1 Patient Information

1 PATIENT DETAILS

Name
Beverly A. Thornton

Date of Examination
05/06/2026

DOB / Age / Sex
04/30/1950 | 75F

Provider
Dr. Steven M. Crawford, MD — Orthopedic Surgery

MRN
ORTHO-2025-4421

GA General Appearance

1 OVERALL CONDITION

Appearance
Well-nourished, well-groomed elderly female in no acute distress. Appears stated age. Ambulates with a rolling walker with antalgic gait favoring the right lower extremity.

Level of Consciousness
Alert and fully oriented to person, place, date, and situation. Pleasant and cooperative throughout examination.

Hygiene & Grooming
Appropriate hygiene and grooming. Dressed neatly in comfortable clothing. No signs of self-neglect.

Posture & Interaction
Mildly flexed posture at the hips with forward trunk lean, consistent with chronic joint pain adaptation. Cooperative and engaged with examination.

V Vitals

V VITAL SIGNS

Temperature
98.0°F (oral)

Blood Pressure
144/82 mmHg (left arm, seated)

Heart Rate
72 bpm (regular)

Respiratory Rate
14 breaths/min

SpO_2
97% on room air

Weight

Height / Weight / BMI
5'3" / 168 lbs / BMI 29.8

Pain Score
Right knee pain: 7/10 at rest, 9/10 with weight-bearing

H HEENT & Neck

3 HEAD, EYES, EARS, NOSE, THROAT, NECK

Head
Normocephalic, atraumatic. No scalp tenderness or lesions.

Eyes
PERRLA bilaterally. EOM intact. Conjunctivae clear, sclerae non-icteric. No cataracts noted on gross inspection.

Ears
External auricles normal bilaterally. Whisper test passed bilaterally. TMs intact with normal light reflex on otoscopy.

Nose
External nose symmetric. Nasal mucosa pink and moist. Septum midline. No discharge.

Throat
Oropharynx pink and moist. Tonsils not enlarged. No posterior pharyngeal erythema or exudates. Dentures present, well-fitting.

Neck
Supple without lymphadenopathy. Trachea midline. No thyromegaly or thyroid nodules palpable. Full range of motion without pain.

CV Cardiovascular & Respiratory

4a CARDIOVASCULAR

Rate & Rhythm
Regular rate and rhythm at 72 bpm.

Heart Sounds

S1 and S2 present. 1/6 systolic ejection murmur at right upper sternal border — known, previously evaluated by cardiology, non-significant AS per echo 2 years ago. No S3 or S4.

Peripheral Pulses
2+ and symmetric at radial, femoral, and dorsalis pedis bilaterally. Posterior tibial pulses 1+ bilaterally.

Cap Refill / Edema
Capillary refill <2 seconds bilaterally. 1+ bilateral ankle edema, pitting, chronic.

4b RESPIRATORY

Respiratory Effort
Unlabored. No accessory muscle use. No nasal flaring.

Breath Sounds
Clear to auscultation bilaterally. No wheezes, crackles, or rhonchi. Symmetric expansion.

AB Abdomen & GU

5a ABDOMEN

Inspection
Abdomen mildly obese, no surgical scars. No visible masses or hernias.

Palpation
Soft, non-tender in all quadrants. No guarding or rebound. No palpable masses.

Bowel Sounds
Present and normoactive in all four quadrants.

Organomegaly
No hepatosplenomegaly palpable.

5b GENITOURINARY

Not assessed (not clinically indicated for this pre-operative orthopedic evaluation). Patient deferred GU examination to PCP.

MS Musculoskeletal & Neurological

6a MUSCULOSKELETAL

Range of Motion
Right knee: Flexion 85° (limited by pain and crepitus; full 135° normal), extension -10° (10° fixed flexion deformity). Left knee: Flexion 110°, extension 0°. Bilateral hips: Flexion 100° bilaterally, internal rotation reduced to 30° bilaterally consistent with mild bilateral hip OA.

Strength & Tone
Quadriceps strength right: 3+/5 (limited by pain). Quadriceps strength left: 4/5. Hamstrings 4/5 bilaterally. Hip flexors and abductors 4/5 bilaterally. Upper extremity strength 5/5.

Joints
Right knee: Marked bony enlargement and medial joint line tenderness. Varus malalignment approximately 10–12° right. Positive valgus stress test (medial laxity). Crepitus on ROM. Effusion palpable — moderate, ballottement positive. No popliteal mass. Left knee: Mild medial joint line tenderness, minimal effusion.

Gait
Antalgic gait pattern — reduced right stance phase, shortened right step length. Requires rolling walker. No trendelenburg sign. Unable to complete tandem gait.

6b NEUROLOGICAL

Mental Status
Alert and oriented x4. MMSE score 27/30 (mild reduction, screened pre-operatively). Appropriate affect and judgment.

Cranial Nerves
CN II–XII grossly intact. Visual fields full to confrontation. Facial sensation and motor symmetric.

Motor / Sensory
Motor strength 4–5/5 in bilateral lower extremities as noted above. Sensation intact to light touch, pinprick, and vibration in bilateral feet. Proprioception intact.

Reflexes
Patellar reflexes 2+ bilaterally. Achilles 1+ bilaterally. Plantar response flexor bilaterally.

SK Skin & Psychiatric

7a SKIN

Color / Temp / Moisture
Warm, dry, intact. No cyanosis or pallor. Normal skin turgor.

Skin Integrity
Well-healed surgical scar on right lateral knee from prior arthroscopy (2015). No open wounds, ulcerations, or pressure injuries. No rashes.

Bruising
No ecchymoses. No petechiae. Old surgical scar without complication.

7b PSYCHIATRIC

Mood & Affect

Behavior

Pleasant and cooperative. Reports situational anxiety regarding surgery — appropriate. No depressed mood noted.	Cooperative, maintains eye contact, appropriate to examination context. Eager to proceed with surgical planning.

A Assessment

8 KEY FINDINGS & SURGICAL READINESS

Mrs. Thornton is a 75-year-old female with severe right knee osteoarthritis confirmed on standing radiographs (K-L grade IV, medial compartment bone-on-bone with varus deformity of 10–12°) presenting for pre-operative evaluation prior to elective right total knee arthroplasty. Physical examination is notable for a 10° fixed flexion deformity, moderate effusion, medial instability, and functional quadriceps weakness limiting ambulation to household distances with an assistive device. Cardiac and pulmonary examination is stable; known 1/6 SEM is non-significant per prior cardiology evaluation. Anesthesia pre-op clearance is needed.

P Plan

9 NEXT STEPS

1. Anesthesiology pre-op consultation requested — patient acceptable surgical candidate pending clearance. 2. Pre-operative labs ordered: CBC, BMP, coagulation panel, type and screen. 3. Cardiac clearance from cardiologist confirming low surgical risk (prior cardiology evaluation from 2 years ago — updated letter requested). 4. Physical therapy pre-operative strengthening program — 6 sessions. 5. Hold aspirin 81 mg 7 days pre-operatively per protocol. 6. Surgical consent obtained and documented. 7. Patient instructed on post-operative expectations, DVT prophylaxis protocol, and rehabilitation timeline.

TIME DOCUMENTATION & BILLING

Total Time	**E/M Level** 99213 — Office visit, established patient
Counseling Time	**Basis** Medical Decision Making — Low to Moderate
Primary Dx Code M17.11 — Primary OA, right knee	**Secondary Dx Code(s)** M17.12 — Primary OA, left knee; I10 — HTN; Z96.641 — Prior arthroscopy right knee

PROVIDER NAME	CREDENTIALS	DATE & TIME
Dr. Steven M. Crawford, MD — Orthopedic Surgery	MD — Orthopedic Surgery	05/06/2026