UK Sinha Physician, P.C.

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July 13, 2022

Office seen at:
Tatay Ninong Physical Therapy
1314 Coney Island Ave
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Re: Kobil, Hamidov
DOB: 08/08/1986
DOA: 09/17/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and left shoulder pain.

HISTORY OF PRESENT ILLNESS: A 35-year-old right-hand dominant male involved in a work-related motor vehicle accident on 09/17/2021. The patient was an Uber driver and was wearing a seatbelt. While at work, the vehicle was T-boned. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Long Island Jewish Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder and left shoulder pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for the last 9 months with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory. No history of prior trauma.

PAST SURGICAL HISTORY: Left shoulder arthroscopy in January 2021 by Dr. Sinha.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient smokes 3-4 cigarettes per day. The patient drinks alcohol socially. 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 heavy objects, carrying heavy objects, childcare, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 1/10, 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. Worse with range of motion and improves with rest and physical therapy.

Left shoulder: Left shoulder pain is 3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. 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 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 8 inches, weight is 165 pounds, and BMI is 25.1. The right shoulder reveals no tenderness. 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. Positive 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 170/180 degrees, adduction 45/45 degrees, forward flexion 175/180 degrees, extension 60/60 degrees, internal rotation 90/90 degrees, and external rotation 90/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the right upper extremity.

The left shoulder reveals no tenderness. 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 165/180 degrees, adduction 45/45 degrees, forward flexion 170/180 degrees, extension 55/60 degrees, internal rotation 85/90 degrees, and

external rotation 90/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 10/13/2021, shows a focal soft tissue contusion is seen anteriorly at the proximal deltoid musculature, as noted. There is no hematoma or seroma. Tendinitis changes are seen at the supraspinatus and infraspinatus tendons. A bursal surface tear is seen anteriorly at the supraspinatus tendon. MRI of the left shoulder, done on, 10/12/2021, a bursal surface tear is seen anteriorly at the supraspinatus tendon, as noted. Tendinosis changes are seen at the supraspinatus and infraspinatus tendons, as noted. There is no fracture.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.
7. Status post arthroscopy, left shoulder.
8. M25.512 Pain, left shoulder.
9. S49.92XA Injury, left shoulder.
10. M25.412 Joint effusion, 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 right shoulder and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.
6. Recommend steroid injections with pain management for right shoulder and left shoulder. The patient refuses due to side effects.
7. Follow up on an as needed basis as no intervention needed as no pain in the right shoulder.

IMPAIRMENT RATING: 25%.

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.

MellitaShakhmurov, PA-C

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

MS/AEI