New Patient Questionnaire

Spinal Reconstructive Surgery
Pediatric and Adult Scoliosis
Complex Spinal Disorders and Trauma
Name: ____________________________________________

Age: _______ Marital Status: M S D W P Height: _______ Weight: _______

Date problem started or injury occurred: ___ / ____ / ___

Is the current problem the result of

Choose ONE from this list

Car Accident Yes No
Work Accident Yes No
Other Yes No

1) Did your back or neck pain get any better once the leg/arm pain began?

☐ Yes ☐ No ☐ Does Not Apply

2) Is your back, arm or leg pain?

Choose ONE from this list

Constant ☐ Intermittent ☐ Neither

Choose ONE from this list

Getting Better ☐ Staying The Same ☐ Getting Worse

3) Does your back, arm or leg pain affect your sleep in any way?

☐ Yes ☐ No In What Way? ____________________________________________

4) Which of the following?

Aggravates Your Pain?

☐ None ☐ Coughing, sneezing, bearing down
☐ Standing ☐ Sitting
☐ Driving ☐ Walking
☐ Bending (ie. brushing your teeth) ☐ Pushing an object (i.e. vacuuming, mowing)
☐ Exercising. Swimming. Dancing ☐ Other ______________________

Relieves Your Pain?

☐ None ☐ Standing
☐ Sitting ☐ Lying down
☐ Walking ☐ Exercise
☐ Other ______________________

5) Is the pain worse on first rising in the morning?

☐ Yes ☐ No

6) Is the pain worse toward the end of the day?

☐ Yes ☐ No
7) Please Indicate the Severity of Your Pain Below.  1 being mild, 10 being severe

Neck_________  Back_________  Right Leg_________  Left Leg_________

8) Activity Level (please check ONE)

☐ Require assistance for all activity
☐ Able to perform self care only
☐ Able to do indoor activities of daily living
☐ Able to do outdoor activities of daily living
☐ Able to do low stress recreation (i.e. golf, swimming)
☐ Able to do most activities

9) Have You Had Any of The Following Symptoms Recently? (please check all that apply)

☐ Feel like you must urinate and cannot
☐ Urgent desire to void and cannot hold
☐ Dribbling (loosing urine involuntarily)
☐ Loss of feeling of voiding
☐ Constipation
☐ Difficulty with sex
☐ None of the above

15) Do You Have Difficulty With Walking?  ☐ Yes  ☐ No

How Far Can You Walk?

☐ Unlimited  ☐ More than 2 blocks  ☐ Less than 2 blocks  ☐ Only in the house

Do You Stumble?  ☐ Yes  ☐ No  Due to Pain?  ☐ Yes  ☐ No

Do You Limp?  ☐ Yes  ☐ No  Due to Pain?  ☐ Yes  ☐ No

16) Have You Seen Any Of The Following For Your Pain / Who?

☐ Chiropractor  ☐ Orthopaedist  ☐ Neurosurgeon
☐ Physical Therapist  ☐ Neurologist  ☐ Rheumatologist
☐ Other  ☐
Please Tell Us Where Your Pain Is. This Will Tell Us Where Your Pain Is Now And Something About It.

Simply draw with the color which represents the type of pain or discomfort you're experiencing.

- **Red**: Burning
- **Yellow**: Numbness
- **Blue**: Aching
- **Purple**: Pins & Needles
- **Green**: Stabbing
- **Orange**: Others
17) Please Check The Treatments You Have Tried And The Results

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<thead>
<tr>
<th></th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
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<tbody>
<tr>
<td>Bedrest</td>
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<tr>
<td>Epidural Steroid Injections</td>
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<td>Steroids by Mouth</td>
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<td>Nerve Blocks</td>
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<td>Manipulation</td>
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<tr>
<td>Cane</td>
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<td>Walker</td>
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<td>Corset or Brace</td>
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<td>Physical Therapy</td>
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<td>Aqua Therapy</td>
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<tr>
<td>Accupuncture</td>
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18) Which Pain Medications Were/Are You Taking?

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<tr>
<th></th>
<th>Previously</th>
<th>Currently</th>
<th>Previously</th>
<th>Currently</th>
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<tbody>
<tr>
<td>Darvocet</td>
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<td>Advil</td>
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<td>Percocet</td>
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<td>Naprosyn</td>
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<td>Tylenol</td>
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<td>Restoril</td>
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<td>Tylenol #3-4</td>
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<td>Elavil</td>
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<td>Tylox</td>
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<td>Ativan</td>
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<td>Vicodin</td>
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<td>Tranxene</td>
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<td>Toradol</td>
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<td>Cortisone</td>
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<td>Talwin</td>
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<td>Celebrex</td>
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<td>Valium</td>
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<td>Vioxx</td>
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<td>Flexeril</td>
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<td>Soma</td>
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<td>Ultram</td>
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<td>Robaxin</td>
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<td>Neurontin</td>
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<td>Motrin</td>
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<td>Other</td>
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Past Medical History

Do you have any of the following medical problems?

- [ ] High Blood Pressure
- [ ] Diabetes
- [ ] Cancer: __________
- [ ] Asthma
- [ ] Heart Disease! M.I
- [ ] Coronary Artery Disease
- [ ] Hypo-Hyper Thyroid
- [ ] Emphysema
- [ ] Strokes
- [ ] Ulcer or Stomach Problems
- [ ] Other: __________________________________________

Past Surgical History

Please List All Prior Surgeries

<table>
<thead>
<tr>
<th>Surgeries</th>
<th>Year</th>
<th>City</th>
<th>Complications</th>
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Have You Ever Had Problems With General Anesthesia?  □ YES  □ NO

Please Describe __________________________________________

Please List Any Allergies To Medications

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Reaction</th>
<th>Last Taken</th>
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Do You Have An Allergy To Latex Or Rubber?  □ YES  □ NO

Please List All Medications You Take:

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Review of Systems

Do You Have Or Have You Had Problems With: (Check And Describe All That Apply)

☐ Eyes
☐ Ears, Nose, Throat
☐ Dental infections
☐ Lungs, breathing, shortness of breath
☐ Chest pain or angina
☐ Leg swelling
☐ Digestion
☐ Loss of appetite
☐ Bowel movements
☐ Infections
☐ Urinary Infections
☐ Bleeding
☐ Anemia
☐ Balance/coordination
☐ Blackouts/fainting
☐ Depression. Do you cry frequently?
☐ Anxiety/ Panic attacks
☐ AIDS / Immunologic
☐ Arthritis
☐ Polio
☐ Tuberculosis
☐ Hepatitis
☐ Epilepsy

Social History

1) Do You Drink Alcohol? ☐ Wine ☐ Beer ☐ Liquor
☐ None ☐ Daily ☐ 1—2 times per WEEK ☐ 1—2 times per MONTH

2) Do You Smoke? ☐ Yes ☐ No

3) If You Quit, How Long Ago?
How Much? _____ packs a day, for ________ years ☐ This Year ☐ >1 years ☐ >5 years ☐ >10 years

4) Have You Ever Used Recreational Drugs? ☐ Yes ☐ No
What Drugs? _____________________

5) Do You Exercise Regularly?
What? _____________________________ ☐ Daily ☐ Weekly ☐ Monthly

6) Are You On A Special Diet? ☐ Yes ☐ No
Which? _________________________
Employment History

1. Who Is Your Employer? _________________________________________
2. What Is Your Job / Profession? _________________________________
3. How Long Have You Worked At This Job? ______________________
4. Have You Taken Time Off Because Of Your Back? ____Yes ____No
5. How Long Have You Been Away From Work? _____________________
6. Are You Currently Receiving Compensation? ____Yes ____No
7. If Yes, From What Source? ___________________________________
8. Do You Plan To Return To Work? ___Yes ___No
9. If Yes, When? ___ / _____ / ___
10. Are You In A Legal Case For This Injury? ___Yes ___No

Family History

<table>
<thead>
<tr>
<th>Relative</th>
<th>Alive</th>
<th>Deceased</th>
<th>Health Problems</th>
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<tbody>
<tr>
<td>Grandmother (mother’s side)</td>
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<td>Grandfather (mother’s side)</td>
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Current Health

29) How Do You Consider Your Health To Be Now?
   ☐ Excellent        ☐ Good          ☐ Fair            ☐ Poor

30) How Was Your Health Before Your Back Problem?
   ☐ Excellent        ☐ Good          ☐ Fair            ☐ Poor