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June 13, 2022

Office seen at:

S.P. Physical Therapy

1320 Louis Nine Boulevard

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Phone # (347) 862-0003

Re: Balerio, Catherine

DOB: 11/14/2006

DOA: 04/30/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and left shoulder pain.

HISTORY OF PRESENT ILLNESS: A 15-year-old right-hand dominant female involved in a motor vehicle accident on 04/30/2022. The patient was a front passenger and was wearing a seatbelt. The vehicle was struck on the passenger's front side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Jacobi Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder and left shoulder pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 6 weeks with good relief.

WORK HISTORY: The patient is currently not working. The patient is a student.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

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 she can walk with no issues. She can stand with no issues before she has to sit. She can sit with no issues before needing to change positions

secondary to pain. As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: lifting heavy objects and carrying heavy objects.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 5/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient is unable to reach overhead and unable to reach behind the back. Worse with range of motion and improves with medication and physical therapy.

Left shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient is unable to reach overhead and unable to reach behind the back. Worse with range of motion and improves with medication and physical therapy.

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 5 feet 2 inches, weight is 130 pounds, and BMI is 23.8. The right shoulder reveals no tenderness. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Negative O'Brien test. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 150/180 degrees, adduction 45/45 degrees, forward flexion 145/180 degrees, internal rotation 85/90 degrees, and external rotation 50/60 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the right upper extremity.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Negative empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 145/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 50/60 degrees, internal rotation 75/90 degrees, and external rotation 70/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 05/18/2022, shows fluid in the long head of the biceps tendon sheath, consistent with tenosynovitis. Mild joint effusion consistent with recent trauma or synovitis in an appropriate clinical setting. Edema in the distal clavicle and adjacent acromion with in the acromioclavicular joint, consistent with recent trauma. MRI of the left shoulder, done on 05/18/2022, shows partial tear of the distal supraspinatus tendon. Severe subcentimeter subcortical cysts in the humeral head under the insertion of the rotator cuff. Edema in the distal clavicle and adjacent acromion with in the acromioclavicular joint, consistent with recent trauma.

ASSESSMENT:

1. M65.811 Tenosynovitis, right shoulder.
2. M25.511 Pain, right shoulder.
3. S49.91XA Injury, right shoulder.
4. M25.411 Joint effusion, right shoulder.
5. S46.012A Partial rotator cuff tear, left shoulder.
6. M24.812 Internal derangement, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. M25.412 Joint effusion, left shoulder.

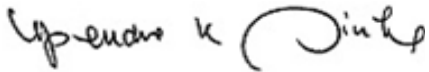
PLAN:

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 and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.
6. Recommend steroid injections with pain management for right shoulder and left shoulder.
The patient refuses due to side effects.
7. No intervention at this time. 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.

Mellita Shakhmurov, PA-C



U.K. Sinha, MD, MS (Ortho), FAAOS

Board Certified Orthopedic Surgeon

MS/AEI