

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

July 29, 2022

Office seen at:

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

Re: Simmons, Jasmin
DOB: 01/22/1986
DOA: 05/11/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 36-year-old right-hand dominant female involved in a motor vehicle accident on 05/11/2022. The patient was a driver and was wearing a seatbelt. Van hit the patient on the side of the car. The vehicle was T-boned on driver's side. The airbags deployed. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to NYC Health + Bellevue Hospital and was treated and released the same day. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle pain sustained in the motor vehicle accident. The patient was attending physical therapy 3-4 times a week with little relief.

WORK HISTORY: The patient is currently not working.

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

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking Tylenol and oxycodone.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that she can walk for 2 blocks. She can stand for 20 minutes before she has to sit. She can sit for 30 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: play sports, carrying heavy objects, and kneeling.

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 unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Left shoulder: Left shoulder pain is 6-7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Right knee: Right knee pain is 9/10, described as constant, sharp, tabbing, 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, popping, buckling, and intermittent locking.

Left knee: Left knee pain is 7-8/10, described as constant, 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.

Right ankle: Right ankle pain is 8/10, described as constant, dull, achy pain. Worse with range of motion and improves with rest.

Left ankle: Left ankle pain is 8/10, described as constant, dull, achy pain. Worse with range of motion and improves with rest.

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 8 inches, weight is 170 pounds, and BMI is 25.6. The right shoulder reveals tenderness to palpation over supraspinatus tendon

region and proximal biceps 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 120/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 50/60 degrees, internal rotation 70/90 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.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region and proximal biceps 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 130/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 50/60 degrees, internal rotation 60/90 degrees, and external rotation 70/90 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 medial joint line. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 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 medial joint line. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 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.

The right ankle reveals tenderness to palpation over lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. Range of motion is limited and painful. ROM: Dorsiflexion 15/20 degrees, plantarflexion 45/50 degrees, inversion 15/15 degrees, eversion 15/15 degrees.

The left ankle reveals tenderness to palpation noted over lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. Range of motion is limited and painful. ROM: Dorsiflexion 15/20 degrees, plantarflexion 45/50 degrees, inversion 15/15 degrees, eversion 15/15 degrees.

DIAGNOSTIC TESTING: MRI of the right knee, done on 06/20/2022, shows edema of the prepatellar bursa. Moderate joint effusion. Lateral patella subluxation. Tendinopathy of the patella tendon. Interstitial partial tear involving the proximal margin of the lateral collateral ligament. Horizontal cleavage tear involving the anterior horn of the medial meniscus. Horizontal cleavage tear involving the anterior horn of the lateral meniscus. MRI of the left knee, done on 06/20/2022, shows moderate infiltration of the subcutaneous tissues. Moderate joint

effusion. Moderate edema of the lateral femoral condyle and patella consistent osseous contusion. Horizontal cleavage tear of the anterior and posterior horn of the medial meniscus. Horizontal cleavage tear of the anterior and posterior horns of the lateral meniscus. MRI of the right ankle, done on 06/20/2022, shows no fracture; bone bruises in the distal tibial and talus. Intact ankle joint. Tendinopathy of the posterior tibial tendon and flexor hallucis longus tendon. Tear of the anterior talofibular ligament. MRI of the left ankle, done on 06/20/2022, shows no fracture; bone bruises in the distal tibial and talus. Intact ankle joint. Tendinopathy of the flexor hallucis longus tendon. Tear of the anterior talonavicular ligament.

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. M75.41 Impingement, right shoulder.
6. M65.811 Tenosynovitis, right shoulder.
7. M75.51 Bursitis, right shoulder.
8. M75.21 Bicipital tendinitis, right shoulder.
9. M25.511 Pain, right shoulder.
10. S49.91XA Injury, right shoulder.
11. M67.211 Hypertrophic synovitis, right shoulder.
12. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
13. M25.411 Joint effusion, right shoulder.
14. M24.812 Internal derangement, left shoulder.
15. M75.02 Adhesive Capsulitis, left shoulder.
16. M75.82 Shoulder tendinitis, left shoulder.
17. S43.432A Labral tear, left shoulder.
18. M75.42 Impingement, left shoulder.
19. M65.812 Tenosynovitis, left shoulder.
20. M75.52 Bursitis, left shoulder.
21. M75.22 Bicipital Tendinitis, left shoulder.
22. M25.512 Pain, left shoulder.
23. S49.92XA Injury, left shoulder.
24. M67.212 Hypertrophic synovitis, left shoulder.
25. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
26. M25.412 Joint effusion, left shoulder
27. S83.241A Medial meniscus tear, right knee.
28. M23.200 Lateral meniscus derangement, right knee.
29. M23.91 Internal derangement, right knee.
30. S83.511A Anterior cruciate ligament sprain, right knee.
31. S83.411A Medial collateral ligament sprain, right knee.
32. M94.261 Chondromalacia, right knee.
33. S83.31XA Tear articular cartilage, right knee.
34. M22.2X1 Patellofemoral chondral injury, right knee.
35. M25.461 Joint effusion, right knee.
36. M12.569 Traumatic arthropathy, right knee.

37. S80.911A Injury, right knee.
38. M25.561 Pain, right knee.
39. M65.161 Synovitis, right knee.
40. M24.611 Adhesions, right knee.
41. M23.92 Internal derangement, left knee.
42. S83.512A Anterior cruciate ligament sprain, left knee.
43. S83.412A Medial collateral ligament sprain, left knee.
44. M94.262 Chondromalacia, left knee.
45. S83.32XA Tear articular cartilage, left knee.
46. M22.2X2 Patellofemoral chondral injury, left knee.
47. M25.462 Joint effusion, left knee.
48. S80.912A Injury, left knee.
49. M25.562 Pain, left knee.
50. M65.162 Synovitis, left knee.
51. M24.662 Adhesions, left knee.
52. Grade III sprain lateral collateral ligament, right ankle.
53. Grade III sprain lateral collateral ligament, left ankle.

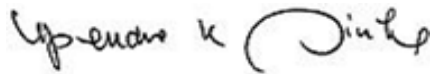
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, left knee, right ankle, and left ankle 3 days/week.
6. Discussed right knee arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient would like to proceed with surgery.
7. It is medically necessary to perform the suggested surgery to properly diagnose the patient's condition and to objectively verify presence and severity of internal derangement and other right knee pathology in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the right knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
10. All the questions in regard to the procedure were answered.
11. The patient verbally consents for the arthroscopy of right knee and the patient will be scheduled for right knee surgery. On the day of the surgery, before the procedure, the surgeon will explain all related questions of the procedure. The patient will sign a written consent and be witnessed by the surgeon.

12. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

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