Ankle Fractures: Lateral vs. Antiglide Plating

Patient Information

To be completed by the PHYSICIAN

Patient Study Number	Completed By:_____ Clinic:_____
Visit Date (MM/DD/YY) __ __ / __ __ / __ __	Visit Schedule *(check appropriate box)* ☑ Pre-Op

Directions: *Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase or cross out the incorrect mark, initial, and fill in the correct information.* **Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●**

(For Internal Use Only)

Physician's Name: _____
Medical Record Number _____

Last Name _____ First Name _____ MI ____

Street Address 1

_____

Street Address 2

_____

City _____ State _____ Zip Code _____

Home Phone (or primary contact) (_____)_____-_____

Work Phone (_____)_____-_____

Date of Birth (MM/DD/YYYY) ___/___/_____

Sex M/F ____

E-mail (example: johndoe@abc.com) _____

Alternate Contact Information 1

Relationship to patient _____ Last Name _____ First Name _____ MI ____

Street Address 1

_____

Home Phone (or primary contact) (___)_____-_____

Street Address 2

_____

City _____ State _____ Zip Code _____

Alternate Contact Information 2

Relationship to patient _____ Last Name _____ First Name _____ MI ____

Street Address 1

_____

Home Phone (or primary contact) (___)_____-_____

Street Address 2

_____

City _____ State _____ Zip Code _____

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01a. Date of Injury __ __ / __ __ / __ __ (MM/DD/YY)

b. Time of Injury __ __ : __ __ AM / PM (circle one)

02. Ethnicity

- ○ American Indian
- ○ Asian or Asian American
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Native Hawaiian or Pacific Islander
- ○ White or Caucasian
- ○ Other *(Specify):* _____

03. Side of injury

○ Left ○ Right

04. Additional upper extremity fractures

	None	Right	Left	Bilateral
a. Clavicle	○	○	○	○
b. Scapula	○	○	○	○
c. Humerus	○	○	○	○
d. Radius	○	○	○	○
e. Ulna	○	○	○	○
f. Wrist	○	○	○	○
g. Hand	○	○	○	○

05. Additional lower extremity fractures

	None	Right	Left	Bilateral
a. Pelvis	○	○	○	○
b. Acetabulum	○	○	○	○
c. Femur	○	○	○	○
d. Tibia	○	○	○	○
e. Ankle	○	○	○	○
f. Foot	○	○	○	○

06. Additional spinal fractures

	None	Right	Left	Bilateral
a. Cervical	○	○	○	○
b. Thoracic	○	○	○	○
c. Lumbar	○	○	○	○

07. Additional injuries

	None	Right	Left	Bilateral
a. Upper extremity	○	○	○	○
b. Lower extremity	○	○	○	○
c. Spine	○	○	○	○

08. Sensation at time of presentation

Location	Normal	Diminished	Absent
a. Superficial peroneal	○	○	○
b. Deep peroneal nerve	○	○	○
c. Posterior tibial nerve	○	○	○

Using the AIS scoring scale, score questions 09-14 (the 6 body regions). Where multiple injuries occur in one region, use the highest scoring injury of that region.

Region	AIS Score	
09.	**Head & Neck**	____
10.	**Face**	____
11.	**Chest**	____
12.	**Abdomen**	____
13.	**Extremity**	____
14.	**External**	____

AIS Score
Minor (AIS 1)
Moderate (AIS 2)
Serious (AIS 3)
Severe (AIS 4)
Critical (AIS 5)
Unsurvivable (AIS 6)

15. If known, please record the ISS score below

__ __ **ISS Score**

16. Primary cause of injury

- ○ Motor vehicle accident
- ○ Motorcycle accident
- ○ Bicycle accident
- ○ Pedestrian accident
- ○ Recreational activity
- ○ Fall from a height greater than 4 feet
- ○ Fall from a height less than 4 feet
- ○ Direct trauma (blunt)
- ○ Direct trauma (penetrating)
- ○ Crush
- ○ Twist
- ○ Other *(Specify)*:_____

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17. High energy injury
O Yes O No

18. Work related injury
O Yes O No *(Skip to question 20)*

19. If "Yes", is patient currently seeking or receiving Workers' Compensation?
O Yes O No *(Skip to question 20)*

20. Patient has been or is currently involved in litigation
O Yes O No

21. History of smoking or tobacco use
O No *(Skip to question 25)*
O Yes, quit smoking *(Continue to question 22)*
O Yes, current smoker *(Skip to question 23)*

22. If "Yes, quit smoking", specify years tobacco free
_____ _____ years

23. If "Yes, current smoker", specify packs smoked per day
_____ . _____ packs per day

24. If "Yes, current smoker", specify years smoked
_____ _____ years smoked

25. History of drug or alcohol use
O Yes O No *(Skip to question 28)*

26a. If "Yes", is there a history of drug or alcohol abuse?
O Yes *(Specify below)*
O No *(Skip to question 28)*

b. If "Yes", specify type of drug or alcohol abuse *(Mark all that apply)*
O Alcohol O Drugs O Both

27a. If "History of drug or alcohol abuse", is the patient recovered?
O Yes *(Specify below)*
O No *(Skip to question 28)*

b. If "Yes", specify years recovered
____ ____ years

28a. Patient's height ____ ____ inches
b. Patient's weight ____ ____ ____ lbs

Current Medications *(Mark all that apply)*

29a. Type	b. Dose	c. Duration
O **Steroids** (examples: Cortone, Deltasone, Medrol, Prelone)	_____mg/day	___yrs___mos
O **Anticoagulants** (examples: Coumadin, Miradon)	_____mg/day	___yrs___mos
O **Anticonvulsants** (examples: Phenytoin, Carbamazepine, Phenobarbital, diazepam)	_____mg/day	___yrs___mos
O **Statins** (examples: Lipitor, Lescol, Pravachol, Zocor)	_____mg/day	___yrs___mos
O **Anti-inflammatories** (examples: Anaprox, Celebrex, Motrin, Naprosyn)	_____mg/day	___yrs___mos
O **Biophosphonates** (examples: Actonel, Boniva, Fosamax)	_____mg/day	___yrs___mos
O **Antibiotics** (examples: Amoxil, Ceporex, Cydomycin, Vibramycin)	_____mg/day	___yrs___mos
O **Calcium channel blockers** (examples: Adalat, Cardizem, Dilacor XR, Norvasc)	_____mg/day	___yrs___mos
O **Calcium or Vitamin D** (examples: Cal-Citrate, Citracal, Os-Cal, Viactiv)	_____mg/day	___yrs___mos
O **Parathyroid hormone** (examples: Forteo)	_____mg/day	___yrs___mos

History of surgery

Procedure	Systemic	Extremity	Date (MM/DD/YY)
30._____	O	O	___/___/___
31._____	O	O	___/___/___
32._____	O	O	___/___/___
33._____	O	O	___/___/___
34._____	O	O	___/___/___
35._____	O	O	___/___/___
36._____	O	O	___/___/___

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Patient's Current Medical History (Mark all that apply)

In question 37, please indicate the patient's personal medical history of the following conditions.
In question 38, please indicate if the patient is receiving treatment or medication for the condition.
In question 39, please indicate if the condition limits the patient's activities.

	37. History	38. Receiving treatment / Medication	39. Limits activity
Anemia or other blood disease	○	○	○
Back pain	○	○	○
Cancer – metastatic	○	○	○
Cancer – not metastatic	○	○	○
Circulatory disorder including ankle or leg swelling, blood clots, peripheral vascular disease, aneurysm	○	○	○
Depression	○	○	○
Diabetes – diet controlled	○	○	○
Diabetes – medication controlled	○	○	○
Diabetes – insulin controlled	○	○	○
Heart disease	○	○	○
High blood pressure	○	○	○
History of stroke	○	○	○
Kidney disease	○	○	○
Leg pain	○	○	○
Liver disease	○	○	○
Lung disease or asthma	○	○	○
Nervous system disorder including Parkinson's disease, multiple sclerosis, cerebral palsy	○	○	○
Obesity	○	○	○
Osteoarthritis/degenerative arthritis	○	○	○
Osteoporosis	○	○	○
Rheumatoid arthritis/lupus/ankylosing spondylitis	○	○	○
Thyroid disease	○	○	○
Ulcer or stomach disease	○	○	○
Other history *(Specify below)*	○	○	○

_____

_____