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: Barnes, Kimyia
DOB: 04/04/1991
DOA: 01/01/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and right knee pain.

HISTORY OF PRESENT ILLNESS: A 31-year-old right-hand dominant female involved in a motor vehicle accident on 01/01/2022. The patient was a passenger and was wearing a seatbelt. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to NY Presbyterian Hospital and was treated and released the same day. The patient presents today complaining of right shoulder and right knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for 3-4 times per week with little relief.

WORK HISTORY: The patient is currently working fulltime (postal service).

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma. There is a previous history of trauma.

PAST SURGICAL HISTORY: The patient had a right shoulder arthroscopy on 05/01/2022 by Dr. Ajoy.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient is a nonsmoker.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes 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: 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 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has weakness, popping, and clicking. 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 3/10, described as intermittent, 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 buckling.

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 right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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. Positive 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 160/180 degrees, extension 50/60 degrees, internal rotation 80/90 degrees, and external rotation 80/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The right knee reveals tenderness along the medial joint line. There is swelling appreciated There is no heat, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 120/130 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.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:

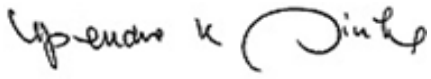
1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M23.91 Internal derangement, right knee.
5. M12.569 Traumatic arthropathy, right knee.
6. S80.911A Injury, right knee.
7. M25.561 Pain, right knee.

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