UK Sinha Physician, P.C.

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July 11, 2022

Office seen at:
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Re: Loggins, Isaac
DOB: 07/31/1982
DOA: 12/13/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and mid back pain.

HISTORY OF PRESENT ILLNESS: A 39-year-old right-hand dominant male involved in a work-related accident on 12/13/2021. The patient was doing maintenance in a building and resident hit the patient with a club. The EMS did not arrive on the scene. The police were called to the scene of the accident. The patient was transported via car to Metropolitan Hospital Center and was treated and released the same day. The patient presents today complaining of left shoulder and mid back pain sustained in the work-related accident. The patient was attending physical therapy for the last 3 weeks with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Left shoulder arthroscopy in April 2022.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient is a smoker. 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, driving, lifting, childcare, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, and squatting.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 9/10. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead or behind the back and unable to sleep at night due to pain. Worse with range of motion and improves with rest, medication, physical therapy, and ice.

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 9 inches, weight is 180 pounds, and BMI is 26.6. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and deltoid. 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 90/180 degrees, adduction 35/45 degrees, forward flexion 100/180 degrees, extension 40/60 degrees, internal rotation 45/90 degrees, and external rotation 60/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 03/16/2022, shows partial-thickness undersurface tear of the supraspinatus tendon. AC joint hypertrophy may contribute to rotator cuff impingement. Small synovial cyst in the superior subscapular recess.

ASSESSMENT:
1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.02 Adhesive capsulitis, left shoulder.
4. M75.82 Shoulder tendinitis, left shoulder.
5. S43.432A Labral tear, left shoulder.
6. M75.42 Impingement, left shoulder.
7. M65.812 Tenosynovitis, left shoulder.

8. M75.52 Bursitis, left shoulder.
9. M25.512 Pain, left shoulder.
10. S49.92XA Injury, left shoulder.
11. M25.412 Joint effusion, left shoulder.
12. Status post arthroscopy, 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 left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder 3 days/week.

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
MS/AEI