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October 28, 2022

Re: Munshi, Aminur
DOB: 07/05/1975
DOA: 12/14/2013

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, right knee, left knee, right hip, left hip, right foot, neck, mid back, and low back pain.

HISTORY OF PRESENT ILLNESS: A 47-year-old right-hand dominant male involved in a motor vehicle accident on 12/14/2013. The patient was a driver and was wearing a seatbelt. Head on collision, other driver crossed 2 constant lanes and came into his lane. 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 Mount Sinai Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, right knee, left knee, right hip, left hip, right foot, neck, mid back, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 years, but not now.

WORK HISTORY: The patient is currently not working. The patient was a taxi driver.

PAST MEDICAL HISTORY: Hypertension and hyperlipidemia. There is no previous history of trauma.

PAST SURGICAL HISTORY: Right shoulder arthroscopy in 2016.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking metoprolol, simvastatin, gabapentin, and tizanidine.

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 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: 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 7/10, described as constant, 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.

Left shoulder: Left shoulder pain is 5/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is able to reach overhead and able to reach behind the back, but is unable to sleep at night due to pain.

Right knee: Right knee pain is 4/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. The patient also notes clicking and popping.

Left knee: Left knee pain is 3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. The patient also notes clicking and popping.

Right foot: Right foot pain is 3-4/10, described as intermittent, dull, achy pain. Pain with standing, walking and climbing.

The patient is taking gabapentin 800 mg t.i.d. for 5 years and tizanidine 4 mg every 8 hours p.r.n. for 1 year.

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 5 feet 7 inches, weight is 155 pounds, and BMI is 24.3. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, and proximal biceps tendon. 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 100/180 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 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 150/180 degrees, adduction 40/45 degrees, forward flexion 160/180 degrees, extension 50/60 degrees, internal rotation 80/90 degrees, and external rotation 80/90 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 medial joint line and superior pole of the patella. There is swelling and crepitus appreciated. There is no heat, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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 right lower extremity.

The left knee reveals tenderness along the medial joint line and superior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive 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: MRI of the right shoulder, done on 03/28/2014, shows small partial tear distal supraspinatus tendon. Slight hypertrophic changes acromioclavicular joint without evidence of static bony impingement. Joint space effusion. Joint space narrowing. MRI of the left shoulder, done on 04/18/2016, partial tear of the distal supraspinatus tendon. Slight bony impingement. Slight joint space narrowing. Slight space effusion. MRI of the right knee, done on 05/30/2016, shows partial intrasubstance meniscal tear posterior horn medial meniscus. Suprapatellar effusion identified extending into the joint space. MRI of the left knee, done on 07/05/2016, shows partial intrasubstance meniscal tear posterior horn medial meniscus. Suprapatellar effusion identified extending into the joint space. MRI of the right foot, done on 04/18/2016, shows mild fluid distention of the metatarsophalangeal joints, no fractures, tendon tears or soft tissue mass.

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. S43.431A SLAP tear, right shoulder.
6. M75.41 Impingement, right shoulder.

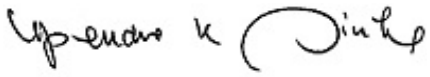
7. M75.51 Bursitis, right shoulder.
8. M75.21 Bicipital tendinitis, right shoulder.
9. M25.511 Pain, right shoulder.
10. S49.91XA Injury, right shoulder.
11. S46.012A Partial rotator cuff tear, left shoulder.
12. M24.812 Internal derangement, left shoulder.
13. M75.02 Adhesive capsulitis, left shoulder.
14. M75.42 Impingement, left shoulder.
15. M25.512 Pain, left shoulder.
16. S49.92XA Injury, left shoulder.
17. S83.241A Medial meniscus tear, right knee.
18. M23.91 Internal derangement, right knee.
19. M12.569 Traumatic arthropathy, right knee.
20. S80.911A Injury, right knee.
21. M25.561 Pain, right knee.
22. S83.242A Medial meniscus tear, left knee.
23. M23.92 Internal derangement, left knee.
24. M25.462 Joint effusion, left knee.
25. M12.569 Traumatic arthropathy, left knee.
26. S80.912A Injury, left knee.
27. M25.562 Pain, left knee.
28. Old healed fracture at the base of the fifth metatarsal, right 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, left shoulder, right knee, left knee, right hip, left hip, right foot.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, left knee, right hip, left hip, right foot 3 days/week.
6. Recommend steroid injections with pain management for right shoulder. The patient accepts.
7. Cortisone plus Lidocaine challenge today in the bicipital groove (right) with excellent pain relief.
8. Failed SLAP repair right. Plan open subpectoral biceps tenodesis, right shoulder. The patient had SLAP repair by Dr. Ajoy Sinha in the right shoulder on 02/22/2016.
9. 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: I hereby certify and affirm that this report is a full and truthful representation of my professional opinion with respect to the claimant's condition. I further certify that no person or entity has caused, directed, or encouraged me to submit a report that differs substantially from my professional opinion and that I have physically examined and reviewed the MRI reports, Surgery report and attest to its accuracy. With reasonable notice, I am available to testify by appointment, should the need arise.



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