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July 15, 2022

Office seen at:
Cruz Banting Imelda MD PT, North Bronx

Re: Dietz, Christopher
DOB: 01/05/1965
DOA: 12/12/2020

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, right knee and right wrist pain.

HISTORY OF PRESENT ILLNESS: A 57-year-old right-handed dominant male, involved in a work related accident on 12/12/2020. The patient did not go to the hospital thus far. Patient works for the NYC Park Department as a supervisor, when pulling a tree branch with a co-worker the tree branch fell on him hurting him. The patient reports no injury to the head and no loss of consciousness. During the accident the patient reports injuries to right shoulder, right knee and right wrist. The patient was attending physical therapy for the last week with little relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Asthma, hypertension, IBP.

PAST SURGICAL HISTORY: Left wrist surgery in October 2021

DRUG ALLERGIES: SEASONAL.

MEDICATIONS: The patient is taking albuterol as needed, amlodipine.

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 5 minutes before he has to sit. He can sit for 5 minutes before needing to change positions secondary to pain. As a direct result of the injuries sustained in this accident, the patient states that he is unable to do the following activities: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right Shoulder: Right shoulder pain is 4-6/10, described as intermittent, dull, achy pain. Worse with range of motion. The patient is unable to reach overhead or behind the back and is frequently woken up at night due to pain.

Right Knee: Right knee pain is 7/10, described as constant sharp, dull, achy pain. Worse with ambulation and slightly improves with rest. The patient has difficulty raising from a chair and walking up and down stairs. The patient also notes clicking, popping, and intermittent locking.

REVIEW OF SYSTEMS: General: No fevers, chills, night sweats, weight gain, or weight loss. **HEENT**: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nose bleeds, sore throat, or hoarseness. **Endocrine:** No cold intolerance, appetite changes, or hair changes. **Skin:** Clear, no rashes or lesions. **Neuro:** No headaches, dizziness, vertigo, or tremor. **Respiratory:** No wheezing, coughing, shortness of breath, or difficulty breathing .**Cardiovascular:** No chest pain, murmurs, irregular heart rate, or hypertension. **GI**: No nausea, vomiting, diarrhea, constipation, jaundice, or changes in BM. **GU:** No blood in urine, painful urination, loss of bladder control, or urinary retention. **Hematology:** No active bleeding, bruising, anemia, or blood clotting disorders. **Psychiatric:** No anxiety, change in sleep pattern, depression, or suicidal thoughts.

PHYSICAL EXAMINATION: The patient's height is 5 feet 7 inches, weight is 175 pounds.

The right shoulder reveals swelling/tenderness to palpation of the labrum. Positive cross-over test. Positive empty can test. Range of motion, as per goniometer, abduction 160/180 degrees, adduction 160/180 degrees, internal rotation 20/90 degrees, and external rotation 90/90 degrees.

The right knee reveals pain to palpation over the patella. Positive McMurray test. Positive anterior drawer. Positive posterior drawer. Range of motion reveals flexion 120/130 degrees and extension 0/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

DIAGNOSTIC STUDIES: Right shoulder MRI, done on 03/24/2021, shows of the right shoulder: full-thickness tearing of the supraspinatus tendon with partial retraction of tendon fibers. partial-thickness tearing in the infraspinatus tendon with marked attenuation of the distal fibers. intrasubstance tear of the subscapularis tendon. AC joint arthrosis. Fluid in the subacromial and subdeltoid bursa.

Right knee MRI, done on 02/15/2021, shows of the right knee: intrasubstance tear within the anterior cruciate ligament without evidence of disruption. Sprain along superficial fibers of medical collateral ligament. Sensitive intrasubstance tear of the patellar tendon with no evidence of disruption. Joint effusion.

FINAL DIAGNOSES:

1. S83.519A Traumatic ACL tear, right knee.
2. M25.561 Right knee pain.
3. M25.511 Right shoulder pain.
4. S46.011A Supraspinatus tendon tear, infraspinatus tear, right shoulder.

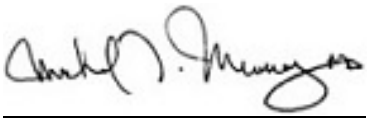
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and right knee 3 days/week.
6. Discussed right shoulder and right knee arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient would like to do it after September.

IMPAIRMENT RATING: 50%.

CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.

Rehan Khan, FNP-BC
RK/AEI



Michael Murray, MD