**Date: 07/13/2022**

Full name: L.J

Address: Queens, NY

Date of Birth: 03/31/1987

Location: Citi Med JFK

Religion: None

Source of Information: Self

Reliability: Reliable

Source of Referral: Workplace

Mode of Transport: Self

**Chief Complaint: “I have chronic back pain” x 2 years**

**History of Presenting Illness**:

35 y/o Hispanic male with no PMHx and PShx of right discectomy, working as a driver/dock worker for UPS, presents for follow-up for a work-related lower back injury sustained on 04/12/20 at 2:00 pm while on duty. On the day of the incident the patient states that he was in a semi-bending position lifting and moving a heavy box when he suddenly felt a dull pain in his lower back, but he continued to work until the end of his shift. He did not take any medications afterwards but felt the pain get progressively worse over the next 3 days. He subsequently reported the injury to his supervisor on 04/15/20 and was advised to come here for further evaluation. The patient denied any prior injuries to his back

Today, the patient presents for a follow-up evaluation and states that the pain is a 6/10, intermittent, dull and sometimes sharp, non-radiating, and is worse in the right side of the lower back when bending, sitting or standing for more than 40 minutes. He complains of difficulty sleeping on his back at night due to the pain. The patient currently takes ibuprofen 3-4 times a week for the pain and reports moderate relief. He states that he uses a back brace 2 times in a week which helps with the pain. The patient also uses lidocaine gel which he states provides moderate relief. He also attends physical therapy 3-4 times a week which he feels is helpful. He also takes cyclobenzaprine before bed only when the pain is severe. He denies any direct trauma to the back, numbness, tingling or weakness of his lower extremities. He is ambulating in the office without any assistive devices. The patient has not worked since his injury, due to continued pain but would like to return to light duty.

**Past Medical History**:

- Denies

**Past Surgical/Procedural History**:

- Discectomy 12/09/2020

**Medications:**

- Ibuprofen 800 mg (3-4 times a week)

- Lidocaine 4% gel (3-4 times a week)

- Cyclobenzaprine (7.5mg once a week, at nighttime)

**Allergies**:

-No known drug, food or environmental allergies.

**Family History:**

Mother – 65 years old, HTN

Father – 68 years old, HTN

Siblings - none

**Social history:**

- He is single and lives alone in an apartment.

- He works as a driver/dock worker for UPS which involves a lot of bending and heavy lifting of items.

- He does home exercises such as mild stretching 3 times a week

- Admits to alcohol use occasionally in social settings.

- Denies illicit drug use

- Denies cigarette or cannabis use

**Review of system**

General – Difficulty sleeping at night due to low back pain. Denies fever and chills.

Skin, hair, and nails - Denies rash, loss of hair

HEENT – Denies any headaches, denies pain or change in vision, denies loss or changes in hearing, denies epistaxis, congestion, dysphagia

Mouth– denies any laceration, pain or swelling

Neck – denies any pain or swelling

Breast – denies any pain

Pulmonary system – denies any cough, shortness of breath or wheezing

Cardiovascular system - denies any chest pain or palpitations

Gastrointestinal system – denies abdominal pain, diarrhea, nausea, vomiting

Genitourinary system – denies dysuria, hematuria

Menstrual /obstetrical – denies any abnormal bleeding

Nervous – denies dizziness, denies falls, numbness or tingling of the spine or upper and lower extremities.

Musculoskeletal – complains of lower back pain, more on the right. Denies any direct trauma to the back.

Peripheral vascular system – Denies any pain in calves

Hematological – denies spontaneous bleeding

Endocrine system – denies polydipsia

Psychiatric – denies any feelings of depression.

**Physical exam:**

**Vital signs:**

Using machine: BP (Sitting & Right arm) 128/ 72 mmHg

Pulse: 88 bpm RRR

RR: 18 breaths/min unlabored

T: 97.2 F using forehead

O2 sat: 98% on room air

BMI: Weight: 143bs, Height: 5’2 = 26.2 kg/m^2

**General appearance:** Hispanic male, is alert and oriented to person, place and time. He appears in no acute distress. Well-developed and Nourished. He is dressed appropriately for weather, has a normal affect, is friendly and cooperative.

**Skin, hair, and nails**: No Jaundice, Skin is warm to touch. No diaphoresis, spoon nails, or splinter hemorrhage. No rash, ecchymosis, bruises, or discoloration on his back.

**Head:** Atraumatic and normocephalic.

**Eyes:** PERRLA. Sclera is white without icterus. Extraocular movements intact.

**Ears**: No tenderness on palpation of the auricle.

**Nose**: Patent bilaterally. No trauma, step-off or deformities of the nose.

**Mouth**: No laceration or bruising of the upper and lower lip.

**Neck**: Supple, non-tender. No lymphadenopathy noted.

**Throat**: Uvula is midline.

**Pulmonary**: Lungs clear to auscultation bilaterally. Pulmonary effort is normal. No wheezing or rales.

**Cardiovascular:** Normal S1 and S2 sounds with a regular rate and rhythm.

**Abdominal exam**: Non distended. Bowel sounds present. Abdomen is soft and non-tender. No guarding or rebound.

**Breast:** Not performed (not applicable)

**Genitourinary**: Not performed (not applicable)

**Endocrine system**: No diaphoresis. No goiter.

**Neuro exam**: No nystagmus or focal deficit. He is alert and oriented x 3. Sensation intact in bilateral upper and lower extremities.

**Musculoskeletal:** Well, healed post-op surgical scars noted along lumbar spine. No open wound, pus or signs of infection. No erythema, ecchymosis, or deformities along the spine. Mild generalized tenderness along the lumbar spine and right paravertebral muscles. Decreased ROM secondary to pain. Flexion 45/90, Extension 20/25, Left rotation 30/40, Right rotation 30/40, left lateral flexion 20/25 and right lateral flexion 20/25. Strength 5/5 left and right lower extremity. Grip 5/5 in bilateral upper extremities. Normal gait without use of assistive device.

**Peripheral vascular system**: No edema of bilateral lower extremities. Capillary refill less than 2 seconds in fingers. 2+ Dorsalis pedis pulse present in both feet.

**Psychiatric**: Negative depression screen. No homicidal or suicidal ideation or plan.

**Previous Imaging:**

X-ray lumbar spine (4/15/2020): Unremarkable. No signs of fracture

MRI lumbar (4/25/2020): Central disc herniation at L5-S1 impressing on the anterior thecal sac.

EMG (4/30/2020): Evidence of right L4-L5 radiculopathy. No evidence of neuropathy.

**Assessment**:

35 y/o Hispanic male with no PMHx, and PShx of right discectomy working as a driver/dock worker for UPS, presents for follow-up for a work-related lower back injury sustained on 04/12/20 at 2:00 pm while on duty. Patient complains of chronic lower back pain after discectomy in 2020 for disc herniation at L5-S1 impressing on the anterior thecal sac. EMG test also indicated radiculopathy at level of L4-L5. The patient has tenderness to the lumbar spine and paravertebral tenderness particularly on the right side with reduced ROM of motion of the lumbar spine.

**Referrals/Follow-ups**:

* **Pain Management:** The patient is being followed by pain management for continued lower back pain. He had received 3 lumbar epidural injections in L4-L5, with the last injection on 09/21/2020 with little relief. The patient underwent a discectomy in 12/09/20 and was recommended after recovery to continue on physical therapy with future follow-ups scheduled as needed.
* **Spine Specialist/surgeon:** The patient underwent a discectomy on12/09/20. The patient was continued on physical therapy and home exercises after recovery with follow-up as needed. The patient has a follow-up scheduled for 7/18/22.

**Problem list**:

1. Disc herniation
2. Radiculopathy

**Plan:**

1. Continue Ibuprofen 800 mg 1 tablet every 8 hrs and lidocaine gel.
2. Follow up with spine specialist for continued lower back pain
3. Continue with pain management follow-up as needed.
4. Continue Physical therapy 3-4x a week
5. Follow-up with office in 2-3 weeks or earlier if needed and contact nearest ED in an emergent situation.