UK Sinha Physician, P.C.

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October 10, 2022

Office seen at:
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Re: Sulbaran, Jose
DOB: 04/03/1987
DOA: 09/14/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, neck, and low back pain.

HISTORY OF PRESENT ILLNESS: A 35-year-old right-hand dominant male involved in a motor vehicle accident on 09/14/2022. The patient was riding an E-Bike, hit by another car. The police were not called to the scene of the accident. The patient did not go to any hospital that same day. The patient went to hospital after 2 days. The patient presents today complaining of right shoulder, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy 3 times a week with little relief.

WORK HISTORY: The patient is currently working full time.

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 Motrin.

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

ADL CAPABILITIES: 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, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 2-3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is able to reach overhead and able to reach behind the back.

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 9 inches, weight is 180 pounds, and BMI is 26.6. The right shoulder reveals no tenderness to palpation. There is no heat, swelling, erythema, crepitus or deformity appreciated. 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. Negative Hawkins test. Range of motion, as per goniometer, abduction 170/180 degrees, adduction 40/45 degrees, forward flexion 170/180 degrees, extension 55/60 degrees, internal rotation 85/90 degrees, and external rotation 85/90 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 09/30/2022, shows there is a mild joint effusion. Minimal subcoracoid fluid.

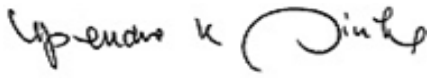
ASSESSMENT:
1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.51 Bursitis, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.

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 right shoulder 3 days/week.

6. 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.



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Board Certified Orthopedic Surgeon

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