced diabetes incidence. Weekly weight logged at the same day and time. No commercial or fasting program given prior regain. Anti-obesity pharmacotherapy to be offered if loss is under 3% at 3 months; bariatric referral not indicated at current BMI.
- **Chronic disease lifestyle plan.** *Prediabetes:* National DPP enrollment (virtual cohort to fit the shift schedule), HbA1c in 3 months, target under 6.0%, metformin 500 mg BID offered if not improving. *Hypertension:* target under 130/80 — stop scheduled ibuprofen in favor of acetaminophen and topical diclofenac, increase lisinopril to 20 mg daily today, home BP log twice weekly. *Hepatic steatosis:* weight loss, alcohol reduction, repeat ALT in 3 months; FIB-4 1.18 (low risk), no elastography at this time. *Dyslipidemia:* statin reconsidered in detail and patient agreed to rosuvastatin 10 mg, with myalgia reassessment at 6 weeks and CK if symptomatic. Vitamin D3 2,000 IU daily for level 19.
- **Behavior-change plan.** Three patient-selected SMART goals recorded verbatim, written copy given and photographed by the patient. Barriers named (overtime, 0200 vending access, fatigue) each with a pre-planned response. Confidence rose from 5/10 to 7/10 after goal-setting. Habit tracking on a printed shift-calendar checklist. Health coach assigned for 15-minute phone check-ins at weeks 2 and 4.
- **Medication coordination.** All agents reviewed for weight, sleep, and metabolic effects — none weight-promoting. Lisinopril increased to 20 mg, rosuvastatin 10 mg started, nicotine patch and lozenge started, NSAID discontinued, vitamin D3 started. Basic metabolic panel in 2 weeks for the lisinopril increase. Coordination note sent to Dr. Vargas the same day.
- **Referrals and coordination.** Registered dietitian (two visits), National DPP virtual cohort, health coach, sleep medicine on a positive study, stress-management group, and physical therapy for lumbar-safe progression. Occupational health notified with patient consent regarding drowsy-driving risk pending the sleep study.

- **Patient education.** Reviewed the 3–6 month timeline for HbA1c and BP response, the meaning of a 5–7% weight target, home BP and weight self-monitoring technique, statin myalgia expectations, and patch site rotation. Instructed to seek emergency care for chest pain, sudden severe dyspnea, focal weakness or speech change, or syncope, and to call the clinic for BP above 180/110, dizziness on the new dose, or new muscle pain.

## F FOLLOW-UP

### 11 REASSESSMENT PLAN

**Follow-up**

Return in 6 weeks (09/25/2026) for lifestyle goal review, weight and home BP log review, sleep study result review, vaping quit-date outcome and patch tolerance, statin tolerance check, PHQ-9 and GAD-7 re-screen, and dietitian follow-through. Basic metabolic panel in 2 weeks after the lisinopril increase. HbA1c, lipid panel, and ALT at 3 months, with health coach calls at weeks 2 and 4 in the interim. Sooner if the sleep study is positive or BP remains above 160/100.

## TB TIME DOCUMENTATION & BILLING

**TOTAL TIME SPENT**
62 minutes

**LIFESTYLE COUNSELING TIME**
24 minutes

**NUTRITION COUNSELING TIME**
14 minutes

**PHYSICAL ACTIVITY COUNSELING TIME**
8 minutes

**BEHAVIOR-CHANGE COUNSELING TIME**
10 minutes

**CARE COORDINATION TIME**
6 minutes

**RECORDS REVIEW TIME**
9 minutes

**LAB REVIEW TIME**
7 minutes

**E/M LEVEL**
99205 — new patient, 62 minutes total time on the date of service

**PREVENTIVE COUNSELING CODE(S)**
99401 not billed separately (bundled in time-based E/M)

**INTENSIVE BEHAVIORAL THERAPY CODE(S)**
G0447 — IBT for obesity, 15 minutes face-to-face

**TOBACCO CESSATION COUNSELING CODE(S)**
99407 — intensive, greater than 10 minutes

**CHRONIC CARE MANAGEMENT CODE(S)**
Not applicable this visit

**BASIS FOR BILLING**
Time-based (62 minutes) with documented high-complexity medical decision making

**PRIMARY DIAGNOSIS**
R73.03 — Prediabetes

**SECONDARY DIAGNOSES**
E66.9 Obesity; Z68.34 BMI 34.0–34.9; I10 Hypertension; E78.5 Hyperlipidemia; K76.0 Hepatic steatosis; F17.290 Nicotine dependence; G47.26 Shift work sleep disorder; R06.83 Snoring

## SO PROVIDER SIGN-OFF

| PROVIDER NAME | CREDENTIALS | SPECIALTY | DATE | TIME |
|---|---|---|---|---|
| Dana R. Osei, MD | MD, Dipl. ABLM | Lifestyle Medicine | 08/14/2026 | 19:42 |

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