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September 01, 2022

Office seen at:
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Re: Powell, Romario
DOB: 02/02/2002
DOA: 07/09/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right knee pain.

HISTORY OF PRESENT ILLNESS: A 20-year-old right-hand dominant male involved in a motor vehicle accident on 07/09/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the rear passenger's side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Interfaith Medical Center Hospital and was treated and released the same day. The patient presents today complaining of right knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 6 weeks with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory. 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 10 blocks. He can stand for 15 minutes 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: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right knee: Right knee pain is 5/10, 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 clicking and popping. 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 177 pounds, and BMI is 25.4. The right knee reveals tenderness along the lateral joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative 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.

DIAGNOSTIC TESTING: MRI of the right knee, done on 07/23/2022, shows synovial fluid in the knee joint. Lateral patellar tilt and lateral subluxation with narrowing of the lateral patellofemoral joint compartment with patellofemoral chondromalacia. Patellar tendinosis/tendinopathy. Fluid posterior to the distal lateral patellar tendon is compatible with localized bursitis/synovitis.

ASSESSMENT:
1. M23.91 Internal derangement, right knee.
2. M94.261 Chondromalacia, right knee.
3. M25.461 Joint effusion, right knee.
4. S80.911A Injury, right knee.
5. M25.561 Pain, right knee.
6. M65.161 Synovitis, right knee.

7. M76.51 Prepatellar bursitis, right 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.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right knee 4 weeks.
6. Recommend steroid injections with pain management for right knee. The patient refuses due to side effects.
7. The patient will consider intervention if pain does not improve after 4 weeks of physical therapy.
8. 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

U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon

MS/AEI