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July 06, 2022

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Re: Reyes, Gladys
DOB: 12/05/1971
DOA: 06/15/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, right hand, left foot pain, neck, low back and right ribs.

HISTORY OF PRESENT ILLNESS: A 51-year-old right-hand dominant female involved in a motor vehicle accident on 06/15/2022. The patient was a pedestrian. Car hit the patient on her left side and the patient fell on the right side. The EMS arrived on the scene. The patient was transported via ambulance to Elmhurst Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, right hand, left foot pain, neck, low back and right ribs. pain sustained in the motor vehicle 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: Hypertension and cardiac.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient is a nonsmoker. 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 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: 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 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has 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, medication, physical therapy, and ice.

Right hand: Right hand pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient has pain with lifting, carry, drive. Worse with range of motion and improves with rest, medications, physical therapy, and ice.

Right ribs: Pain is 8-9/10.

Left foot: Right hip pain is 8-9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has pain with standing, walking, and climbing. Worse with range of motion and improves with rest, medications, 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, or irregular heart rate. The patient has 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 150 cm, weight is 160 pounds, and BMI is 35.6. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and deltoid. 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 120/180 degrees, adduction 35/45 degrees, forward flexion 120/180 degrees, extension 45/60 degrees, internal rotation 60/90 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 right hand reveals pain to palpation over thumb. 3/5 grip strength. Negative Tinel sign. Negative Phalen test. Range of motion reveals flexion 70/80 degrees, extension 60/70 degrees, radial deviation 10/20 degrees, ulnar deviation 20/30 degrees.

The left foot reveals swelling, hematoma and bruises noted over anterior. Negative anterior drawer test. Negative inversion stress test. Range of motion is limited and painful. ROM: Dorsiflexion 10/20 degrees, plantarflexion 35/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

DIAGNOSTIC TESTING: MRI pending.

ASSESSMENT:

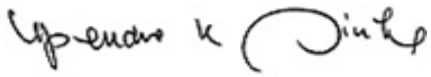
1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A Labral tear, right shoulder.
5. M75.41 Impingement, right shoulder.
6. M75.51 Bursitis, right shoulder.
7. M25.511 Pain, right shoulder.
8. S49.91XA Injury, right shoulder.
9. M25.411 Joint effusion, right shoulder.
10. Internal derangement, right hand.
11. Internal derangement, left foot.

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, right hand and left foot.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, right hand and left foot 3 days/week.
6. MRI ordered of right hand and left foot to rule out ligament tear and/or synovial injury.
7. Follow up in 4 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.



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MS/AEI