1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Sofia L. Marchetti

DOB
07/22/1997

AGE/SEX
29 / Female

MRN / PATIENT ID
SLM-6604215

DATE OF SERVICE
11/05/2026

PROVIDER
Nadia Haddad

CREDENTIALS
MD (Endocrinology — Pituitary & Reproductive)

VISIT TYPE
Follow-Up — 3-month cabergoline review

CARE SETTING
Outpatient — Reproductive Endocrinology Clinic

PRIMARY CARE PROVIDER, IF APPLICABLE
Ethan Brooks, PA-C

REFERRING PROVIDER, IF APPLICABLE
Grace Liu, MD (Gynecology)

INTERPRETER USED, IF APPLICABLE
Not required

CC CHIEF COMPLAINT

2 PRIMARY CONCERN

"I got my first period in nine months and the milky discharge has almost stopped. The headaches are gone. I want to know how soon my husband and I can try for a baby, and if the tumor will grow when I'm pregnant."

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

3a PRESENTATION

Reason for Hormone Disorder Evaluation:

Follow-up of established pituitary disorder (macroprolactinoma) — hormone therapy monitoring and pregnancy planning.

History of Present Illness:

Periods stopped 01/2026 after stopping the combined pill to conceive. Milky nipple discharge, frontal headaches, low libido, vaginal dryness. Gynecology labs 07/2026: prolactin 2,150 ng/mL, pregnancy test negative. MRI 07/2026: 1.4 cm macroadenoma. Started cabergoline 08/05/2026, 0.25 mg twice weekly → 0.5 mg twice weekly from 09/02. Prolactin 38 ng/mL on 10/30. First period 10/12. Goals: safe pregnancy within a year.

3b REPRODUCTIVE & HORMONE SYMPTOMS

Menstrual / Ovulatory History, if applicable:

Menarche 12; regular 28-day cycles on and off the pill until 01/2026. Secondary amenorrhea 9 months. LMP 10/12/2026, 5 days, normal flow. Noticed mid-cycle discharge late October (possible ovulation). Normal pelvic ultrasound 07/2026.

Fertility / Reproductive History:

G0. Married; tried to conceive 01–07/2026 without success (anovulatory). Using condoms since starting cabergoline, per our advice. No fertility treatment. Husband 31, healthy, no semen analysis. Not lactating.

Androgen-Related Symptoms:

None. No acne or excess hair. Testosterone normal 07/2026.

Hypogonadism Symptoms:

Low libido, vaginal dryness, and painful intercourse during amenorrhea — all improving. Fatigue better. Low bone density on DEXA (estrogen deficiency).

Menopause / Perimenopause Symptoms:

Not applicable — symptoms were from low estrogen due to prolactin, not menopause. Occasional night sweats in summer, now gone.

Prolactin / Galactorrhea Symptoms:

Bilateral milky discharge on expression only now (was spontaneous, staining bras). No blood, lump, or breast pain. Headaches resolved by week 6. No visual symptoms. No dopamine-blocking drugs (no antipsychotics, metoclopramide, or domperidone).

Pituitary Hormone Symptoms:

Headache resolved. No field loss. No acromegalic or Cushingoid features. No dizziness on standing, salt craving, or cold intolerance. MRI 07/2026 as above; no surgery.

Adrenal Hormone Symptoms:

Mild light-headedness the morning after each cabergoline dose (first 2 weeks only). No other symptoms.

Thyroid-Related Hormone Symptoms:

None. Thyroid axis normal at baseline. Aware thyroid needs checking before pregnancy.

Growth Hormone / IGF-1-Related Symptoms, if applicable:

No ring or shoe size change, facial changes, snoring, or carpal tunnel symptoms. IGF-1 normal 07/2026 (excludes co-secreting tumor).

Calcium / Parathyroid Hormone Symptoms:

No fractures or stones. Low dairy (lactose intolerant). Started calcium 600 mg + vitamin D3 1,000 IU in 08/2026.

3c TREATMENT & BACKGROUND

Medication / Hormone Therapy History:

Cabergoline 0.5 mg twice weekly (Mon/Thu) with food at bedtime — no missed doses. Nausea first week of each dose step, now gone. Combined oral contraceptive 2015–2025. Prenatal vitamin with folic acid. Calcium + vitamin D. Commercial insurance; generic cabergoline $18/month.

Exogenous Hormone / Supplement Exposure:

Prenatal vitamin contains biotin 30 mcg (too low to affect assays). No herbal fertility products, DHEA, or hormone creams.

Past Medical and Surgical History:

Macroprolactinoma (2026). Low bone density for age. Migraine without aura in teens. Generalized anxiety (therapy, no medication). No surgery.

Family History:

Mother — hypothyroidism, osteoporosis at 58. Maternal grandmother — breast cancer at 70. No pituitary tumors, hyperparathyroidism, or MEN in family.

Social / Lifestyle History:

Graphic designer, works from home. Yoga 3×/week. Sleeps 7–8 h. Alcohol stopped when trying to conceive. Never smoked. No substance use. Supportive husband; both keen to start a family in 2027.

Pertinent Negatives:

No severe or sudden headache, visual loss, double vision, clear nasal drainage, chest pain, shortness of breath, compulsive behaviors, or leg swelling.

ROS HORMONE DISORDERS REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fatigue, weight change, appetite change, heat/cold intolerance, sleep disruption, or mood change
Fatigue improving; mild anxiety (baseline).

Menstrual irregularity, amenorrhea, infertility, hot flashes, night sweats, vaginal dryness, or libido changes
Positive — amenorrhea (resolving), dryness, low libido (improving).

Acne, hirsutism, scalp hair thinning, voice change, or rapid androgenic symptoms
Negative.

Erectile dysfunction, decreased morning erections, gynecomastia, testicular symptoms, or low libido
Low libido only (improving).

Headache, visual changes, galactorrhea, breast discharge, or pituitary-related symptoms
Positive — galactorrhea on expression; headache resolved.

Dizziness, salt craving, weakness, hyperpigmentation, bruising, striae, episodic headaches, sweating, or hypertension
Brief post-dose light-headedness, resolved.

Bone pain, fractures, kidney stones, muscle cramps, paresthesias, or height loss
Negative.

Medication side effects, adherence barriers, hormone therapy concerns, supplement use, or access issues
Early nausea, resolved. No impulse-control symptoms.

O OBJECTIVE

5 EXAMINATION

5a VITALS

TEMPERATURE	BLOOD PRESSURE	HEART RATE
98.2 °F	108/68 mmHg	70 bpm
RESPIRATORY RATE	**OXYGEN SATURATION**	**HEIGHT**
14 /min	99% RA	168 cm
WEIGHT	**BMI**	**WAIST CIRCUMFERENCE, IF APPLICABLE**
61.0 kg	21.6	72 cm

PAIN SCORE, IF APPLICABLE

0/10

5b EXAMINATION

General Appearance:

Well, slim, relaxed. No distress.

Head / Eyes / Ears / Nose / Throat:

Visual fields full to red-pin confrontation, both eyes. Pupils normal; eye movements full. No acromegalic or Cushingoid features. No acne. No rhinorrhea.

Neck / Thyroid:

Normal-size, smooth thyroid. No nodes.

Cardiovascular:

Regular. No murmur (relevant to dopamine agonist). Orthostatic BP: 108/68 → 104/66 standing, no symptoms.

Pulmonary:

Clear.

Breast / Chest, if examined:

Chaperone present (M. Ortiz, MA). Scant milky discharge from multiple ducts both sides on expression only. No masses, skin change, or bloody discharge.

Abdomen:

Soft, non-tender. No striae.

Genitourinary / Reproductive Exam, if performed:

Not performed today — gynecology exam 07/2026 normal (atrophic vaginal mucosa then).

Extremities:

No edema or tremor. Normal hands and feet. Strength normal.

Skin:

Normal. Modified Ferriman–Gallwey 4.

Neurologic:

Cranial nerves II–XII intact. No focal deficit.

Psychiatric:

Bright, mildly anxious about pregnancy. No compulsive gambling, shopping, or hypersexuality on direct questioning.

HA HORMONE AXIS ASSESSMENT

6 AXIS REVIEW

SUSPECTED HORMONE AXIS INVOLVED

Lactotroph (prolactin) with secondary gonadal axis suppression

SYMPTOMS OF HORMONE EXCESS OR DEFICIENCY

Prolactin excess → low estrogen; both resolving

RELEVANT HORMONE LAB TRENDS

Prolactin 2,150 → 410 → 38 ng/mL

TIMING OF LABS RELATIVE TO MENSTRUAL CYCLE, MEDICATION DOSING, FASTING STATUS, OR TIME OF DAY WHEN RELEVANT

Prolactin drawn mid-morning, rested, 3 days after last dose; estradiol cycle day 18

MEDICATION OR SUPPLEMENT INTERFERENCE RISK

None (no dopamine blockers, low-dose biotin)

IMAGING CORRELATION WHEN APPLICABLE

1.4 cm macroadenoma, 07/2026; repeat due

CURRENT THERAPY AND RESPONSE

Cabergoline — excellent biochemical response

SAFETY CONCERNS OR CONTRAINDICATIONS

No valve disease risk at this dose; no impulse symptoms

NEED FOR REPEAT TESTING, DYNAMIC TESTING, IMAGING, REFERRAL, OR TREATMENT ADJUSTMENT

Repeat MRI before conception; prolactin in 8 weeks

HT HORMONE THERAPY MONITORING

7 DOPAMINE AGONIST REVIEW

CURRENT HORMONE THERAPY OR ENDOCRINE MEDICATION

Cabergoline 0.5 mg twice weekly (1 mg/week)

DOSE, ROUTE, FREQUENCY, AND DURATION

Oral, Mon/Thu bedtime; 3 months

TREATMENT INDICATION AND GOALS

Normal prolactin, tumor shrinkage, ovulation

SYMPTOM RESPONSE

Menses back, headaches gone, galactorrhea minimal

SIDE EFFECTS AND SAFETY CONCERNS

Early nausea and light-headedness, resolved

LAB MONITORING STATUS

Prolactin 10/30; CMP normal

CONTRAINDICATIONS OR RISK FACTORS

None; no valvular disease, no psychosis history

FERTILITY, PREGNANCY, CONTRACEPTION, OR LACTATION CONSIDERATIONS WHEN RELEVANT

Ovulation likely returning — condoms until MRI review; stop at positive test

CARDIOVASCULAR, THROMBOEMBOLIC, CANCER, BONE, LIVER, OR METABOLIC RISK CONSIDERATIONS

Low bone density; no echo needed at under 2 mg/week

REFILL NEEDS AND INSURANCE/ACCESS BARRIERS

90-day supply sent

SHARED DECISION-MAKING AND INFORMED CONSENT WHEN APPLICABLE

Pregnancy-timing options discussed; agreed plan

DX DIAGNOSTIC TESTING / IMAGING ASSESSMENT

8 STUDIES REVIEWED

HORMONE LAB VALUES AND TRENDS

Prolactin 2,150 → 38; estradiol 18 → 96 pg/mL

DYNAMIC ENDOCRINE TESTING RESULTS

Not needed

PITUITARY MRI

07/2026: 14 × 11 × 10 mm macroadenoma; 2 mm below chiasm; Knosp 1

ADRENAL CT/MRI

Not indicated

THYROID ULTRASOUND OR UPTAKE SCAN

Not indicated

PELVIC ULTRASOUND WHEN RELEVANT

07/2026 normal; thin lining (4 mm)

TESTICULAR ULTRASOUND WHEN RELEVANT

Not applicable

DEXA WHEN BONE HEALTH IS RELEVANT

VISUAL FIELD TESTING

DEXA WHEN BONE HEALTH IS RELEVANT

08/2026: L-spine Z –1.6, hip Z –1.0

VISUAL FIELD TESTING

Humphrey 24-2, 08/2026: normal both eyes

GENETIC TESTING WHEN RELEVANT

Not indicated (no MEN features or family history)

PREGNANCY TESTING WHEN RELEVANT

Urine hCG negative today

TIMING, ASSAY LIMITATIONS, AND NEED FOR REPEAT CONFIRMATION

High-dose hook effect excluded (diluted sample 07/2026)

ST SCREENING / ASSESSMENT TOOLS

9 SCORES & INTERPRETATION

Menopause symptom scale: not applicable. Modified Ferriman–Gallwey 4 (normal). FSFI 24.1 (was 17.8 in 08/2026; below 26.6 cutoff, improving). PHQ-9 4, GAD-7 6 (mild, baseline anxiety). QUIP-RS impulse-control screen: negative. Bone: DEXA Z-scores as above (below expected for age); FRAX not valid at 29. ASCVD not applicable. STOP-Bang 0. Adherence: 100% by pill calendar. Symptom diary: headache-free 7 weeks; galactorrhea score 1/4 (was 3/4).

L LABORATORY AND DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

Reproductive / Gonadal Hormones:

Prolactin 07/2026 2,150 → 08/2026 410 → 10/30 38 ng/mL (normal under 25). LH 1.2 → 6.8, FSH 2.4 → 5.9 IU/L. Estradiol 18 → 96 pg/mL. Day-21 progesterone ordered for next cycle (confirm ovulation). AMH 3.1 ng/mL. Testosterone 28 ng/dL. hCG negative.

Pituitary Testing:

IGF-1 198 ng/mL (normal for age). 8 am cortisol 14.2 mcg/dL (normal). TSH 1.6, free T4 1.1 (central hypothyroidism excluded). MRI and fields as above.

Adrenal Testing:

AM cortisol normal as above — no further testing. Na 140, K 4.0. DHEA-S normal.

Thyroid Testing:

TSH and free T4 normal. TPO antibodies negative (relevant to pregnancy planning).

PCOS / Hyperandrogenism Evaluation:

Not PCOS — normal androgens, normal ovaries on ultrasound, cause of amenorrhea explained by prolactin.

Bone / Calcium / Parathyroid Testing:

Calcium 9.4, albumin 4.4, PTH 38, 25-OH vitamin D 34 ng/mL (on supplement). ALP normal. DEXA as above.

Metabolic / Safety Labs:

CBC and CMP normal. Lipids normal. A1c 5.1%. Rubella immune; varicella immune.

Prior Records Reviewed:

Gynecology notes and labs 07/2026, pelvic ultrasound, MRI report and images, neuro-ophthalmology visual fields 08/2026, DEXA 08/2026, our notes 08–09/2026.

A ASSESSMENT

11 HORMONE DISORDER INTERPRETATION

1) Macroprolactinoma (1.4 cm) causing hyperprolactinemia with secondary hypogonadotropic hypogonadism: amenorrhea, galactorrhea, anovulatory infertility, and low bone density. 2) Differential: non-functioning macroadenoma with stalk compression (excluded — prolactin over 2,000 and fast fall on cabergoline); drug-induced or hypothyroid hyperprolactinemia (excluded); macroprolactin (not relevant at this level). Hook effect excluded. 3) Excellent response at 3 months: prolactin 98% lower, near normal; gonadal axis recovering (period, rising estradiol and LH). Other pituitary axes intact. 4) Cabergoline well tolerated at 1 mg/week. No impulse-control symptoms. Valve risk negligible at this dose. 5) Pregnancy: macroadenoma has about a 20% risk of symptomatic growth in pregnancy if not shrunk first. Plan: confirm shrinkage (ideally under 1 cm and away from the chiasm) on MRI at 6 months before trying. Cabergoline is the preferred agonist for conception and is stopped at a positive test. 6) Bone: estrogen-deficient bone loss (Z –1.6) should recover with return of cycles; calcium and vitamin D adequate. 7) Psychosocial: mild anxiety about pregnancy risk — reassured with a clear plan.

P PLAN

12 MANAGEMENT BY PROBLEM

Diagnostic plan,

Prolactin in 8 weeks. Day-21 progesterone next cycle. Pituitary MRI with contrast 02/2027 (6 months). Visual fields before conception and each trimester. Urine hCG if a period is more than 7 days late.

Hormone therapy plan,

Continue cabergoline 0.5 mg twice weekly. Increase to 0.75 mg twice weekly only if prolactin is still above 25 in 8 weeks. Stop when pregnancy is confirmed.

Menstrual irregularity or PCOS plan,

Not PCOS. Track cycles with an app and ovulation kits. Endometrial protection not needed now that she is cycling.

Hypogonadism plan,

Functional hypogonadism from prolactin — treat the cause; no estrogen therapy. Vaginal moisturizer and water-based lubricant until estrogen recovers.

Menopause/perimenopause plan,

Not applicable.

Pituitary plan,

Medical therapy first-line. MRI 02/2027. If no shrinkage or intolerance: neurosurgery (transsphenoidal) opinion before pregnancy. Annual pituitary function screen.

Adrenal plan,

Adrenal axis intact — no treatment or stress-dose plan needed.

Thyroid hormone plan,

TSH before conception and at first positive test (normal now, TPO negative).

Bone and metabolic plan,

Continue calcium 600 mg + vitamin D3 1,000 IU. Add weight-bearing exercise. Repeat DEXA in 2 years.

Medication safety plan,

Report compulsive behaviors (gambling, shopping, sexual urges) — partner informed. No echocardiogram needed below 2 mg/week. 90-day refills.

Lifestyle and supportive care plan,

Continue prenatal vitamin (folic acid 0.4 mg). Yoga plus strength training. Therapist for pregnancy-related anxiety.

Referral and care coordination plan

Neuro-ophthalmology for fields before conception. Gynecology/OB informed of plan; MFM not required unless tumor grows. Neurosurgery only if MRI response is poor.

Patient education

Explained ovulation can return before tests confirm it — use condoms until the MRI clears her to try. Stop cabergoline and call at a positive test. Seek emergency care for sudden severe headache, vision loss or double vision, vomiting with headache, or clear salty nasal drip.

F FOLLOW-UP

13 REASSESSMENT PLAN

Prolactin and day-21 progesterone results by portal in 8 weeks. Visit 02/2027 after MRI: review shrinkage and approve conception. Then visits each trimester if pregnant, with visual fields. Urgent return precautions as above.

TB TIME DOCUMENTATION & BILLING

14 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT
40 minutes

HORMONE DISORDER COUNSELING TIME
10 minutes (prolactinoma, response)

MEDICATION / HORMONE THERAPY COUNSELING TIME
5 minutes (cabergoline safety)

REPRODUCTIVE / FERTILITY COUNSELING TIME, IF APPLICABLE
15 minutes (pregnancy timing, tumor risk)

LIFESTYLE / METABOLIC COUNSELING TIME, IF APPLICABLE
Not applicable

CARE COORDINATION TIME
5 minutes (neuro-ophthalmology, OB)

RECORDS REVIEW TIME, IF APPLICABLE
Included in lab review

LAB / IMAGING REVIEW TIME, IF APPLICABLE
5 minutes (labs, MRI, DEXA)

14a BILLING CONSIDERATIONS — E/M / HORMONE DISORDERS CODING

E/M LEVEL
99215 (time ≥40 min) + G2211

DYNAMIC ENDOCRINE TESTING REVIEW / COORDINATION, IF APPLICABLE
Not applicable

HORMONE THERAPY MONITORING DOCUMENTATION, IF APPLICABLE
Cabergoline response and safety reviewed

MEDICATION MONITORING DOCUMENTATION, IF APPLICABLE

Impulse-control and valve-risk review

CARE COORDINATION CODE(S), IF APPLICABLE

Not separately billed

BASIS FOR BILLING

Time-based

ICD-10 DIAGNOSIS CODES

D35.2 — Benign neoplasm of pituitary gland (prolactin-secreting macroadenoma)

[SECONDARY PITUITARY / ADRENAL / THYROID / GONADAL / METABOLIC / MEDICATION MONITORING DIAGNOSIS CODE(S), IF APPLICABLE]

E22.1 — Hyperprolactinemia; N91.1 — Secondary amenorrhea; N64.3 — Galactorrhea not associated with childbirth; M85.80 — Other specified disorders of bone density, unspecified site; Z31.69 — Other general counseling and advice on procreation

SO SIGNATURE

15 PROVIDER SIGN-OFF

PROVIDER NAME

Nadia Haddad

CREDENTIALS

MD

SPECIALTY

Endocrinology / Hormone Disorders

DATE

11/05/2026

TIME

11:30