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Re: Del Pilar, Michelle
DOB: 09/01/2006
DOA: 02/27/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, left knee and left ankle pain.

HISTORY OF PRESENT ILLNESS: A 15-year-old female involved in a motor vehicle accident on 02/272022. The patient was a pedestrian. The patient was struck on the rear side. The police were called to the scene of the accident. The patient was transported via ambulance to Elmhurst Hospital and was treated and released the same day. The patient presents today complaining of left shoulder, left knee and left ankle pain sustained in the motor vehicle accident. The patient was attending physical therapy 4 times a week with little relief.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. The patient does not use recreational drug use.

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: Left shoulder: Left shoulder pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has clicking. The patient is able to reach overhead and 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.

Left knee: Left knee pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes intermittent locking. Worse with range of motion and improves with rest, medication, physical therapy, and ice.

Left ankle: Left ankle pain is 5/10, described as constant, dull, achy pain. 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 left shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 170/180 degrees, adduction 40/45 degrees, forward flexion 170/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 80/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the superior pole of patella, inferior pole of the patella. There is swelling and crepitus appreciated. There is no heat, erythema or deformity appreciated. Negative 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.

The left ankle reveals ROM: Dorsiflexion 15/20 degrees, plantarflexion 40/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 04/22/2022, shows tendinosis changes are seen at the supraspinatus and infraspinatus tendons, as described. There is slight disorganization of the fibers of the subscapularis tendon at the upper aspect. A low-grade strain is noted at the subscapularis tendon. MRI of the left ankle, done on 05/02/2022, shows a focal contusion is noted anterolateral to the lateral malleolus. A partial-thickness tear of the anterior talofibular ligament is seen medially. There is no bone bruise or fracture

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive Capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M65.812 Tenosynovitis, left shoulder.
6. M75.52 Bursitis, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. S46.102A Biceps tendon tear, left shoulder.
10. M67.212 Hypertrophic synovitis, left shoulder.
11. M25.412 Joint effusion, left shoulder.
12. M23.92 Internal derangement, left knee.
13. S83.512A Anterior cruciate ligament sprain, left knee.
14. S83.412A Medial collateral ligament sprain, left knee.
15. M94.262 Chondromalacia, left knee.
16. M25.462 Joint effusion, left knee.
17. M12.569 Traumatic arthropathy, left knee.
18. S80.912A Injury, left knee.
19. M25.562 Pain, left knee.
20. M65.162 Synovitis, left knee.
21. M24.662 Adhesions, left knee.
22. Strain of lateral collateral ligament, left ankle.

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, left knee, and left ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, left knee, and left ankle 3 days/week.
6. 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.

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

MS/AEI