John,Smith
DOB: January 20th, 1984
MRN: Unarmed c1
Date of Encounter: June 19th, 2022

Return: 1 month
Diagnosis: S/P Right Shoulder REPAIR SHOULD CUFF AVULSI (23420)
Date of Surgery: Jun 6, 2022
Work Duty: Full duty

History of Presenting Illness
John Smith presents today for his first post-op visit. Since surgery, he admits to tingling and numbness. He states his pain is controlled with medication including Oxycodone and methocarbamol . Pain is graded at 2 to 5 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: 120 / 80
Pulse: 70
RR: 14
Temp: 98°F

Skin: Incision:

- Clean dry & intact

Vascular Exam:

Right	Name	Left
1+	Radial Pulse	2+
1+	Brachial Pulse	2+

Neuro Exam:

- Diminished sensation - Radial Nerve Distribution

Range of motion:

- Right Shoulder Abduction 45°-0°
- 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:

- NSAIDS
- Tylenol

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