UK Sinha Physician, P.C.

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Office seen at:
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Re: Rouse, Joseph
DOB: 03/21/1989
DOA: 03/24/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and left shoulder pain.

HISTORY OF PRESENT ILLNESS: A 33-year-old right-hand dominant male involved in a motor vehicle accident on 03/24/2022. The patient was a rear seat passenger and was wearing a seatbelt. The patient ambulates in wheelchair. The vehicle was struck on the front end. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Brookdale University Hospital Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder and left shoulder pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 4 months with no relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Paraplegia in 2010 and shot in back and left leg.

PAST SURGICAL HISTORY: Status post trauma, ____ surgery in 2010, bilateral hip wound debridement for infected ulcers done 3-4 years ago.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n. and oxycodone. The patient is following up with pain management specialist.

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 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has weakness. The patient is able to reach overhead and behind the back but unable to sleep at night due to pain. Worse with range of motion and improves with rest.

Left shoulder: Left shoulder pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has weakness. The patient is able to reach overhead and behind the back but unable to sleep at night due to pain. Worse with range of motion and improves with rest.

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 145 pounds, and BMI is 20.2. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint. There is no swelling, heat, erythema, or deformity appreciated. There is crepitus appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 130/180 degrees, adduction 30/45 degrees, forward flexion 140/180 degrees, extension 40/60 degrees, internal rotation 50/90 degrees, and external rotation 45/90 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, AC joint. There is no swelling, heat, erythema, crepitus or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 125/180 degrees, adduction 30/45 degrees, forward flexion 140/180 degrees, extension 40/60 degrees, internal rotation 45/90 degrees, and external rotation 40/90 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 07/19/2022, shows undisplaced fracture of the right 4th rib along the angle. Right shoulder is unremarkable. However, CT has limited evaluation of rotator cuff tendons and soft tissue pathology. If there is further clinical concern, MRI of the right shoulder may be obtained as clinically warranted. MRI of the left shoulder, done on 07/19/2022, shows left shoulder is unremarkable. However, CT has limited evaluation of rotator cuff tendons and soft tissue pathology. If there is further clinical concern, MRI of the left shoulder may be obtained as clinically warranted.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.81 Shoulder tendinitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.
7. M24.812 Internal derangement, left shoulder.
8. M75.82 Shoulder tendinitis, left shoulder.
9. M75.42 Impingement, left shoulder.
10. M25.512 Pain, left shoulder.
11. S49.92XA Injury, left shoulder.
12. 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. Recommend steroid injections with pain management for right shoulder and left shoulder. The patient accepts. Card given.
7. Follow up in 4 weeks after injection. If there is no improvement, patient will consider surgical intervention.

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.

Mellita Shakhmurov, PA-C
MS/AEI

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