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June 9, 2022

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Phone# (718) 566-0022

Re: Diaz, Jenille

DOB: 04/19/1987

DOA: 04/11/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and left knee pain.

HISTORY OF PRESENT ILLNESS: A 35-year-old right-hand dominant female involved in a motor vehicle accident on 04/11/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the passenger's front side. The airbags did not deploy. The EMS did not arrive on the scene. The police were called to the scene of the accident. The patient was transported via car to Whittier Hospital Medical Center and was treated and released the same day. The patient presents today complaining of left shoulder and left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 2 months with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Asthma.

PAST SURGICAL HISTORY: C-section in 2017.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

SOCIAL HISTORY: The patient smokes one-fourth packs of cigarettes per day. The patient drinks alcohol socially. The patient uses recreational drugs socially.

ADL CAPABILITIES: The patient states that she can walk for 3 blocks. She can stand for 60 minutes before she has to sit. She can sit for 30 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: play sports, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, kneeling, squatting, negotiating stairs, and jogging.

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

Left knee: Left knee pain is 10/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, and buckling.

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. The patient has asthma.

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 4 feet 11 inches, weight is 200 pounds, and BMI is 40.4. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, proximal biceps tendon, and deltoid. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 95/180 degrees, adduction 30/45 degrees, forward flexion 110/180 degrees, extension 35/60 degrees, internal rotation 30/90 degrees, and external rotation 60/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the lateral joint line and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative 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 4/5 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 left shoulder, done on 05/18/2022, shows tear of the inferior glenoid labrum with a 6 x 3 mm paralabral cyst decompressing inferiorly. Supraspinatus and infraspinatus tendinitis with subdeltoid/subacromial bursitis. Evidence of rotator cuff impingement secondary to lateral downsloping of the acromion and thickening of the coracoacromial ligament. Acromioclavicular joint capsule sprain sequelae. Background of moderate acromioclavicular joint disease. MRI of the left knee, done on 05/18/2022, shows posterior medial meniscocapsular junction sprain. Joint effusion. Deep chondral fissuring at the weightbearing lateral femoral condyle.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.82 Shoulder tendinitis, left shoulder.
3. S43.432A Labral tear, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M75.52 Bursitis, left shoulder.
6. M25.512 Pain, left shoulder.
7. S49.92XA Injury, left shoulder.
8. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
9. M25.412 Joint effusion, left shoulder.
10. Paralabral cyst, left shoulder.
11. Type II acromion, left shoulder.
12. M23.92 Internal derangement, left knee.
13. M22.2X2 Patellofemoral chondral injury, left knee.
14. M25.462 Joint effusion, left knee.
15. S80.912A Injury, left knee.
16. M25.562 Pain, left knee.
17. Medial meniscocapsular sprain, left knee.

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 shoulder and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and left knee 3 days/week.
6. Recommend steroid injections with pain management for left shoulder and left knee. The patient refuses due to side effects.
7. Discussed left shoulder and left knee arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient would like to proceed with surgery.
8. It is medically necessary to perform the suggested surgery to properly diagnose the patient's condition and to objectively verify presence and severity of internal derangement and other left shoulder and left knee pathology in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.

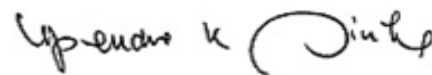
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the left shoulder and left knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
11. All the questions in regard to the procedure were answered.
12. The patient verbally consents for the arthroscopy of left shoulder and the patient will be scheduled for left shoulder surgery. On the day of the surgery, before the procedure, the surgeon will explain all related questions of the procedure. The patient will sign a written consent and be witnessed by the surgeon.
13. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

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



U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon