# NEW SPINE PATIENT QUESTIONNAIRE

**Patient Name (please print) _____Date_____**

**Age _____ Birthdate _____ Gender: Male Female**

**Primary Care Doctor_____Phone#_____**

**Referring Doctor _____Phone#_____**

**We routinely send a copy of all clinic notes to your primary doctor and referring doctor. Please let us know if there is someone else you would like to send a copy.**

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We know that filling out these forms can be difficult, but please complete them carefully.

It will give us a better understanding of you and your problem and enable us to provide you the best possible medical care.

Thank you for your cooperation.

Center for Spinal Surgery
EmergeOrtho
David Musante, MD
Roger Ordronneau, PA-C

**For office use only:**

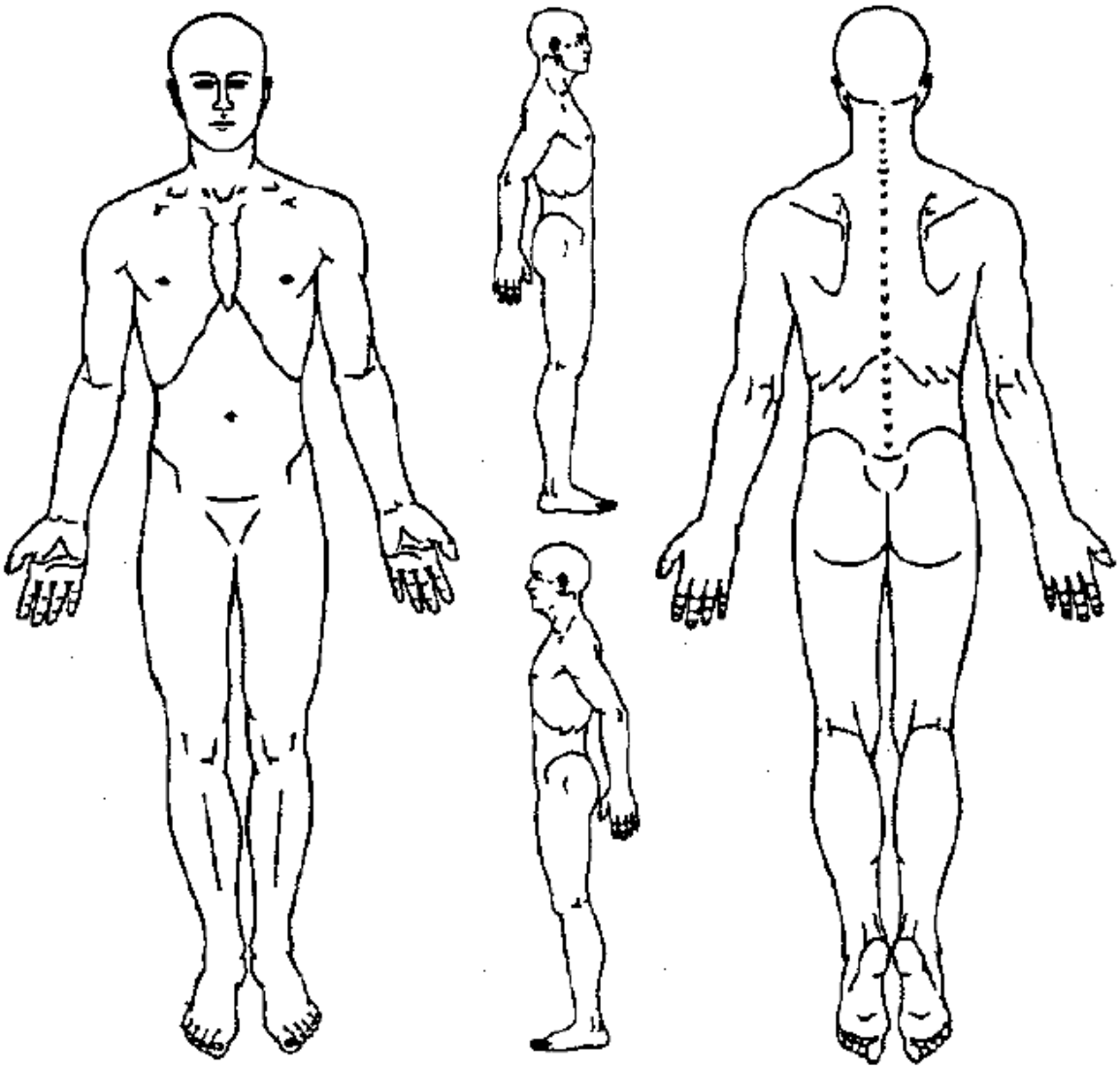
**Ht_____ Wt_____HR_____**

**Revised 4/5/2011**

## PAIN DIAGRAM

**Please mark the areas where you experience the following sensations:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | xxx | | ooo | | --- | ^^^ | | /// |
| Ache | xxx | Numbness | ooo | Pins & | --- | Burning ^^^ | Stabbing | /// |
| | xxx | | ooo | Needles | --- | ^^^ | | /// |



## HISTORY OF PRESENT ILLNESS

**How and when did your BACK or NECK problem begin?**

❑ Injury (date of injury _____)
Explain how the injury happened: _____
❑ On-the-job
❑ I don't know how it began
❑ I've had it for about _____ weeks/months/years (circle one)
❑ It comes and goes OR ❑ It is constant

**Draw a vertical line like this | on the lines below to show your severity of pain today.**

How bad is your low back pain?
No pain ——————————— Worst possible pain

How bad is your leg pain?
No pain ——————————— Worst possible pain

How bad is your upper back pain?
No pain ——————————— Worst possible pain

How bad is your neck pain?
No pain ——————————— Worst possible pain

How bad is your arm pain?
No pain ——————————— Worst possible pain

**For patients with NECK or ARM pain, numbness or weakness (*skip to next page if you have none*):**

**When comparing your neck pain to your arm pain:**
What percent of your pain is in your neck? _____% or ❑ no neck pain
What percent of your pain is in your arm? _____% or ❑ no arm pain (total should = 100%)
_____% right arm _____% left arm

Raising the arm: ❑ improves the pain ❑worsens the pain ❑no change
Moving the neck: ❑ improves the pain ❑worsens the pain ❑no change

There is: ❑weakness ❑NO weakness in the arms or hands
There is: ❑numbness or tingling ❑NO numbness or tingling in the arms or hands

Have you noticed clumsiness, difficulty buttoning buttons or picking up small objects like coins? ❑yes ❑no
Have you noticed balance problems or do you trip easily? ❑ yes ❑ no

**For patients with BACK or LEG pain, numbness or weakness (*skip if you have none*):**

**When comparing your back pain to your leg pain:**
What percent of your pain is in your back? _____% or ❑ no back pain
What percent of your pain is in your leg? _____% or ❑ no leg pain (total should = 100%)
_____% right leg _____% left leg

Do you have pain that goes below your knees? ❑ yes ❑ no

There is weakness of my:
LEFT: ❑thigh ❑calf ❑ankle ❑foot ❑toe ❑no weakness
RIGHT: ❑thigh ❑calf ❑ankle ❑foot ❑toe ❑no weakness
There is numbness of my:
LEFT: ❑thigh ❑calf ❑ankle ❑foot ❑toe ❑no numbness
RIGHT: ❑thigh ❑calf ❑ankle ❑foot ❑toe ❑no numbness

The worst position for your pain is: ❑sitting ❑standing ❑walking

How many minutes can you STAND in one place without pain?
❑ 0-10 ❑ 15-30 ❑ 30-60 ❑ 60+

How many blocks can you WALK without having to stop and rest due to pain?
❑ less than 1 ❑ 1-3 ❑ 1 mile ❑ 2 miles or more

Lying down: ❑eases my pain ❑ makes it worse ❑no change
Bending forward: ❑eases my pain ❑ makes it worse ❑no change

**ALL PATIENTS please answer the following:**

Does coughing or sneezing worsen your pain? ❑yes ❑no
There is: ❑ NO loss of bowel or bladder control
❑ Loss of control since _____, please describe: _____

Prior to my neck/back problem starting, I was:
❑ working full-time (Occupation:_____)
❑ working part-time (Occupation:_____)
❑ disabled, not working
❑ not working by choice (retired, student, etc)

I have: ❑ not missed any work because of this problem
❑ missed work (how much? _____)
❑ been out of work since _____

Because of this back/neck problem, do you have or plan to have:
❑ lawsuit ❑ worker's compensation claim ❑ unsure ❑ none

## Previous SPINE Testing

| | | | If yes, date of most recent test: |
|---|---|---|---|
| X-rays | No | Yes | _____ |
| MRI scan | No | Yes | _____ |
| CT scan | No | Yes | _____ |
| Myelogram | No | Yes | _____ |
| Discogram | No | Yes | _____ |
| Bone Density Study | No | Yes | _____ |
| Nerve test (EMG/NCV) | No | Yes | _____ |

## Previous SPINE Treatments

Treatments so far for my BACK or NECK problem include:

- ❑ Physical therapy (How many visits?_____ Last visit?_____)
- ❑ Chiropractic care (How many visits?_____ Last visit?_____)
- ❑ Epidural injections or nerve blocks (How many times?_____ How long did they help?_____)
- ❑ Anti-inflammatory medications (e.g. Motrin, Advil, Aleve, ibuprofen, naproxen)
- ❑ Narcotic medication (e.g. Tylenol #3, hydrocodone, oxycodone)
- ❑ Chiropractic ❑ Massage ❑ TENS unit ❑ Braces ❑ Psychological consultation
- ❑ Other: _____

**Are there any other non-surgical treatments that you would like to try?**_____

_____

**Previous doctors you have seen for your back/neck problem:**

| Doctor | Specialty | City |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Have you ever had surgery on your <u>SPINE</u>? ❑ Yes ❑ No If yes, complete the following:**

| | |
|---|---|
| Type of surgery _____ | Type of surgery_____ |
| When_____ | When_____ |
| Surgeon_____ | Surgeon_____ |
| Did it help your pain? ❑ Yes ❑ No | Did it help your pain? ❑ Yes ❑ No |

**Some patients who continue to have disabling pain and/or limited function due to their back/neck problem and who have tried all non-surgical options without relief may benefit from surgery. However, surgery does have significant risks such as: 1% or less risk of major complications (including heart attack, stroke, paralysis, clot to the lungs, death) as well as 5-15% risk of lesser complications (including bleeding, infection, worsening symptoms, bowel or bladder problems, blood clots in legs, spinal fluid leak, spinal implant failure). Other risks may apply to your specific problem.**

**Do you feel that your problem limits your activities enough or causes you enough pain that you would consider having surgery?** ❑ Yes ❑ No

## REVIEW OF SYSTEMS

**Do you have any of the following?**

- ❑ Recent weight loss more than 10 pounds
- ❑ Recent weight gain more than 10 pounds
- ❑ Fever or chills
- ❑ Night sweats

- ❑ Eye problems
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing

- ❑ Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Leg/feet swelling
- ❑ Leg/foot ulcer

- ❑ Wheezing
- ❑ Difficulty breathing
- ❑ Cough
- ❑ Shortness of breath

- ❑ Stomach pain
- ❑ Heartburn
- ❑ Nausea or Vomiting
- ❑ Diarrhea or ❑ Constipation
- ❑ Black tar-like or bloody stools

- ❑ Rash
- ❑ Open sores
- ❑ New moles
- ❑ Skin infection

- ❑ Toothache
- ❑ Nosebleeds
- ❑ Easy bleeding or bruising
- ❑ Poor healing

- ❑ Joint pain or swelling in many joints
- ❑ General body weakness or fatigue
- ❑ Feeling hot or cold all the time
- ❑ Calf cramps when walking

- ❑ Bladder infection
- ❑ Pain with urination
- ❑ Getting up frequently at night to urinate
- ❑ Difficulty starting urination
- ❑ Males: erection problems

- ❑ Feelings of hopelessness or crying spells
- ❑ Poor appetite
- ❑ Headaches
- ❑ Tremors
- ❑ Insomnia

**Is your primary care doctor aware of all of the above checked problems?** ❑ yes ❑ no

**(GO TO NEXT PAGE)**

## GENERAL MEDICAL HISTORY

### Do you have or have you ever had any of the following conditions? (Please circle)

| | | |
|---|---|---|
| Anemia | Enlarged prostate | Lupus/immune disorder |
| Asthma | Fibromyalgia | Osteoarthritis |
| Bleeding Tendency | Gastric reflux/stomach ulcer | Osteoporosis |
| Blood clot in leg – phlebitis | Gout | Other psychiatric problems |
| Blood clot in lung | Heart attack/Angina | Previous oral steroids (prednisone) |
| Cancer – Type_____ | Heart failure | Previous fractures |
| Colitis | Hepatitis – liver failure | Psoriasis |
| Depression/Anxiety | High blood pressure | Rheumatoid arthritis |
| Diabetes – Type 1__, Type 2__ | High cholesterol | Sleep apnea |
| Drug/Alcohol dependence | Intestinal problems | Stroke/TIA's |
| Epilepsy/Seizures | Kidney disease/stones | Thyroid problems |
| Emphysema/COPD | Lung problems | Tuberculosis |

### Please list any surgery you have had OTHER THAN SPINE SURGERY.

| | Type of Surgery | Date |
|---|---|---|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |

## MEDICATIONS

**Please list all medication you take including prescription, nonprescription, herbal and vitamins.**

❑ I do not take any medication

| Medication | Reason taken | Dose & How often | Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Any ALLERGIES to medications, foods, tape, latex or iodine/betadine? ❑ No ❑ Yes**

**If yes, please list and describe reaction.**_____

## FAMILY MEDICAL HISTORY

❑ I do not know the medical history of my biological parents or other family members (go to next section)

Mother: ❑ My mother is alive and is ____ years old
❑ She is in good health ❑ She suffers with _____
❑ My mother is deceased at age _____ Cause_____

Father: ❑ My father is alive and is ____ years old
❑ He is in good health ❑ He suffers with _____
❑ My father is deceased at age _____ Cause_____

I have _____ living brothers/sisters.
I have _____ deceased brothers/sisters. Cause(s)_____

Members of my family (biological parents, brothers/sisters, grandparents, aunts/uncles) have been diagnosed with the following (please circle all that apply):

| | | |
|---|---|---|
| Stroke | Back problems | Arthritis |
| Diabetes | Scoliosis or Kyphosis | Bleeding problems |
| Lung disease | Kidney problems | Other_____ |
| High blood pressure | Cancer | None of these |
| Heart trouble | Osteoporosis | |

## SOCIAL HISTORY

**Marital Status (circle one answer)** married single separated divorced widow/widower

**Smoking**
Do you, or have you ever, smoked? ❑ No ❑ Yes If yes, please complete the following:
I smoke _____ packs per day and I have smoked for _____ years.
I did smoke _____ packs per day, but I quit smoking _____ years ago.
Do you use any smokeless tobacco products? ❑ No ❑ Yes

**Alcohol**
Do you drink? ❑ No ❑ Yes If yes, how much: ❑ Daily ❑ Occasionally ❑ Never

**Education (circle the highest level of education you completed)**
Grammar School High school College Post-graduate

**Advance Directive**? ❑ No ❑ Yes

**Medical Power of Attorney**? ❑ No ❑ Yes

## THANK YOU.

Patient's initials_____ Date____