

**John,Smith**

**DOB:** January 20th, 1984

**MRN:** Unarmed c1

**Date of Encounter:** June 26th, 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 pleasant 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.

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