John,Smith
DOB: January 20th, 1984
MRN: Unarmed c1
Date of Encounter: June 27th, 2022

Return: 1 month
Diagnosis: S/P Right Shoulder REPAIR SHOULD CUFF AVULSI (23420)
Date of Surgery: Jun 6, 2022
Work Duty: Sedentary Work - false greater than to the leftfalse until next

History of Presenting Illness
John Smith presents today for his first post-op visit. He states his pain is controlled without medication. Pain is graded at 0 to 1 out of 10 level intensity. He is ambulating without any assistive devices.

Physical Examination:
General Examination: John Smith is an awake, alert and oriented male. He appears stated age. He has a pleasent demeanor. He is able to follow instructions. He is in no acute distress. Gait is nonantalgic.

Vitals:
Ht: 5' 6"
Wt: 130 lbs
BMI: 20.980257
BP: 98.6°F
Pulse: 70
RR: 14
Temp: 98.6°F
CV: Regular rate and rhythm
Pulm: CTAB

Skin: Incision:
- Clean dry & intact

Neuro Exam:
- Normal sensation distally

Range of motion:
- Right Cervical Cervical Lateral Flexion 40°
- Left Cervical Cervical Lateral Flexion 40°
- Right Cervical Cervical Rotation 70°
- Left Cervical Cervical Rotation 70°
- Right Shoulder Abduction 0°-100°
- Left Shoulder Abduction 0°-180°

Assessment: John Smith is a 38 year old male S/P:

- Right Shoulder REPAIR SHOULD CUFF AVULSI

Plan: Treatment plan includes:

- Physical Therapy
- Suture Removal

The patient will follow up in 1 month. The patient is happy with the plan moving forward.

Work Duty: Sedentary Work - false greater than to the leftfalse until next