UK Sinha Physician, P.C.

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September 26, 2022

Office seen at:
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Re: Agosto, Justin
DOB: 11/16/1994
DOA: 07/23/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left knee, left wrist, right elbow, neck, and low-back pain.

HISTORY OF PRESENT ILLNESS: A 27-year-old right-hand dominant male involved in a motor vehicle accident on 07/23/2022. The patient was a driver and was wearing a seatbelt. The patient was driving, some malfunction in the car and he hit standing double decker bus. The airbags did not deploy. The police were called to the scene of the accident. The patient was transported via ambulance to NYC Health + Jacob and was treated and released the same day. The patient presents today complaining of right shoulder, left knee, left wrist, right elbow, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy 3-4 times a week with good relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. The patient does not use recreational drugs.

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: garden, play sports, lifting heavy objects, carrying heavy objects, squatting, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 10/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Left knee: Left knee pain is 1-2/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs.

Left wrist/thumb: Left wrist pain is 8/10, described as constant, dull, achy pain. Admits to weakness, numbness, tingling. The patient has pain with lifting, carrying, and driving.

Right elbow: Right elbow pain is 1-2/10, described as intermittent, dull, achy pain. The patient has pain with lifting, carrying, and driving.

REVIEW OF SYSTEMS: Temperature taken at the time of exam was 98.6 degrees Fahrenheit.
General: No fever, chills, night sweats, weight gain, or weight loss.
HEENT: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nosebleeds, 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 bowel habits.
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 6 feet, weight is 150 pounds, and BMI is 20.3. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and proximal biceps tendon. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 145/180 degrees, adduction 40/45 degrees, forward flexion 160/180 degrees, extension 50/60 degrees, internal rotation 80/90 degrees, and external rotation 80/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the superior pole of patella. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 130/130 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 left lower extremity.

The right elbow reveals muscle strength is 5/5. Negative Varus test. Negative Valgus test. Negative Tinel sign. Range of motion reveals flexion 150/150 degrees, extension 0/150 degrees, supination 90/90 degrees, pronation 90/90 degrees.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A Labral tear, right shoulder.
5. S43.431A SLAP tear, right shoulder.
6. M75.41 Impingement, right shoulder.
7. M65.811 Tenosynovitis, right shoulder.
8. M75.51 Bursitis, right shoulder.
9. M75.21 Bicipital tendinitis, right shoulder.
10. M25.511 Pain, right shoulder.
11. S49.91XA Injury, right shoulder.
12. S46.101A Biceps tendon tear, right shoulder.
13. M67.211 Hypertrophic synovitis, right shoulder.
14. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
15. M24.011 Loose Bodies, right shoulder.
16. M25.311 Shoulder instability, right shoulder.
17. M19.011 Primary osteoarthritis, right shoulder.
18. M25.411 Joint effusion, right shoulder.
19. Very minimal pain, left knee.
20. M23.92 Internal derangement, left knee.
21. S80.912A Injury, left knee.
22. M25.562 Pain, left knee.
23. Grade I sprain ulnar collateral ligament, left thumb.
24. Tenosynovitis, left thumb.
25. FPL tendon (no locking), left thumb.

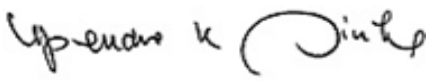
PLAN:

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, left knee, left wrist, and right elbow.

4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left knee, left wrist, and right elbow 3 days/week.
6. Return after MRI of the right shoulder and left thumb.
7. At present, the patient has no pain or minimal pain in the left knee and right elbow.
8. Follow up in 2 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.



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