

UK Sinha Physician, P.C.

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July 29, 2022

Office seen at:

Liberty Rhea Ranada Ebarle PT PC
14 Bruckner Blvd
Bronx, NY 10454
Phone# (718) 402-5200

Re: Baldera, Lorena
DOB: 11/28/1996
DOA: 03/08/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, right knee, and left knee pain.

HISTORY OF PRESENT ILLNESS: A 25-year-old right-hand dominant female involved in a work-related motor vehicle accident on 03/08/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the rear side. The airbags did not deploy. The police were called to the scene of the accident. The patient was transported via ambulance to a hospital and was treated and released the same day. The patient presents today complaining of left shoulder, right knee, and left knee pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for 3 times per week with good relief.

WORK HISTORY: The patient is currently 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 does not drink alcohol. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that she can walk for 5 blocks. She can stand for 30 minutes before she has to sit. She can sit for 20 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, laundry, shopping, running errands, kneeling, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 2-3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient is able to reach overhead and able to reach behind the back.

Left shoulder: Left shoulder pain is 2-3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient is able to reach overhead and able to reach behind the back.

Right knee: Right knee pain is 2-3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has difficulty rising from a chair and difficulty going up and down stairs.

Left knee: Left knee pain is 2-3/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking and popping.

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 3 inches, weight is 147 pounds, and BMI is 24.5 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. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 155/180 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 left 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. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 155/180 degrees, adduction 45/45 degrees, forward flexion 160/180 degrees, extension 55/60 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 left upper extremity.

The right knee reveals tenderness along the superior pole of patella and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema, 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.

The left knee reveals tenderness along the superior pole of patella and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema 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 left lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 05/18/2022, shows partial-thickness supraspinatus tendon. Tenosynovitis of the extra articular long head of the biceps tendon. MRI of the right knee, done on 04/30/2022, shows linear interstitial tearing of the distal quadriceps tendon superimposed on tendinitis. Suprapatellar fat pad impingement. MRI of the left knee, done on 04/30/2022, shows edema along the myofascial planes of the partially imaged medial head of the gastrocnemius muscle consistent with myofascial strain. Significant edema in the prepatellar region compatible with trauma sequelae.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A Labral tear, right shoulder.
5. S43.431A SLAP tear, right shoulder.
6. M75.41 Impingement, right shoulder.
7. M65.811 Tenosynovitis, right shoulder.
8. M75.51 Bursitis, right shoulder.
9. M75.21 Bicipital tendinitis, right shoulder.
10. M25.511 Pain, right shoulder.
11. S49.91XA Injury, right shoulder.
12. M67.211 Hypertrophic synovitis, right shoulder.
13. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
14. M25.411 Joint effusion, right shoulder.
15. M24.812 Internal derangement, left shoulder.
16. M75.02 Adhesive Capsulitis, left shoulder.

17. M75.82 Shoulder tendinitis, left shoulder.
18. S43.432A Labral tear, left shoulder.
19. M75.42 Impingement, left shoulder.
20. M65.812 Tenosynovitis, left shoulder.
21. M75.52 Bursitis, left shoulder.
22. S49.92XA Injury, left shoulder.
23. M67.212 Hypertrophic synovitis, left shoulder.
24. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
25. M25.412 Joint effusion, left shoulder.
26. M23.91 Internal derangement, right knee.
27. S83.511A Anterior cruciate ligament sprain, right knee.
28. S83.411A Medial collateral ligament sprain, right knee.
29. M25.461 Joint effusion, right knee.
30. M12.669 Traumatic arthropathy, right knee.
31. S80.911A Injury, right knee.
32. M25.561 Pain, right knee.
33. M65.161 Synovitis, right knee.
34. M24.661 Adhesions, right knee.
35. M23.92 Internal derangement, left knee.
36. S83.512A Anterior cruciate ligament sprain, left knee.
37. S83.412A Medial collateral ligament sprain, left knee.
38. M25.462 Joint effusion, left knee.
39. M12.569 Traumatic arthropathy, left knee.
40. S80.912A Injury, left knee.
41. M25.562 Pain, left knee.
42. M65.162 Synovitis, left knee.
43. M24.662 Adhesions, left knee.

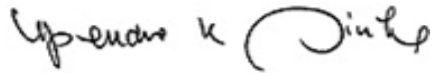
PLAN:

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, left shoulder, right knee and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee and left knee 3 days/week.
6. Follow up in 4 weeks.

IMPAIRMENT RATING: 50%.

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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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

UKS/AEI