UK Sinha Physician, P.C.

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August 24, 2022

Office seen at:
Tatay Ninong Physical Therapy
1314 Coney Island Ave
Brooklyn, NY 11230
Phone# (718) 377-0100

Re: Burch, Reno
DOB: 10/10/1969
DOA: 04/02/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, right knee and right ankle pain.

HISTORY OF PRESENT ILLNESS: A 52-year-old right-hand dominant male involved in a slip and fall accident on 04/02/2022. The patient fell through the roof. The EMS arrived on the scene. The police not called to the scene of the accident. The patient was transported via ambulance to Coney Island Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, right knee and right ankle pain sustained in a slip and fall accident. The patient was attending physical therapy for 3 times a week with little 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: BENADRYL AND RUBBER.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a smoker. The patient does not drink alcohol. The patient does 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 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 9/10, described as constant, 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.

Right knee: Right knee pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. The patient also notes clicking, popping, and buckling.

Right ankle: Right ankle pain is 7/10, described as constant, dull, achy pain. Pain with standing, walking and climbing.

Right elbow: Right elbow pain is 7.5/10, described as constant, dull, achy pain. Pain with lift, carry and drive.

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 11 inches, weight is 180 pounds, and BMI is 25.1. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 160/180 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 and AC joint. 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. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 165/180 degrees, adduction 45/45 degrees, forward flexion 140/180 degrees, extension 60/60 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 medial joint line. There is no heat, swelling, erythema, crepitus or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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.

The right ankle reveals swelling, hematoma and bruises noted over lateral malleolar aspect. Tenderness to palpation noted in the medial/lateral aspect. Range of motion is limited and painful. ROM: Dorsiflexion 20/20 degrees, plantarflexion 30/50 degrees, inversion 15/15 degrees, eversion 15/15 degrees.

The right elbow reveals swelling, erythema, bruise, and deltoid atrophy. Muscle strength is 4/5. There is tenderness to palpation over the lateral epicondyle. Negative Varus test. Negative Valgus test. Negative Tinel sign. Range of motion reveals flexion 140/150 degrees, extension 0/150 degrees, supination 90/90 degrees, pronation 90/90 degrees.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M25.511 Pain, right shoulder.
3. S49.91XA Injury, right shoulder.
4. M24.812 Internal derangement, left shoulder.
5. M25.512 Pain, left shoulder.
6. S49.92XA Injury, left shoulder.
7. M23.91 Internal derangement, right knee.
8. M12.569 Traumatic arthropathy, right knee.
9. S80.911A Injury, right knee.
10. M25.561 Pain, right knee.
11. Grade III sprain lateral collateral ligament, right ankle.
12. Lateral epicondylitis, right elbow.

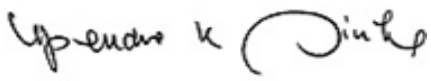
PLAN:

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, left shoulder, right knee, right ankle, and right elbow.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, right ankle, and right elbow 3 days/week.
6. MRI ordered today.
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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