Knee Osteoarthritis Patient Charts

# Chart 1

Patient Name: Barbara Thomas

Age/Sex: 66-year-old female

MRN: KR0001

Visit Date: 2025-07-24

Chief Complaint: Knee instability

## History of Present Illness (HPI):

Barbara Thomas reports that her knee has gradually become more painful and stiff over the last 62 weeks. The pain is primarily aching, though she experiences sharp flares with stair climbing. She also describes grinding and popping with movement. Conservative measures have included six weeks of PT, Tylenol, meloxicam, tramadol, and heat, none of which meaningfully changed her baseline pain. She has not had prior knee injections. Pain is currently 9/10, with walking tolerance limited to about 500 feet. She denies bowel or bladder symptoms and has no history of cancer.

While describing her limitations, Barbara told a story about going laser tagging with her grandchildren last year. She admitted she should have known better, but the excitement of chasing them through the dark arena got the better of her. She laughed that her knee gave out halfway through a sprint, forcing her to take cover behind a wall of neon barriers while her grandchildren gleefully “took her out” from both sides. Since then, she jokes that she’s retired from competitive laser tag, though she admits the incident was one of the first times she realized just how much her knee was holding her back.

## Past Medical History:

Smoking, Blood clot, Obstructive sleep apnea, Hyperlipidemia

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 34.4. Antalgic gait. Knee ROM limited: flexion 106°, extension lag 2°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and went over the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. She understands the process and agrees with the plan, joking that if surgery helps her knee, maybe she’ll even come out of retirement for another round of laser tag with her grandchildren. We will see her back in three weeks for reassessment.

# Chart 2

Patient Name: James Johnson

Age/Sex: 73-year-old male

MRN: KR0002

Visit Date: 2025-07-22

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

For the better part of 80 weeks, James Johnson has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 400 feet. Corticosteroid injection 14 weeks ago with about 47% relief for 8 weeks. Current pain 6/10. No systemic red flags. No prior knee surgery.

## Past Medical History:

Hypertension, Hyperlipidemia

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.9 ppd × 31 yrs. No illicit drug use.

## Exam:

BMI 38.5. Antalgic gait. Knee ROM limited: flexion 94°, extension lag 5°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 3

Patient Name: David Wilson

Age/Sex: 77-year-old male

MRN: KR0003

Visit Date: 2025-07-02

Chief Complaint: Knee instability

## History of Present Illness (HPI):

For the better part of 34 weeks, David Wilson has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 400 feet. No prior knee injections. Current pain 9/10. No systemic red flags. No prior knee surgery. David says his knee pain is interrupting playing with his grandchildren and going to his favorite salsa classes. He is also planning a vacation to Portugal so he needs to be able to climb the steps and hills of the country, which he wouldn’t be able to do at the moment.

## Past Medical History:

Smoking, Diabetes, Hyperlipidemia

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 31.6. Antalgic gait. Knee ROM limited: flexion 92°, extension lag 3°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and clinical findings, which confirm advanced osteoarthritis of the knee. After discussing diagnosis and treatment options, he is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. I advised him that surgery should help restore function so he can return to activities that are important to him, including playing with his grandchildren, dancing, and traveling. His diabetes will need to be optimized with his PCP to achieve an HbA1c <8% prior to surgery. We will plan for reassessment in 3 weeks to review his readiness and finalize next steps.

# Chart 4

Patient Name: Maria Taylor

Age/Sex: 59-year-old female

MRN: KR0004

Visit Date: 2025-08-11

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

Maria Taylor reports knee pain for the past 35 weeks, described as an aching discomfort that worsens with activity and eases somewhat with rest. She notes reduced range of motion, with pain at the end ranges, as well as swelling and increased pain after longer walks. Current pain is 6/10, and she can walk about 500 feet before needing to stop. She has tried Tylenol, meloxicam, tramadol, physical therapy, and heat, with limited improvement. A corticosteroid injection 21 weeks ago gave about 50% relief, lasting 8 weeks. She denies systemic symptoms, has no history of cancer, and no prior knee surgery.

While describing her limitations, Maria shared a story about a recent trip to the zoo with her grandchildren. She managed the first stretch without much trouble, but by the time they reached the giraffe exhibit, her knee had stiffened and swollen, forcing her to sit while everyone else continued on. She laughed that she “saw more of the benches than the animals,” but admitted the experience was discouraging—it reminded her that even simple family outings are being cut short by her knee pain.

## Past Medical History:

Obstructive sleep apnea, Hypertension

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 48.1. Antalgic gait. Knee ROM limited: flexion 104°, extension lag 2°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. With her BMI, I advised working toward at least a 10% weight reduction prior to surgery to reduce operative risks and support recovery. She understood and expressed motivation, noting she wants to be able to enjoy outings like the zoo with her grandchildren without having to stop early. We agreed she will return in 3 weeks for reassessment.

# Chart 5

Patient Name: Robert Gonzalez

Age/Sex: 69-year-old male

MRN: KR0005

Visit Date: 2025-08-20

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

Robert Gonzalez tells me that the knee has gradually become more painful and stiff over the last 37 weeks. The pain is mostly aching, sometimes sharp with stairs, and he describes grinding and popping with movement. Conservative measures have included PT for six weeks, Tylenol, meloxicam, tramadol, and heat, none of which changed the baseline pain. No prior knee injections. Pain currently 9/10, walking tolerance about 800 feet. No bowel or bladder issues, no cancer history.

## Past Medical History:

Hyperlipidemia, GERD, Smoking, Diabetes

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 26.9. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 3°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 6

Patient Name: Charles Smith

Age/Sex: 65-year-old male

MRN: KR0006

Visit Date: 2025-08-21

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

This is a 65-year-old male who has been struggling with his knee for the past 46 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 9/10, and walking tolerance is about 500 feet. Denies systemic symptoms or prior knee surgery. He talked about his love of surfing which he can not do right now and that soon he will need to defend his surfing titles, so his knee must be fixed as soon as possible.

## Past Medical History:

Hyperlipidemia, Hypertension, Diabetes

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 45.0. Antalgic gait. Knee ROM limited: flexion 101°, extension lag 0°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis along with treatment options. Given his BMI, I recommended working toward at least a 10% weight reduction before surgery to improve safety and outcomes. His diabetes will also need to be optimized with his primary care physician, targeting an HbA1c <8% prior to surgery. He understands the recommendations and expressed urgency, noting his desire to return to surfing and defend his titles once his knee is fixed. We will plan to follow up in 3 weeks to reassess his progress and continue pre-operative planning.

# Chart 7

Patient Name: Christopher Anderson

Age/Sex: 84-year-old male

MRN: KR0007

Visit Date: 2025-06-02

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

For the better part of 51 weeks, Christopher Anderson has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 500 feet. A corticosteroid injection 15 weeks ago provided about 53% relief for 7 weeks. Current pain is 9/10. No systemic red flags. No prior knee surgery.

While discussing his symptoms, Christopher shared a story about how he used to pride himself on walking to the corner café each morning for coffee with friends. He laughed that now it takes him so long to get there that his friends joke about ordering his cup “to go” before he even arrives. He admitted the humor stings a little, as it reminds him of how far his mobility has declined. He said simply, “I just want to sit with them again without feeling like my knee is the slowest one at the table.”

## Past Medical History:

Obstructive sleep apnea, GERD

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 34.4. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 10°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. Christopher said he’s hopeful that surgery will allow him to return to his café mornings without worrying about being left behind. We will plan for reassessment in 3 weeks to continue with surgical preparation.

# Chart 8

Patient Name: David Martinez

Age/Sex: 64-year-old male

MRN: KR0008

Visit Date: 2025-07-19

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

David Martinez tells me that the knee has gradually become more painful and stiff over the last 60 weeks. The pain is mostly aching, sometimes sharp with stairs, and he describes grinding and popping with movement. Conservative measures have included PT for six weeks, Tylenol, meloxicam, tramadol, and heat, none of which changed the baseline pain. No prior knee injections. Pain currently 9/10, walking tolerance about 700 feet. No bowel or bladder issues, no cancer history.

## Past Medical History:

Smoking, Blood clot, Hypertension, Hyperlipidemia

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 25.0. Antalgic gait. Knee ROM limited: flexion 102°, extension lag 3°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 9

Patient Name: John Hernandez

Age/Sex: 80-year-old male

MRN: KR0009

Visit Date: 2025-06-05

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

This is a 80-year-old male who has been struggling with his knee for the past 56 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 7/10, and walking tolerance is about 300 feet. Denies systemic symptoms or prior knee surgery. He is a former war vet and feels ashamed in his lack of ability to walk long distances at the moment.

## Past Medical History:

Diabetes, GERD, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 34.3. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 0°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

This is a 80-year-old male who has been struggling with his knee for the past 56 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 7/10, and walking tolerance is about 300 feet. Denies systemic symptoms or prior knee surgery. He is a former war vet and feels ashamed in his lack of ability to walk long distances at the moment.

# Chart 10

Patient Name: Thomas Jackson

Age/Sex: 55-year-old male

MRN: KR0010

Visit Date: 2025-07-18

Chief Complaint: Knee instability

## History of Present Illness (HPI):

This is a 55-year-old male who has been struggling with knee pain for the past 77 weeks. He describes it as a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for about half an hour, when he gets up, the first dozen steps are extremely stiff until the knee gradually loosens. Conservative measures have included Tylenol, meloxicam, tramadol, physical therapy, and heat packs, though the relief has been short-lived. A corticosteroid injection 13 weeks ago provided about 75% relief, but only for 6 weeks. His current pain is 7/10, and his walking tolerance is about 700 feet. He denies systemic symptoms and has no history of prior knee surgery.

While discussing his limitations, he shared a story about his hobby of gem hunting. He used to spend entire afternoons scouring rocky riverbeds and hillsides, bending and climbing without a second thought. Now, he says the knee pain makes even short treks feel daunting. He laughed as he recalled his last outing, when he had to sit on a folding chair and direct his nephew like a “gem-hunting foreman,” pointing out where to dig instead of doing it himself. Though he joked that delegating made him “the boss,” he admitted that what he really misses is the thrill of spotting a glimmer in the dirt and kneeling down to uncover it himself.

## Past Medical History:

Blood clot, Smoking, Hyperlipidemia, Diabetes

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 34.2. Antalgic gait. Knee ROM limited: flexion 90°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis along with treatment options. He is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. Because of his diabetes, I advised coordination with his primary care physician to optimize HbA1c to <8% prior to surgery. He expressed hope that surgery will allow him to return to his gem-hunting trips without relying on others to do the digging. We agreed to follow up in 3 weeks for reassessment and to continue preparation for surgery.t.

# Chart 11

Patient Name: William Smith

Age/Sex: 58-year-old male

MRN: KR0011

Visit Date: 2025-06-01

Chief Complaint: Knee instability

## History of Present Illness (HPI):

William Smith reports knee pain for 56 weeks with stiffness after inactivity, especially mornings, swelling and pain after long walks, crepitus with knee motion. Pain 7/10. Walk tolerance ~300 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. No prior knee injections. Denies systemic symptoms, no cancer history, no prior knee surgery.

## Past Medical History:

Hyperlipidemia, Obstructive sleep apnea, Hypertension, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 33.9. Antalgic gait. Knee ROM limited: flexion 108°, extension lag 1°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 12

Patient Name: Christopher Gonzalez

Age/Sex: 56-year-old male

MRN: KR0012

Visit Date: 2025-07-27

Chief Complaint: Knee instability

## History of Present Illness (HPI):

Christopher Gonzalez reports knee pain for 53 weeks with aching pain worsened by activity and improved with rest, difficulty with walking, stairs, and rising from a chair, reduced knee range of motion with painful end ranges. Pain 9/10. Walk tolerance ~700 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. No prior knee injections. Denies systemic symptoms, no cancer history, no prior knee surgery. Chris is very into rock climbing and misses the activity very badly. He has described that nothing can replace his love for rock climbing.

## Past Medical History:

Blood clot, Diabetes, Hyperlipidemia, GERD

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.8 ppd × 32 yrs. Occasional marijuana use.

## Exam:

BMI 43.4. Antalgic gait. Knee ROM limited: flexion 94°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, and we will begin pre-operative planning. I recommended working on weight reduction prior to surgery to improve safety and recovery. His diabetes will need to be coordinated with his PCP for better control. As he is an active smoker, I counseled him on the importance of nicotine cessation, and testing will be required before proceeding. Chris shared that his main goal is to regain enough mobility to return to rock climbing, and I explained that these steps will help give him the best chance of success. We will see him back in 3 weeks for reassessment.

# Chart 13

Patient Name: Patricia Taylor

Age/Sex: 71-year-old female

MRN: KR0013

Visit Date: 2025-08-11

Chief Complaint: Knee pain

## History of Present Illness (HPI):

Patricia Taylor reports knee pain for the past 72 weeks, with stiffness most pronounced after inactivity, especially in the mornings. She describes crepitus with knee motion and a deep aching pain that worsens with activity and improves somewhat with rest. Current pain is 9/10, and her walking tolerance is about 700 feet before she has to stop. She has tried Tylenol, meloxicam, tramadol, physical therapy, and heat, without meaningful long-term relief. She has not had prior knee injections. She denies systemic symptoms, has no cancer history, and no prior knee surgery.

While discussing her limitations, Patricia shared her love for painting. She explained that standing at the easel for long stretches has become nearly impossible, and even sitting at a table to work leaves her knee stiff and throbbing when she tries to get up. She laughed that her last landscape painting ended up with a crooked horizon because she had to stop halfway through and finish the piece while propping her leg on a stool. Despite joking about it, she admitted the knee pain has started to rob her of the simple joy she once felt while painting uninterrupted.

## Past Medical History:

Hyperlipidemia, GERD

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 24.7. Antalgic gait. Knee ROM limited: flexion 105°, extension lag 3°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. Patricia shared that her hope is to return to painting comfortably without being forced to stop because of knee pain. I reassured her that surgery should help restore function and allow her more freedom with her art. She will return in 3 weeks for reassessment and to continue surgical planning.

# Chart 14

Patient Name: Mary Williams

Age/Sex: 58-year-old female

MRN: KR0014

Visit Date: 2025-08-08

Chief Complaint: Knee pain

## History of Present Illness (HPI):

Mary Williams tells me that the knee has gradually become more painful and stiff over the last 79 weeks. The pain is mostly aching, sometimes sharp with stairs, and she describes grinding and popping with movement. Conservative measures have included PT for six weeks, Tylenol, meloxicam, tramadol, and heat, none of which changed the baseline pain. Corticosteroid injection 12 weeks ago with about 66% relief for 8 weeks. Pain currently 8/10, walking tolerance about 400 feet. No bowel or bladder issues, no cancer history.

## Past Medical History:

GERD, Smoking, Diabetes

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 0.3 ppd × 27 yrs. Occasional marijuana use.

## Exam:

BMI 40.1. Antalgic gait. Knee ROM limited: flexion 103°, extension lag 2°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Diabetes—coordinate with PCP to optimize HbA1c <8%. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 15

Patient Name: Patricia Jackson

Age/Sex: 57-year-old female

MRN: KR0015

Visit Date: 2025-08-26

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

For the better part of 35 weeks, Patricia Jackson has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. She has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 600 feet. No prior knee injections. Current pain 9/10. No systemic red flags. No prior knee surgery. Patricia expressed that her cat often sits on her knee so she is curious if the cat’s weight may be damaging her joints. She loves her cat but she is worried that her cat may have started or making her knee problems worse.

## Past Medical History:

Blood clot, Hypertension, Diabetes

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 25 yrs. No illicit drug use.

## Exam:

BMI 30.5. Antalgic gait. Knee ROM limited: flexion 108°, extension lag 6°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis as well as treatment options. She is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. I reassured her that her cat sitting on her knee is not contributing to joint damage, and that her osteoarthritis is related to underlying degeneration rather than her pet. Her diabetes will need to be coordinated with her PCP for optimization prior to surgery, and we discussed the importance of smoking cessation, with cotinine testing required before proceeding. She will return in 3 weeks for reassessment and to continue surgical preparation.

# Chart 16

Patient Name: Robert Johnson

Age/Sex: 81-year-old male

MRN: KR0016

Visit Date: 2025-07-02

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

Robert Johnson reports that his knee has gradually become more painful and stiff over the past 75 weeks. He describes the pain as mostly aching, with sharper flares when climbing stairs, along with grinding and popping during movement. Conservative measures—including six weeks of PT, Tylenol, meloxicam, tramadol, and heat—have not changed his baseline pain. He has not had prior knee injections. Current pain is 9/10, and his walking tolerance is limited to about 300 feet. He denies bowel or bladder issues, cancer history, or systemic symptoms.

Robert shared that he sometimes wonders if his knee troubles began back in college. He told a story about joining an intramural rugby team with no prior experience, admitting he “had no business on that field.” In one game he took a hard hit, twisted his knee awkwardly, and spent weeks limping around campus. He never had it properly checked at the time, brushing it off as a sprain, but now he jokes that the knee has “never forgiven him for those years of abuse.” He believes that injury may have planted the seed for the problems he faces today.

## Past Medical History:

Hyperlipidemia, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 41.5. Antalgic gait. Knee ROM limited: flexion 95°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis as well as treatment options. He is an appropriate candidate for total knee arthroplasty; however, with BMI over 40, I recommended weight reduction prior to surgery to improve safety and recovery. Robert reflected on his old college rugby injury and joked that if he’d taken care of it back then, he might not be here now. We agreed he will return in 3 weeks for reassessment and to continue pre-operative planning.

# Chart 17

Patient Name: Elizabeth Martinez

Age/Sex: 84-year-old female

MRN: KR0017

Visit Date: 2025-06-24

Chief Complaint: Knee pain

## History of Present Illness (HPI):

This is a 84-year-old female who has been struggling with her knee for the past 55 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. She explains that after sitting for half an hour, when she gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 8/10, and walking tolerance is about 300 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

Hyperlipidemia, Hypertension

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 22.7. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 10°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 18

Patient Name: Michael Hernandez

Age/Sex: 65-year-old male

MRN: KR0018

Visit Date: 2025-06-16

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

This is a 65-year-old male who has been struggling with knee pain for the past 79 weeks. He describes it less as a sharp pain and more as a grinding, dragging weight in the joint that seems to “clamp down” with every step, especially when walking or climbing stairs. After sitting for even half an hour, standing feels like his knee is locked in place, and the first dozen steps are stiff and awkward before it finally loosens.

Conservative measures have included Tylenol, meloxicam, tramadol, physical therapy, and heat packs, but the relief has been temporary and incomplete. He has not had prior knee injections. Current pain is rated 6/10, and his walking tolerance is about 800 feet. He denies systemic symptoms and has no history of knee surgery.

He shared that the knee troubles have started to interfere with one of his favorite hobbies—fishing. In the past, he could stand for hours at the edge of the lake or climb along the riverbank to find the best spot. Now, he says even carrying his tackle box across uneven ground feels like a chore, and kneeling to unhook a catch is nearly impossible. He joked that the fish seem safer these days, since he can’t chase them down the way he used to, but behind the humor he admitted he misses the peace and freedom that fishing once gave him.

## Past Medical History:

Smoking, Obstructive sleep apnea, Hyperlipidemia, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 13 yrs. Remote cocaine use (no current use).

## Exam:

BMI 34.9. Antalgic gait. Knee ROM limited: flexion 97°, extension lag 8°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. As he is an active smoker, I counseled him on the importance of nicotine cessation for healing and recovery, with cotinine testing required before surgery. He shared that his goal is to return to fishing without being limited by knee pain, and I explained that taking these steps will give him the best chance of getting back to the activities he loves. We will see him again in 3 weeks for reassessment.

# Chart 19

Patient Name: Joseph Smith

Age/Sex: 66-year-old male

MRN: KR0019

Visit Date: 2025-08-08

Chief Complaint: Knee pain

## History of Present Illness (HPI):

For the better part of 50 weeks, Joseph Smith has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 400 feet. Corticosteroid injection 8 weeks ago with about 47% relief for 4 weeks. Current pain 9/10. No systemic red flags. No prior knee surgery.

## Past Medical History:

GERD, Hypertension, Hyperlipidemia, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 47.0. Antalgic gait. Knee ROM limited: flexion 102°, extension lag 1°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Recent injection <12 weeks; defer arthroplasty until safe interval passes. Return in 3 weeks for reassessment.

# Chart 20

Patient Name: Margaret Anderson

Age/Sex: 62-year-old female

MRN: KR0020

Visit Date: 2025-08-28

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

For the better part of 45 weeks, Margaret Anderson has been limited by progressive knee pain. She describes it not just as aching, but as a grinding, twisting sensation inside the joint—“like gears slipping out of place.” At times it pulses sharply with steps, and after longer walks it feels as though her knee is carrying a weight far heavier than her body. Walking beyond 800 feet leaves her stiff and frustrated. Conservative measures have included PT, Tylenol, meloxicam, and tramadol at night, but none have provided lasting relief. She has not had prior knee injections. Current pain is rated 8/10. She denies systemic symptoms, and has no prior knee surgery.

While describing her knee, Margaret told a story from last summer: she was at a family picnic when a rogue peacock from a nearby farm wandered into the yard. Against better judgment, she decided to chase it away—but her knee locked up mid-sprint, leaving her stumbling after the bird while her grandchildren cheered her on. She laughed, saying the peacock strutted away victorious, and ever since, her family teases her that “the bird won the race.” She admits it was funny in hindsight, but also the moment she realized just how unpredictable and limiting her knee had become.

## Past Medical History:

Hyperlipidemia, Blood clot, Hypertension

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 32.2. Antalgic gait. Knee ROM limited: flexion 97°, extension lag 4°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. Margaret mentioned again the picnic incident when her knee gave out chasing the peacock, and I reassured her that surgery should help reduce those unpredictable limitations. She will return in 3 weeks for reassessment and to continue surgical planning.

# Chart 21

Patient Name: Robert Lopez

Age/Sex: 77-year-old male

MRN: KR0021

Visit Date: 2025-08-13

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

This is a 77-year-old male who has been struggling with his knee for the past 78 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. Corticosteroid injection 12 weeks ago with about 59% relief for 6 weeks. Current pain is rated 6/10, and walking tolerance is about 300 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

Obstructive sleep apnea, Smoking, Hypertension

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 10 yrs. Remote cocaine use (no current use).

## Exam:

BMI 45.7. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 6°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 22

Patient Name: Dorothy Davis

Age/Sex: 79-year-old female

MRN: KR0022

Visit Date: 2025-08-27

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

This is a 79-year-old female who has been struggling with her knee for the past 36 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. She explains that after sitting for half an hour, when she gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. Corticosteroid injection 13 weeks ago with about 54% relief for 3 weeks. Current pain is rated 9/10, and walking tolerance is about 500 feet. Denies systemic symptoms or prior knee surgery. She enjoys pottery making but her knee pain is disrupting this activity due to the ache.

## Past Medical History:

Hyperlipidemia, Blood clot, Smoking

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 44.1. Antalgic gait. Knee ROM limited: flexion 109°, extension lag 4°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis along with treatment options. Given his BMI over 40, I recommended working toward at least a 10% weight reduction prior to surgery to lower operative risks and improve recovery. He expressed understanding of the recommendation, and we agreed to follow up in 3 weeks to reassess progress and continue surgical planning.

# Chart 23

Patient Name: Patricia Anderson

Age/Sex: 84-year-old female

MRN: KR0023

Visit Date: 2025-08-01

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

Patricia Anderson reports knee pain for the past 63 weeks, described as aching discomfort that worsens with activity and eases somewhat with rest. She also notes stiffness after inactivity, especially in the mornings, and reduced range of motion with pain at the end ranges. Current pain is 8/10, and she can walk about 600 feet before needing to stop. Conservative measures have included Tylenol, meloxicam, tramadol, physical therapy, and heat, with limited relief. A corticosteroid injection 8 weeks ago gave her about 79% improvement, though only for 8 weeks. She denies systemic symptoms, has no history of cancer, and no prior knee surgery.

While recounting her symptoms, Patricia told a wild story about her last attempt at hosting a family dinner. She insisted on making her famous chili, but halfway through, her knee stiffened so badly she couldn’t move from the counter. To keep going, she pulled over a rolling chair and scooted around the kitchen, stirring pots and chopping onions like she was in a bumper car. At one point, she lost her balance and nearly launched a whole pan of cornbread across the room. Her family now jokes that it was the most entertaining dinner she’s ever hosted. She laughed retelling it, but admitted the episode also made her realize just how much her knee is interfering with the simple routines she loves.

## Past Medical History:

Hypertension, Hyperlipidemia, Smoking, GERD

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 37.4. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. Because she received a corticosteroid injection less than 12 weeks ago, arthroplasty will be deferred until the safe interval has passed. In the meantime, she will continue her current measures. Patricia joked about needing her knee working properly before attempting another “bumper-car style cooking session,” and I reassured her that surgery should help restore stability for daily activities. She will return in 3 weeks for reassessment.

# Chart 24

Patient Name: Thomas Thomas

Age/Sex: 73-year-old male

MRN: KR0024

Visit Date: 2025-07-01

Chief Complaint: Knee pain

## History of Present Illness (HPI):

This is a 73-year-old male who has been struggling with his knee for the past 41 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 8/10, and walking tolerance is about 700 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

Obstructive sleep apnea, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.5 ppd × 26 yrs. Occasional marijuana use.

## Exam:

BMI 31.6. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 6°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 25

Patient Name: Dorothy Garcia

Age/Sex: 69-year-old female

MRN: KR0025

Visit Date: 2025-06-11

Chief Complaint: Knee pain

## History of Present Illness (HPI):

Dorothy Garcia reports knee pain for 33 weeks with crepitus with knee motion, reduced knee range of motion with painful end ranges, stiffness after inactivity, especially mornings. Pain 6/10. Walk tolerance ~700 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. No prior knee injections. Denies systemic symptoms, no cancer history, no prior knee surgery.

## Past Medical History:

GERD, Blood clot

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 41.0. Antalgic gait. Knee ROM limited: flexion 93°, extension lag 5°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Return in 3 weeks for reassessment.

# Chart 26

Patient Name: Joseph Martin

Age/Sex: 56-year-old male

MRN: KR0026

Visit Date: 2025-07-17

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

This is a 56-year-old male who has been struggling with his knee for the past 67 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. Corticosteroid injection 20 weeks ago with about 68% relief for 4 weeks. Current pain is rated 8/10, and walking tolerance is about 600 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

Obstructive sleep apnea, Blood clot, GERD, Smoking

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 40.3. Antalgic gait. Knee ROM limited: flexion 91°, extension lag 1°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Return in 3 weeks for reassessment.

# Chart 27

Patient Name: Joseph Martin

Age/Sex: 55-year-old male

MRN: KR0027

Visit Date: 2025-06-02

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

Joseph Martin tells me that the knee has gradually become more painful and stiff over the last 80 weeks. The pain is mostly aching, sometimes sharp with stairs, and he describes grinding and popping with movement. Conservative measures have included PT for six weeks, Tylenol, meloxicam, tramadol, and heat, none of which changed the baseline pain. Corticosteroid injection 21 weeks ago with about 46% relief for 6 weeks. Pain currently 7/10, walking tolerance about 500 feet. No bowel or bladder issues, no cancer history.

## Past Medical History:

Smoking, Blood clot, Hyperlipidemia, Diabetes

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.4 ppd × 26 yrs. No illicit drug use.

## Exam:

BMI 26.1. Antalgic gait. Knee ROM limited: flexion 95°, extension lag 0°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 28

Patient Name: John Moore

Age/Sex: 71-year-old male

MRN: KR0028

Visit Date: 2025-07-09

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

For the better part of 31 weeks, John Moore has been limited by progressive knee pain. He describes the discomfort as aching and stiff, worse with walking and only partly relieved by rest. He has tried PT, Tylenol, meloxicam, and tramadol at night, but he still cannot walk beyond 400 feet. A corticosteroid injection 11 weeks ago provided about 77% relief, lasting 8 weeks. Current pain is 7/10. He denies systemic red flags and has no history of knee surgery.

John shared that his knee pain recently became especially noticeable during a neighborhood community event. He was helping set up tables and chairs, something he used to do without a second thought, but after just a few trips back and forth carrying folding chairs, his knee stiffened and forced him to stop. He admitted it was frustrating to watch others finish the setup while he sat down, and he felt embarrassed having to explain that it wasn’t a lack of effort but his knee holding him back.

## Past Medical History:

Hypertension, Blood clot, GERD, Hyperlipidemia

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 25.1. Antalgic gait. Knee ROM limited: flexion 99°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. Because he had a corticosteroid injection less than 12 weeks ago, arthroplasty will be deferred until the safe interval has passed. He expressed frustration that the pain continues to interfere with simple tasks, such as helping with community events, but understands the importance of timing for surgery. We will plan to follow up in 3 weeks for reassessment.

# Chart 29

Patient Name: Thomas Brown

Age/Sex: 61-year-old male

MRN: KR0029

Visit Date: 2025-08-21

Chief Complaint: Knee instability

## History of Present Illness (HPI):

For the better part of 40 weeks, Thomas Brown has been limited by progressive knee pain. He describes the discomfort as aching and stiff, worsened by walking and relieved only a little by rest. Conservative measures have included PT, Tylenol, meloxicam, and tramadol at night, but despite these efforts, he still cannot walk beyond 500 feet. A corticosteroid injection 21 weeks ago provided about 44% relief for 8 weeks. His current pain is 8/10. He denies systemic red flags and has no prior knee surgery.

Thomas shared a lighthearted story about how his knee problems first became obvious while trying to catch his granddaughter’s pet bunny that had escaped into the backyard. He laughed, saying the bunny darted under the bushes and around the garden while he shuffled stiffly after it, only to have his knee lock mid-chase. He ended up calling for help while the rabbit hopped back on its own terms. He admits it was funny in the moment, but also frustrating—a clear reminder that he can no longer move the way he once did.

## Past Medical History:

Smoking, Hyperlipidemia

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.4 ppd × 14 yrs. No illicit drug use.

## Exam:

BMI 41.4. Antalgic gait. Knee ROM limited: flexion 100°, extension lag 4°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, but with a BMI >40, I advised working toward at least a 10% weight reduction before surgery. As he is an active smoker, I counseled nicotine cessation and explained that cotinine testing will be required prior to surgery. Thomas mentioned wanting his knee strong enough to keep up with his granddaughter’s bunny, and I reassured him that taking these steps will help improve both his safety and his long-term recovery. He will return in 3 weeks for reassessment.

# Chart 30

Patient Name: James Garcia

Age/Sex: 69-year-old male

MRN: KR0030

Visit Date: 2025-07-20

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

For the better part of 58 weeks, James Garcia has been limited by progressive knee pain. Rather than sharp pain, he describes it as a grinding pressure deep inside the joint, “like two stones rubbing together.” At times it feels heavy, almost as if he’s dragging weight with each step. The stiffness is most noticeable after sitting, when his knee feels locked until it gradually gives way. Walking and stairs worsen his discomfort, and rest provides only limited relief. He has tried PT, Tylenol, meloxicam, and tramadol at night, but despite these measures, he still cannot walk beyond 400 feet. He has not had prior knee injections. Current pain is rated 7/10. He denies systemic red flags and has no history of knee surgery.

James shared that this was especially clear during a family trip to the beach earlier this year. The uneven sand made his knee feel unstable and heavy, and he said every step felt like the joint was “sinking and grinding at the same time.” While his grandchildren played at the water’s edge, he had to stop and rest on a bench, admitting it was frustrating to be in such a beautiful place yet feel held back by his knee.

## Past Medical History:

Hypertension, Diabetes

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.8 ppd × 9 yrs. Remote cocaine use (no current use).

## Exam:

BMI 32.7. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis as well as treatment options. He is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. His diabetes will need to be coordinated with his PCP for improved control prior to surgery, and as he is an active smoker, I counseled him on nicotine cessation, noting that cotinine testing will be required before moving forward. James shared that his biggest goal is to be able to walk on the beach again without having to stop after just a few steps, and I reassured him that taking these steps toward surgery will give him the best chance of regaining that freedom. We will follow up in 3 weeks for reassessment.

# Chart 31

Patient Name: William Rodriguez

Age/Sex: 61-year-old male

MRN: KR0031

Visit Date: 2025-08-03

Chief Complaint: Knee instability

## History of Present Illness (HPI):

William Rodriguez reports that his knee has gradually become more painful and stiff over the past 54 weeks. He describes the discomfort less as simple aching and more as a constant heaviness in the joint, “like carrying a weight inside the knee.” At times, especially on stairs, the pain spikes sharply, making him hesitate mid-step. He also reports a coarse grinding and catching sensation, as though the joint “doesn’t glide the way it used to.” The stiffness is most noticeable after sitting, when the knee feels locked until it loosens.

He has tried six weeks of PT, along with Tylenol, meloxicam, tramadol, and heat, but none of these have changed his baseline pain. He has not had prior knee injections. Current pain is 9/10, with walking tolerance limited to about 700 feet before stopping. He denies bowel or bladder issues, has no cancer history, and no prior knee surgery.

## Past Medical History:

Diabetes, Obstructive sleep apnea

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 23.3. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 6°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Diabetes—coordinate with PCP to optimize HbA1c <8%. Return in 3 weeks for reassessment.

# Chart 32

Patient Name: Elizabeth Lopez

Age/Sex: 77-year-old female

MRN: KR0032

Visit Date: 2025-07-11

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

Elizabeth Lopez reports knee pain for 49 weeks with difficulty with walking, stairs, and rising from a chair, crepitus with knee motion, aching pain worsened by activity and improved with rest. Pain 9/10. Walk tolerance ~500 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. No prior knee injections. Denies systemic symptoms, no cancer history, no prior knee surgery.

## Past Medical History:

Blood clot, Obstructive sleep apnea

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.5 ppd × 22 yrs. Remote cocaine use (no current use).

## Exam:

BMI 30.0. Antalgic gait. Knee ROM limited: flexion 110°, extension lag 2°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 33

Patient Name: Dorothy Smith

Age/Sex: 81-year-old female

MRN: KR0033

Visit Date: 2025-06-24

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

For the better part of 52 weeks, Dorothy Smith has been limited by progressive knee pain. She describes the discomfort as aching and stiff, worsened by walking and only partly relieved by rest. Conservative measures have included PT, Tylenol, meloxicam, and tramadol at night, but despite these efforts she still cannot walk beyond 300 feet. A corticosteroid injection 24 weeks ago provided about 59% relief for 7 weeks. Current pain is 8/10. She denies systemic red flags and has no history of knee surgery.

Dorothy shared that her knee problems have become especially frustrating during her pottery classes. She loves working with clay, but sitting at the wheel for too long leaves her knee stiff, and standing up afterward feels like trying to move stone instead of a joint. She laughed as she recalled one class where she nearly toppled a half-finished vase because her knee locked as she tried to get up. While her classmates teased that it was “modern art,” she admitted it was disheartening to feel her body limiting her creativity. She misses being able to lose herself in her craft without worrying about whether her knee will cooperate.

## Past Medical History:

Hypertension, Obstructive sleep apnea, Blood clot

## Past Surgical History:

Cholecystectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 10 yrs. Occasional marijuana use.

## Exam:

BMI 41.2. Antalgic gait. Knee ROM limited: flexion 101°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty; however, with BMI >40, I advised working toward at least a 10% weight reduction before surgery. As she is an active smoker, I counseled nicotine cessation, and cotinine testing will be required prior to surgery. Dorothy mentioned her goal of being able to return to pottery without worrying about her knee locking at the wheel, and I reassured her that these steps will help give her the best chance for a safe recovery. She will return in 3 weeks for reassessment.

# Chart 34

Patient Name: Maria Wilson

Age/Sex: 65-year-old female

MRN: KR0034

Visit Date: 2025-06-02

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

Maria Wilson reports knee pain for 62 weeks with aching pain worsened by activity and improved with rest, reduced knee range of motion with painful end ranges, stiffness after inactivity, especially mornings. Pain 9/10. Walk tolerance ~600 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. No prior knee injections. Denies systemic symptoms, no cancer history, no prior knee surgery. She used to go to spin classes and even teach yoga classes but her knee pain is so bad that she lost her job from the lack of instruction she was able to provide.

## Past Medical History:

Hyperlipidemia, Diabetes, Obstructive sleep apnea, GERD

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.5 ppd × 33 yrs. Remote cocaine use (no current use).

## Exam:

BMI 41.4. Antalgic gait. Knee ROM limited: flexion 105°, extension lag 6°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed the diagnosis and treatment options. The patient is an appropriate candidate for total knee arthroplasty, but pre-operative optimization is required. With BMI >40, I advised weight reduction prior to surgery. Diabetes management will need to be coordinated with the PCP to optimize HbA1c before proceeding. As the patient is an active smoker, I counseled nicotine cessation and explained that cotinine testing will be required. During our discussion, the patient became emotional, sharing that they recently lost their job and are worried about the costs of treatment. I acknowledged these concerns and encouraged them to explore available resources and financial assistance options, reassuring them that we will work together to address both the medical and practical aspects of their care. We will follow up in 3 weeks for reassessment.

# Chart 35

Patient Name: Linda Garcia

Age/Sex: 70-year-old female

MRN: KR0035

Visit Date: 2025-07-01

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

For the better part of 39 weeks, Linda Garcia has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. She has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 600 feet. No prior knee injections. Current pain 7/10. No systemic red flags. No prior knee surgery.

## Past Medical History:

Hyperlipidemia, Smoking, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 41.2. Antalgic gait. Knee ROM limited: flexion 94°, extension lag 4°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Return in 3 weeks for reassessment.

# Chart 36

Patient Name: Joseph Hernandez

Age/Sex: 71-year-old male

MRN: KR0036

Visit Date: 2025-08-26

Chief Complaint: Knee pain

## History of Present Illness (HPI):

Joseph Hernandez reports that his knee has gradually become more painful and stiff over the past 67 weeks. He describes the pain as mostly aching, with sharper flares on stairs, and notes grinding and popping with movement. Conservative measures have included six weeks of PT, Tylenol, meloxicam, tramadol, and heat, though none have improved his baseline pain. A corticosteroid injection 17 weeks ago provided about 76% relief, though it only lasted for 3 weeks. Current pain is 7/10, and his walking tolerance is limited to about 400 feet. He denies bowel or bladder symptoms, has no cancer history, and has not had prior knee surgery.

Joseph shared that the limitations became especially clear during a family trip to Lake George earlier this summer. He recalled how much he used to enjoy walking along the lakeside paths and climbing down to the docks, but this time he had to stop after just a few minutes. He laughed that while the rest of the family made it to the shoreline for photos, he ended up sitting on a bench with the ice cream cooler, joking that he was “guarding the snacks.” Still, he admitted it was discouraging to be surrounded by such a beautiful place yet feel held back by his knee pain.

## Past Medical History:

Hyperlipidemia, Hypertension, Blood clot

## Past Surgical History:

Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 0.8 ppd × 9 yrs. Remote cocaine use (no current use).

## Exam:

BMI 49.4. Antalgic gait. Knee ROM limited: flexion 92°, extension lag 10°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty; however, with BMI >40, I advised working toward at least a 10% weight reduction before surgery. As he is an active smoker, I counseled nicotine cessation and explained that cotinine testing will be required prior to surgery. Joseph shared that his hope is to return to Lake George and enjoy walking along the shoreline without being limited by his knee. I reassured him that these steps will help improve both surgical safety and his chances of getting back to the activities he values. We will follow up in 3 weeks for reassessment.

# Chart 37

Patient Name: Linda Moore

Age/Sex: 75-year-old female

MRN: KR0037

Visit Date: 2025-07-28

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

Linda Moore reports that her knee has gradually become more painful and stiff over the last 35 weeks. She describes the pain as mostly aching, with sharper flares when climbing stairs, and notes grinding and popping with movement. Conservative measures have included six weeks of PT, Tylenol, meloxicam, tramadol, and heat, but none have changed her baseline pain. She has not had prior knee injections. Current pain is rated 8/10, and her walking tolerance is about 700 feet. She denies bowel or bladder issues, has no cancer history, and has not had prior knee surgery.

Linda shared a memorable story about her younger days when she went skydiving with friends. She recalled the adrenaline of the freefall and how powerful her knees felt when she landed and ran it out on the grass. Now, she laughed that if she tried the same thing today, her knees would “crumble like a bad parachute.” She admitted that the memory is bittersweet—while she’s glad she had those adventures, it makes her current limitations feel even sharper. She says her biggest wish is simply to walk confidently again, even if she’ll never leap out of another plane.

## Past Medical History:

Diabetes, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Smoker, 1.0 ppd × 18 yrs. Occasional marijuana use.

## Exam:

BMI 22.3. Antalgic gait. Knee ROM limited: flexion 92°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. Her diabetes will need to be coordinated with her PCP for improved control, and as she is an active smoker, I counseled her on nicotine cessation, noting that cotinine testing will be required before surgery. Linda reflected on her skydiving days and expressed hope that surgery will give her the confidence to walk strongly again, even if she never jumps from a plane. We will follow up in 3 weeks for reassessment.

# Chart 38

Patient Name: William Brown

Age/Sex: 72-year-old male

MRN: KR0038

Visit Date: 2025-08-03

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

For the better part of 40 weeks, William Brown has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 600 feet. Corticosteroid injection 19 weeks ago with about 53% relief for 8 weeks. Current pain 6/10. No systemic red flags. No prior knee surgery.

## Past Medical History:

Hyperlipidemia, Smoking, Hypertension, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Smoker, 1.2 ppd × 32 yrs. No illicit drug use.

## Exam:

BMI 32.5. Antalgic gait. Knee ROM limited: flexion 100°, extension lag 4°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 39

Patient Name: James Hernandez

Age/Sex: 73-year-old male

MRN: KR0039

Visit Date: 2025-07-05

Chief Complaint: Knee instability

## History of Present Illness (HPI):

For the better part of 33 weeks, James Hernandez has been limited by progressive knee pain. The discomfort is in the joint, aching and stiff, made worse with walking and relieved only a little by rest. He has tried PT, Tylenol, meloxicam, and even tramadol at night but still cannot walk beyond 400 feet. Corticosteroid injection 12 weeks ago with about 80% relief for 6 weeks. Current pain 8/10. No systemic red flags. No prior knee surgery.

## Past Medical History:

Obstructive sleep apnea, Smoking, Blood clot, GERD

## Past Surgical History:

Tonsillectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 41.6. Antalgic gait. Knee ROM limited: flexion 97°, extension lag 5°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Return in 3 weeks for reassessment.

# Chart 40

Patient Name: Christopher Lopez

Age/Sex: 69-year-old male

MRN: KR0040

Visit Date: 2025-07-13

Chief Complaint: Knee pain

## History of Present Illness (HPI):

For the better part of 51 weeks, Christopher Lopez has been limited by progressive knee pain. He describes it as a constant heaviness in the joint, with stiffness that makes his knee feel “locked” after periods of rest. With walking, the discomfort builds into a grinding, dragging sensation, sometimes sharp enough to stop him on stairs. Rest provides only partial relief, and the ache tends to linger regardless of activity. He has tried PT, Tylenol, meloxicam, and even tramadol at night, but he still cannot walk beyond 700 feet without stopping. He has not had prior knee injections. Current pain is 6/10. He denies systemic red flags and has no history of knee surgery.

## Past Medical History:

Diabetes, Obstructive sleep apnea, Blood clot

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 42.7. Antalgic gait. Knee ROM limited: flexion 104°, extension lag 5°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. I advised weight reduction prior to surgery to support safety and recovery. His diabetes will need to be coordinated with his PCP for better control. We will follow up in 3 weeks for reassessment and to continue planning.

# Chart 41

Patient Name: Elizabeth Smith

Age/Sex: 79-year-old female

MRN: KR0041

Visit Date: 2025-08-03

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

EElizabeth Smith reports knee pain for the past 63 weeks, with swelling and increased pain after long walks. She describes reduced range of motion, with pain at the end ranges, along with stiffness that is especially noticeable after inactivity and in the mornings. Current pain is 8/10, and her walking tolerance is about 600 feet before she must stop. She has tried Tylenol, meloxicam, tramadol, PT, and heat, but relief has been limited. A corticosteroid injection 23 weeks ago gave her about 67% improvement, though only for 5 weeks. She denies systemic symptoms, has no cancer history, and no prior knee surgery.

While describing her symptoms, Elizabeth shared a funny story about helping her granddaughter with a slime-making project. She explained that kneeling down to get supplies from the lower kitchen cabinets turned into a challenge, as her knee stiffened and popped when she tried to stand back up. She ended up sliding across the floor on her hands and knees, joking that she “looked like part of the slime experiment.” Though she laughed about it, she admitted moments like these remind her how unpredictable and limiting her knee pain has become.

## Past Medical History:

Smoking, Obstructive sleep apnea

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 44.4. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 8°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, but with BMI >40 I advised working on weight reduction before surgery to improve safety and outcomes. Elizabeth mentioned wanting to get back to activities like playing with her granddaughter—without her knee locking up mid–slime project—and I reassured her that surgery will help restore that freedom. We will follow up in 3 weeks for reassessment.

# Chart 42

Patient Name: John Thomas

Age/Sex: 55-year-old male

MRN: KR0042

Visit Date: 2025-08-06

Chief Complaint: Knee pain

## History of Present Illness (HPI):

This is a 55-year-old male who has been struggling with his knee for the past 32 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens. Conservative measures have included Tylenol, meloxicam, tramadol, PT, and heat packs, but the relief is short-lived. No prior knee injections. Current pain is rated 6/10, and walking tolerance is about 500 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

Blood clot, Smoking, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Penicillin allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 35.5. Antalgic gait. Knee ROM limited: flexion 99°, extension lag 10°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. Appropriate candidate for total knee arthroplasty; proceed with pre-op planning. Return in 3 weeks for reassessment.

# Chart 43

Patient Name: Linda Brown

Age/Sex: 77-year-old female

MRN: KR0043

Visit Date: 2025-06-10

Chief Complaint: Knee swelling

## History of Present Illness (HPI):

Linda Brown reports knee pain for the past 70 weeks. She describes it not as a sharp sensation but more like a grinding heaviness in the joint, “as if the knee is carrying gravel inside it.” The stiffness is worst after inactivity, especially in the mornings, when it feels locked until she takes several steps. After long walks, her knee swells and throbs, and with motion she hears and feels crepitus, which she describes as “like walking on broken twigs.” Pain is currently 8/10, and her walking tolerance is about 600 feet before stopping. She has tried Tylenol, meloxicam, tramadol, PT, and heat, with only limited relief. A corticosteroid injection 14 weeks ago provided about 73% improvement, though the benefit lasted only 5 weeks. She denies systemic symptoms, has no cancer history, and has not had prior knee surgery.

Linda shared a story about visiting the countryside to see an old friend. She recalled how much she loved walking the rolling paths and leaning on the split-rail fences, but this time, she had to stop often, her knee locking and aching with every slope. She joked that the cows in the pasture looked at her “like they were winning the race,” as she lagged behind. Though she laughed at the memory, she admitted it was discouraging—realizing that even in the peaceful countryside, where she once felt free and strong, her knee pain now dictates how far she can go.

## Past Medical History:

Hypertension, Smoking

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 32.3. Antalgic gait. Knee ROM limited: flexion 109°, extension lag 0°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. Linda mentioned wanting to return to countryside walks without being slowed by knee pain, and I reassured her that surgery is aimed at restoring her mobility so she can enjoy those activities again. We will follow up in 3 weeks for reassessment.

# Chart 44

Patient Name: David Gonzalez

Age/Sex: 69-year-old male

MRN: KR0044

Visit Date: 2025-06-15

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

David Gonzalez reports knee pain for 68 weeks with aching pain worsened by activity and improved with rest, swelling and pain after long walks, crepitus with knee motion. Pain 6/10. Walk tolerance ~400 ft. Tried Tylenol, meloxicam, tramadol, PT, and heat. Corticosteroid injection 22 weeks ago with about 72% relief for 3 weeks. Denies systemic symptoms, no cancer history, no prior knee surgery.

## Past Medical History:

Obstructive sleep apnea, GERD

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.1 ppd × 13 yrs. No illicit drug use.

## Exam:

BMI 40.6. Antalgic gait. Knee ROM limited: flexion 95°, extension lag 8°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Active smoker—counseled nicotine cessation; cotinine testing before surgery. Return in 3 weeks for reassessment.

# Chart 45

Patient Name: Christopher Anderson

Age/Sex: 60-year-old male

MRN: KR0045

Visit Date: 2025-08-13

Chief Complaint: Knee pain

## History of Present Illness (HPI):

Christopher Anderson tells me that the knee has gradually become more painful and stiff over the last 30 weeks. The pain is mostly aching, sometimes sharp with stairs, and he describes grinding and popping with movement. Conservative measures have included PT for six weeks, Tylenol, meloxicam, tramadol, and heat, none of which changed the baseline pain. No prior knee injections. Pain currently 9/10, walking tolerance about 800 feet. No bowel or bladder issues, no cancer history.

## Past Medical History:

Obstructive sleep apnea, GERD, Blood clot, Hyperlipidemia

## Past Surgical History:

Cholecystectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 43.8. Antalgic gait. Knee ROM limited: flexion 98°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed diagnosis and treatment options. BMI >40; advised ≥10% weight reduction before surgery. Return in 3 weeks for reassessment.

# Chart 46

Patient Name: Charles Gonzalez

Age/Sex: 55-year-old male

MRN: KR0046

Visit Date: 2025-08-05

Chief Complaint: Knee instability

## History of Present Illness (HPI):

This is a 55-year-old male who has been struggling with his knee for the past 49 weeks, describing a deep, aching pain that worsens with walking and climbing stairs. He explains that after sitting for half an hour, when he gets up, the first dozen steps are extremely stiff until the knee loosens.. Current pain is rated 8/10, and walking tolerance is about 600 feet. Denies systemic symptoms or prior knee surgery.

## Past Medical History:

GERD, Blood clot, Hypertension

## Past Surgical History:

Appendectomy, Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Remote cocaine use (no current use).

## Exam:

BMI 40.7. Antalgic gait. Knee ROM limited: flexion 96°, extension lag 3°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed imaging and discussed the diagnosis along with treatment options. Although she is an appropriate candidate for total knee arthroplasty, she expressed reluctance about pursuing surgery at this time. We discussed the role of weight reduction in improving both pain and mobility, and I advised working toward this goal as part of her ongoing management. We will continue to focus on non-surgical strategies for now and plan to follow up in 3 weeks for reassessment.

# Chart 47

Patient Name: Linda Taylor

Age/Sex: 76-year-old female

MRN: KR0047

Visit Date: 2025-07-12

Chief Complaint: Knee stiffness

## History of Present Illness (HPI):

For the better part of 68 weeks, Linda Taylor has been limited by progressive knee pain. She describes the discomfort as aching and stiff, worsened by walking and only partly relieved by rest. She has tried PT, Tylenol, meloxicam, and tramadol at night, but despite these measures she still cannot walk beyond 300 feet. A corticosteroid injection 17 weeks ago provided about 75% relief, though it only lasted 6 weeks. Current pain is 6/10. She denies systemic red flags and has no history of knee surgery.

Linda shared a story about a recent neighborhood block party. She said she was determined to join in the festivities and tried to help set up tables and decorations, but after just a few trips back and forth carrying chairs, her knee stiffened and forced her to sit down. She laughed that she ended up “supervising” with a plate of pie while everyone else did the heavy lifting, but admitted it was frustrating to watch instead of participate. She explained that moments like this make her realize how much her knee pain is limiting her daily life.

## Past Medical History:

Obstructive sleep apnea, Hypertension, Hyperlipidemia, GERD

## Past Surgical History:

Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

No known drug allergies. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 24.4. Antalgic gait. Knee ROM limited: flexion 99°, extension lag 5°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty, and we will move forward with pre-operative planning. Linda mentioned wanting to be more active at neighborhood gatherings instead of sitting on the sidelines, and I reassured her that surgery is aimed at improving her mobility so she can fully participate again. We will follow up in 3 weeks for reassessment.

# Chart 48

Patient Name: Barbara Jones

Age/Sex: 67-year-old female

MRN: KR0048

Visit Date: 2025-07-02

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

Barbara Jones reports knee pain for the past 55 weeks. She describes an aching pain that worsens with activity and improves somewhat with rest. She notes reduced knee range of motion with pain at the end ranges, along with difficulty walking, climbing stairs, and rising from a chair. Current pain is 8/10, and her walking tolerance is about 300 feet. She has tried Tylenol, meloxicam, tramadol, PT, and heat, with limited relief. A corticosteroid injection 20 weeks ago gave her about 55% improvement, though only for 4 weeks. She denies systemic symptoms, has no history of cancer, and no prior knee surgery.

Barbara shared that her knee pain has been especially discouraging when it comes to rowing, a hobby she picked up years ago and always enjoyed for exercise and peace of mind. She recalled a recent outing where she struggled just getting in and out of the boat, saying her knee felt locked and unstable on the dock. Once in the water, she could still row, but the strain of getting back out left her frustrated and worried about falling. She laughed that her friends teased her for “rowing like a champion but docking like a disaster,” but she admitted the episode made her realize how much her knee is interfering with the activities she loves.

## Past Medical History:

Hypertension, Blood clot

## Past Surgical History:

Tonsillectomy, Appendectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. No illicit drug use.

## Exam:

BMI 45.1. Antalgic gait. Knee ROM limited: flexion 108°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed her imaging and discussed the diagnosis and treatment options. She is an appropriate candidate for total knee arthroplasty; however, with BMI >40, I advised working on weight reduction prior to surgery to improve safety and recovery. Barbara mentioned her hope of being able to return to rowing without struggling on and off the dock, and I reassured her that surgery should help her regain more stability and mobility for the activities she values. We will follow up in 3 weeks for reassessment.

# Chart 49

Patient Name: John Moore

Age/Sex: 68-year-old male

MRN: KR0049

Visit Date: 2025-07-21

Chief Complaint: Knee buckling

## History of Present Illness (HPI):

John Moore has been limited by progressive knee pain. He describes it not as a sharp pain but as a deep, nagging throb that feels “like a rope pulled too tight inside the joint.” At times, particularly on stairs, it sends sudden jolts that make him pause mid-step. He also reports episodes of stiffness after rest, when the knee feels stuck in place until he forces it into motion. He says the combination of throbbing, stiffness, and sudden jolts makes him feel as though the joint can’t be trusted. Despite PT, Tylenol, meloxicam, and tramadol at night, he still cannot walk beyond 600 feet without having to stop. A corticosteroid injection 24 weeks ago provided about 56% relief, but only for 7 weeks. Current pain is 6/10. He denies systemic red flags and has no history of knee surgery.

John shared that this became especially clear during a recent fishing trip with a friend. They had always enjoyed hiking down to a quiet spot along the riverbank, but this time his knee locked up halfway down the path. He ended up sitting on a rock, holding the tackle box, while his friend did the fishing. He laughed that he “caught nothing but sore knees” that day, but admitted it was frustrating to realize how much the pain is keeping him from simple outdoor activities he once loved.

## Past Medical History:

Obstructive sleep apnea, Diabetes

## Past Surgical History:

Cholecystectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Smoker, 1.3 ppd × 29 yrs. No illicit drug use.

## Exam:

BMI 35.8. Antalgic gait. Knee ROM limited: flexion 93°, extension lag 7°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Bicompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

​​We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty, and we will proceed with pre-operative planning. His diabetes will need to be coordinated with his PCP for better control prior to surgery, and as he is an active smoker, I counseled him on nicotine cessation with cotinine testing required before proceeding. John mentioned wanting to return to fishing without being sidelined by knee pain, and I reassured him that surgery and these preparatory steps will help give him the best chance of regaining that ability. We will follow up in 3 weeks for reassessment.

# Chart 50

Patient Name: William Hernandez

Age/Sex: 67-year-old male

MRN: KR0050

Visit Date: 2025-07-06

Chief Complaint: Knee instability

## History of Present Illness (HPI):

William Hernandez reports that his knee has gradually become more painful and stiff over the past 30 weeks. He describes the pain not only as aching, but as something that wears on him emotionally—“a constant reminder that I can’t move the way I want to.” On stairs, the sharp jolts make him anxious about losing his footing, and the grinding and popping with motion leaves him feeling like his joint is betraying him. He says the frustration is almost as hard as the pain itself, as even simple movements now come with hesitation and worry.

Conservative measures have included six weeks of PT, Tylenol, meloxicam, tramadol, and heat, but none have meaningfully changed his baseline pain. A corticosteroid injection 14 weeks ago gave him about 56% relief, though it only lasted 5 weeks. Pain is currently 7/10, with walking tolerance limited to about 400 feet. He denies bowel or bladder issues, has no cancer history, and no prior knee surgery.

William shared a story about a recent afternoon at the park with his grandson. The boy asked him to race to the swings, something William used to do without a second thought. Instead, he had to smile and wave him on, sitting on a bench while his grandson sprinted ahead. He admitted he clapped and cheered as though nothing was wrong, but inside it hurt to realize he couldn’t join in. He said moments like that are what make the pain feel heavier—“it’s not just my knee that’s stiff, it’s my whole world shrinking around it.”

## Past Medical History:

Hyperlipidemia, Smoking, Blood clot, Obstructive sleep apnea

## Past Surgical History:

Appendectomy, Tonsillectomy

## Medications:

Atorvastatin, beta blocker, Meloxicam, Tylenol, Tramadol.

## Allergies:

Sulfa allergy. No metal allergies.

## Social History:

Non-smoker. Occasional marijuana use.

## Exam:

BMI 44.1. Antalgic gait. Knee ROM limited: flexion 103°, extension lag 9°. Varus/valgus alignment noted. Crepitus with motion. Strength intact. Sensation intact. DP pulse palpable.

## Imaging:

Standing AP, lateral, sunrise, and Rosenberg knee X-rays show severe joint space narrowing with osteophyte formation. Tricompartmental bone-on-bone osteoarthritis. No fracture.

## Assessment:

Knee osteoarthritis with progressive pain and functional decline despite conservative care.

## Plan:

We reviewed his imaging and discussed the diagnosis and treatment options. He is an appropriate candidate for total knee arthroplasty; however, with BMI >40, I advised working on weight reduction before surgery to support safety and recovery. William expressed frustration that his pain has begun limiting time with his grandson, and I reassured him that surgery—combined with lifestyle changes—can help him regain the ability to be more active with his family. We agreed to follow up in 3 weeks for reassessment.