UK Sinha Physician, P.C.

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October 18, 2022

Office seen at:
Dolphin Family Chiropractic, P.C.
430 W Merrick Road
Valley Stream, NY 11580
Phone# (516) 612-7288

Re: Carter, Latasha
DOB: 09/06/1976
DOA: 07/02/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 44-year-old right-hand dominant female involved in a motor vehicle accident on 07/02/2022. The patient was a front passenger and was wearing a seatbelt. The vehicle was struck on the rear driver side. The airbags did not deploy. The police were not called to the scene of the accident. The patient went by car to NYU Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, right knee, left knee, left ankle, right wrist, left wrist, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy 3 times a week with little relief.

WORK HISTORY: The patient is currently not working. The patient was working in homecare.

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 taking Motrin, Lidocaine gel, and muscle relaxant.

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

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She 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 she 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 9/10, described as constant, 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 shoulder: Left shoulder pain is 8/10, 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.

Right knee: Right knee pain is 9/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

Left knee: Left knee pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

Left ankle: Left ankle pain is 9/10, described as intermittent, dull, achy pain. The patient has pain with standing, walking, and climbing. The patient had ORIF left ankle in 2016.

Right wrist: Right wrist pain is 8/10, described as intermittent, dull, achy pain. Admits to weakness. The patient has pain with lifting, carrying, and driving.

Left wrist: Left wrist pain is 8/10, described as intermittent, dull, achy pain. Admits to weakness. 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 5 feet 4 inches, weight is 170 pounds, and BMI is 29.2. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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 100/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 70/90 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.

The left shoulder reveals tenderness to palpation over AC joint. There is crepitus appreciated. There is no heat, swelling, erythema 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 110/180 degrees, adduction 45/45 degrees, forward flexion 140/180 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 right knee reveals tenderness along the superior pole of patella and inferior pole of the patella. There is swelling appreciated. There is no heat, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 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.

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

The left ankle reveals swelling, hematoma and bruises noted over lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. Range of motion is limited and painful. ROM: Dorsiflexion 15/20 degrees, plantarflexion 45/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

The right wrist reveals pain to palpation over the ulnar styloid. Negative Tinel sign. Negative Phalen test. Range of motion reveals flexion 75/80 degrees, extension 60/70 degrees, radial deviation 20/20 degrees, ulnar deviation 30/30 degrees.

The left wrist reveals pain to palpation over the ulnar styloid. Negative Tinel sign. Negative Phalen test. Range of motion reveals flexion 70/80 degrees, extension 65/70 degrees, radial deviation 20/20 degrees, ulnar deviation 30/30 degrees.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 08/31/2022, shows complete tear of supraspinatus tendon extending into the anterior infraspinatus tendon with retraction. Small undersurface tear at the superior labrum. Mild acromioclavicular Joint arthrosis with undersurface spurring. Mild subacromial/subdeltoid bursitis. MRI of the left shoulder, done on 08/19/2022, shows tendinosis of anterior fibers of the supraspinatus. Posterior inferior quadrant labral tear. MRI of the right knee, done on 07/26/2022, shows presence of joint fluid compatible with synovitis and fluid in the proximal tibiofibular articulation likewise compatible with synovitis. Increased signal and swelling of the ACL compatible with grade I ACL sprain. The meniscal structures are intact. CT of the left ankle, done on 08/31/2022, shows prior ORIF of the distal fibula. Small ossicles adjacent to the talus and medial malleolus likely represent sequelae of prior avulsion injuries. No acute fracture.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive capsulitis, left shoulder.
3. M75.42 Impingement, left shoulder.
4. M25.512 Pain, left shoulder.
5. S49.92XA Injury, left shoulder.
6. M25.412 Joint effusion, left shoulder.
7. M23.91 Internal derangement, right knee.
8. M25.461 Joint effusion, right knee.
9. M12.569 Traumatic arthropathy, right knee.
10. S80.911A Injury, right knee.
11. M25.561 Pain, right knee.
12. M23.92 Internal derangement, left knee.
13. M12.569 Traumatic arthropathy, left knee.
14. S80.912A Injury, left knee.
15. M25.562 Pain, left knee.
16. Internal derangement, right wrist.
17. Internal derangement, left wrist.
18. Internal derangement, left ankle.

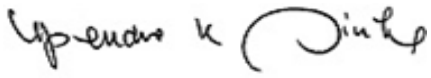
PLAN:

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 shoulder, right knee, left knee, left ankle, right wrist, and left wrist.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, left knee, left ankle, right wrist, and left wrist 3 days/week.

6. 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.



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