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June 8, 2022

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Re: Sarker, Vhanjan
DOB: 01/02/1981
DOA: 02/01/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 41-year-old right-hand dominant male involved in a work-related motor vehicle accident on 02/01/2022. The patient was a driver and was wearing a seatbelt. 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 right ankle pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for 4 times per week with little 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 Tylenol 500 mg.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. 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: Exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient is unable to reach overhead or behind the back and unable to sleep at night due to pain.

Left shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient is unable to reach overhead or 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. The patient has no difficulty rising from a chair and no difficulty going up and down stairs. The patient also notes clicking, popping, buckling.

Right ankle: Right ankle pain is 8/10, described as intermittent, 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 patient's height is 5 feet 4 inches, weight is 140 pounds, and BMI is 24. The right 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 110/180 degrees, adduction 40/45 degrees, forward flexion 110/180 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 right upper extremity.

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 145180 degrees, adduction 40/45 degrees, forward flexion 170/180 degrees, extension 40/60 degrees, internal rotation 70/90 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 medial joint line, lateral joint line, superior pole of patella, inferior pole of the patella. There is no heat, swelling, erythema, crepitus or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative 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 right ankle reveals negative inversion stress test. No tenderness to palpation noted in the medial or lateral aspect. Range of motion is limited and painful. ROM: Dorsiflexion 15/20 degrees, plantarflexion 40/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

The right foot has minimal pain in MP joint of right big toe. No pain in second toe.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 02/18/2022, shows a tear of the mid and distal subscapularis tendon is seen. There is no attenuation. Mild tendinitis changes are seen at the supraspinatus and infraspinatus tendons. There is no impingement. There is no fracture or bone bruise. MRI of the left shoulder, done on 03/30/2022, shows a bursal surface tear is seen anteriorly at the supraspinatus tendon, as described. There is no attenuation or atrophy. Tendinosis changes are seen at the supraspinatus and infraspinatus tendons. There is no fracture or bone bruise. There is no impingement. MRI of the right foot, done on 03/24/2022, shows a focal bone bruise and subtle partial-thickness hairline fracture is noted at the base of the second metatarsal. Medial and lateral cortices are intact. The arch and the Lisfranc joint appear unremarkable. Talus and calcaneus are within normal limits.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.81 Shoulder tendinitis, right shoulder.
5. S43.431A Labral tear, right shoulder.
6. M75.41 Impingement, right shoulder.
7. M75.51 Bursitis, right shoulder.
8. M25.511 Pain, right shoulder.
9. S49.91XA Injury, right shoulder.
10. M67.211 Hypertrophic synovitis, right shoulder.
11. M25.411 Joint effusion, right shoulder.
12. S46.012A Partial rotator cuff tear, left shoulder.
13. M24.812 Internal derangement, left shoulder.
14. M75.82 Shoulder tendinitis, left shoulder.

15. S43.432A Labral tear, left shoulder.
16. M75.42 Impingement, left shoulder.
17. M65.812 Tenosynovitis, left shoulder.
18. M75.52 Bursitis, left shoulder.
19. M25.512 Pain, left shoulder.
20. S49.92XA Injury, left shoulder.
21. Grade 3 sprain lateral collateral ligament, right ankle.

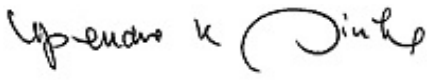
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, right knee, and right ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, and right ankle 3 days/week.
6. Follow up in 4 weeks.

IMPAIRMENT RATING: 50%

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

MS/AEI