WALTER R. LOWE, M.D.
INITIAL KNEE 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: ______________________

PAST KNEE HISTORY

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

If YES, what was the injury? ______________________

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

If YES, what procedure and when? ______________________

PLEASE RATE THE FOLLOWING BY FILLING IN THE CIRCLE OF YOUR CHOICE.

SYMPTOMS: DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Click on the appropriate circle to respond.)

1. Pain — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
2. Swelling — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
3. Giving Way — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
4. Stiffness — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
5. Popping — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
6. Clicking — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
7. Catching — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
8. Locking — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
9. Night pain *(Does your pain wake you up at night?)* — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always
10. Pain with prolonged sitting *(Pain relieved after standing up.)* — Never ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Always

ACTIVITY: DO YOU HAVE PROBLEMS WITH THE FOLLOWING?

1. Walking — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
2. Any Type of Squats — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
3. Going UP Stairs — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
4. Going DOWN Stairs — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
5. Running — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
6. Cutting — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
7. Jumping — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
8. Twisting — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable

FUNCTION:

1. Are you able to walk on level ground? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
2. Are you able to walk on rough ground, inclines, or negotiate curves? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
3. Do you have problems running? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
4. Do you have problems cutting while running or jogging? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
5. Do you have problems jumping? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable
6. Do you have problems participating in competitive sports? — No Problem ... ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ... Unable

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

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

Where do you go to school? ______________

(THIS FORM TO BE COMPLETED BY PATIENT)

WALTER R. LOWE, M.D.
INITIAL KNEE EXAM
(THIS PAGE TO BE COMPLETED BY PHYSICIAN)

(Place UT Label Here)

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

Chief Complaint: ❑ Left ❑ Right Please Explain: ______________________

RANGE OF MOTION: **LEFT** Flexion _____ Extension _____ **EFFUSION:** **LEFT** None + ++ +++ ++++
RIGHT Flexion _____ Extension _____ **RIGHT** None + ++ +++ ++++

MUSCLE STRENGTH:

	Quadriceps		Hamstrings		Gastroc	
LEFT	_____ / 5	❑ Painful	_____ / 5	❑ Painful	_____ / 5	❑ Painful
RIGHT	_____ / 5	❑ Painful	_____ / 5	❑ Painful	_____ / 5	❑ Painful

LIGAMENT EXAM:

		LEFT ❑ NORMAL EXAM			**RIGHT** ❑ NORMAL EXAM		
ACL	Lachman	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
	Anterior Drawer	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
	Pivot Shift	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
	KT-1000	Manual Maximum	_________		Manual Maximum	_________	
PCL	Posterior Lachman	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
	Posterior Drawer	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
MCL	Medial Joint Opening	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
LCL	Medial Joint Opening	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
POST LAT COMPLEX	20º External Rotation	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft
	90º External Rotation	0 1+ 2+ 3+	❑ Firm	❑ Soft	0 1+ 2+ 3+	❑ Firm	❑ Soft

MENISCAL EXAM:

	LEFT ❑ NORMAL EXAM			**RIGHT** ❑ NORMAL EXAM		
Joint Line Tenderness	❑ None	❑ Medial	❑ Lateral	❑ None	❑ Medial	❑ Lateral
Meniscal Provocate Test	❑ None	❑ Medial	❑ Lateral	❑ None	❑ Medial	❑ Lateral

PATELLOFEMORAL EXAM:

	LEFT ❑ NORMAL EXAM				**RIGHT** ❑ NORMAL EXAM			
Patellar Glide	❑ None	❑ 25%	❑ 50%	❑ 75%	❑ None	❑ 25%	❑ 50%	❑ 75%
Crepitus	❑ Negative		❑ Positive		❑ Negative		❑ Positive	
Patellar Compression	❑ Negative		❑ Positive		❑ Negative		❑ Positive	
Retinacular Tenderness	❑ Negative		❑ Positive		❑ Negative		❑ Positive	
Tilt	❑ Normal		❑ Excessive		❑ Normal		❑ Excessive	
Inferior Pole Tenderness	❑ Negative		❑ Positive		❑ Negative		❑ Positive	
Tibial Tubercle Tenderness	❑ Negative		❑ Positive		❑ Negative		❑ Positive	
Q-Angle	____________				____________			

X-RAYS: ❑ YES ❑ NO Site / Views: ______________________
Results: ______________________

IMAGING: ❑ Brought in MRI to Exam Results: ______________________
❑ Order MRI Location: ____________ Reason: ______________________

IMPRESSION: ______________________
____

PLAN: ❑ Aspiration Amount: ____________ Description: ______________________
❑ Injection Medication(s): ______________________ Location: ______________________
❑ PHYSICAL THERAPY ❑ Pre-Op ACL Exercises ❑ PF Protocol ❑ SportsMetrics Program
❑ ACL Accelerated ❑ Meniscal Repair ❑ ____________
❑ ACL Delayed ❑ Meniscal Transplant ❑ ____________
❑ 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)

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Physician / Physician Assistant Signature