WALTER R. LOWE, M.D.
FOLLOW-UP SHOULDER EXAM
(THIS PAGE 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: _____

SINCE YOUR LAST VISIT …

Have your symptoms: ❒ Improved ❒ Not Changed ❒ Increased

Please Explain: _____

My current work status: ❒ Full Duty ❒ Light Duty ❒ Not Able to Work

Please Explain: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS.

SYMPTOMS: (Click on YES or NO to respond.)

❒ Yes ❒ No 1. Is your shoulder comfortable at your side?
❒ Yes ❒ No 2. Does your shoulder allow you to sleep comfortably?
❒ Yes ❒ No 3. Can you reach the small of your back to tuck in your shirt?
❒ Yes ❒ No 4. Can you place your hand behind your head with your elbow straight out to the side?
❒ Yes ❒ No 5. Can you place a coin on a shelf at shoulder level without bending your elbow?
❒ Yes ❒ No 6. Can you lift 1 lb. (a full pint container) to shoulder level without bending your elbow?
❒ Yes ❒ No 7. Can you lift 8 lbs. (a full gallon container) to shoulder level without bending your elbow?
❒ Yes ❒ No 8. Can you carry 20 lbs. at your side with the affected upper extremity?
❒ Yes ❒ No 9. Do you think you can toss a softball underhand 10 yards with the affected upper extremity?
❒ Yes ❒ No 10. Do you think you can toss a softball overhand 20 yards with the affected upper extremity?
❒ Yes ❒ No 11. Can you wash the back of your opposite shoulder with the affected upper extremity?
❒ Yes ❒ No 12. Would your shoulder allow you to work a full time job at your current regular job?

ACTIVITY: Do you have problems with the following?

❒ Yes ❒ No 1. Are you currently receiving physical therapy for the affected upper extremity?
If YES, where are you going for your physical therapy? _____
❒ Yes ❒ No 2. Do your symptoms allow you to play sports? Explain: _____
❒ Yes ❒ No 3. Are you currently working?
If YES, are you… ❒ Full Duty ❒ Light Duty Explain: _____

FUNCTION: (Click on the appropriate circle to respond.)

1. How would you rate your overall level of pain? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Disabling
2. How would you rate your shoulder comfort with your arm at REST? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Painful
3. How would you rate your shoulder comfort during SLEEP? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Painful
4. How would you rate your overall level of shoulder function with the affected upper extremity? Comfortable … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Unable to Use
5. How would you rate your ability to use your arm full time at work or for playing sports? No Problem … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Unable to Use
6. How would you rate your overall quality of life as is with your shoulder injury? Very Good … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Very Bad

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

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

Where do you go to school? _____

(THIS PAGE TO BE COMPLETED BY PATIENT)

WALTER R. LOWE, M.D.
FOLLOW-UP SHOULDER EXAM
(THIS PAGE TO BE COMPLETED BY PHYSICIAN)

(Place UT Label Here)

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

Chief Complaint: ❑ Left ❑ Right Please Explain: _____

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

TENDERNESS: ❑ AC Joint ❑ Anterior Acromion ❑ Posterior Acromion ❑ Coracoid ❑ Bicipital Groove ❑ _____

RANGE OF MOTION:

	LEFT	RIGHT		LEFT	RIGHT
PATIENT SITTING	❑ FULL	❑ FULL	PATIENT SUPINE	❑ FULL	❑ FULL
Active Horizontal Abduction	_____	_____	Passive Horizontal Abduction	_____	_____
Active Forward Flexion	_____	_____	Passive External Rotation	_____	_____
Active Internal Rotation	_____	_____			
Active External Rotation	_____	_____			
Passive Internal Rotation	_____	_____			
Passive External Rotation	_____	_____			
Scapular Motion	❑ Synchronous		❑ Asynchronous		

MUSCLE STRENGTH:

Deltoid	_____ / 5	❑ Painful	Biceps	_____ / 5	❑ Painful
Scaption	_____ / 5	❑ Painful	Triceps	_____ / 5	❑ Painful
Lift-Off	_____ / 5	❑ Painful	Wrist Extension	_____ / 5	❑ Painful
External Rotation	_____ / 5	❑ Painful	Wrist Flexion	_____ / 5	❑ Painful
Internal Rotation	_____ / 5	❑ Painful	Finger Abduction	_____ / 5	❑ Painful

STABILITY:

Anterior	❑ NORMAL	❑ Apprehension	❑ Subluxation	Relocation: ❑ (+) ❑ (-)
Posteior	❑ NORMAL	❑ Apprehension	❑ Subluxation	Relocation: ❑ (+) ❑ (-)
Inferior	❑ NORMAL	❑ Apprehension	❑ Subluxation	Relocation: ❑ (+) ❑ (-)

IMPINGEMENT SIGNS: ❑ NORMAL
❑ Neer ❑ Hawkins ❑ Jobe ❑ Speed ❑ O'Brien ❑ SLAP Test

CERVIAL SPINE EXAM: ❑ NORMAL EXAM

			SENSORY	(N)	(↓'D)	SENSORY	(N)	(↓'D)
Range of Motion	❑ Normal	❑ Abnormal	C -1	❑	❑	C -6	❑	❑
Head Compression	❑ Negative	❑ Positive	C -2	❑	❑	C -7	❑	❑
Foraminal Closure	❑ Negative	❑ Positive	C -3	❑	❑	C -8	❑	❑
			C -4	❑	❑	T -1	❑	❑
			C -5	❑	❑			

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 ❑ RC Strengthening ❑ SS Strengthening ❑ Rotator Cuff Repair ❑ Anterior Instability ❑ Posterior Instability ❑ SLAP Repair ❑ Arthroscopic Bankart ❑ Open Bankart ❑ _____
❑ 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:

_____

(THIS PAGE TO BE COMPLETED BY PHYSICIAN)

_____
Physician / Physician Assistant Signature