WALTER R. LOWE, M.D.
ELBOW EXAM

(TOP SECTION TO BE COMPLETED BY PATIENT)

(Place UT Label Here)

Patient Name: _____ Date of Visit: ____/____/____

Referred by: _____ Date of Injury / Onset: _____

Current Medications: _____ Allergies: _____ ❒ **NONE**

Chief Complaint: ❑ Left ❑ Right Please Explain: _____

PAST ELBOW HISTORY

Have you had any previous elbow problems? ❒ Yes ❒ No If yes, which elbow? ❒ Left ❒ Right ❒ Both

If YES, what was the injury? _____

Did any elbow injury require surgery? ❒Yes ❒No If yes, which elbow? ❒ Left ❒ Right ❒ Both

If YES, what procedure and when? _____

DO YOU PLAY SPORTS? ❑ Yes ❑ No What Sport? _____ Position: _____

WHAT LEVEL OF SPORT? ❑ High School ❑ College ❑ Other _____

Where do you go to school? _____

(BOTTOM SECTION TO BE COMPLETED BY PHYSICIAN)

❑ Please refer to PATIENT HISTORY FORM completed by patient at previous visit on: _____

SUBJECTIVE: _____

TENDERNESS: _____

SWELLING / EFFUSION: None + ++ +++ ++++ Description: _____

RANGE OF MOTION:

	LEFT	RIGHT		LEFT	RIGHT
ELBOW	❑ Full	❑ Full	WRIST	❑ Full	❑ Full
Flexion	_____	_____	Flexion	_____	_____
Extension	_____	_____	Extension	_____	_____

MUSCLE STRENGTH:

Wrist Flexion	_____ / 5	❑ Painful	Pronation	_____ / 5	❑ Painful
Wrist Extension	_____ / 5	❑ Painful	Supination	_____ / 5	❑ Painful
Elbow Flexion	_____ / 5	❑ Painful	Finger Flexion	_____ / 5	❑ Painful
Elbow Extension	_____ / 5	❑ Painful	Finger Extension	_____ / 5	❑ Painful

LIGAMENT EXAM: ❑ Valgus Stress _____ ❑ Varus Stress _____ ❑ Other: _____

X-RAYS: ❑ YES ❑ NO Site / Views: _____

Results: _____

IMAGING: ❑ Brought in MRI to Exam Results: _____

❑ Order MRI Location: _____ Reason: _____

MRI Type: ❑ MRI with IA GAD ❑ MRI w/o IA GAD Other: _____

IMPRESSION: _____

PLAN: ❑ Aspiration Amount: _____ Description: _____

❑ Injection Medication(s): _____ Location: _____

❑ PHYSICAL THERAPY ❑ UCL Protocol ❑ Other _____

❑ Throwing Program _____

❑ If no changes in improvement, order an MRI to rule out: _____

❑ Patient to call to report progress (Explain): _____

SURGICAL PROCEDURE: _____

COMMENTS: _____

TIME SPENT WITH PATIENT: _____

❑ Over 50% of time spent with patient was for counseling regarding: _____

RETURN TO CLINIC: _____ weeks / months

RETURN TO WORK: ❑ No Work ❑ Light Duty ❑ Full Duty

_____

Fellow / Resident Signature

❑ I agree with the exam and plan of care for this patient.

❑ I agree with the exam and plan of care for this patient, except for the following modifications:

_____

_____

Physician / Physician Assistant Signature