

UK Sinha Physician, P.C.

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September 09, 2022

Re: Acevedo, Joseph

DOB: 10/28/1976

DOA: 08/31/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 45-year-old right-hand dominant male involved in a motor vehicle accident on 08/31/2022. The patient was a driver and was wearing a seatbelt. The patient was going to make a left turn and another car hit him in the front. The vehicle was struck on the front side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder, left shoulder, right knee, and left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for 3 times a week with little relief.

WORK HISTORY: The patient is currently not working. The patient was working as a train conductor.

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

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 drugs.

ADL CAPABILITIES: The patient states that he can walk for 2 blocks. He can stand for 20 minutes before he has to sit. He 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 he 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.

Left shoulder: Left shoulder pain is 9/10, 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.

Right knee: Right knee pain is 6/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, and buckling.

Left knee: Left knee pain is 5/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has 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 6 feet 0 inches, weight is 282 pounds, and BMI is 38.2. The right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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. Negative O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 120/180 degrees, adduction 40/45 degrees, forward flexion 115/180 degrees, extension 50/60 degrees, internal rotation 70/90 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.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 115/180 degrees, adduction 40/45 degrees, forward flexion 110/180 degrees, extension 50/60 degrees, internal rotation 60/90 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 superior pole of 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. posterior drawer. Range of motion reveals flexion 110/130 degrees and extension -5/5 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 superior pole of 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.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.
7. M24.812 Internal derangement, left shoulder.
8. M75.02 Adhesive Capsulitis, left shoulder.
9. M75.42 Impingement, left shoulder.
10. M25.512 Pain, left shoulder.
11. S49.92XA Injury, left shoulder.
12. M23.91 Internal derangement, right knee.
13. M25.461 Joint effusion, right knee.
14. M12.569 Traumatic arthropathy, right knee.
15. S80.911A Injury, right knee.
16. M25.561 Pain, right knee.
17. M24.661 Adhesions, right knee
18. M23.92 Internal derangement, left knee.
19. M25.462 Joint effusion, left knee.
20. M12.569 Traumatic arthropathy, left knee.
21. S80.912A Injury, left knee.
22. M25.562 Pain, left knee.

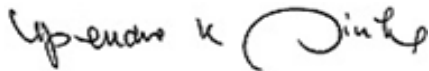
23. M24.662 Adhesions, left knee.

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. The patient is going for MRI of the right shoulder, left shoulder, right knee, and left knee. The patient has started physical therapy on 09/09/2022.
7. Follow up in 2 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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Board Certified Orthopedic Surgeon

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