

UK Sinha Physician, P.C.

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July 11, 2022

Office seen at:

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Re: Sidhilall, Melissa
DOB: 06/10/1997
DOA: 03/18/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 25-year-old female involved in a motor vehicle accident on 03/18/2022. The patient was a front seat passenger and was wearing a seatbelt. The vehicle was struck on the rear driver's side. The airbags deployed. The EMS arrived on the scene. The police were not called to the scene of the accident. The patient was transported via ambulance to Metropolitan Hospital Center and was treated and released the same day. The patient presents today complaining of right shoulder, neck and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. The patient does not use recreational drugs.

ADL CAPABILITIES: 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, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 3-4/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has popping and clicking. The patient is able to reach overhead and unable to reach behind the back. Worse with range of motion and improves with rest, medication, physical therapy.

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 130 pounds, and BMI is 26.3. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and deltoid. There is crepitus appreciated. There is no heat, swelling, erythema 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. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 120/180 degrees, adduction 35/45 degrees, forward flexion 125/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and external rotation 60/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 05/16/2022, shows mild subluxation of the acromioclavicular joint with significant hypertrophy of the joint capsule. Significant susceptibility artifacts.

ASSESSMENT:

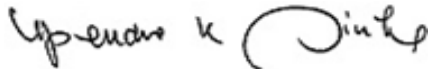
1. M24.811 Internal derangement, right shoulder.
2. M75.81 Shoulder tendinitis, right shoulder.
3. M65.811 Tenosynovitis, right shoulder.
4. M75.51 Bursitis, right shoulder.
5. M25.511 Pain, right shoulder.
6. S49.91XA Injury, right shoulder.

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

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
MS/AEI