

Scapula Fracture Study

Patient Injury Form

Patient Study ID = _____ Injury Date = _____

1. Date of birth: ____ / ____ / ____ (MM/DD/YYYY)
2. Gender (check one) Male Female
3. Height ____ feet ____ inches
4. Weight ____ pounds
5. Hand dominance (Mark one)
 - Right
 - Left
6. Shoulder injured (Mark one)
 - Right shoulder
 - Left shoulder
7. Race (Check all that apply)
 - White
 - Black or African-American
 - Hispanic
 - Asian or Pacific Islander
 - Native American Indian
 - Other (please specify): _____
8. Current marital situation (Mark one)
 - Married
 - Living with significant other
 - Divorced/Separated
 - Widowed
 - Single (never married)
9. Current employment situation (Check all that apply)
 - Currently working
 - On leave of absence as of ____ / ____ / ____ (MM/DD/YYYY)
 - Unemployed
 - Homemaker
 - Student
 - Retired (not due to ill health)
 - Disabled and/or Retired due to ill health
 - Other, please specify: _____
10. Is the patient currently receiving disability?
 - Yes
 - No

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11. Is the patient currently involved in litigation?

- Yes
- No

12. **Pre-injury** pain medication use, including narcotics or over-the-counter medications (Mark one)

- Three or more times a day
- Once or twice a day
- Once every couple of days
- Once a week
- Not at all

13. Does the patient smoke cigarettes? (Mark one response)

- Yes (answer question 14)
- No, I quit smoking less than 12 months ago
- No, I quit smoking more than 12 months ago
- No, I have never smoked

14. If yes to #14, how much? (Mark one)

- I have never smoked
- ½ pack per day
- 1 pack per day
- 2 packs per day
- 3 packs per day
- More than 3 packs per day
- Other: _____

15. If patient has positive smoking history, for how many years did they use? _____ Years

16. **Common** health problems assessment:

<i>Please answer</i>	1			2		3	
Condition:	Patient condition?		If yes in 1, then continue to 2 & 3.	Receiving treatment for it?		Does it limit activities?	
Heart Disease	Yes	No	→	Yes	No	No	Yes
High Blood Pressure	Yes	No	→	Yes	No	No	Yes
Lung Disease	Yes	No	→	Yes	No	No	Yes
Diabetes	Yes	No	→	Yes	No	No	Yes
Ulcer or Stomach Disease	Yes	No	→	Yes	No	No	Yes
Kidney Disease	Yes	No	→	Yes	No	No	Yes
Liver Disease	Yes	No	→	Yes	No	No	Yes

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Continue Health Problems Assessment

Please answer	1		If yes in 1, then continue to 2 & 3.	2		3	
	Patient condition?			Receiving treatment for it?		Does it limit activities?	
Condition:	Yes	No	→	Yes	No	No	Yes
Anemia or Other Blood Disease	Yes	No	→	Yes	No	No	Yes
Cancer	Yes	No	→	Yes	No	No	Yes
Depression	Yes	No	→	Yes	No	No	Yes
Osteoarthritis/Degenerative Arthritis	Yes	No	→	Yes	No	No	Yes
Back Pain	Yes	No	→	Yes	No	No	Yes
Rheumatoid Arthritis	Yes	No	→	Yes	No	No	Yes
Other Medical Problem please specify here:	Yes	No	→	Yes	No	No	Yes

17. If known, please record **ISS Score** _____

18. Mechanism of injury (mark all that apply)

- 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*): _____

19. Over-the-counter and prescription medication use **following** injury (Check all that apply)

- None
- Muscle relaxants (Valium)
- Non-steroids (ie, Motrin)
- Narcotics (Morphine)
- Steroids (Cortisone)

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20. Patient condition following traumatic event

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"/>

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"/>

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"/>

Additional soft tissue or other 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"/>

Additional Regional Injury Scores

<u>Region</u>	<u>AIS Score</u>
Head & Neck	_____
Face	_____
Chest	_____
Abdomen	_____
Extremity	_____
External	_____

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

21. Date of fracture _____

22. Initial treatment plan

- Non-operative
- Operative