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June 20, 2022

Office seen at:
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Re: Cruz, Norris
DOB: 08/18/1974
DOA: 05/30/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee and right ankle pain.

HISTORY OF PRESENT ILLNESS: A 47-year-old right-hand dominant male involved in a motor vehicle accident on 05/30/2022. The patient was a front 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 not 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 and right ankle pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with little relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Hypertension.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking amlodipine 10 mg daily.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for 3-4 blocks. He can stand for half an hour before he has to sit. He 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 he is unable to do the following activities: garden, play sports, drive, carrying heavy objects, shopping, running errands, kneeling, squatting, and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 7-8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. 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.

Right ankle: Right ankle pain is 6/10, described as intermittent, dull, achy pain. Pain with standing, walking and climbing.

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 7 inches, weight is 200 pounds, and BMI is 31.3. The left knee reveals tenderness along the medial joint line, superior pole of patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema 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 left lower extremity.

The right ankle reveals swelling, hematoma and bruises noted over anterior/posterior/lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. Tenderness to palpation noted in the lateral aspect. Range of motion is limited and painful. ROM: Dorsiflexion 15/20 degrees, plantarflexion 45/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

DIAGNOSTIC TESTING: MRI of the left knee, done on 06/14/2022, shows anterior cruciate ligament sprain sequelae. Edema along the myofascial planes of the partially imaged medial head of the gastrocnemius muscle consistent with myofascial strain. MRI of the right ankle, done on 06/14/2022, shows hyperintense signal of the fibular attachment of the posterior talofibular ligament compatible with a partial tear.

ASSESSMENT:

1. S83.242A Medial meniscus tear, left knee.
2. M23.92 Internal derangement, left knee.
3. S83.519A Anterior cruciate ligament tear, left knee.
4. S83.512A Anterior cruciate ligament sprain, left knee.
5. S83.412A Medial collateral ligament sprain, left knee.
6. M94.262 Chondromalacia, left knee.
7. S83.32XA Tear articular cartilage, left knee.
8. M22.2X2 Patellofemoral chondral injury, left knee.
9. M25.462 Joint effusion, left knee.
10. S80.912A Injury, left knee.
11. M25.562 Pain, left knee.
12. M65.162 Synovitis, left knee.
13. M24.10 Chondral lesion, left knee.
14. M24.662 Adhesions, left knee.
15. Grade III sprain of lateral collateral ligament, right ankle.
16. Posttraumatic impingement, right ankle.

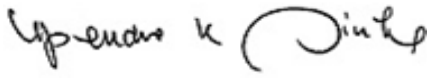
PLAN:

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.
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 states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient would like to proceed with surgery.
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. The patient verbally consents for the arthroscopy of left knee and the patient will be scheduled for left knee surgery. On the day of the surgery, before the procedure, the surgeon will explain all related questions of the procedure. The patient will sign a written consent and be witnessed by the surgeon.

13. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

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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