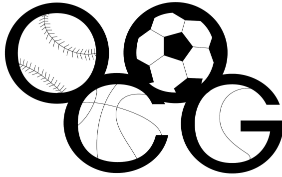


ORANGE COUNTY ORTHOPAEDIC GROUP
NEW PATIENT QUESTIONNAIRE

David W. Lee, MD

Name: ______________________ Age: __________ DOB: __________

Who referred you to our office? ______________________

What problem do you have with your neck or back? ______________________

When did your problem start? ______________________

Instructions: Only complete sections A-G below that apply to you. There will be a General Medical section that will be to be completed in full, which starts on Page 5.

INJURY OR TRAUMA (SECTION A)

Did a particlar accident or injury case your problem? □ No (skip to Section B) □ Yes (continue this section)

Check only one:

□ I never had a back/neck problem in this area of my spine before this injury.
□ I had back/neck problems in this area of my spine before, and this injury made the problem worse.

Check all that apply:

□ This injury occurred at work.
□ This injury did not occurr at work.
□ I have filed a claim through workers compensation.

DO NOT WRITE BELOW THIS LINE.

HT __________
WT __________
BP __________
P __________
R __________

__________ FILMS

PCP: ______________________

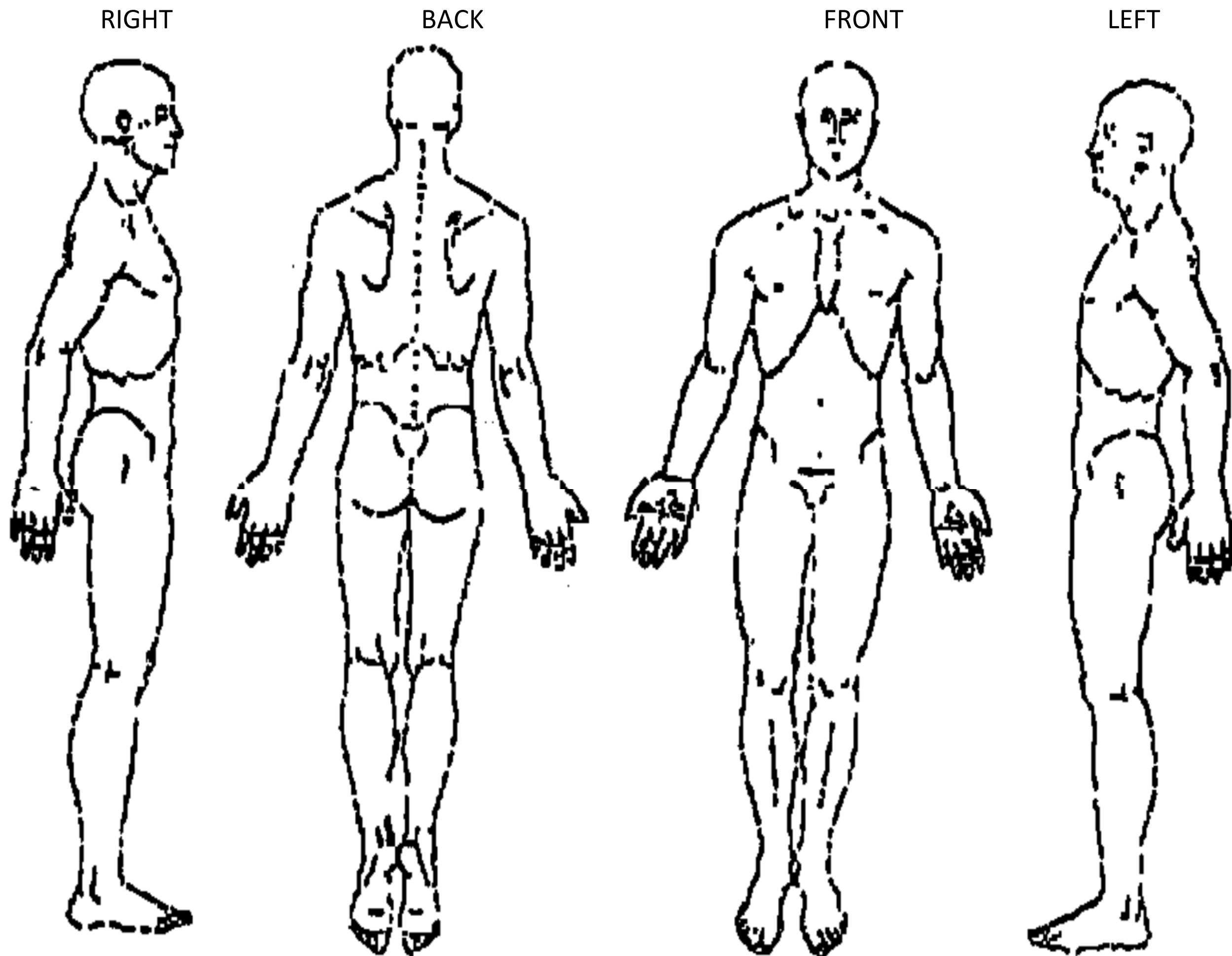
REFERRED BY: ______________________

PAIN AND DISABILITY (SECTION B)

This section pertains to pain only. You will have an opportunity to answer questions about numbness and tingling in Section C.

Does your neck or back problem cause pain?: □ No (skip to Section C) □ Yes (continue this section)

Mark your pain on the figures below:



Pain scale 0-10 (0=No pain, 10=pain severe enough to pass out)

What number would you give your pain today?: ____________

What number would you give your pain on average?: ____________

What number would you give your pain at its worst?: ____________

Please check all that describe your pain:

□ Burning □ Sharp/Stabbing □ Tingling □ Aching □ Throbbing

□ Shooting □ Pulling/Tearing □ Cramping Other: ____________________

Please check all of the appropriate responses in each category to complete the phrase:

My pain…

□ began suddenly □ began gradually □ interrupts my sleep

□ is constant □ comes and goes

My pain is worse…

□ during the day □ at night □ in the AM □ in the afternoon

My pain is worse when…

□ walking □ running □ standing □ sitting □ bending

□ applying heat □ applying ice □ exercising □ frequently changing positions

□ sports (list): ____________________ □ over head activity □ lying

□ other (describe): ____________________ □ lifting □ driving

□ nothing makes my pain worse

My pain is better while…

□ walking □ running □ standing □ sitting □ bending

□ applying heat □ applying ice □ exercising □ frequently changing positions

□ sports (list): ____________________ □ over head activity □ lying

□ other (describe): ____________________ □ lifting □ driving

□ lying on back □ lying on side □ lying on stomach

□ other (describe): ____________________

□ nothing makes my pain better □ nothing makes my pain worse

Overall, which single word or phrase would you use to describe your pain the majority of the time?

□ trivial/minimal annoying □ limiting □ disabling □ unbearable

Because of my pain, I am unable to…

□ walk over ____________ miles □ run over ____________miles

□ sit longer than ____________minutes □ lift over ____________ lbs

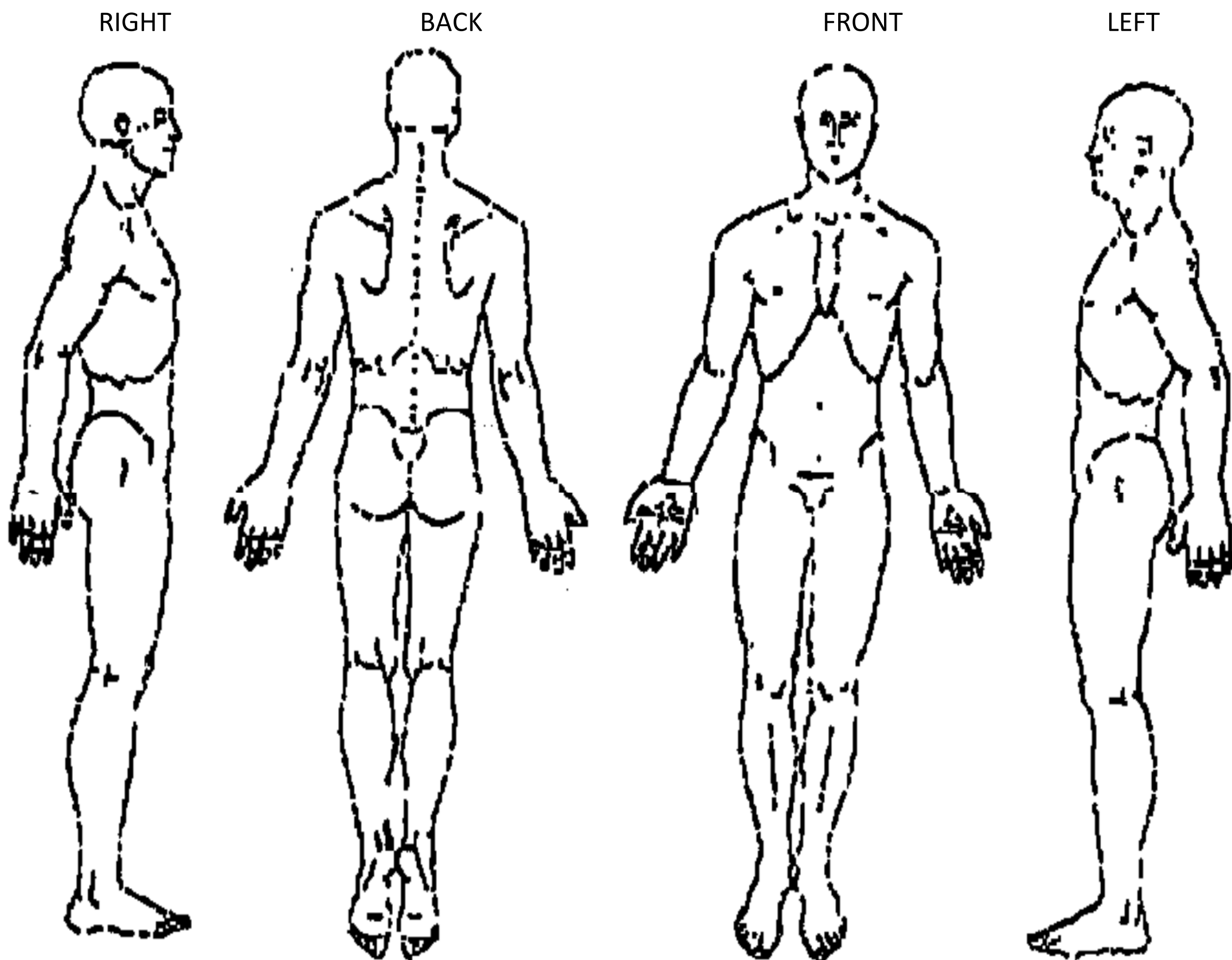
□ stand longer than ____________ mins/hrs

NUMBNESS/TINGLING (SECTION C)

This section pertains to numbness/tingling only. Questions about pain are in the previous section (Section B).

Do you feel numbness or tingling? □ No (please skip to Section D) □ Yes (continue this section)

Please mark on the figure below to show where you feel numbness (loss of feeling) or tingling (pins and needles).



My numbness and tingling is made worse while…

□ walking □ running □ standing □ sitting □ bending
□ heat □ ice □ exercising □ frequent change of position
□ nothing makes my pain worse □ lifting □ driving
□ sports (list): ______________________________
□ other (describe): ______________________

My numbness and tingling is made better while…

□ walking □ running □ standing □ sitting □ bending
□ heat □ ice □ exercising □ frequent change of position
□ sports (list): ______________________________
□ nothing makes my pain better □ lifting □ driving
□ other (describe): ______________________

SPINAL DEFORMITY/TUMOR (SECTION D)

Do you have a curve, lump, or mass near or on your spine?: □ no (skip to Section E)
□ yes (complete this section)

Please check all that apply to your situation:

□ I have a spinal curvature or deformity (scoliosis or kyphosis) that was present at birth.
□ I have a spinal curvature or deformity (scoliosis or kyphosis) that developed in childhood, and was not present or obvious at birth.
□ I have a spinal curvature or deformity (scoliosis or kyphosis) that developed as an adult, and was not present in childhood.
□ I wore a brace when I was younger to help my scoliosis or kyphosis.
□ I am wearing a brace now.
□ I have noticed my spinal curvature getting worse.
□ My clothes no longer fit or hang properly.

□ I have a lump or mass on my spine that is getting bigger.
□ I have a lump or mass on my spine that is not getting larger.
□ The mass is painful.
□ The mass is not painful.

ASSOCIATED PROBLEMS (SECTION E)

Please check all that apply to you:

□ I HAVE NONE OF THE FOLLOWING PROBLEMS
□ frequent falling or stumbling
□ clumsiness in hands
□ unable to stand up straight
□ must look at feet in order to walk
□ leakage of urine or staining underwear
□ leakage of bowel contents or staining underwear
□ impotence
□ unable to completely empty your bladder
□ unable to look forward without bending knees

TESTING AND TREATMENT (Section F)

Which of the following tests have you had in the last year for your spine problems?(check all that apply)

□ x-rays □ blood test □ myelogram □ MRI
□ discogram □ bone density scan □ nuclear bone scan □ CT (CAT Scan)
□ other: ______________________________ □ nerve study (EMG/NCS)
□ I HAVE HAD NO TESTS TO EVALUATE MY PROBLEM

Your treatment history (please check all that apply)

	Complete Relief	Improved	Unchanged	Worse
Physical Therapy				
Home Exercises				
Chiropractic				
Epidural Steroid Injection (performed in the Hospital)				
Facet Joint Injection (performed in the Hospital)				
Local or Trigger Point Injection (performed in the office)				
Massage				
Brace, corset, or other support				
Accupuncture				
Other				
I HAVE NOT STARTED OR COMPLETED ANY OF THE ABOVE TREATMENTS				

Please list all medications you have tried, the dose, and the number of pills used per day for this problem (examples are naproxen, voltaren, ibuprofen, vicodin, percocet, oxycontin, darvocet, morphine, soma, flexeril, robaxin, baclofen, celebrex, vioxx, bextra, etc.):

When last used	Medication	Dose	# of pills per day	Did the medication help?
mm/yy	Example: Motrin	800mg	4	very helpful

PRIOR SPINE SURGERY (SECTION G)

Have you ever had surgery on your spine? □ no (skip to medical history) □ yes (complete this section)
(This includes fusions, decompressions, or any disc procedures.)

Date	Procedure	Rate the outcome of surgery (poor, good, or excellent - see legend below)

Legend: Poor = the surgery had no change or made me worse
Good = the surgery improved my symptoms
Excellent = dramatically improved or resolved my symptoms

□ I have not, nor do I plan to take legal action related to this injury.
□ I am considering or have taken legal action as a result of this injury.
□ Legal action related to this injury is closed or settled.

Medical Health History: Have you ever suffered from any of the following?
Please check appropriate answer:

□ yes □ no Tumors or Cancer? If yes, what type?
□ yes □ no any infection in the last year? If yes, what**?** ___________________________________
□ yes □ no Epilepsy/Seizures?
□ yes □ no Treated for headaches?
□ yes □ no Head injury with loss of consciousness?
□ yes □ no thyroid problem
□ yes □ no Treated for a psychiatric disorder?
□ yes □ no Circulatory problems?
□ yes □ no Do you have a history of stroke?
□ yes □ no Heart problem? If yes, describe:
□ yes □ no Currently do you have high blood pressure?
□ yes □ no Do you have high cholesterol? If yes, what is it?
□ yes □ no Are you diabetic? If yes, are you insulin dependent? □ yes □ no
□ yes □ no History of respiratory disorders? (Asthma, Emphysema)
□ yes □ no Intestinal disorder?
□ yes □ no Gastrointestinal reflux? (GERD)
□ yes □ no AIDS or related diseases (HIV positive)?
□ yes □ no Hepatitis?
□ yes □ no Any disease of the nerves or muscles? If so, what ______________________________
□ yes □ no Arthritis? What type____
□ yes □ no Gout?
□ yes □ no Any injuries to other bones or joints?
□ yes □ no Allergies? If so, please describe: ____
□ yes □ no Do you have any other health problems not mentioned above?
If yes, please explain:

Please list all prior surgeries and dates if known:

____
____
____
____

<u>Review of Systems</u>:

Check all that apply: □ None apply

□ **Fever or chills**	□ **Bowel incontinence**	□ **urinary incontinence**	□ Frequent urination
□ Frequent Constipation	□ bleeding with bowel movements		□ Burning on urination
□ Swollen ankles	□ Hot or cold spells	□ Frequent rash	□ Difficulty starting urination
□ Loss of hearing	□ Calf cramps w/walking	□ Frequent headaches	□ Bleeding with urination
□ Ear pain	□ Poor appetite	□ Blackouts	□ Frequent diarrhea
□ Hoarseness	□ Tooth ache	□ Seizures	□ Recent wt. change
□ Stomach pain	□ Gum trouble	□ Heart or chest pain	□ Shortness of breath
□ Ulcers	□ Difficulty swallowing	□ Nausea or vomiting	

Other: ____

How well are you sleeping?
____

<u>Family History:</u>

Has any family member had any of the following? Please check (√) each that apply
□ yes □ no Any blood relatives who have had a heart attack before age 55?

□ yes □ no Disabling back pain?
□ yes □ no Arthritis?
□ yes □ no Muscle or nerve disease? If so, what____
□ yes □ no Cancers? If so, what type____
□ yes □ no Any other disease which might affect your treatment? Please list:______________________

Social History:

How much alcohol do you usually drink ?

□ None
□ 1 to 2 drinks per week
□ 1 to 2 drinks per day
□ 3 to 5 drinks per day
□ more than 5 drinks per day

□ yes □ no Have you been treated for drug or alcohol abuse?
□ yes □ no Do you use street drugs?
□ yes □ no Have you been a cigarette smoker in the past 5 years?
□ yes □ no Currently, do you smoke? If yes, how much per day _______________