DAVID A COHEN Home: (732)846-4842
36 Years Old Male -DOB: 05/04/1982 RWJ MRN: 2909221 Ins: UNITEDHE (1318)

04/02/2019 - Office Visit: IPV
Provider: Jennifer Chen MD
Location of Care: RWJ-Neurology

Visit Type: IPV

CC: tourettes.

Note patient is a poor historian.

This is a 36 yo man with history of mild intellectual deficiency who presents for evaluation of Tourette's syndrome.

Mother reports that pt developed tics around the age of 11-12 with head jerking, jumping around and arm flailing. Mother reports no vocal tics but patient says he may have coughed a lot. This occurred around the time that his parents got divorced. He was evaluated by pediatric neurologist and placed on clonidine. This was discontinued in 2003. Mother reports that his tics had substantially improved.

He currently still has occasional tics. Mother reports that he had a period where he was stamping his feet but that has also resolved. His main tics now are occasional blinking and shoulder shrug. Patient does not seem perfectly aware of his movements. When pointed out they cease. No vocalizations per mom. He has not been on any medication since clonidine

Denies anxiety, obsessions, attention problems. Denies any changes with memory. Still manages finances, daily schedule, etc.

No changes in walking, balance. No weakness or numbness.

Incoming Medications (prior to this update):
* EVALUATE AND TREAT FOR COCHLEAR IMPLANT Dx: H90.3

Medications removed:
* EVALUATE AND TREAT FOR COCHLEAR IMPLANT Dx: H90.3

Current Medication Allergies:
PENICILLIN (PENICILLIN V POTASSIUM) (Critical)

Medication allergies reviewed by: Melina Lopez-Jett CMA

Problem List Review
Problems list reviewed by: Jennifer Chen MD

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Past Medical History:

Reviewed history from 11/19/2018 and no changes required:
- Tourette's
  - Dx in 8/1982
  - Previously took clonidine; has been off since 2003; doing well
- ED eval for ? head trauma
- MR IQ 76
- Ear wax.
- Hearing impaired; uses hearing aids

Family History:

Reviewed history from 02/27/2015 and no changes required:
- mother - healthy
- father - healthy
- sister - healthy
- uncle - stroke, HTN

Social History:

Reviewed history from 11/19/2018 and no changes required:
- Never EtOH, smoke, drug use.
- Exercise: Walking, situps
- Currently ~~not working~~, temporarily recieving benefits because of recent move from West Orange to Highland Park. In correspondence with Depart of Labor –
- Not married, no children
- Lives with mother.

→ working part-time

Risk Factors

Alcohol use: no

Vital Signs:

Height:	71 inches
Weight:	193.25 pounds
BMI:	27.05 kg/m^2
BSA:	2.08 m^2
Pulse rate:	100 / minute
Pulse rhythm:	regular
Resp:	18 per minute

1st BP reading: 142/89 mm Hg (L. arm sitting)
2nd BP reading: 147/88 mm Hg (R. arm sitting)
BP standing: 130/85 mm Hg (R. arm standing)
Cuff size: large
Vitals Entered By: Melina Lopez-Jett CMA (April 2, 2019 3:50 PM)

Smoking Status: never

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E-cigarette use: Never

Pain Scale
Patient reports pain: no

Fatigue
Patient experiencing fatigue: no

Preferred Method of Learning
Patient learns best by: Demonstration by provider or staff, Reading a Handout

Mental Status: Patient is awake and alert, oriented to time, place and situation. Speech is fluent with appropriate syntax. Language is grossly intact. Comprehension is grossly intact during normal conversation; he is able to answer questions appropriately. He seems to have a good general fund of knowledge and has intact distant and recent personal memory. However, when asked to perform specific tasks or commands, it seems difficult for him to process. E.g. when asked to follow pen with eyes, he does not seem to understand tasks and exhibits difficulty performing it but when casually observed he is able to look in all directions without difficulty. During stregnth testing he will pick up his legs with his hands when asked to hold up his leg but then is able to run and walk without difficulty. In addition although he denies anxiety, during exam he becomes overtly worried about what the test is finding and asks persistently "am I weak" when he is exhibitin functional difficulty performing a tasks.

Cranial Nerves: PERRL, although notably during forma testing when patient's glasses were taken off, left eye closed and resisted opening. Once glasses were replaced, eyes opened normally. When attempting to lift eyelids there was signficant resistance and both eyes rolled up. The resumed normal position once glasses were placed back on. Grossly EOMI but formal testing was limited as described above. Facial activation and sensation is symmetrically intact. patient with hearing aids, documented sensorineural hearing loss, b/l. Tongue and uvula/palate midline. Shoulder shrug is symmetric.

Motor: Grossly full strength throughout. However during formal testing, patient seems confused when asked to resist and has poor effor. When asked to lif legs he uses his hand to lift it. He has poor effort when testing DF/PF, again does not seem to understand commands. When asked to walk on tip toes he seems to have difficulty and appears effortful but does not fall. This is also true when walking on heels. However despite all this he is able to run.

Reflexes: trace throughout. Toes down.

Sensory: testing unreliable.

Coordination: no dysmetria on FNF.

Gait: patient rises without difficulty, good stride length. There is odd posturing of the arms which resolves with running. No postural instability.

Movement disorder exam
Speech and facial expression: normal speech and expressions.

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Tremor: No tremor
Tone: normal throughout.
Bradykinesia: no bradykinesia overtly but response when asked to peform tasks again he seems confused and will lift his finger with other hand to perform finger taps. However, when asked to take off and replace his watch there is no issues. He has no difficulty writing or putting on his coate.
Hyperkinetic (dystonia, chorea, myoclonus et): there is occasional left shoulder shrugging and frequent blinking when take glasses off.

Comments for Lab/Rad Rpts.

Comments Neuropsych testing from 2005 and 2018 reviewed. Reports scanned into EMR. Both testing suggest mild intellectual disability.

Impression & Recommendations:

Problem # 1: TOURETTE'S DISORDER (ICD-307.23)
This is a 36 yo man with mild intellectual disability who presents for evaluation of Tourette's disorder. Neurological exam shows no objective deficits however there multipole functional behaviors during formal testing (see exam above for details). On casual observance there is only occasional shoulder shrugging which patient does not even realize he is doing. When asked to every day tasks (writing, taking off watch) there does not seem to be any difficulty with fine motor movements.

Findings are likely due to combination of underlying intellectual and functional disorder. He has some evidence of tics but these are mild and not impairing. In the past he would meet criteria for Tourette's but not at this time. Would recommend housing with support otherwise there is no need for further neurological work up or treatment at this time.

Electronically Signed by Jennifer Chen MD on 04/04/2019 at 8:36 AM