UK Sinha Physician, P.C.

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August 03, 2022

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

Re: Caban, Jocelyn
DOB: 06/25/1980
DOA: 06/02/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 42-year-old right-hand dominant female involved in a motor vehicle accident on 06/02/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the front passenger's side. The airbags did not deploy. The police were called to the scene of the accident. The patient was transported via ambulance to New York Community Hospital and was treated and released the same day. The patient presents today complaining of left shoulder, left knee, neck, and low-back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 4 times per week with little relief.

WORK HISTORY: The patient is currently not working since December 2020.

PAST MEDICAL HISTORY: Asthma, takes albuterol, Singulair, and Advair. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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 she can walk for 1-2 blocks. She can stand for 1 hour before she has to sit. She can sit for 1 hour 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, childcare, carrying heavy objects, laundry, 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, 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.

Left knee: Left knee pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

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 7 inches, weight is 286 pounds, and BMI is 44.8. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and trapezius. 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 120/180 degrees, adduction 40/45 degrees, forward flexion 110/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 75/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the medial joint line and superior pole of patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion

110/130 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 left lower extremity.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, 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.
14. M23.92 Internal derangement, left knee.
15. S83.512A Anterior cruciate ligament sprain, left knee.
16. S83.412A Medial collateral ligament sprain, left knee.
17. M94.262 Chondromalacia, left knee.
18. S83.32XA Tear articular cartilage, left knee.
19. M22.2X2 Patellofemoral chondral injury, left knee.
20. M25.462 Joint effusion, left knee.
21. M12.569 Traumatic arthropathy, left knee.
22. S80.912A Injury, left knee.
23. M25.562 Pain, left knee.
24. M65.162 Synovitis, left knee.
25. M24.662 Adhesions, left knee.
26. Left tibial pain in dorsal aspect of IP joint. No locking. No triggering. Stable joint.

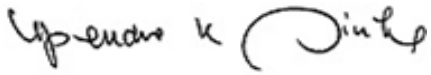
PLAN:

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 and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and left knee 3 days/week.
6. The patient is awaiting MRI of the left shoulder, left knee, and left tibia. (The patient had ultrasound of the left shoulder and left knee 5 weeks ago).
7. Follow up in 2 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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