EXAMPLE BASIC CHRONOLOGY - FICTIONAL DATA
FOR DEMONSTRATIVE PURPOSES ONLY

CONFIDENTIAL

MEDICAL CHRONOLOGY AND RECORDS BUNDLE

Patient: David Basic

Date Completed: 01/01/2025

Prepared by A1 Chronologies

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A1 Chronologies

CONFIDENTIAL
MEDICAL CHRONOLOGY

This is an example chronology representative of our Basic Service
All information and data contained is fictional

Patient Information

Name:	David Basic
DOB:	01/01/1960
Address:	123 Example Lane, London
Date Of Incident:	RTC - 01/02/2024

Key Health Metrics

Height	1.75 m	08/06/2023
Weight	92 kg	08/06/2023
BMI	30 kg/m²	08/06/2023
Blood Pressure	135/80 mmHg	08/06/2023

[Any readings are from the closest date to injury available in the provided medical records]

Significant Past

Osteoarthritis of Hip	09/04/2018
Left Hip Resurfacing	04/01/2017

Case Summary

The patient is a man in his early sixties. He developed left-sided lumbar and hip pain in 2017 related to manual work. Physiotherapy was advised though not attended. Imaging in 2018 confirmed advanced left hip degeneration and he underwent left hip resurfacing in January 2019, recovering well but with ongoing limits on prolonged standing that affected work.

From 2018 he also required treatment for elevated blood pressure, which stabilised with monitoring through 2020–2023.

The accident in question occurred on 1 February 2024, the patient was knocked from his bicycle by a car, sustaining a right lateral tibial plateau fracture. He had surgical fixation and was discharged non-weight-bearing in a brace with anticoagulation. Follow-up showed good healing, but he continued to experience knee pain and neck stiffness from the incident, remained on crutches and off work, and attended rehabilitation.

Source Map

1. "Example GP records.PDF" – 104-page file
   Chronology Review: 104 pages of records.

2. "Example Ambulance Records.PDF" – 6-page file
   Chronology Review: 6 pages of records.

3. "Example Hospital Records.PDF" – 30-page file
   Chronology Review: 30 pages of records.

All the above records were provided in one combined PDF bundle of 140 pages
Source pages referenced are those of the bundle pagination, printed in the bottom-right of each page.

Total Pages Reviewed: 140 out of 140 pages provided

Chronology Of Events

Date	Record Description	Source: Page
	PAST MEDICAL HISTORY	
07/06/17	**GP Records – Consultation** Left lower back and hip pain for about five months, onset shortly after starting warehouse work involving repetitive bending. Left-sided symptoms radiating toward the groin. Straight leg raise normal. No lumbar spinal tenderness. Localised tenderness over upper buttock. Assessment consistent with lumbar strain. Referred to physiotherapy for manual therapy and strengthening.	20
26/06/17	**GP Records – Consultation** Review of back symptoms. Pain persists and interfering with sleep. Patient reminded to arrange physiotherapy. No red flags. Referral re-issued to MSK service.	20
26/06/17	**Physiotherapy Referral** Request to assess a 58-year-old male with left posterior hip and lower back pain that began soon after starting work lifting crates. Normal neurological findings. Mild buttock tenderness with pain toward the groin. No regular medication. No other significant history.	103
22/08/17	**MSK Physio Letter** No response from patient to booking invitation. Discharged from service. New referral required if physiotherapy still needed.	101
05/02/18	**GP Records – Consultation** Persistent left hip and knee pain for around a year. Missed physio appointment. Limping on exertion. Sleep disturbed. Using analgesics obtained abroad. Naproxen and PPI prescribed. Hip X-ray and routine bloods requested. Exam: gait slightly antalgic, normal power and sensation.	19–20
22/03/18	**GP Records – Lab Results** Routine tests including HbA1c, U&E, LFTs and FBC all within normal ranges.	19

09/04/18	**GP Records – Consultation** Hip osteoarthritis first identified. X-ray shows marked left sided degeneration and milder degeneration on the right. Discussed referral to orthopaedics for possible left hip joint resurfacing. Patient aware of expected waiting times.	19
22/04/18	**Orthopaedic Referral** Referral for specialist review due to progressive left hip joint disease-causing daily pain and affecting manual work.	91
11/05/18	**GP Records – Consultation** Blood pressure elevated at home and in clinic. Weight 93 kg. Cycling for transport but no structured exercise. Lifestyle advice given. Follow-up planned.	18
18/06/18	**GP Records – Lab Results** Cholesterol raised. Dietary guidance provided.	18
15/07/18	**GP Records – Consultation** Blood pressure still raised. Reports intermittent numbness under right heel after long periods standing at recycling centre job. Examination normal. Not convinced sciatica. Conservative management advised with supportive footwear and pacing.	17–18
18/07/18	**GP Records – Lab Results** Folate, B12 and FBC normal.	17
03/09/18	**GP Records – Significant Past** History of recurrent lumbar strain recorded.	1
26/09/18	**Orthopaedic Clinic Letter** Left hip stiffness and pain on short walking distances. Sleep affected. Examination shows reduced range of motion. Imaging confirms severe left hip joint arthritis. Treatment options explained via interpreter. Patient wishes to proceed with joint resurfacing surgery. Added to waiting list.	85
12/12/18	**GP Records – Consultation** Surgery postponed because patient ate pre-operatively. New date awaited. Sick note issued for missed work.	17
04/01/19	**GP Records – Significant Past** Left hip resurfacing procedure completed.	1

19/01/19	**Hospital Discharge Summary** Elective left hip resurfacing carried out. No intra-operative complications. Good postoperative progress with physiotherapy.	79–81
01/02/19	**GP Records – Consultation** Postoperative review. Wound healing well. Sick note required. Works at recycling facility. Continuing analgesia.	16–17
10/03/19	**GP Records – Consultation** Successful staple removal two weeks post-op. No wound issues.	16
30/04/19	**GP Records – Consultation** Post-op functional recovery continues. Independent with self-care. Encouraged regular paracetamol and steady increase in walking. Sick note extended.	16
23/06/19	**GP Records – Consultation** Persistent pain on prolonged standing limits return to full duties. Encouraged physical conditioning. Employer unable to provide light duties. Further sickness certification.	16
23/08/19	**GP Records – Consultation** Lost job due to ongoing absence. Increasing activity, including cycling, but remains symptomatic at night. Avoids taking regular analgesia. Advised on pacing and realistic rehabilitation expectations.	15–16
21/09/19	**Orthopaedic Clinic** Left hip function good at review. Full range achieved. Advised to avoid frequent squatting and heavy lifting. Amended duties recommended.	65
18/12/19	**GP Records – Consultation** Raised blood pressure noted for around two years. Home systolic values mid-150s. Started low-dose antihypertensive therapy.	15
11/02/20	**GP Records – Consultation** New right thigh and knee aching since hip surgery. Working full time again. Exam normal. Suspected musculoskeletal adaptation. Naproxen PRN advised.	15
25/02/20	**GP Records – Consultation** Blood pressure remains high despite medication. Statin commenced for cardiovascular risk. Dose increase planned for blood pressure tablet. Encouraged home readings. Patient managing amended work tasks.	14–15

23/03/20	**Physiotherapy Referral** Referral for guidance on posture and functional mobility following hip operation.	61
13/04/20	**GP Records – Consultation** Sharp sporadic hip pain without focal tenderness. Trial of gabapentin for neuropathic features. Awaiting MSK review.	13–14
06/05/20	**GP Records – Consultation** Past varicose vein surgery. New localised skin irritation treated with topical antibiotic and steroid mix.	13
09/05/20	**GP Records – Consultation** Blood pressure check 152/88 mmHg. Weight increased to BMI 32. Discussed medication adjustment at next review.	12–13
26/06/20	**GP Records – Consultation** BP 147/85 mmHg. Good compliance. Awaiting blood results. Considering further dose increase.	12
01/07/20	**GP Records – Lab Results** FBC, lipids, U&E all acceptable. No medication changes required.	12
20/07/20	**GP Records – Consultation** Blood pressure 144/80 mmHg. Dose increased to achieve better control.	12
26/07/20	**GP Records – Consultation** Annual hypertension review. Ex-smoker. Compliant with medication. BMI 31.6.	11
06/08/20	**GP Records – Lab Results** Routine panel largely normal. Slight variation in liver and renal markers without clinical concern.	10
19/09/20	**GP Records – Telephone Consultation** BP 125/72 mmHg at home. Continue medication.	10
26/11/20	**GP Records – Observations** BP 173/84 mmHg recorded after cycling to appointment. BMI 30.4. Teetotal. Non-smoker.	9
04/05/21	**GP Records – Observations** BP 158/87 mmHg. BMI 29.7. Lifestyle advice repeated.	9

13/05/21	**GP Records – Consultation** BP 140/74 mmHg. Patient anxious during check. Plan blood test.	9
06/08/21	**GP Records – Lab Results** Blood panel normal. Continue current regimen.	9
30/09/21	**GP Records – Consultation** BP 151/77 mmHg. BMI 30.1. No smoking or alcohol. Continue review schedule.	8
21/12/21	**GP Records – Consultation** Blood pressure 145/86 mmHg. Patient reports home readings always lower. Encouraged home logs. Routine monitoring continues.	7–8
25/02/22	**GP Records – Lab Results** Blood results normal including HbA1c and lipids.	7
12/05/22	**GP Records – Significant Past** Mild anaemia noted previously. Haematinics supplied.	7
29/05/22	**GP Records – Consultation** BP 130/75 mmHg after rest. Home logs consistent. Cycling frequently.	6–7
14/06/22	**GP Records – Lab Results** Repeat ESR normal. FBC borderline abnormal historically but improved.	6
12/08/22	**GP Records – Significant Past** Former abnormal blood result now stable. Discussed findings.	6
27/02/23	**GP Records – Lab Results** Continued routine monitoring. Stable profile.	5
08/06/23	**GP Records – Consultation** BP 135/80 mmHg. Height 1.75m. Weight 92 kg. BMI ~30. Alcohol 6 units weekly. No concerns. Follow-up planned.	5
18/10/23	**GP Records – Consultation** Left lower back and hip pain for about five months, onset shortly after starting warehouse work involving repetitive bending. Left-sided symptoms radiating toward the groin. Straight leg raises normal. No lumbar spinal tenderness. Localised tenderness over upper buttock.	5

	Assessment consistent with lumbar strain. Referred to physiotherapy for manual therapy and strengthening.	
01/02/24	**Date of Accident** - **Cyclist RTC** While riding his bicycle across a junction, a vehicle entered from the right and collided with his right leg, causing him to fall onto the road. Immediate knee pain and difficulty weight-bearing.	2
	HISTORY SINCE ACCIDENT/INCIDENT	
01/02/24 20:48 to 21:22	**Ambulance Records** Low-speed collision. Right knee and shin pain. No loss of consciousness. Not transported after assessment.	105–110, 111
01/02/24 23:14	**A&E Admission** Right knee swollen and tender. Minor abrasion present. Pulses intact. Pain on movement. CT requested for suspected intra-articular injury. Admitted under orthopaedics.	135
02/02/24 01:43	**Radiology** X-ray: haemarthrosis and suspicion of lateral plateau injury. CT confirms comminuted intra-articular right tibial plateau fracture with subchondral depression around 5 mm. Minor background degenerative change.	112–113
02/02/24 05:38	**Orthopaedic Admission** Diagnosis: right tibial plateau fracture. Planned operative fixation.	43
05/02/24 15:00 to 17:06	**Operation Notes** Open reduction and internal fixation of right lateral tibial plateau. Plate and multiple locking screws used. Spinal anaesthesia. Good reduction achieved. Postoperative instructions: non-weight-bearing six weeks with knee brace 0–90° range and dalteparin prophylaxis.	130–133
06/02/24 15:30	**Inpatient Discharge Summary** Mobilising with crutches. Pain controlled. Wound clean. Post-op imaging satisfactory. Wound check in 10 days and fracture clinic in six weeks. Sick note provided.	112
07/02/24 13:00	**Referral – Orthopaedic Follow-Up** Review in fracture clinic arranged to assess healing and progression to weight-bearing.	43–47

16/02/24	**GP Records – Consultation** Wound check: incision healing well, steri-strips removed. Brace continued.	115–116
02/03/24	**GP Records – Consultation** Reports poor sleep due to knee pain and morning neck stiffness from collision. Friend translating. Codeine at night suggested. Physio ongoing.	4
02/03/24	**GP Records – Consultation** Neck pain in mornings lasting hours. Normal neurological findings. Ibuprofen spray prescribed.	4
11/03/24	**GP Records – Consultation** Whiplash-type cervical strain confirmed. Antalgic gait due to knee injury. Home exercise plan and pacing advice.	3–4
17/03/24	**GP Records – Administration Note** Fit note issued: not fit for work due to neck injury.	3
20/03/24	**GP Records – Tele-Consultation** Knee fracture review. Continuing brace and non-weight-bearing status. Sick note extended.	3
30/03/24	**GP Records – Consultation** Follow-up on knee fracture. Ongoing incapacity for work. Plan continued rehabilitation.	3

Disclaimer

This chronology is fictional. Some inspiration may have been taken from real cases. It does not represent medical opinion, legal advice, or expert witness evidence.