UK Sinha Physician, P.C.

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November 11, 2022

Office seen at:
S.P. Physical Therapy
1320 Louis Nine Boulevard
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Phone # (347) 862-0003

Re: Mohammadu, Ibrahim
DOB: 07/28/1990
DOA: 07/16/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 32-year-old right-hand dominant male involved in a motor vehicle accident on 07/16/2022. 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 arrived 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 3.5 months with no relief.

WORK HISTORY: The patient is currently working.

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

PAST SURGICAL HISTORY: Positive for left shoulder cyst/lipoma removal about one month ago, fracture of tibia/fibula with rod placement in 2010 and fixture removal in 2011.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient smokes one-fourth pack per day. The patient does not take any recreational drugs. The patient does not drink alcohol.

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: Left knee: Left knee pain is 6/10, 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 intermittent locking. 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 11 inches, weight is 181 pounds, and BMI is 25.2. The left knee reveals tenderness along the medial joint line, lateral joint line and popliteal fossa. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Positive 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 of the left knee, done on 11/05/2022, shows low signal intensity defect throughout the proximal tibial likely due to an intramedullary rod which may have been removed and it is not clear on this examination. X-ray of the knee, tibia and fibula is recommended for further evaluation. Horizontal tear in the posterior horn of the medial meniscus. Anterior horn and body of the medial meniscus appears truncated likely due to prior meniscectomy, in an appropriate clinical setting. The PCL appears thickened and heterogeneous consistent with a high-grade partial or full-thickness tear. 6.0 x 5.0 mm fluid collection likely in the prepatellar bursa, consistent with prepatellar bursitis. Markedly thickened patellar tendon near the distal attachment likely due to prior repair. Multiple erosive/osteochondral lesions on the patellar articular surfaces. Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting.

ASSESSMENT:

1. S83.242A Medial meniscus tear, left knee.

2. M23.92 Internal derangement, left knee.
3. M25.462 Joint effusion, left knee.
4. S80.912A Injury, left knee.
5. M25.562 Pain, left knee.
6. M65.162 Synovitis, left knee.
7. M93.262 Osteochondral lesion, left knee.
8. M70.42 Prepatellar bursitis, left knee.
9. Posterior cruciate ligament tear, 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 left knee 3 days/week.
6. X-ray ordered of left knee to rule out ligament tear and/or synovial injury.
7. Follow up in 1 month.

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

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