UK Sinha Physician, P.C.

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October 03, 2022

Office seen at:
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Re: Blackman, Darold
DOB: 07/31/2001
DOA: 09/19/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right knee and right hip pain.

HISTORY OF PRESENT ILLNESS: A 21-year-old right-hand dominant male involved in a motor vehicle accident on 09/19/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the front driver 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 right knee and right hip pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 2.5 weeks with no relief.

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

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

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

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 5 minutes 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: 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 weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking and buckling. Worse with range of motion and improves with rest.

Right hip: Right hip pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. 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 5 feet 10 inches, weight is 220 pounds, and BMI is 31.6. The right knee reveals tenderness along the medial joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 90/130 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 right lower extremity.

The right hip reveals tenderness to palpation in the greater trochanter. Range of motion is limited and painful. ROM: Abduction 30/45 degrees, adduction 30/35 degrees, flexion 95/120 degrees, extension 25/30 degrees, internal rotation 30/45 degrees, and external rotation 35/45 degrees.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:
1. M23.91 Internal derangement, right knee.
2. M25.461 Joint effusion, right knee.
3. S80.911A Injury, right knee.
4. M25.561 Pain, right knee.
5. Derangement, right hip.
6. Injury, right hip.
7. Pain, right hip.

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 right hip.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right knee and right hip 3 days/week.
6. MRI ordered by PCP, results are pending.
7. Follow up in 4 weeks after MRI.

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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Board Certified Orthopedic Surgeon

MS/AEI