

UK Sinha Physician, P.C.

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September 20, 2022

Office seen at:
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Re: Ventura, Alvic
DOB: 10/15/2000
DOA: 06/14/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder pain.

HISTORY OF PRESENT ILLNESS: A 21-year-old left-hand dominant male involved in a work-related accident on 06/14/2022. The patient is working as a painter and the ladder fell, fell with it as it broke from the side. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient went by car to The Mount Sinai Hospital and was treated and released the same day. The patient presents today complaining of left shoulder pain sustained in the work-related accident. The patient was attending physical therapy for the last 3 months with no relief.

WORK HISTORY: The patient is currently not working.

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

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 socially. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 5 minutes before he has to sit. He 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 he is unable to do the following activities: lifting heavy objects, carrying heavy objects, reaching overhead, running errands, and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 9/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with 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 6 feet 0 inches, weight is 210 pounds, and BMI is 28.5. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 110/180 degrees, adduction 40/45 degrees, forward flexion 125/180 degrees, extension 45/60 degrees, internal rotation 40/90 degrees, and external rotation 55/90 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 09/07/2022, shows no fracture or focal bony lesion. Intact acromioclavicular and glenohumeral joints. Tendinopathy of the supraspinatus tendon. No additional focal soft tissue abnormality.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.82 Shoulder tendinitis, left shoulder.
3. M75.42 Impingement, left shoulder.
4. M25.512 Pain, left shoulder.
5. S49.92XA Injury, left shoulder.
6. 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. Recommend steroid injections with pain management for left shoulder. The patient accepts. If there is no improvement with injection, the patient will consider surgery.
7. Follow up in 4 weeks.

IMPAIRMENT RATING: 100%.

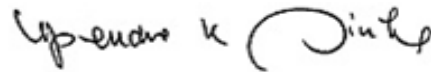
CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the 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



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Board Certified Orthopedic Surgeon