Davis Spine & Orthopaedics

Spine and Orthopaedic Surgeon
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New Patient Questionnaire

Today's Date_____

Please take the time to complete all of this form. Your careful, accurate, complete, and legible answers will help us to understand your presenting problem and help us design the best treatment program for you.

Name _____ Date of Birth _____ Age: _____

Height _____ Weight _____

Are you currently working? □ Yes □ No If yes, then how many hours per week? _____
Is your job □ sedentary □light □ medium □ heavy?
If you are not currently employed, indicate how long you have been off work; _____

Do you currently smoke? □ Yes □ No
If Yes, and how many packs per day? _____
Do you consume alcoholic beverages (Include quantity and frequency)? _____

Is there a history of low back pain, arthritis, or other major chronic illness that runs in your family? (please state)
_____

Are you: □ Right □ Left Handed

What is the **main** problem(s) for which you are seeking treatment?_____

_____

When did your current problem start? _____/_____/_____ (month/day/year)

Have you ever had similar problems before? □ yes □ no Did your symptoms start: □ suddenly □ gradually

Please indicate how your present symptoms **began**?

□ during an athletic activity □ while seated
□ while lifting □ as a result of an auto accident
□ while bending □ while working
□ unknown □ other _____

Please indicate where your pain/symptom was **initially** located:

□ neck □ mid back
□ low back □ low back and legs
□ neck and arms □ unknown
□ other _____

Please check the most appropriate statement: my symptoms
□ have remained the same since the time of injury
□ are more severe since the time of injury
□ are less severe since the time of injury

How have the symptoms of your pain **changed**?
□they are unchanged
□increased aggravation in one arm or leg
□increased aggravation in both arms or legs
□increased aggravation in the back or neck
□ increased aggravation in both arms/legs and back/neck

THE NEXT 2 QUESTIONS ARE FOR SPINE PATIENTS ONLY
Which of the following best describes your back and leg ratio? (PICK ONE if it applies)
□100% back pain
□75% back pain and 25% leg pain
□50% back pain and 50% leg pain
□25% back pain and 75% leg pain
□ 100% leg pain

Which of the following best describes your neck and arm ratio? (PICK ONE if it applies)
□100% neck pain
□75% neck pain and 25% arm pain
□50% neck pain and 50% arm pain
□25% neck pain and 75% arm pain
□ 100% arm pain

You have already provided us with Information about your present pain please give us the approximate dates of any **other** episodes of back /neck pain:
Episode A _____/_____ / _____ _____
Episode B _____/_____ / _____ _____

Is your **current** pain (please check one)?
□constant □intermittent and occurring daily □ intermittent and occurring on most days □infrequent

How would you describe the pain (choose **as many** adjectives as are applicable)?

□burning	□sharp	□electric-like	□ pins and needles	□ shooting
□stabbing	□numb	□tearing	□penetrating	□aching
□gnawing	□dull	□throbbing	□miserable	□_____

Approximate amount of time you can perform the following activities:

	unable	15 min	30 min	45 min	1 hour	indefinitely
Sit	□	□	□	□	□	□
Stand	□	□	□	□	□	□
Walk	□	□	□	□	□	□
Lift	□	□	□	□	□	□
Carry	□	□	□	□	□	□

PAIN SEVERITY
PRIMARY location of pain: ____

Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

Are there additional locations with pain? ☐Yes ☐No

Additional location of pain: ____
Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

Additional location of pain: ____
Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

Additional location of pain: ____
Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

Additional location of pain: ____
Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

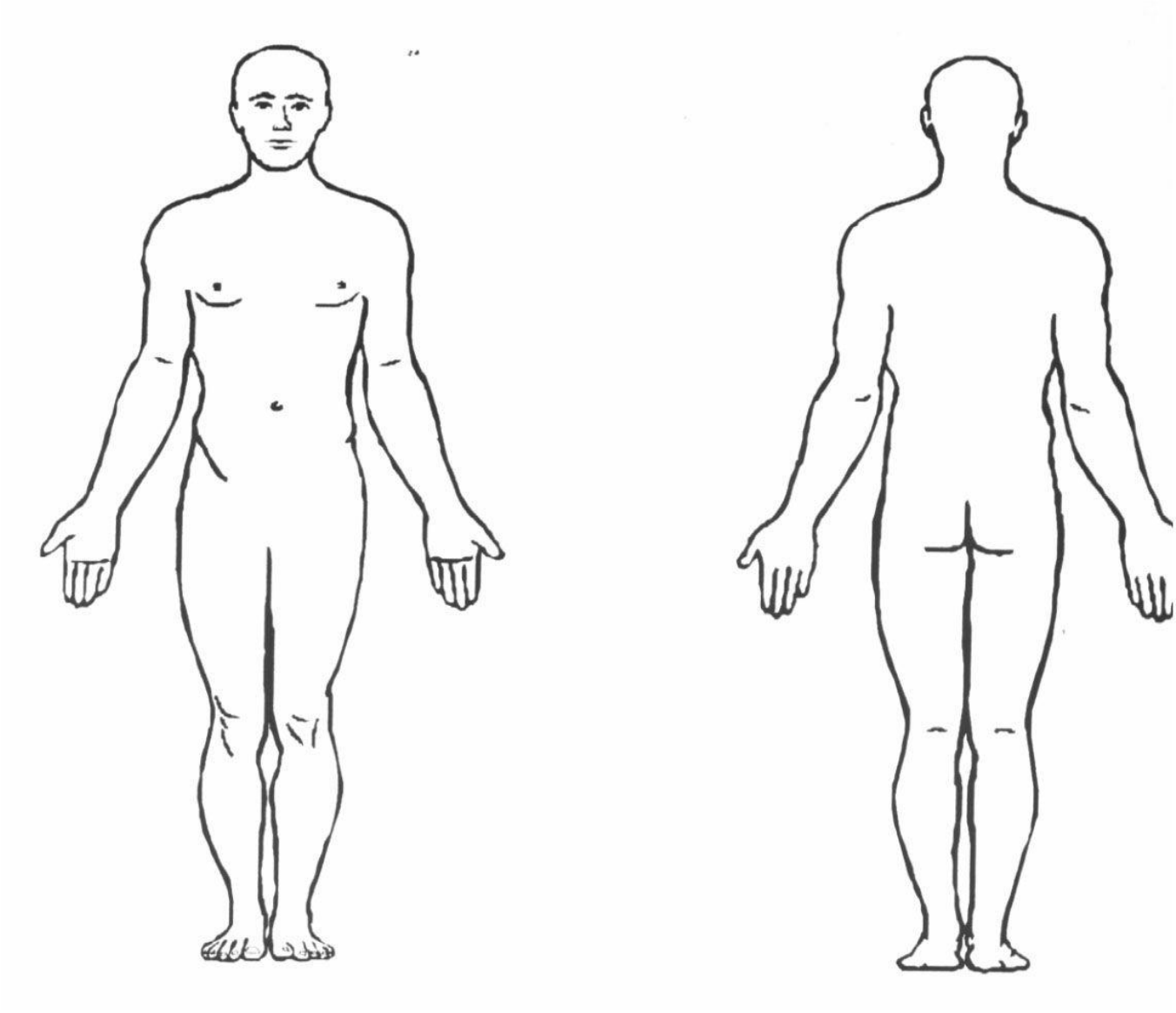
Additional location of pain: ____
Pain severity (circle your average level of pain where 0 means no pain and 10 means severe pain)
0 1 2 3 4 5 6 7 8 9 10

RELIEVING AND AGGRAVATING FACTORS
How do the following affect your pain? (Check one for each line)

	Decrease	No Change	Increase
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Rising from sitting	☐	☐	☐
Bending forward	☐	☐	☐
Bending backward	☐	☐	☐
Lying on your back	☐	☐	☐
Lying on your side	☐	☐	☐
Lying on your stomach	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Lifting	☐	☐	☐
Carrying	☐	☐	☐
Overhead lifting	☐	☐	☐

Describe your pain on the pain drawing using the appropriate symbols:

N	Numbness
//	Stabbing
X	Burning
O	Stiffness
+	Pins and needles
=	Dull aching
^	Cramps



PAST MEDICATIONS
Using the list below indicate the prescription medications that you have tried in the past for your present problem. Please tell us the dosage and number of pills you took of this medication per day.

Opioids
- □ Tylenol with codeine
- □ Darvocet (Propoxyphene)
- □ Percocet
- □ Vicodin
- □ Dilaudid (Hydromorphone)
- □ Oxycontin
- □ MS Contin
- □ Methadone
- □Duragesic (Fentanyl) patch
- □ Butrans patch
- □ Demerol (Meperidine)
- □ Kadian

Antispasmodics
- □ Flexeril (Cyclobenzaprine)
- □ Soma (Carisoprodol)
- □ Baclofen (Lioresal)
- □ Zanaflex (TIzanldlne)
- □ Norflex (Orphenadrine)
- □ Robaxin (Methocarbamol)

Anti-inflammatories (NSAIDS)
- □ Ibuprofen (Motrin, Advil)
- □ Naprosyn (Naproxen)
- □ Aleve (Naproxen)
- □ Aspirin
- □ Lodine (Etodotac)
- □ Relafen (Nabumetone)
- □ Feldene (Piroxkam)
- □ Indomethacin (Indodn)
- □ Toradol (Ketorotec)
- □ Mobic (Meloxicam)
- □ Celebrex (Celecoxib)
- □ Steroids (Prednisone, Cortisone, etc)

Antianxiety
- □ Ativan (Lorezapam)
- □ Klonopin (Clonazepam)
- □ Valium (Diazepam)
- □ Xanax (Alprazolam)
- □ Serax (Oxazepam)
- □ Halcion (Triazolam)
- □ Buspar (Busplrone)

Antidepressants
- □Elavil (Amitriptyllne)
- □Pamelor (Nortriptyline)
- □Norpramin (Desipramine)
- □Sinequan (Doxepin)
- □Trazodone (Desyrel)
- □Zoloft (Sertraline)
- □Prozac (Fluoxetine)
- □Paxil (Paroxetine)
- □Wellbutrin (Bupropion)
- □Effexor (Venlafaxine)
- □Serzone (Nefazodone)

Others
- □Neurontin (Gabapentin)
- □Lyrica
- □Ultram (Tramadol)
- □Ambien (Zolpidem)
- □Topomax (Topiramate)
- □Tegretol (Carbamezapine)
- □Dilantin (Phenytoin)
- □Lamictal (Lamotrigine)
- □Blood thinners

CURRENT MEDICATIONS (please fill out the dosages and how often taken):

_____
_____
_____
_____
_____
_____
_____

ALLERGIES
Please indicate the names of any products (latex, tape, etc); foods (peanuts, etc); medications that you are allergic to (and what happened to you?):

_____

Please check all of the treatments you have tried for your pain and then complete the appropriate column:

Treatment	Date Started	Length of treatment	No Relief	Moderate Relief	Excellent Relief
□ Physical Therapy			□	□	□
□ Occupational Therapy			□	□	□
□ Aqua Therapy			□	□	□
□ Surgery			□	□	□
□ Heat			□	□	□
□ Ice			□	□	□
□ Traction			□	□	□
□ Injection (epidural, facet, etc)			□	□	□
□TENS			□	□	□
□ Ultrasound			□	□	□
□ Brace or Collar			□	□	□
□ Massage			□	□	□
□ Meditation			□	□	□
□ Acupuncture			□	□	□
□ Chiropractic			□	□	□

Please list below all of the **surgeries** that you have had indicate the approximate date and type of operations:
Laminectornies/ discectomies:_____
Fusions:_____
Other surgeries: _____
For spine surgeries, where was your surgery (hospital name) and who was your surgeon?

_____

Did you **improve** from your surgical procedure(s)? □ Yes □No

Have you had any of the following tests done for the current problem?
□ MRI □CT □ X-rays □ Discogram □ Myelogram □ EMG/NCS □ Bone Scan

Have you had any of the following health problems? Please check all that apply?
□ High blood pressure □ Sleep apnea □ Bleeding problems □ Addiction to drugs/alcohol
□ Liver Disease □ Hepatitis □ Kidney disease
□ HIV □ Heart disease □ Seizures – Past / Epilepsy
□ Diabetes or high blood sugar
Is it controlled? _____ Last A1C? _____ When was it performed? _____

Have you experienced significant **stress** this past year? Please explain:

_____

Please check all that apply to you:

□ recent infections	□ fever or chills	□ arm numbness	□ leg numbness	□ bowel accidents
□ weight loss	□ genital numbness	□ bladder incontinence	□ severe nighttime pain	□ muscle weakness
□ anemia	□ murmur	□ headaches	□ cold hands/feet	□ palpitations
□ hoarse voice	□ leg swelling	□ asthma	□ chest pain	□ double vision
□ cough	□ coughing blood	□ shortness of breath	□ loss of vision	□ ringing in ears
□ ulcer	□ kidney infection	□ arthritis	□ dry eyes	□ excess sweating
□ menopause	□ pain on urination	□ kidney stones	□ red joints	□ cold intolerance
□ blood in stool	□ blood in urine	□ swollen joints	□ gout	□ diarrhea
□ nausea	□ abdominal pain	□ black stool	□ muscle aches	□ thyroid problem
□ osteoporosis	□ eczema	□ psoriasis	□ dizziness	□ feeling depressed
□ rash				