UK Sinha Physician, P.C.

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September 12, 2022

Office seen at:
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150 Graham Avenue Suite A
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Re: Lodge, Severa
DOB: 10/08/1979
DOA: 06/29/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 42-year-old right-hand dominant female involved in a motor vehicle accident on 06/29/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the rear 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 2.5 months with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Seizure and migraines. There is no previous history of trauma.
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PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n., Keppra 750 mg t.i.d., and Robaxin 400 mg p.r.n.

SOCIAL HISTORY: The patient smokes one-half a pack of cigarettes per day. The patient does not drink alcohol. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that she can walk for 1.5 blocks. She can stand for 5 minutes before she has to sit. She can sit for 15 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: running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes buckling and intermittent locking. Worse with range of motion and improves with ice.

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 6 inches, weight is 210 pounds, and BMI is 33.9. The left knee reveals tenderness along the medial joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 80/130 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 08/09/2022, shows sprain of the medial collateral ligament which demonstrates heterogeneous intrasubstance signal abnormality approaching the proximal insertion on the medial femoral condyle. Lateral patellar tilt and insertional tendinosis distal quadriceps tendon. Trace fluid within the knee joint, predominantly within the patellofemoral compartment and small ruptured ganglion cyst which dissects inferiorly along the medial margin of the gastrocnemius.

ASSESSMENT:
1. M23.92 Internal derangement, left knee.
2. S83.412A Medial collateral ligament sprain, left knee.
3. M25.462 Joint effusion, left knee.
4. S80.912A Injury, left knee.

5. M25.562 Pain, left knee.
6. M67.52 Medial plica, left knee.

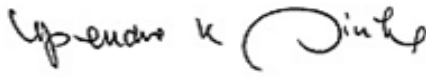
PLAN:

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 4 weeks for the left knee. If pain does not improve, will consider offering intervention.
6. Recommend steroid injections with pain management for left knee. The patient refuses due to side effects.
7. Follow up in 4 weeks.

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