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July 11, 2022

Office seen at:
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Office # (718) 402-5200

Re: Seabrook, Latoya
DOB: 10/08/1976
DOA: 02/17/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, right elbow, right hip, neck, and low back pain.

HISTORY OF PRESENT ILLNESS: A 45-year-old right-hand dominant female involved in a motor vehicle accident on 02/17/2022. The patient was a front seat passenger and was wearing a seatbelt. The vehicle was T-boned on the driver's side. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Mount Sinai Queens Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, right elbow, right hip, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Asthma.

PAST SURGICAL HISTORY: Status post right shoulder surgery (05/06/2021).

DRUG ALLERGIES: PENICILLIN.

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

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. The patient uses 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: play sports, lifting heavy objects, carrying heavy objects, negotiating stairs, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with rest, medication, and physical therapy.

Left shoulder: Left shoulder pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has 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. Worse with range of motion and improves with rest, medication, and physical therapy.

Right hip: Right hip pain radiates from back. Right hip pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has pain with standing, walking, climbing, and standing from sitting. Worse with range of motion and improves with rest, medications, and physical therapy.

Right elbow: Right wrist pain is 7-8/10, described as constant, dull, achy pain. Admits to numbness and tingling. The patient has pain with lifting, carrying, and driving. Worse with range of motion and improves with rest, 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 3 inches, weight is 275 pounds, and BMI is 48.7. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, proximal biceps tendon, 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 115/180 degrees, adduction 35/45 degrees, forward

flexion 110/180 degrees, extension 45/60 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 right upper extremity.

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 115/180 degrees, adduction 35/45 degrees, forward flexion 100/180 degrees, extension 45/60 degrees, internal rotation 35/90 degrees, and external rotation 65/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The right hip pain is coming from back.

The right elbow reveals tenderness to palpation over the lateral epicondyle. Muscle strength is 4/5. Negative Varus test. Negative Valgus test. Negative Tinel sign. Range of motion reveals flexion 140/150 degrees, extension 140/150 degrees, supination 80/90 degrees, pronation 80/90 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 06/21/2022, shows mild fluid in subacromial/subdeltoid bursa compatible with bursitis or may be seen with full thickness rotator cuff tear. Tenosynovitis of the extra articular long head of the biceps tendon.

ASSESSMENT:

1. Status post arthroscopy with rotator cuff repair, right shoulder.
2. S46.012A Partial rotator cuff tear, left shoulder.
3. M24.812 Internal derangement, left shoulder.
4. M75.02 Adhesive Capsulitis, 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. Pain coming from back, right hip.
13. Internal derangement, right elbow.
14. Lateral epicondylitis, right elbow.

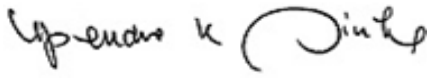
PLAN:

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 elbow, and right hip.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.

5. Continue physical therapy for right shoulder, left shoulder, right elbow, and right hip 3 days/week.
6. Recommend steroid injections with pain management for right elbow. The patient accepts.

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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