

UK Sinha Physician, P.C.

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July 27, 2022

Office seen at:

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Re: Green, Ricardo
DOB: 05/18/1985
DOA: 05/06/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 37-year-old right-hand dominant male involved in a slip and fall accident on 05/06/2022. The patient purchased a bed from Bob's Furniture. The bed broke and patient fell while still in bed/mattress and injured back and left knee from impact. 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 pain sustained in the slip and fall accident. The patient was attending physical therapy for the last 2 months with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Asthma, last attack less than a year about 3 months ago. There is a previous history of trauma, MVA in 2020.

PAST SURGICAL HISTORY: Left shoulder arthroscopy in 2020.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient smokes cigarettes socially. The patient drinks alcohol socially. 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 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: running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 9/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking and popping. Worse with range of motion and improves with medication.

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. The patient has asthma.

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 205 pounds, and BMI is 29.4. The left knee reveals tenderness along the medial joint line, lateral 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. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 85/130 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 pending.

ASSESSMENT:

1. M23.92 Internal derangement, left knee.
2. M25.462 Joint effusion, left knee.
3. S80.912A Injury, left knee.
4. M25.562 Pain, left knee.

PLAN:

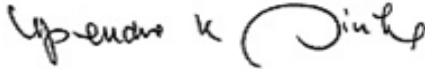
1. Clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.

5. Continue physical therapy for left knee for 4 weeks.
6. Recommend steroid injections with pain management for left knee. The patient refuses due to side effects.
7. MRI ordered of left knee to rule out ligament tear and/or synovial injury.
8. Follow up 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
MS/AEI



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