UK Sinha Physician, P.C.

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November 11, 2022

Re: Leon, Marie
DOB: 12/08/1981
DOA: 01/01/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right knee, left knee, neck, mid back and low back pain.

HISTORY OF PRESENT ILLNESS: A 40-year-old right-hand dominant female involved in a motor vehicle accident on 01/01/2021. The patient was the rear seat passenger of an Uber car and was wearing a seatbelt. The vehicle was struck on the front passenger side. 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 right knee, left knee, neck, mid back and low back pain sustained in the motor vehicle accident. The patient attended physical therapy one year ago with little relief.

WORK HISTORY: The patient is currently working full-time in airport.

PAST MEDICAL HISTORY: Positive for diabetes. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking metformin 500 mg b.i.d. for one year.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She can sit for 5 minutes before needing to change positions secondary to pain. As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: carrying heavy objects, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: Right knee: Right knee pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking. Worse with range of motion and improves with rest, medication, physical therapy, and ice.

Left knee: Left knee pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking. Worse with range of motion and improves with rest, medication, physical therapy, and ice.

The patient had left knee ACL reconstruction done by me on 04/19/2021. The patient also had lumbar epidural injection in August 2021 from me.

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 5 feet 4 inches, weight is 190 pounds, and BMI is 32.6. The lumbar spine reveals sharp, shooting, burning, intermittent pain with numbness and tingling. The pain radiates to the left. There is pain with standing, walking, sitting, bending. Improves with rest, medications, physical therapy, and ice. ROM: Flexion 60/80 degrees, extension 10/25 degrees, right lateral flexion 20/35 degrees, left lateral extension 20/45 degrees.

The right knee reveals tenderness along the medial joint line. There is no heat, swelling, erythema, crepitus or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 degrees and extension 0/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

The left knee reveals tenderness along the superior pole of patella. There is no heat, erythema, or deformity appreciated. There is swelling and crepitus appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 degrees and extension 0/5 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 right knee, done on 02/25/2021, shows small oblique peripheral tear at the posterior horn of the medial meniscus. Mild knee joint effusion. No fracture or ACL tear. MRI of the left knee, done on 03/04/2021, shows full thickness tear of the anterior cruciate ligament. Oblique tear at the posterior horn of the lateral meniscus. Mild knee joint effusion.

ASSESSMENT:

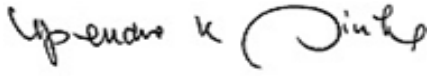
1. S83.241A Medial meniscus tear, right knee.
2. M23.91 Internal derangement, right knee.
3. M25.461 Joint effusion, right knee.
4. M12.569 Traumatic arthropathy, right knee.
5. S80.911A Injury, right knee.
6. M25.561 Pain, right knee.
7. M65.161 Synovitis, right knee.
8. M23.92 Internal derangement, left knee.
9. M12.569 Traumatic arthropathy, left knee.
10. S80.912A Injury, left knee.
11. M25.562 Pain, left knee.
12. Status post ACL repair, 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 right knee and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right knee and left knee 3 days/week.
6. The patient had discogenic disc disease of lumbar spine. The patient has history of epidural cortisone injection and facet block injection.

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.



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