

UK Sinha Physician, P.C.

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July 29, 2022

Office seen at:

Liberty Rhea Ranada Ebarle PT PC
14 Bruckner Blvd
Bronx, NY 10454
Phone# (718) 402-5200

Re: Miller, Najiyyah
DOB: 02/10/1979
DOA: 05/11/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 43-year-old right-hand dominant female involved in a work-related motor vehicle accident on 05/11/2022. The patient was pushing a heavy cart and pulled a muscle. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient went by car to NYC Health + Harlem Hospital Center and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, right knee, left knee pain, neck and low back pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy 3 times a week with little relief.

WORK HISTORY: The patient is currently not working.

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

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n., muscle relaxant and ibuprofen.

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 she can walk for 5 blocks. She can stand for 30 minutes before she has to sit. She can sit for 1 hour 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 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.

Left shoulder: Left shoulder pain is 9/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. 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 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has no difficulty rising from a chair and no difficulty going up and down stairs. The patient also notes clicking, popping, and buckling.

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 difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

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 370 pounds, and BMI is 48.7. The right shoulder reveals tenderness to palpation over supraspinatus tendon region. There is crepitus appreciated. There is no heat, swelling, erythema or other abnormality. 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 140/180 degrees, adduction 40/45 degrees, forward flexion 120/180

degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 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 proximal biceps tendon. 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 160/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 40/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 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 no heat, swelling, erythema, crepitus or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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 medial joint line and lateral joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive 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.

DIAGNOSTIC TESTING: MRI of the left knee, done on 07/18/2022, shows anterior cruciate ligament sprain at the tibial attachment. Mild bone marrow edema at the superior pole of the patella. Muroid degeneration in posterior horns of medial menisci extending into body of menisci. Joint effusion. MRI of the left shoulder, done on 07/08/2022, shows interstitial tear of the length 8 mm at the attachment of the infraspinatus tendon. Type II SLAP tear. Mild fluid in subacromial-subdeltoid bursa compatible with bursitis. Joint effusion.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A Labral tear, right shoulder.
5. M75.41 Impingement, right shoulder.
6. M65.811 Tenosynovitis, right shoulder.
7. M75.51 Bursitis, right shoulder.
8. M75.21 Bicipital tendinitis, right shoulder.
9. M25.511 Pain, right shoulder.
10. S49.91XA Injury, right shoulder.

11. M67.211 Hypertrophic synovitis, right shoulder.
12. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
13. M25.411 Joint effusion, right shoulder.
14. M24.812 Internal derangement, left shoulder.
15. M75.02 Adhesive capsulitis, left shoulder.
16. M75.82 Shoulder tendinitis, left shoulder.
17. S43.432A Labral tear, left shoulder.
18. M75.42 Impingement, left shoulder.
19. M65.812 Tenosynovitis, left shoulder.
20. M75.52 Bursitis, left shoulder.
21. M75.22 Bicipital tendinitis, left shoulder.
22. M25.512 Pain, left shoulder.
23. S49.92XA Injury, left shoulder.
24. M67.212 Hypertrophic synovitis, left shoulder.
25. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
26. M25.412 Joint effusion, left shoulder.
27. M23.91 Internal derangement, right knee.
28. S83.511A Anterior cruciate ligament sprain, right knee.
29. S83.411A Medial collateral ligament sprain, right knee.
30. M22.2X1 Patellofemoral chondral injury, right knee.
31. M25.461 Joint effusion, right knee.
32. M12.669 Traumatic arthropathy, right knee.
33. S80.911A Injury, right knee.
34. M25.561 Pain, right knee.
35. M65.161 Synovitis, right knee.
36. M24.661 Adhesions, right knee.
37. S83.242A Medial meniscus tear, left knee.
38. S83.282A Lateral meniscus tear, left knee.
39. M23.92 Internal derangement, left knee.
40. S83.512A Anterior cruciate ligament sprain, left knee.
41. S83.412A Medial collateral ligament sprain, left knee.
42. S83.32XA Tear articular cartilage, left knee.
43. M22.2X2 Patellofemoral chondral injury, left knee.
44. M25.462 Joint effusion, left knee.
45. M12.569 Traumatic arthropathy, left knee.
46. S80.912A Injury, left knee.
47. M25.562 Pain, left knee.
48. M65.162 Synovitis, left knee.
49. M24.662 Adhesions, left knee.

PLAN:

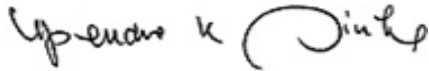
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, right knee, and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.

5. Continue physical therapy for right shoulder, left shoulder, right knee, and left knee 3 days/week.
6. Follow up in 6 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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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

UKS/AEI