

UK Sinha Physician, P.C.

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July 19, 2022

Office seen at:

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Re: Senior-Francis, Barbara
DOB: 10/17/1966
DOA: 06/27/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: A 55-year-old right-hand dominant female involved in a motor vehicle accident on 06/27/2021. The patient was a driver and was wearing a seatbelt. The police were called to the scene of the accident. The patient was transported via ambulance to Long Island Jewish Medical Center and was treated and released the same day. The patient presents today complaining of right shoulder pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 months with no relief. The patient states that the pain is interfering with day-to-day activities.

WORK HISTORY: The patient is currently working with disabled people. There is no previous history of trauma.

PAST MEDICAL HISTORY: Noncontributory.

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.

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: lifting heavy objects, carrying heavy objects, reaching overhead, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right 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. Worse with range of motion and improves with medication.

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 4 inches, weight is 149 pounds, and BMI is 25.6. The right 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. 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 140/180 degrees, adduction 35/45 degrees, forward flexion 145/180 degrees, extension 45/60 degrees, internal rotation 65/90 degrees, and external rotation 70/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 07/16/2021, shows moderate rotator cuff tendinopathy and bursitis.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.81 Shoulder tendinitis, right shoulder.
3. M75.51 Bursitis, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.

PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.

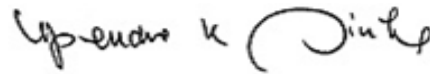
3. Cold compresses for right shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder 3 days/week.
6. Recommend steroid injections with pain management for right shoulder. The patient accepts and will call to schedule.
7. Follow up in 4 weeks after injection.

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