

S.O.L.V.E.D
(Distal Femur)
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: _____
Street Address 1 _____			Medical Record Number _____
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: john.doe@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 _____

Please continue on next page

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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.

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

☐ 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)

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

History of surgery

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

	37. <u>History</u>	38. Receiving treatment / <u>Medication</u>	39. <u>Limits activity</u>
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"/>