

UK Sinha Physician, P.C.

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September 14, 2022

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Re: Lowman, Fatima
DOB: 06/05/1983
DOA: 07/23/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and right knee pain.

HISTORY OF PRESENT ILLNESS: A 39-year-old right-hand dominant female involved in a motor vehicle accident on 07/23/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the rear driver side. The airbags did not deploy. The EMS did not arrive on the scene. The police were called to the scene of the accident. The patient went by car to NYC Health + Hospitals/Lincoln and was treated and released the same day. The patient presents today complaining of left shoulder and right knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 6 weeks with no relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: CA of liver, status post radiation. There is no previous history of trauma.

PAST SURGICAL HISTORY: Embolization of liver, hepatic adenoma in 2021.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking gabapentin.

SOCIAL HISTORY: The patient smokes one-fifth pack of cigarettes per day. The patient does not drink alcohol. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 10 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: lifting heavy objects, carrying heavy objects, reaching overhead, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

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

Right knee: Right knee pain is 8/10, described as constant, 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 buckling and intermittent locking. Worse with range of motion and improves with rest.

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 165 pounds, and BMI is 29.2. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, and proximal biceps tendon. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive 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 120/180 degrees, adduction 40/45 degrees, forward flexion 135/180 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 left upper extremity.

The right knee reveals tenderness along the medial joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer.

Negative posterior drawer. Range of motion reveals flexion 100/130 degrees and extension 4/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 08/30/2022, shows no fracture; spurring of the acromioclavicular joint. Tendinopathy of the supraspinatus tendon. Intact glenohumeral joint. MRI of the right knee, done on 08/30/2022, shows intact right knee; no fracture or focal bony lesion. Intact menisci and cruciate ligaments. Strain of the medial collateral ligament. Pretibial bursitis.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.82 Shoulder tendinitis, left shoulder.
3. M25.512 Pain, left shoulder.
4. S49.92XA Injury, left shoulder.
5. M25.412 Joint effusion, left shoulder.
6. M23.91 Internal derangement, right knee.
7. S83.411 Medial collateral ligament sprain, right knee.
8. M25.461 Joint effusion, right knee.
9. S80.911A Injury, right knee.
10. M25.561 Pain, right knee.

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 and right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for 4-6 weeks for the left shoulder and right knee. If pain does not improve, will consider offering intervention then.
6. Recommend steroid injections with pain management for left shoulder and right knee. The patient refuses due to side effects.
7. Follow up in 4-6 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.

A stylized, cursive handwritten signature in black ink, featuring a large, sweeping loop that crosses itself.

Mellita Shakhmurov, PA-C

MS/AEI

A handwritten signature in black ink, appearing to read 'U.K. Sinha' in a cursive script.

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