UK Sinha Physician, P.C.

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September 08, 2022

Office seen at:
S.P. Physical Therapy
1320 Louis Nine Boulevard
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Phone# (347) 862-0003

Re: Bradley, Jonathan
DOB: 12/25/1977
DOA: 02/26/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 44-year-old right-hand dominant male involved in a motor vehicle accident on 02/26/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the rear driver's side. The airbags did not deploy. The EMS did not arrive on the scene. The police were called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 8.5 months with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Bilateral hip surgery at 12 years old, slipped capital femoral epiphysis.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

SOCIAL HISTORY: The patient smokes one-half pack of cigarettes per day. The patient drinks alcohol socially. The patient does use recreational drugs socially.

ADL CAPABILITIES: The patient states that he can walk with no issues. He can stand with no issues before he has to sit. He can sit with no issues before needing to change positions

secondary to pain. As a direct result of the injuries sustained in this accident, the patient states that he is unable to do the following activities: play sports, squatting, and jogging.

PRESENT COMPLAINTS: Left knee: Left knee pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. The patient also notes buckling. Worse with range of motion and improves with rest.

REVIEW OF SYSTEMS: Temperature taken at the time of exam was 98.6 degrees Fahrenheit.
General: No fever, chills, night sweats, weight gain, or weight loss.
HEENT: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nosebleeds, sore throat or hoarseness.
Endocrine: No cold intolerance, appetite changes or hair changes.
Skin: Clear, no rashes or lesions.
Neuro: No headaches, dizziness, vertigo or tremor.
Respiratory: No wheezing, coughing, shortness of breath or difficulty breathing.
Cardiovascular: No chest pain, murmurs, irregular heart rate or hypertension.
GI: No nausea, vomiting, diarrhea, constipation, jaundice or changes in bowel habits.
GU: No blood in urine, painful urination, loss of bladder control or urinary retention.
Hematology: No active bleeding, bruising, anemia or blood clotting disorders.
Psychiatric: No anxiety, change in sleep pattern, depression or suicidal thoughts.

PHYSICAL EXAMINATION: The patient's height is 6 feet 4 inches, weight is 245 pounds, and BMI is 29.8. The left knee reveals tenderness along the medial joint line and lateral joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 95/130 degrees and extension 4/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

DIAGNOSTIC TESTING: MRI of the left knee, done on 08/29/2022, shows increased T2 signal in the anterior aspect of the medial femoral condyle consistent with bone contusion/nondisplaced fracture with overlying soft tissue swelling and edema consistent with recent trauma. CT of the femoral diaphysis/knee joint is recommended for further evaluation. Complex tear in the posterior horn/body of the medial meniscus. Approximately 8.0 x 2.5 x 2.7 cm heterogeneous high T2 signal intensity lesion in the femoral distal diaphysis/metaphysis with well defined serpiginous border, consistent with bone infarction. Mild osteoarthritic changes.

ASSESSMENT:
1. S83.242A Medial meniscus tear, left knee.
2. M23.92 Internal derangement, left knee.
3. M25.462 Joint effusion, left knee.
4. S80.912A Injury, left knee.
5. M25.562 Pain, left knee.
6. M17.12 Osteoarthritis, left knee.

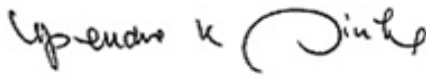
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left knee 3 days/week.
6. Recommend steroid injections with pain management for left knee. The patient refuses due to side effects.
7. Discussed left knee arthroscopy versus conservative management with the patient. The patient refused surgical intervention.
8. It is medically necessary to perform the suggested surgery to properly diagnose the patient's condition and to objectively verify presence and severity of internal derangement and other left knee pathology in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the left knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
11. All the questions in regard to the procedure were answered.
12. Follow up on a p.r.n. basis.

CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.

AFFIRMATION: Being duly licensed to practice medicine in the state of New York, pursuant to the applicable provisions of the Civil Practice Laws and Rules, I hereby affirm under penalty of perjury that the statements contained herein are true and accurate.

Mellita Shakhmurov, PA-C



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MS/AEI