

**ANKLE EVALUATION**

UCLA Sports Medicine  
David R. McAllister, M.D.  
UCLA Medical Center  
Dept of Orthopaedic Surgery

**Chief Complaint:**

**History of Present Illness:**

Sports/level:  none  recreational  collegiate  competitive  semi-professional  professional

Date of injury: \_\_\_\_\_

No specific injury

- Trauma  Yes  No
- Prior Injury  Yes  No
- Locking  Yes  No
- Clicking  Yes  No
- Instability  Yes  No

**Pain:**

Location:  Anterior  Posterior  Medial  Lateral

Pain at Rest  Yes  No

Nighttime Pain  Yes  No

Activity Related Pain  Yes  No

Pain with Sports  Yes  No

Other (specify): \_\_\_\_\_

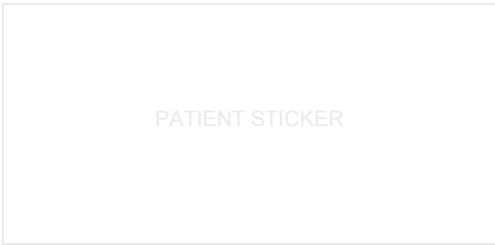
**Prior Treatments:**

- NSAID  Improved  No Benefit  Did not Try
- Brace  Improved  No Benefit  Did not Try
- Physical Therapy  Improved  No Benefit  Did not Try
- Injection  Improved  No Benefit  Did not Try

Previous Surgery on ankle?  Yes  No

If yes, specify: \_\_\_\_\_

\_\_\_\_\_



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**Physical Examination:**

Motion:

	<b>R</b>	<b>L</b>
Subtalar Motion	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted
Plantar Flexion	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted, degree _____ (0 – 50)	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted, degree _____ (0 – 50)
Dorsiflexion	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted, degree _____ (0 – 20)	<input type="checkbox"/> Normal <input type="checkbox"/> Restricted, degree _____ (0 – 20)

Alignment:

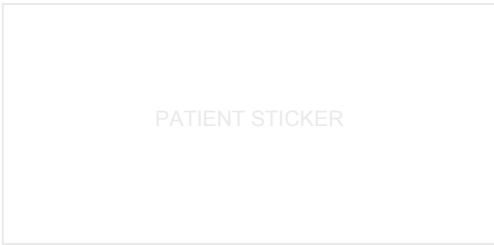
	<b>R</b>	<b>L</b>
Hindfoot	<input type="checkbox"/> Varus <input type="checkbox"/> Valgus	<input type="checkbox"/> Varus <input type="checkbox"/> Valgus
Forefoot	<input type="checkbox"/> Varus <input type="checkbox"/> Valgus	<input type="checkbox"/> Varus <input type="checkbox"/> Valgus
Arch	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

Tenderness:

	<b>R</b>	<b>L</b>
Syndesmosis	_____	_____
Squeeze Test	_____	_____
ATFL	_____	_____
Calcaneofibular Ligament	_____	_____
Medial Malleolus	_____	_____
Lateral Malleolus	_____	_____
Anterior Tibial	_____	_____
Posterior Tibial	_____	_____
Achilles Insertion	_____	_____
Retrocalcaneal Bursa	_____	_____
Plantar Fascia	_____	_____
Talar Neck	_____	_____
Anterior Distal Tibia	_____	_____
Proximal Fibula	_____	_____

Instability:

	<b>R</b>	<b>L</b>
Anterior Drawer	<input type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Normal <input type="checkbox"/> Increased
Lateral Tilt	<input type="checkbox"/> Normal <input type="checkbox"/> Increased	<input type="checkbox"/> Normal <input type="checkbox"/> Increased



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<u>Soft Tissue:</u>	<b>R</b>	<b>L</b>
Effusion	_____	_____
Lateral Swelling	_____	_____
Medial Swelling	_____	_____
Posterior Swelling	_____	_____
Echimosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Location: \_\_\_\_\_

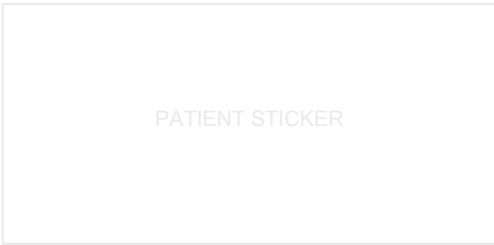
<u>Vascular:</u>	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
Capillary Refill	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Abnormal

	<b>R</b>	<b>L</b>
Pulse	DP 2+ 1+	2+ 1+
	PT 2+ 1+	2+ 1+

<u>Motor (1-5):</u>	<b>R</b>	<b>L</b>
PF	_____	_____
DF	_____	_____
Inversion	_____	_____
Eversion	_____	_____
Single Heel Raise	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Balance	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

<u>Sensory (Light Touch):</u>	<b>R</b>	<b>L</b>
Lateral	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished
Medial	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished
1 <sup>st</sup> Web Space	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished
Bottom Foot	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished	<input type="checkbox"/> Intact <input type="checkbox"/> Diminished

Gait:  Normal  
 Antalgic



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<u>Reflexes:</u>	<b>R</b>	<b>L</b>
Patellar Tendon		
Normal	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Jerk		
Normal	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal	<input type="checkbox"/>	<input type="checkbox"/>

**Diagnostic Studies:**

Radiographs:  Normal  
 Abnormal (specify): \_\_\_\_\_

\_\_\_\_\_

MRI:  Normal  
 Abnormal (specify): \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

**Assessment:** \_\_\_\_\_

\_\_\_\_\_

**Plan:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
David R. McAllister, MD

\_\_\_\_\_  
Date