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September 19, 2022

Office seen at:
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Re: Jordan, David
DOB: 08/11/1966
DOA: 06/12/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: A 56-year-old left-hand dominant male involved in a motor vehicle accident on 06/12/2022. The patient was a driver and was wearing a seatbelt. The patient developed RSD after crush injury right hand in 1997. The vehicle was struck on the rear driver side. The airbags did not deploy. The police were not 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 pain sustained in the motor vehicle accident. The patient was attending physical therapy for 3 times per week with little relief.

WORK HISTORY: The patient is currently not working. The patient has no work since 1997.

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

PAST SURGICAL HISTORY: The patient had 2 MI and had stent twice.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n. and Oxycodone 15 mg q.i.d., 7 years see list.

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

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 15 minutes before he has to sit. He can sit for 1/2 hour 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: garden, play sports, driving, lifting heavy objects, childcare, carrying heavy objects, shopping, running errands, kneeling, squatting, and negotiating stairs.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 9/10, 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.

The patient has RSD right upper extremity since 1997, had back fusion (lumbar) in 2017. No help. Now, the patient had spinal cord stimulator.

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 5 inches, weight is 165 pounds, and BMI is 27.5. 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. Negative O'Brien test. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 10/180 degrees, adduction 5/45 degrees, forward flexion 15/180 degrees, extension 10/60 degrees, internal rotation 10/90 degrees, and external rotation 10/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity. The patient has burning in right upper extremity.

DIAGNOSTIC TESTING: CT of the right shoulder, done on 07/30/2022, shows 2.5 x 2.3 cm well corticated ligament along the lateral aspect of the bony acromion-differentials include old fracture with nonunion/congenital etiology.

ASSESSMENT:
1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.41 Impingement, 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. No indication for any operation. The patient has RSD, chronic regional pain syndrome since 1997.
7. The patient has fracture of acromion, minimal displacement. Any operation in right shoulder will make it worst.
8. CT scan of the right shoulder, done on 07/30/2022, shows fracture of the acromion.
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: 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

UKS/AEI