

UK Sinha Physician, P.C.

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September 12, 2022

Office seen at:
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150 Graham Avenue Suite A
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Re: Canty III, Edward
DOB: 02/29/1988
DOA: 08/08/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: A 34-year-old right-hand dominant male involved in a motor vehicle accident on 08/08/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the front driver's 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 did not go to any hospital that same day. The patient presents today complaining of right shoulder pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 1 month 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: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient smokes one-fifth pack of cigarettes per day. The patient drinks alcohol socially. The patient does use recreational drugs daily.

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: play sports, lifting heavy objects, carrying heavy objects, reaching overhead, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. 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, medication, physical therapy, and ice.

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 6 inches, weight is 270 pounds, and BMI is 31.2. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, and proximal biceps tendon. 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 120/180 degrees, adduction 40/45 degrees, forward flexion 125/180 degrees, extension 40/60 degrees, internal rotation 35/90 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.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 08/25/2022, shows mild subluxation of the acromioclavicular joint with significant hypertrophy of the joint capsule. Tenosynovitis of the extra articular long head of the biceps tendon.

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. M65.811 Tenosynovitis, right shoulder.
6. M75.21 Bicipital tendinitis, right shoulder.
7. M25.511 Pain, right shoulder.

8. S49.91XA Injury, right shoulder.
9. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
10. M25.411 Joint effusion, right 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.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for 4 weeks for the right shoulder. If pain does not improve, will consider offering intervention.
6. Recommend steroid injections with pain management for right shoulder. The patient refuses due to side effects.
7. Follow up in 4 weeks.

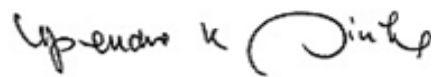
CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the 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.



Mellita Shakhmurov, PA-C

MS/AEI



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