Smith, John
DOB: January 20th, 1984
MRN: Unarmed
Date: May 30th, 2022

Follow-up: in 1 month
Diagnosis: other meniscus derangements, unspecified medial meniscus, right knee (m23.303)
Work Duty: Full duty

Chief Complaint: Left knee pain

History Of Presenting Illness:
John Smith is a very pleasant 38 year old, left hand dominant, male who works as an engineer. He comes in today complaining of occasional sore pain to his left knee. He states the symptoms have been present since May 1st, 2022, at severe to mild level intensity and developed gradually. He denies any injury. He states symptoms are worse with in & out of chair and get better with massage. He admits to the radiation of symptoms . He has received previous treatment. He has not taken any medications to help with this issue.

Allergies:
1. Sulfamethoxazole/Trimethoprim (Oral Pill) - Hives
2. SYNTHROID (Oral Pill) - Sun reaction
3. Levothyroxine (Oral Pill) - Testing reaction
4. LEVO-T (Oral Pill) - Levi reaction

Medications:
1. amLODIPine/Hydrochlorothiazide/Valsartan (Oral Pill) mg 1x Daily
2. AMLACTIN (Topical) mg 1x Daily

Past Medical History:
1. Anxiety
2. COPD/Emphysema
3. Hypertension
4. Seizure disorder

Past Surgical History:
- REPAIR EXTEN. MUSCLE/TEN.
- Knee replacement
- Carpal tunnel release
- REPAIR EXTENSOR TENDON LE
- REPAIR EXTENSOR TENDON LE
- NEEDLE ASPIRATION-ABS/HEMATOMA
- I&D ABSCESS-COMPLICATED
- I&D ABSCESS-COMPLICATED

Family History:
Mother's Conditions: blood clots
Fathers's Conditions: heart disease, and stroke

Grand Parents Conditions: cancer, and stroke
Siblings Conditions: heart disease

Social History:
Occupation: Engineer
Martial Status: single
Smokes: No
Drinks: No
Hand Dominance: left

Review of Systems:
General: fever or chills, and trouble sleeping
Neurological: tingling
Skin: none
Hematologic: none
Musculoskeletal: muscle or joint pain, and back pain
Endocrine: none
Psychiatric: none

Physical Examination:
General Examination: John Smith is is awake, alert and oriented. He apprears appears equal to the stated age.. He has a pleasent demeanor.. He is able to follow instructions. He is in no acute distress.. Gait is nonantalgic.

Vitals:
Ht: 5' 9"
Wt: 161 lbs
BMI: 23.772945
BP: 120 / 80
Pulse: 82
RR: 14
CV: Regular rate and rhythm
Pulm: CTAB

Skin Exam positive for:
- Normal

The Patient has tenderness to palpation at:
- Right Knee Posteromedial Joint Line
- Right Knee Medial Joint Line
- Plane

Range of motion:
- Right Knee Flexion/Extension 10°-115° Left Knee Flexion/Extension 0°-140°

Strength:

Right	Name	Left

5/5	Knee Flexion	5/5
5/5	Knee Extension	5/5

The patient has a positive:

- McMurray on the Right Knee

Assessment: John Smith is a 38 year old male with:

1. Other meniscus derangements, unspecified medial meniscus, right knee (M23.303)

Plan: John Smith presents signs and symptoms consistent with: other meniscus derangements, unspecified medial meniscus, right knee (m23.303)

Diagnosis and treatment plan was reviewed with the patient at today's visit.
Treatment plan includes:

- NSAIDS
- Tylenol
- Rest, ice, compress, elevate
- Cortisone - After review of risks and benefits including hypopigmentation and fat atrophy, decision made to proceed with injection. Expectations from injection were reviewed including temporary anesthesia followed by possible flare response from steroid. This can be managed with ice and non-steroidal medications. Response to injection is typically 1-3 days after injection. Intraarticular injection was performed to the right knee using a supralateral approach after sterile prep with a combination of 2.0 cc of Celestone and 8.0 cc of 2% Lidocaine.
- Hinged knee brace

The patient will follow up in 1 month.

Work Duty:

Full duty