

***I.M.P.R.E.S.S.***  
***(Proximal Tibia)***  
***Patient Information***  
**To be completed by the PHYSICIAN**

(For Internal Use Only)

Patient Study Number	Completed By: _____ Clinic: _____
Visit Date (MM/DD/YY) ____ / ____ / ____	Visit Schedule (check appropriate box) <input type="checkbox"/> 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: ●**

Last Name	First Name	MI	(For Internal Use Only) Physician's Name: _____
_____			Medical Record Number _____
Street Address 1	_____		
_____			
Street Address 2	_____		
_____			
City	State	Zip Code	
_____			
Home Phone (or primary contact) (____)____-____	Work Phone (____)____-____	Date of Birth (MM/DD/YYYY) ____/____/____	
Social Security Number ____-____-____	Sex M/F ____	E-mail (example: <a href="mailto:john.doe@abc.com">john.doe@abc.com</a> ) _____	

**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	
_____			

*Please continue on next page*

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## (Proximal Tibia)

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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**

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Clavicle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Scapula	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Humerus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Radius	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Ulna	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Wrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**05. Additional lower extremity fractures**

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Pelvis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Acetabulum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Femur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Tibia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**06. Additional spinal fractures**

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Cervical	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Thoracic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lumbar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**07. Additional injuries**

	<u>None</u>	<u>Right</u>	<u>Left</u>	<u>Bilateral</u>
a. Upper extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Lower extremity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Spine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**08. Sensation at time of presentation**

<u>Location</u>	<u>Normal</u>	<u>Diminished</u>	<u>Absent</u>
a. Superficial peroneal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Deep peroneal nerve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Posterior tibial nerve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

<u>Region</u>	<u>AIS Score</u>
<b>09.</b> <b>Head &amp; Neck</b>	___
<b>10.</b> <b>Face</b>	___
<b>11.</b> <b>Chest</b>	___
<b>12.</b> <b>Abdomen</b>	___
<b>13.</b> <b>Extremity</b>	___
<b>14.</b> <b>External</b>	___

**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**

- Yes       No

**18. Work related injury**

- Yes       No (Skip to question 20)

**19. If "Yes", is patient currently seeking or receiving Workers' Compensation?**

- Yes       No (Skip to question 20)

**20. Patient has been or is currently involved in litigation**

- Yes       No

**21. History of smoking or tobacco use**

- No (Skip to question 25)  
 Yes, quit smoking (Continue to question 22)  
 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**

- Yes       No (Skip to question 28)

**26a. If "Yes", is there a history of drug or alcohol abuse?**

- Yes (Specify below)  
 No (Skip to question 28)

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

- Alcohol       Drugs       Both

**27a. If "History of drug or alcohol abuse", is the patient recovered?**

- Yes (Specify below)  
 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)

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

**History of surgery**

<b>Procedure</b>	<b>Systemic</b>	<b>Extremity</b>	<b>Date (MM/DD/YY)</b>
<b>30.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>31.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>32.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>33.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>34.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>35.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___
<b>36.</b> _____	<input type="radio"/>	<input type="radio"/>	___/___/___

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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.*

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