The Leader in Less Invasive & Complex Spine Surgery

M. Darryl Antonacci, M.D., F.A.C.S., Director
Spine & Scoliosis Surgeon
Specializing in Complex Reconstructive Adult & Pediatric Spine

Randal R. Betz, M.D.
Spine Surgeon
Specializing in Scoliosis & Pediatric Spine

Laury A. Cuddihy, M.D.
Spine Surgeon
Specializing in Adult & Pediatric Spine

New Jersey
3100 Princeton Pike · Building 1
Lawrenceville, New Jersey 08648
Tel: 609.912.1500

New York
800A Fifth Avenue at 61st, Suite 301
New York, NY 10065
Tel: 800.372.6001

TEL 800.372.6001
FAX 609.912.1600

Web www.spineandscoliosis.com
Twitter @spinescoliosis
Facebook instituteforspineandscoliosis

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

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_______

Right Arm_______ Left Arm_______

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

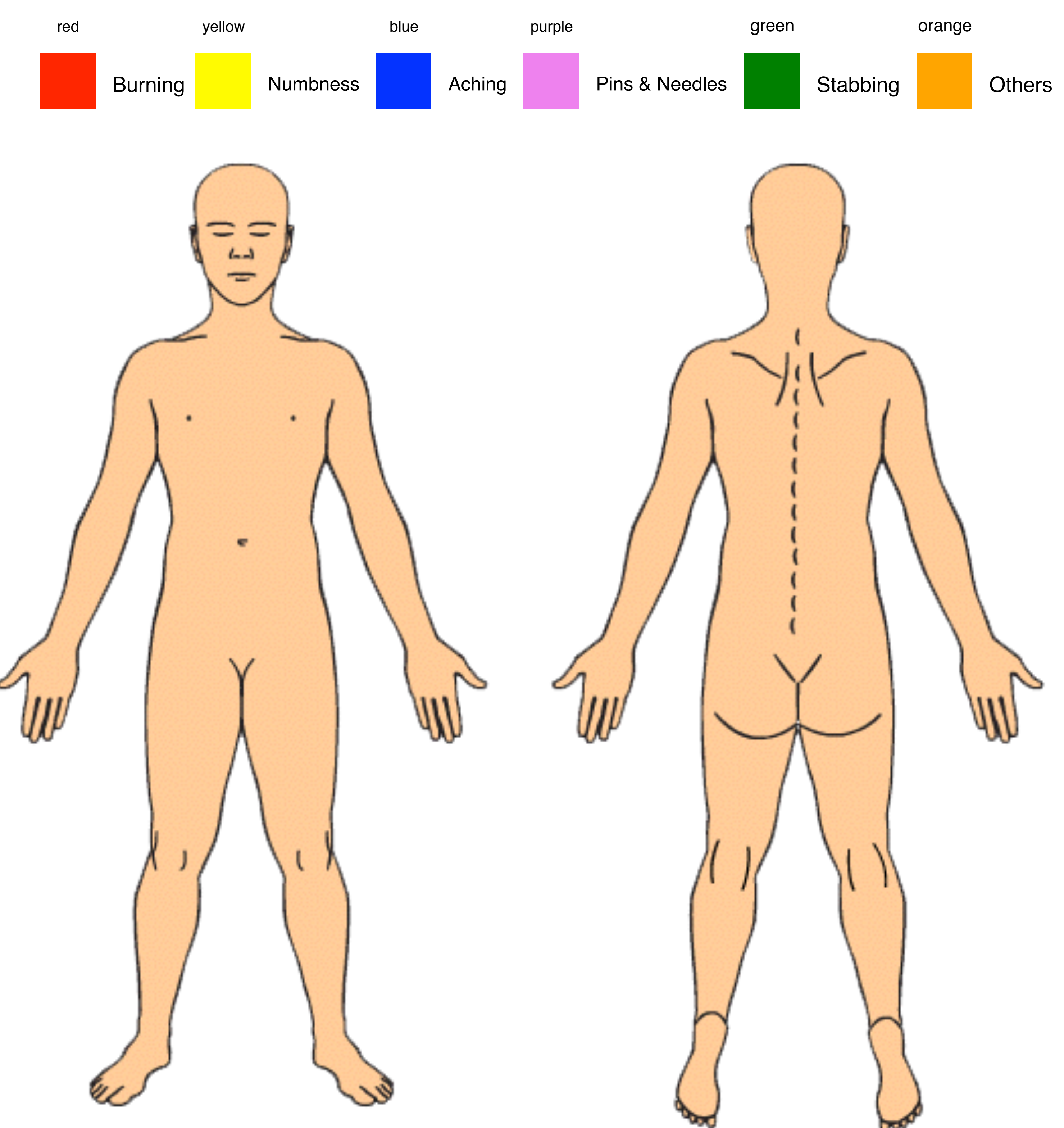
Do You Limp? ☐ Yes ☐ No **Due to Pain?** ☐ Yes ☐ No

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



17) Please Check The Treatments You Have Tried And The Results

	Better	Same	Worse
Bedrest			
Epidural Steroid Injections			
Steroids by Mouth			
Nerve Blocks			
Manipulation			
Cane			
Walker			
Corset or Brace			
Physical Therapy			
Aqua Therapy			
Accupuncture			

18) Which Pain Medications Were/Are You Taking?

	Previously	Currently		Previously	Currently
Darvocet			Advil		
Percocet			Naprosyn		
Tylenol			Restoril		
Tylenol #3-4			Elavil		
Tylox			Ativan		
Vicodin			Tranxene		
Toradol			Cortisone		
Talwin			Celebrex		
Valium			Vioxx		
Flexeril			Relafen		
Soma			Ultram		
Robaxin			Neurontin		
Motrin			Other		

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
- ☐ HypoIHyper Thyroid
- ☐ Emphysema
- ☐ Strokes
- ☐ Ulcer or Stomach Problems
- ☐ Other:____
  ____

Past Surgical History

Please List All Prior Surgeries

Surgeries	Year	City	Complications

Have You Ever Had Problems With General Anesthesia? ☐ YES ☐ NO

Please Describe ____

Please List Any Allergies To Medications

Medicine	Reaction	Last Taken

Do You Have An Allergy To Latex Or Rubber? ☐ YES ☐ NO

Please List All Medications You Take:

Medication	Dose / How Often?	How Long?	Side Effects?

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

How Much? ______ packs a day, for _________ years

3) If You Quit, How Long Ago?

☐ This Year ☐ > 1 years ☐ > 5 years ☐ > 10 years

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

5) Do You Exercise Regularly? ☐ Yes ☐ No

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

Relative	Alive	Deceased	Health Problems
Grandmother (mother's side)	☐	☐	____________________
Grandfather (mother's side)	☐	☐	____________________
Grandmother (father's side)	☐	☐	____________________
Grandfather (father's side)	☐	☐	____________________
Father	☐	☐	____________________
Mother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________
Sister / Brother	☐	☐	____________________

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