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June 28, 2022

Office seen at:
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Re: Peart, Jacqueline
DOB: 03/10/1971
DOA: 04/03/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 51-year-old right-hand dominant female involved in a motor vehicle accident on 04/03/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the rear side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient went by car to Franklin Northwell Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, neck and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications, ibuprofen.

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 2 blocks. She can stand for 30 minutes before she has to sit. She can sit for 30 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: garden, play sports, 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 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and clicking. The patient is unable to reach overhead or 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.

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 2 inches, weight is 155 pounds, and BMI is 28.3. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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. Negative Hawkins test. Range of motion, as per goniometer, abduction 150/180 degrees, adduction 35/45 degrees, forward flexion 115/180 degrees, extension 50/60 degrees, internal rotation 60/90 degrees, and external rotation 80/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

DIAGNOSTIC TESTING: MRI of the cervical spine, done on -05/12/2022, shows signal loss at C2-C3, C3-C4 with posterior disc bulges effacing anterior epidural fat within close proximity upon thecal takeoff of central C4, CS, C7 and C8 nerves nerves. There is also signal loss at CG-C7 with more bibbed disc bulge and a concomitant left lateral osteophyte encroaching the left extra foraminal space, and with mild to moderate left foraminal stenosis. MRI of the lumbar spine, done on 05/12/2022, shows L4-5 broad-based posterior subligamentous herniation with regional nerve root impingement. L4-5-disc signal loss noted which may be attributed to dispersal of herniated central nucleus pulposus in setting of trauma. Follow-up EMG evaluation may be helpful.

ASSESSMENT:
1. M24.811 Internal derangement, right shoulder.

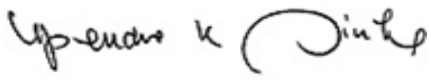
2. M25.511 Pain, right shoulder.
3. S49.91XA Injur, right shoulder.

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.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder 3 days/week.
6. MRI ordered of right shoulder 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