

Involved Elbow: Right Left

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ELBOW EXAMINATION

Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Initial Recheck Referred by: \_\_\_\_\_

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Date of Injury: \_\_\_/\_\_\_/\_\_\_ Where were you injured? Sport Work School Other: \_\_\_\_\_

**Past Elbow History**

Have you had any previous elbow problems? Yes No If yes, which elbow(s)? Right Left

If yes, what was the injury? \_\_\_\_\_

Did this injury require surgery? Yes No If yes, which elbow(s)? Right Left

If yes, what procedure was done, and when? \_\_\_\_\_

S: \_\_\_\_\_

**Exam**

Effusion None + ++ +++ +++++ And/Or Swelling None + ++ +++ +++++

ROM Extension: \_\_\_\_\_ Flexion: \_\_\_\_\_

Supination: \_\_\_\_\_ Pronation: \_\_\_\_\_

Palpation Pain: \_\_\_\_\_

Valgus Stress: \_\_\_\_\_ Varus Stress: \_\_\_\_\_

| Strength:        |       | Painful                  |                | Painful                        |
|------------------|-------|--------------------------|----------------|--------------------------------|
| Wrist Extension  | ___/5 | <input type="checkbox"/> | Wrist Flexion  | ___/5 <input type="checkbox"/> |
| Supination       | ___/5 | <input type="checkbox"/> | Pronation      | ___/5 <input type="checkbox"/> |
| Elbow Extension  | ___/5 | <input type="checkbox"/> | Elbow Flexion  | ___/5 <input type="checkbox"/> |
| Finger Extension | ___/5 | <input type="checkbox"/> | Finger Flexion | ___/5 <input type="checkbox"/> |

X-Ray Results: \_\_\_\_\_

Impression: \_\_\_\_\_

**Plan**

Injection: Yes No If yes, medications: \_\_\_\_\_cc Xylocaine \_\_\_\_\_cc

Medial Lateral Epicondyle

Medication Prescribed: \_\_\_\_\_

Physical Therapy Protocol: \_\_\_\_\_

Additional Imaging: MRI EMG DX: \_\_\_\_\_

RTC: \_\_\_\_\_ weeks / months

Comments: \_\_\_\_\_