Case 1

MEDICAL DOCUMENT

Report 11/17/20XX 10:12

Subjective: Patient comes in for follow-up on her MRI of her left knee. She has been playing basketball. She can tell the brace helps, but she does feel like the knee could slip if she pushed it.

Objective: On physical examination of her left knee, she does have a loose Lachman's. Certainly, something has changed between our last two visits from the previous, as she has a slight pivot glide as well on today's exam. ROM is 3-0-130. MCL, LCL and PCL are stable.

X-rays: Review of the MRI does appear to show a retear of her ACL. She has some meniscus changes as well although I certainly would expect this with post-operative changes.

Impression: Left knee ACL retear.

Plan: She does not have a real loose knee and she has been tolerating basketball. I think that as long as she can prevent her knee from the big instability episodes that I would be okay with her continuing to play basketball. If she has instability episodes, then we need to sit down and discuss doing a surgical revision. I will see her back sometime in the basketball season.

I personally performed the history and physical examination on the patient and formulated the treatment plan.

Case 2

Outpatient E/M

Re: James J. Jones Date of Service: January 5, 20XX

MR # 100-4

Subjective:

Chief Complaints: Back pain

HPI:

Lower Back:

A 31-year-old male returns with low back pain in the midline, that is piercing and radiates bilaterally and wraps around lower back. Had direct trauma injury and previous MVA injury to the back in past, with physical therapy to these injuries. Previous MRI of lower back 5 years ago, possible lower back disk injury. Denies fall, previous surgery, bowel, or bladder changes . Per patient, back pain usually resolves on own in 1-2 days, but now notices constant persistent pain . He was picking up his child when he felt spasm begin.

ROS:

CONSTITUTIONAL: Denies fever, recent chills, fatigue, decrease in appetite .

NEUROLOGY: Denies tingling/ numbness. Admits pain to buttocks L>R ,

MUSCULOSKELETAL: Denies any other injury or trauma.

SKIN: Denies rash.

Medical History: Asthma, tumor found on spine T-7 at age 24, no biopsy,

Surgical History: Right and left knee - meniscus.

Hospitalization/Major Diagnostic Procedure: Denies previous hospitalizations .

Family History: Father: alive, healthy. Mother: alive, healthy. One sister: healthy. One son: healthy.

Social History: General: Tobacco use: Chewing tobacco. Alcohol use: Socially. Recreational drug use: Marijuana, 1-2 times a month. Caffeine: 1 cup a day. Exercise: 2-3 times a week. Marital Status: Married Seatbelts/Car Seats: Always. Helmets: Always.

Medications: None

Allergies: NKDA

Objective:

Vitals: Time 3:12 pm, Temp 98.1, BP 135/61, O2 Sat 94, HR 84, RR 16, Ht 71.5, Wt 192, BMI 26.40.

Examination:

General Appearance: Well-built and nourished, uncomfortable due to pain . Skin: normal, no rash.

Lower back: Normal curvature of spine. Palpation: No vertebral spine tenderness, no paraspinal spasm, no tenderness on S1 joints. Straight leg raising test: Positive at 45 degrees on right, positive at 30 degrees on left. Motor system: V/V bilaterally. Sensory exam: Normal bilateral LE. Reflexes: Bilaterally symmetrical. Gait: Slow to ambulate ROM: all ROM restricted secondary to pain.

Assessment:

1- Lumbar pain

Plan:

1 - Lumbar pain

Start Percocet-5/325 tablet, 325 mg-5 019, 1 tab(s), orally, every 6 hours, 20. Notes: will bring hard copy of Rxs. Start diazepam tablet, 10 mg, 1 tablet, 3 times a day, 12. Ibuprofen PRN will add above medications, reviewed dosing and possible side effects. Notes: Discussed conservative treatment options to begin with, patient agrees, will refer to PT. Continue with ice to area. Follow up in 2 weeks if symptoms persist; consider MRI then. He agrees with plan. Patient Education was published to portal.

2 - Others

Referral To: Peak Performance Physical Medicine and Rehabilitation

Reason: Lower back pain

Follow Up: Two weeks

Electronically signed by Robert Smith, MD on 1/5/20XX at 04:56 PM

Sign off status: Completed

Case 3

The patient is a 32 year-old male here for the first time.

Chief Complaint: Left knee area is bothersome, painful moderate severity. The patient also notes swelling in the knee area, limited ambulation, and inability to perform physical activities such as sports or exercises. The patient first noticed symptoms approximately 4 months ago. Problem occurred spontaneously. Problem is sporadic. Patient has been prescribed hydrocodone and meloxicam. Patient has had temporary pain relief with the medications. The meloxicam has caused digestion problems so patient has avoided using it.

Past Medical History: Patient denies any past medical problems.

Surgeries: Patient has undergone surgery on the appendix.

Hospitalizations: Patient denies any past hospitalizations that are noteworthy.

Medications: Hydrocodone.

Allergies: Patient denies having allergies.

Family History: Mother: No serious medical problems; Father: No serious medical problems.

Social History: Patient is married. Occupation: Patient is a chef.

Review of Systems:

Constitutional: Denies fevers. Denies chills. Denies rapid weight loss.

Eyes: Denies vision problems.

Ears, Nose, Throat: Denies any infection. Denies loss of hearing. Denies ringing in the ears. Denies dizziness. Denies a sore throat. Denies sinus problems.

Cardiovascular: Denies chest pains. Denies an irregular heartbeat.

Respiratory: Denies wheezing. Denies coughing. Denies shortness of breath.

Gastrointestinal: Denies diarrhea. Denies constipation. Denies indigestion. Denies any blood in stool.

Genitourinary: Denies any urine retention problems. Denies frequent urination. Denies blood in the urine. Denies painful urination.

Integumentary: Denies any rashes. Denies having any insect bites.

Neurological: Denies numbness. Denies tremors. Denies loss of consciousness.

Hematologic/Lymphatic: Denies easy bruising. Denies blood clots.

Psychiatric: Denies depression. Denies sleep disorders. Denies loss of appetite.

Review of Previous Studies: Patient brings an MRI which is reviewed. Large knee effusion. No lateral meniscal tear. No ACL/PCL tear. No collateral fracture. Medial meniscus tear with grade I signal.

Vitals: Height: 6’0”, Weight: 160

Physical Examination: Patient is alert, appropriate, and comfortable. Patient holds a normal gaze. Pupils are round and reactive. Gait is normal. Skin is intact. No rashes, abrasions, contusions, or lacerations. No venous stasis. No varicosities. Reflexes are normal patellar. No clonus.

Knee: Range of motion is approximately from 5 to 100 degrees. Pain with motion. No localized pain. Negative mechanical findings. There is an effusion. Patella is tracking well. No tenderness. Patient feels pain especially when taking stairs or squatting.

Hip: Exam is unremarkable. Normal range of motion, flexion approximately 105 degrees, extension approximately 10 degrees, abduction approximately 25 degrees, adduction approximately 30 degrees, internal rotation approximately 30 degrees, external rotation approximately 30 degrees.

Neck: Neck is supple. No JVD.

Impression:

1. Infective synovitis of the left knee

2. Contracture of the left knee

3. Possible medial meniscal tear of right knee

Assessment and Plan: A discussion is held with the patient regarding his condition and possible treatment options. Patient has GI upset. Patient is recommended to take Motrin 400 two to three times a day, discussion is held regarding proper use and precautions. Patient is given a prescription for physical therapy. We will obtain an MRI to rule out potential medial meniscus tear. Patient is instructed to follow up with PMD with labs. Patient is referred to Dr. XYZ. Patient may need arthroscopy if patient does have medial meniscus tear and repeat effusion.

Case 4

Chief Complaint: Left tibia fracture.

History of Present Illness: Patient is a 13-year-old male we first saw on 05/09/xx. He was noted to have been injured when he jumped while running down a hill. He sustained a Salter-Harris II fracture of the distal tibia. He is currently non-weight bearing in a short-leg cast. He has been compliant with his activity modifications.

Physical Examination: He is intact to sensation. His capillary refill of the toes remains stable. There is no skin breakdown at the proximal or distal aspect of the cast. The cast is intact.

Ancillary Studies: AP and mortise views radiographs of the left ankle were ordered and obtained in our office today May 24, 20xx and show good alignment and positioning of the fracture. Growth plate is stable.

Impression: Left distal tibia fracture.

Plan: He will continue with the use of his cast, maintain non-weight bearing status. Return for reassessment with X-ray in two weeks. Cast care instructions are once again being reviewed.

Case 5

This 25-year-old female presents for the first time to discuss her right knee pain. She has had several injuries to the knee, the first was in 1995 when while running track, she jumped over hurdles but missed and hit the hurdle with her knee. She received no medical care at the time but did have what sounds like effusion and edema as well as a limp for some time. About six months later, she was clipped by a car as the car took off. She did not receive care for her knee at that point either.

MEDICATIONS: The patient takes the occasional Motrin and takes Darvocet for her back. She also takes St. John's Wort and Zyrtec.

The patient describes her knee pain as aching and recurrent. She has an occasional sharp pain but does not truly describe locking. She states the knee occasionally buckles, but further discussion revealed that she unweights it because it hurts. She has difficulty doing a squat. She denies other joint pain.

SOCIAL HISTORY: The pt. works as an aide for special needs children.

An MRI is scheduled for this Saturday.

PHYSICAL EXAMINATION: B/P: 118/78, T: 98.2, P: 80. Well developed, well nourished. The right knee has no edema or effusion and FROM. She has slight pain over the medial joint line. Collaterals are non-tender and stable. Negative anterior drawer, Lachman's, and sag. Calf non-tender, DNVI. She does not like to get up from doing a squat secondary to pain.

PLAN: Certainly, an MRI is indicated as the patient may have a medical meniscus tear. She was instructed to take her Motrin on a routine basis and she will follow-up with us after her MRI is completed.