

UK Sinha Physician, P.C.

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November 09, 2022

Office seen at:
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Re: Rodriguez, Johan
DOB: 03/07/1999
DOA: 10/24/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 23-year-old male involved in a work-related accident on 10/24/2022. While dislodging a package that fell into a hole between the elevator, the full package fell on him. The patient did not go to any hospital that same day. The patient presents today complaining of left knee pain sustained in the work-related accident. The patient was attending physical therapy for the last 4 weeks with little relief.

WORK HISTORY: The patient is currently not 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 not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally.

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 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and difficulty going up and down stairs. Worse with range of motion and improves with rest. The patient walks with one crutch nonweightbearing.

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 7 inches, weight is 160 pounds, and BMI is 25.1. The left knee reveals tenderness along the medial joint line and lateral joint line. There is no heat, erythema, crepitus or deformity appreciated. There is swelling appreciated. Positive 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 -15/5 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: Pending.

ASSESSMENT:

1. M23.92 Internal derangement, left knee.
2. M25.462 Joint effusion, left knee.
3. M12.569 Traumatic arthropathy, left knee.
4. S80.912A Injury, left knee.
5. M25.562 Pain, left knee.

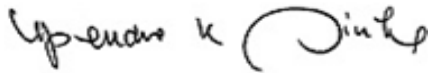
PLAN:

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. MRI ordered of left knee to rule out ligament tear and/or synovial injury.

IMPAIRMENT RATING: 100%.

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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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