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Initial Comprehensive Medical Evaluation

Date: 07/01/2022

RE: Freddy Tiburcio

DOB: 10/30/1975

DOA: 08/31/2011

Location: Cruz Banting Imelda MD PT, North Bronx

Case Type: WC

1st Evaluation

Work Status: Working.

HISTORY:

On 07/01/2022, Mr. Freddy Tiburcio, a right-handed 46-year-old male presents for the evaluation of the injuries sustained in a work-related incident which occurred on the date of 08/31/2011. The patient reports no injury to the head and no loss of consciousness. During the accident the patient reports injuries to left shoulder and left knee.

CHIEF COMPLAINTS:

The patient complains of left shoulder pain that is 7/10, with 10 being the worst, which is sharp and shooting in nature. Left shoulder pain is worsened with raising the arm and lifting objects.

The patient complains of left knee pain that is 7/10, with 10 being the worst, which is sharp and shooting in nature. Left knee pain is worsened with walking, climbing stairs and squatting.

REVIEW OF SYSTEMS: The patient denies seizures, chest pain, shortness of breath, jaw pain, abdominal pain, fevers, night sweats, diarrhea, blood in urine, bowel/bladder incontinence, double vision, hearing loss, recent weight loss, episodic lightheadedness and rashes.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL / HOSPITALIZATION HISTORY: Noncontributory.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Unknown.

PHYSICAL EXAM:

General: The patient presents in an uncomfortable state.

Neurological Exam: Patient is alert and cooperative and responding appropriately. Cranial nerves II-XII grossly intact.

Deep Tendon Reflexes: Are 2+ and equal.

Sensory Examination: It is intact.

Manual Muscle Strength Testing: Is 5/5 normal.

Left Shoulder Examination: Reveals tenderness upon palpation of the left AC joint region with muscle spasm present at deltoid muscle and trapezius muscle. Neer's test is positive and Hawkins test is positive.

Left Knee Examination: Reveals tenderness upon palpation of the left peripatellar region.. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110, normal is 130 degrees and extension -5, normal is 0 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

GAIT: Normal.

Diagnostic Studies: None reviewed.

Diagnoses:

1. M24.812 Internal derangement, left shoulder.
2. M25.512 Pain, left shoulder.
3. S49.92XA Injury, left shoulder.
4. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
5. M25.412 Joint effusion, left shoulder.
6. Type II acromion, left shoulder.
7. M23.92 Internal derangement, left knee.
8. M25.462 Joint effusion, left knee.
9. S80.912A Injury, left knee.
10. M25.562 Pain, left knee.
11. M65.162 Synovitis, left knee.

PLAN:

1. All treatment options discussed with the patient.
2. Continue anti-inflammatory and muscle relaxant medications p.r.n.
3. Continue physical therapy for left shoulder and left knee 3 days/week.
4. Recommend steroid injections with pain management for left shoulder and left knee.
5. Follow up in 4 weeks.

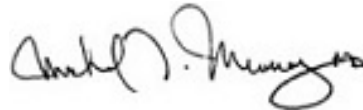
CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered

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.

AFFIRMATION: Being duly licensed to practice medicine in the state of New York, pursuant to the applicable provisions of the Civil Practice Laws and Rules, I hereby affirm under penalty of perjury that the statements contained herein are true and accurate.



Rehan Khan, FNP-BC
RK/AEI



Michael Murray, MD