UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

July 13, 2022

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

Re: Mamatova, Shakhlo
DOB: 03/11/1984
DOA: 05/01/2020

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 38-year-old right-hand dominant female involved in a work-related accident on 05/01/2020. While at work, the patient had a heavy object (ceiling) fall on her. The patient did not go to any hospital that same day. The patient presents today complaining of left shoulder, neck and low back pain sustained in the work-related accident. The patient was attending physical therapy for 4 times per week with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Arthroscopic surgery of left shoulder in 2021 and had neck and low back fusion in the past.

DRUG ALLERGIES: ANALGESICS.

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

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 she can walk for 1/2 block. She can stand for 1 hour before she has to sit. She 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 she is unable to do the following activities: garden, play sports, driving, lifting heavy objects, carrying

heavy objects, childcare, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient is unable to reach overhead and 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 5 feet 2 inches, weight is 130 pounds, and BMI is 23.8. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and proximal biceps tendon. 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 100/180 degrees, adduction 40/45 degrees, forward flexion 105/180 degrees, extension 40/60 degrees, internal rotation 60/90 degrees, and external rotation 70/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 08/25/2020, shows normal MRI of the left shoulder. Addendum: Upon further review, there are findings suggestive of a tear of the anterior glenoid labrum from approximately the 2 to 4 o'clock positions. The posterior labrum is intact. There is mild glenohumeral synovitis. Additionally, there is trace subacromial/subdeltoid bursitis.

ASSESSMENT:
1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.02 Adhesive Capsulitis, left shoulder.
4. S43.432A Labral tear, left shoulder.
5. M75.42 Impingement, left shoulder.
6. M65.812 Tenosynovitis, left shoulder.
7. M75.52 Bursitis, left shoulder.

8. M75.22 Bicipital Tendinitis, left shoulder.
9. M25.512 Pain, left shoulder.
10. S49.92XA Injury, left shoulder.
11. M67.212 Hypertrophic synovitis, left shoulder.
12. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
13. 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 left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder 3 days/week.
6. Follow up in 4 weeks.

IMPAIRMENT RATING: 50%.

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.

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

UKS/AEI