UCLA Health System

ANKLE EVALUATION

UCLA Sports Medicine

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

PATIENT STICKER

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:	**R**	**L**
Subtalar Motion	❑ Normal ❑ Restricted	❑ Normal ❑ Restricted
Plantar Flexion	❑ Normal ❑ Restricted, degree _____ (0 – 50)	❑ Normal ❑ Restricted, degree _____ (0 – 50)
Dorsiflexion	❑ Normal ❑ Restricted, degree _____ (0 – 20)	❑ Normal ❑ Restricted, degree _____ (0 – 20)
Alignment:	**R**	**L**
Hindfoot	❑ Varus ❑ Valgus	❑ Varus ❑ Valgus
Forefoot	❑ Varus ❑ Valgus	❑ Varus ❑ Valgus
Arch	❑ Normal ❑ Abnormal	❑ Normal ❑ Abnormal

Tenderness:	**R**	**L**
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:	**R**	**L**
Anterior Drawer	❑ Normal ❑ Increased	❑ Normal ❑ Increased
Lateral Tilt	❑ Normal ❑ Increased	❑ Normal ❑ Increased

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Soft Tissue:	**R**	**L**
Effusion	_____	_____
Lateral Swelling	_____	_____
Medial Swelling	_____	_____
Posterior Swelling	_____	_____
Echimosis	❑ Yes	❑ No

Location: _____

Vascular:

Capillary Refill		❑ Normal ❑ Abnormal		❑ Normal ❑ Abnormal	
		R		**L**	
Pulse	DP	2+	1+	2+	1+
	PT	2+	1+	2+	1+

Motor (1-5):	**R**	**L**
PF	_____	_____
DF	_____	_____
Inversion	_____	_____
Eversion	_____	_____

Single Heel Raise	❑ Yes ❑ No	❑ Yes ❑ No
Balance	❑ Normal ❑ Abnormal	❑ Normal ❑ Abnormal

Sensory (Light Touch):	**R**	**L**
Lateral	❑ Intact ❑ Diminished	❑ Intact ❑ Diminished
Medial	❑ Intact ❑ Diminished	❑ Intact ❑ Diminished
1st Web Space	❑ Intact ❑ Diminished	❑ Intact ❑ Diminished
Bottom Foot	❑ Intact ❑ Diminished	❑ Intact ❑ Diminished

Gait: ❑ Normal
❑ Antalgic

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Reflexes:	R	L
Patellar Tendon		
Normal	❑	❑
Abnormal	❑	❑
Ankle Jerk		
Normal	❑	❑
Abnormal	❑	❑

Diagnostic Studies:

Radiographs: ❑ Normal
❑ Abnormal (specify): _____

_____

MRI: ❑ Normal
❑ Abnormal (specify): _____

_____

Other: _____

Assessment: _____

_____

Plan: _____

_____

_____ _____
David R. McAllister, MD Date