

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

August 24, 2022

Office seen at:

Tatay Ninong Physical Therapy
1314 Coney Island Ave
Brooklyn, NY 11230
Phone# (718) 377-0100

Re: Suleymanov, Vyatcheslav
DOB: 08/31/1981
DOA: 09/10/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: A 41-year-old left-hand dominant male involved in a work-related accident on 09/10/2021. The patient slipped and fell down while on the job. The patient was transported via ambulance to NYC Health Coney Island Hospital and was treated and released the same day. The patient presents today complaining of right shoulder pain sustained in the work-related accident. The patient was attending physical therapy for 3 times a week with little relief.

WORK HISTORY: The patient is currently not working. The patient worked in ER in Coney Island Hospital. The patient's last date of work is January 2022 since accident in September 2021. The patient was working for only 2 months and then was off work.

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

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: PENICILLIN.

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

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

ADL CAPABILITIES: The patient states that he can walk for 2 blocks. He can stand for 2 minutes before he has to sit. He can sit for 2 hours 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: shopping.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 6/10, described as constant, sharp, stabbing, dull, achy pain. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

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 1 inches, weight is 250 pounds, and BMI is 33. The right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 95/180 degrees, adduction 40/45 degrees, forward flexion 110/180 degrees, extension 50/60 degrees, internal rotation 60/90 degrees, and external rotation 80/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done in 09/2021, shows partial tear of the bursal surface.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M75.51 Bursitis, right shoulder.

PLAN:

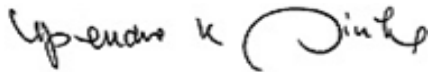
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder.

4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder 3 days/week.
6. The patient refuses cortisone injection. The patient does not want any surgical intervention.
7. Follow up in 4 weeks.

IMPAIRMENT RATING: 100%.

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.



U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon

UKS/AEI