UK Sinha Physician, P.C.

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August 3, 2022

Office seen at:
Tatay Ninong Physical Therapy
1314 Coney Island Ave
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Re: Cruz, Victor
DOB: 06/30/1981
DOA: 12/14/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, right ankle, neck, midback, and low back pain.

HISTORY OF PRESENT ILLNESS: A 41-year-old right-hand dominant male involved in a work-related motor vehicle accident on 12/14/2021. The patient was a pedestrian, was uploading supply from his truck, another truck came and hit him. 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 NYU Langone Hospital and was treated and released the same day. The patient presents today complaining of left shoulder, right knee, neck, midback and low back pain sustained in the work-related motor vehicle accident. The patient was attending physical therapy for 2-3 times a week with little relief.

WORK HISTORY: The patient is currently working as a truck driver.

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 not taking any medication at this time.

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 he can walk for 1-2 blocks. He can stand for 15 minutes before he has to sit. He can sit for 45 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: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is able to reach overhead and able to reach behind the back, and unable to sleep at night due to pain.

Right ankle: Right ankle pain is 6/10, described as intermittent, dull, achy pain. Worse with range of motion and improves with rest. Pain with standing, walking and climbing.

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 10 inches, weight is 175 pounds, and BMI is 25.1. The left shoulder reveals tenderness to palpation over supraspinatus tendon. 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 140/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 75/90 degrees, and external rotation 75/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: Pending.

ASSESSMENT:
1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. S43.432A Labral tear, left shoulder.
5. M75.42 Impingement, left shoulder.

6. M65.812 Tenosynovitis, left shoulder.
7. M75.52 Bursitis, left shoulder.
8. M67.212 Hypertrophic synovitis, left shoulder.
9. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
10. M25.412 Joint effusion, left shoulder.
11. Grade III sprain of collateral ligament, right ankle.

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 and right ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and right ankle 3 days/week.
6. The patient is being scheduled for MRI of the left shoulder.
7. 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.

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

UKS/AEI