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October 26, 2022

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Re: Minaya, Luis
DOB: 11/14/1983
DOA: 07/13/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and left knee pain.

HISTORY OF PRESENT ILLNESS: A 38-year-old right-hand dominant male involved in a work-related motor vehicle accident on 07/13/2022. The patient was an Uber driver and was wearing a seatbelt. While on work duty, the vehicle was struck on the driver side rear. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient went by car to Westchester Square Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder and left knee pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for the last 3.5 months with no relief.

WORK HISTORY: The patient is currently not working.

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

PAST SURGICAL HISTORY: Right shoulder surgery, status post fall and fracture in 2019.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

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 he can walk for 1/2 block. He can stand for 5 minutes before he has to sit. He 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 he 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: 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 able to reach overhead and able to reach behind the back, but is unable to sleep at night due to pain. Worse with range of motion and improves with rest.

Left knee: Left 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. 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 5 feet 7 inches, weight is 150 pounds, and BMI is 23.5. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, and proximal biceps tendon. Surgical incisions healed. 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 105/180 degrees, adduction 35/45 degrees, forward flexion 120/180 degrees, extension 45/60 degrees, internal rotation 40/90 degrees, and external rotation 50/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of the patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 90/130 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: CT of the right shoulder, done on 09/20/2022, shows prior surgery for fracture of the humeral neck with metallic plate and multiple screws in place and with anatomic alignment. No acute fracture or destructive bone lesion. Intact acromioclavicular and glenohumeral joints. No abnormal soft tissue calcification. CT of the left knee, done on 09/20/2022, shows no fracture or focal bony lesion. Intact joint spaces. Knee effusion.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.81 Shoulder tendinitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.
7. Status post surgery with metal placement, right shoulder.
8. M23.92 Internal derangement, left knee.
9. M25.462 Joint effusion, left knee.
10. S80.912A Injury, left knee.
11. M25.562 Pain, 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 right shoulder and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left knee 3 days/week.
6. Recommend steroid injections with pain management for right shoulder and left knee. The patient accepts with PCP in physical therapy office.
7. Follow up in 2 weeks post injection.

IMPAIRMENT RATING: 100%.

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

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

MS/AEI