

UK Sinha Physician, P.C.

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October 31, 2022

Office seen at:
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Re: Huaman, Maria
DOB: 05/27/1971
DOA: 08/07/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, right knee, neck, and low back pain.

HISTORY OF PRESENT ILLNESS: A 51-year-old right-hand dominant female involved in a motor vehicle accident on 08/07/2022. The patient was walking on the street and was hit by a car. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Flushing Hospital and was treated and released the same day. The patient presents today complaining of left shoulder, right knee, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy 3 times a week with little relief.

PAST MEDICAL HISTORY: Hypertension.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking Tylenol.

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

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 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: driving, lifting heavy objects, carrying heavy

objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Right knee: Right knee pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

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 2 inches, weight is 148 pounds, and BMI is 27.1. The left shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 130/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 80/90 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 superior pole of the patella 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 0/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 08/17/2022, shows an interstitial tear of the ACL noted, as described. There is no laxity. There is a focal contusion over the patellar tendon. MRI of the right knee, done on 08/17/2022, shows a tear seen at the subscapularis tendon at the upper aspect. There is no attenuation. Mild tendinitis changes are seen at the supraspinatus and infraspinatus tendons.

ASSESSMENT:

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.02 Adhesive capsulitis, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M25.512 Pain, left shoulder.
6. S49.92XA Injury, left shoulder.
7. M23.91 Internal derangement, right knee.
8. S83.519A Anterior cruciate ligament tear, right knee.
9. S83.511A Anterior cruciate ligament sprain, right knee.
10. M12.569 Traumatic arthropathy, right knee.
11. S80.911A Injury, right knee.
12. M25.561 Pain, right knee.

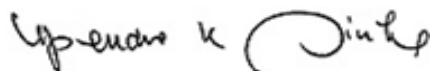
PLAN:

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 right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and right knee 3 days/week.
6. Discussed right shoulder 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 wants to think about surgery.
7. 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 right shoulder 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.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the right shoulder 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.
10. All the questions in regard to the procedure were answered.
11. 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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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

UKS/AEI