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October 11, 2022

Office seen at:
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Re: Salisbury, Breon
DOB: 09/13/1992
DOA: 07/03/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 30-year-old right-hand dominant male involved in a motor vehicle accident on 07/03/2022. The patient was a driver and was wearing a seatbelt. The driver on the left side tried cutting in front of patient and impacted his front left 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, neck and back pain sustained in the motor vehicle accident. The patient was attending physical therapy 4 times a week with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Diabetes, type 2 diabetes mellitus. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking insulin (Admelog x3 days and Semglee x1 day).

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

ADL CAPABILITIES: 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, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has popping and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with rest.

Left shoulder: Left shoulder pain is 9-10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has weakness, popping, and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to 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 6 feet 0 inches, weight is 187 pounds, and BMI is 25.4. The right shoulder reveals tenderness to palpation over AC joint. 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 140/180 degrees, adduction 40/45 degrees, forward flexion 120/180 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 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. Positive Hawkins test. Range of motion, as per goniometer, abduction 140/180 degrees, adduction 40/45 degrees, forward flexion 110/180 degrees, extension 50/60 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.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 09/30/2022, shows synovitis of the patulous axillary pouch of the inferior glenohumeral ligament. Impingement. Hypoplastic anterior and posterior labrum. Hypoplastic biceps tendon. Tendinosis/tendonitis of supraspinatus, subscapularis and infraspinatus tendons. AC joint narrowing and acromion spurring. MRI of the left shoulder, done on 10/07/2022, shows malalignment of the AC joint with impingement. Myotendinous supraspinatus strain/interstitial tear with associated tenosynovitis/bursitis as discussed in the body of the report. Minimal fluid in the subcoracoid bursa compatible with subcoracoid bursitis. The visualized portions of the labrum are intact.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M25.511 Pain, right shoulder.
6. S49.91XA Injury, right shoulder.
7. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
8. M25.411 Joint effusion, right shoulder.
9. S46.012A Partial rotator cuff tear, left shoulder.
10. M24.812 Internal derangement, left shoulder.
11. M75.02 Adhesive capsulitis, left shoulder.
12. M75.82 Shoulder tendinitis, left shoulder.
13. M75.42 Impingement, left shoulder.
14. M75.52 Bursitis, left shoulder.
15. M25.512 Pain, left shoulder.
16. S49.92XA Injury, left shoulder.
17. M25.412 Joint effusion, left shoulder.

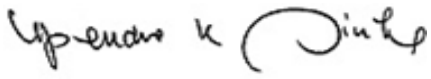
PLAN:

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 and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.
6. The patient will consider arthroscopy of the left shoulder.
7. The patient was recently diagnosed with type II diabetes (on insulin), last A1c was 8.8 a few weeks ago.
8. 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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