

UK Sinha Physician, P.C.

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June 22, 2022

Office seen at:
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Re: Morris, Theresa
DOB: 09/20/1957
DOA: 05/02/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left hip pain.

HISTORY OF PRESENT ILLNESS: A 64-year-old right-hand dominant female involved in a motor vehicle accident on 05/02/2022. The patient was a driver and was wearing a seatbelt. The vehicle T-boned on the driver's side. The airbags deployed. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Jacobi Medical Center and was treated and released the same day. The patient presents today complaining of left hip pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 6 weeks with no relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Diabetes, hypertension, hyperlipidemia, cardiac issues, and atrial fibrillation.

PAST SURGICAL HISTORY: TAH-BSO in 30s (fibroids), cardiac ablation on February of 2022, and left big toe surgery in 2001.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n., losartan 50 mg, Eliquis 5 mg, atorvastatin 40 mg, amlodipine, hydralazine 50 mg, and HCTZ 12.5 mg.

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 she can walk for 5 blocks. She can stand for 10 minutes before she has to sit. She 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 she is unable to do the following activities: laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left hip: Left hip pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has pain with standing, walking, climbing, standing from sitting. Worse with range of motion and improves with medications.

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 225 pounds, and BMI is 35.2. The left hip reveals positive Trendelenburg test. Tenderness to palpation in the greater trochanter and medial thigh. Range of motion is limited and painful. ROM: Abduction 25/45 degrees, adduction 20/35 degrees, flexion 75/120 degrees, extension 15/30 degrees, internal rotation 30/45 degrees, and external rotation 25/45 degrees.

DIAGNOSTIC TESTING: MRI of the left hip, done on 06/17/2022, shows increased T2 signal, consistent with edema in the gluteus medius and minimus muscles/tendons near the attachment to greater trochanter, consistent with muscular/tendinous strains/sprains and/or partial tear and /or trochanteritis or trochanteric bursitis, in an appropriate clinical setting. Mild osteoarthritic changes. Mild joint effusion consistent with recent trauma or synovitis. in an appropriate clinical setting.

ASSESSMENT:

1. Gluteus medius and minimus muscles partial tear, left hip.
2. Osteoarthritic, left hip.
3. Joint effusion, left hip.

PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left hip.

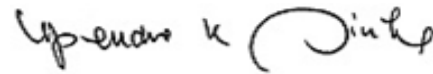
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left hip 3 days/week.
6. Recommend steroid injections with pain management for left hip. The patient refuses due to side effects.
7. Referral for left hip at the earliest.
8. Follow up on a p.r.n. basis.

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.

Mellita Shakhmurov, PA-C

MS/AEI



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Board Certified Orthopedic Surgeon