# UK Sinha Physician, P.C.

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August 08, 2022

Office seen at:
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Re: Jackson, Jasmine
DOB: 04/20/1987
DOA: 08/30/2021

## INITIAL ORTHOPEDIC CONSULT EXAMINATION

**CHIEF COMPLAINT:** Right shoulder, left shoulder, neck, mid-back, and low-back pain.

**HISTORY OF PRESENT ILLNESS:** A 35-year-old right-hand dominant female involved in a motor vehicle accident on 08/30/2021. The patient was a driver and was wearing a seatbelt. The patient was going from a left lane to the right lane and was hit. The vehicle was struck on the front driver's side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Mount Sinai Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, neck, mid-back, and low-back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 2 times per week with little relief.

**WORK HISTORY:** The patient is currently working in home health.

**PAST MEDICAL HISTORY:** Asthma.

**PAST SURGICAL HISTORY:** Left shoulder arthroscopy in November 2021 and right shoulder arthroscopy in January 2022.

**DRUG ALLERGIES:** IODINE AND RITALIN.

**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 use recreational drugs.

**ADL CAPABILITIES:** The patient states that she can walk for 3 blocks. She can stand for 30 minutes before she has to sit. She can sit for 20 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:** Right shoulder: Right shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

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

**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 4 feet 11 inches, weight is 190 pounds, and BMI is 38.4. The right 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. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 125/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

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. Positive 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 140/180 degrees, extension 50/60 degrees, internal rotation

80/90 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.

**DIAGNOSTIC TESTING:** MRI of the right shoulder, done on 11/18/2021, shows evidence supporting rotator cuff tendinitis and partial tear. Associated bursitis. No gross bony derangement suspected. MRI of the left shoulder, done on 10/26/2021, shows tendinopathy/tendinosis of the supraspinatus tendon. Type II to type III acromion with slight hypertrophic changes of the acromioclavicular joint.

**ASSESSMENT:**

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A Labral tear, right shoulder.
5. M75.41 Impingement, right shoulder.
6. M65.811 Tenosynovitis, right shoulder.
7. M75.51 Bursitis, right shoulder.
8. M75.21 Bicipital tendinitis, right shoulder.
9. M25.511 Pain, right shoulder.
10. S49.91XA Injury, right shoulder.
11. M67.211 Hypertrophic synovitis, right shoulder.
12. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
13. M25.411 Joint effusion, right shoulder.
14. M24.812 Internal derangement, left shoulder.
15. M75.02 Adhesive capsulitis, left shoulder.
16. M75.82 Shoulder tendinitis, left shoulder.
17. S43.432A Labral tear, left shoulder.
18. S43.432A SLAP tear, left shoulder.
19. M75.42 Impingement, left shoulder.
20. M65.812 Tenosynovitis, left shoulder.
21. M75.52 Bursitis, left shoulder.
22. M25.512 Pain, left shoulder.
23. S49.92XA Injury, left shoulder.
24. S46.102A Biceps tendon tear, left shoulder.
25. M67.212 Hypertrophic synovitis, left shoulder.
26. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
27. M25.412 Joint effusion, left shoulder.

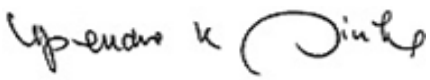
**PLAN:**

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 and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.

6. Repeat MRI ordered of right shoulder and left shoulder to rule out ligament tear and/or synovial injury.
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.



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Board Certified Orthopedic Surgeon

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