Name: Nicky Chan | DOB: 11/23/1992 | MRN: 000704405 | PCP: Deborah E. Dreyfus, MD | Legal Name: Nicholas Chan

Office Visit - May 01, 2025

with Deborah Dreyfus, MD at UMass Memorial Medical Center- University Campus Family and Community Medicine

Notes from Care Team

Progress Notes

Deborah Dreyfus, MD at 5/2/2025 9:27 AM

After visit, nurse showed me that legs were ruddy/reddish in color. Ben reports that this is baseline for Nicky and he had no concerns. Redness is blanchable. No signs of swelling, spreading erythema, or tenderness. Redness is bilateral. Pt afebrile. Ben reports that Nicky has been out in the sun.

Given this not new for Nicky, I let Ben know we should monitor for now. If redness appears to worsen or spread, if he develops a fever or appears to be uncomfortable, could be considered to be an infection which we would treat. However, given this is baseline and could be related to sun exposure, if no change or improves, I will hold off on further intervention.

Deborah Dreyfus, MD at 5/1/2025 9:13 AM

MEDICARE WELLNESS VISIT

Nicholas Chan is a 32 y.o. male who presents for an annual physical. No concerns today. Here with Ben. Mom called. Mom's only concern is, given his episodes in the past of head banging, what should they be looking for in terms of chronic findings due to prior episodes of concussion.

In terms of chronic conditions:

1. Seasonal Allergies. No signs of allergies. Receives allergy medicine.
2. History of bee sting allergy. He has an EpiPen and diphenhydramine to be used on a p.r.n. Basis.
3. Constipation. Every morning with a BM.
4. Dermatitis. No current skin concerns
5. Acne: No current skin concerns
6. Gastritis: Has been years since seen Dr. Buie. No issues. No burping or signs of discomfort after eating.
7. SIB. Per Ben, pt has been doing well with his current medications. No changes. Mood has been OK.
8. Food allergies: reported to red dyes and caffeine. Had IgE allergy tests (2/13) are negative for wheat and casein.
9. Vitamin D deficiency: Given vitamin D supplement last year.
10. Seizure disorder: doing well with current medications. No recent seizures.
11. Elevated A1c: A1c 5.7 when checked a year ago.

UTD w dental.

Family History

Problem	Relation	Age of Onset
• Other	Mother	

Family History of celiac disease
- Other Father
  Family History of atrial fibrillation

Social History[1]

[1]

Social History

Socioeconomic History
- Marital status: Single
  Spouse name: Not on file
- Number of children: Not on file
- Years of education: Not on file
- Highest education level: Not on file

Occupational History
- Not on file

Tobacco Use
- Smoking status: Never
- Smokeless tobacco: Never
- Tobacco comments:
  :

Vaping Use
- Vaping status: Never Used

Substance and Sexual Activity
- Alcohol use: Never
- Drug use: Never
- Sexual activity: Not on file

Other Topics Concern
- Not on file

Social History Narrative
Self-destructive behavior

Past Surgical History:

Procedure	Laterality	Date
• PR EXCISION TUMOR SOFT TISS FACE/SCALP SUBQ 2+CM *Procedure: EXCISION, SOFT TISSUE TUMOR, FACE OR SCALP, SUBCUTANEOUS, 2 CM OR GREATER; Surgeon: Janice F Lalikos, MD; Location: UNV OR; Service: Plastics*	N/A	4/18/2023
• PR RECMPL WND LID,NOS,EAR 2.5-7.5 CM *Procedure: REPAIR, COMPLEX WOUNDS OF FACE, 2.6 CM TO 7.5 CM; Surgeon: Janice F Lalikos, MD; Location: UNV OR; Service: Plastics*	N/A	4/18/2023

Allergies

Allergen	Reactions
• Bee Venom Protein (Honey Bee)	Anaphylaxis
• Fd And C Red No.40 *behavior*	Rash
• Lactose	Abdominal Pain
• Other *Food Colour Red POWD*	Unknown
• Versed [Midazolam]	Unknown

To be completed for G0402, G0438, and/or G0439:

☑ Past medical, family and social history, allergies have been reviewed, assessed and updated in Epic

☑ Patient current medication list has been reviewed and documented

☑ Patient completed Patient Health Risk Assessment Questionnaire and reviewed with provider

Risk of Falls:

Does the patient exhibit steady gait? …… ☐ No ☑ Yes
Did the patient take longer than 30 seconds for the timed “get up and go” test? ……..
☑ No ☐ Yes

Vitals:

	05/01/25 0910
BP:	126/88
Pulse:	**(!) 114**
Temp:	35.6 °C (96 °F)
TempSrc:	Temporal
SpO2:	95%
Weight:	79.8 kg (176 lb)
Height:	1.702 m (5' 7")

Body mass index is 27.57 kg/m².

Physical Exam (problem focused):

GENERAL: WN, WD male in no acute distress.
HEENT: Normocephalic. Extraocular movements are intact.
NECK: Supple. There is no lymphadenopathy, no thyromegaly.
HEART: Tachycardic regular rhythm.
LUNGS: Clear.
ABDOMEN: Positive bowel sounds, soft, nontender, negative hepatosplenomegaly.
EXTREMITIES: No edema noted.
LYMPH: No nodes palpable.
NEURO: wide-based, stable gait

EKG: Sinus tachycardia. QTc 446 ms
Assessment and Plan (patient must be provided with written screening schedule):
Health Maintenance ☑ See Preventative Service Schedule

Acute/Chronic Problems Assessed:
1. Elevated A1c: labs today. We did discuss consideration of metformin if A1c still elevated.
2. Seasonal Allergies. Doing well- continue current care..
3. History of bee sting allergy. Continue PRN epi.
4. Constipation. Doing well. Continue current care.
5. Dermatitis. No current skin concerns. Continue to monitor.
6. Acne: No current skin concerns. Continue to monitor.
7. Gastritis: No current issues. Continue current care.
8. SIB. FB psyc. EKG reassuring today in terms of QTc. Mom asks a reasonable question re: history of head hitting. We discussed movement symptoms to consider and referral to movement neurologist when that happens. Continue to monitor.
9. Food allergies: reported to red dyes and caffeine. Had IgE allergy tests (2/13) are negative for wheat and casein. Continue to monitor.
10. Vitamin D deficiency: Labs today.
11. Seizure disorder: doing well with current medications. Labs today.

HCM: Continue current dental care. Labs today. UTD w vaccines

Assessment of Cognitive Function (by report of patient or family members, and/or provider observation):
☐ No cognitive deficits noted.
☑ Cognitive deficits noted:

Furnish personalized health advise and referral, as appropriate, to health education or preventive counseling services or programs or community-based lifestyle interventions

aimed at reducing identified risk factors and improving self-management.

Areas Addressed:
☐ Weight Loss ☐ Smoking Cessation ☐ Alcohol dependence ☐ Physical Activity
☐ Nutrition ☐ Other:

Advance Care Planning:
Guardianship in place