UK Sinha Physician, P.C.

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October 31, 2022

Office seen at:
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Re: Carbonell Latrique, Estela
DOB: 03/22/1971
DOA: 07/11/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, neck, mid back, and low back pain.

HISTORY OF PRESENT ILLNESS: A 51-year-old right-hand dominant female involved in a work-related accident on 07/11/2022. The patient was a bus passenger in a shuttle bus in London and the bus rear ended another car causing her to slam the front chair on the left side. The EMS arrived on the scene, not examined. The police were called to the scene of the accident. The patient went by car to the hospital in London and was treated and released the same day. The patient presents today complaining of left shoulder, neck, mid back, and low back pain sustained in the work-related accident. The patient was attending physical therapy 2 times a week with good relief.

WORK HISTORY: The patient is currently not working since the date of accident.

PAST MEDICAL HISTORY: Hypertension and asthma. There is a previous history of trauma, MVA in 1999-2000 case closed.

PAST SURGICAL HISTORY: Left ankle surgery, ganglion cyst removal in July 2020.

DRUG ALLERGIES: PROGESTIN.

MEDICATIONS: The patient is taking Singulair and Latuda.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. 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: 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, able to reach behind the back, and unable to sleep at night due to pain.

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. The patient has asthma.
Cardiovascular: No chest pain, murmurs, or irregular heart rate. The patient has 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 1 inch, weight is 155 pounds, and BMI is 29.3. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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. 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 70/90 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.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 10/06/2022, shows mild to moderate supraspinatus and infraspinatus tendinosis with undersurface fraying of the confluence fibers. Mild subscapularis tendinosis. Blunting of the free edge of the posterior labrum. Small inferior humeral head spur. Acromioclavicular joint arthrosis.

ASSESSMENT:
1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.02 Adhesive capsulitis, left shoulder.
4. M25.512 Pain, left shoulder.
5. S49.92XA Injury, left shoulder.

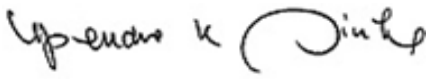
PLAN:

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.
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.



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