FONDREN ORTHOPEDIC GROUP L.L.P

David W. Wimberley, MD

Please fill out these forms completely!

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.

Thank you for helping us get to know you better!

Patient Name:_____

Date: _____

Gender: ☐ Male ☐ Female

Date of Birth: _____ Current Age: _____

Height:_____ Weight:_____

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

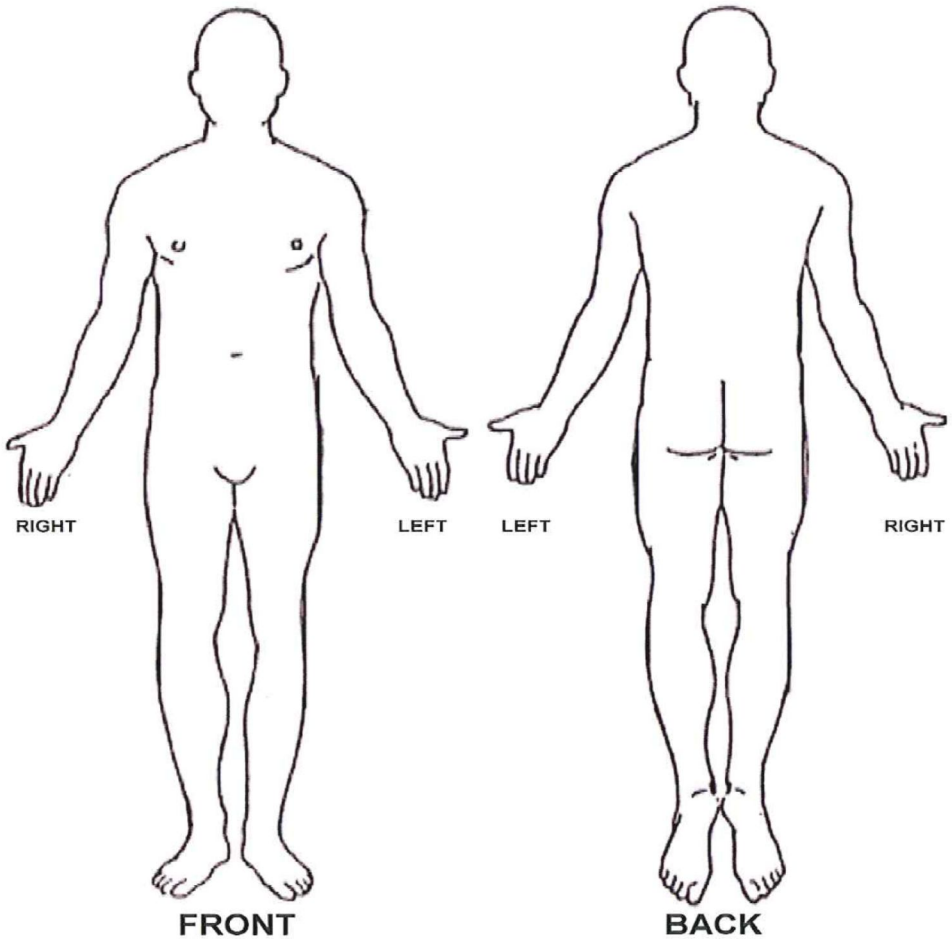
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
= = = =
= = = =
= = = =

Burning
XXXX
XXXX
XXXX

Stabbing
/ / / / /
/ / / / /
/ / / / /



How bad is your pain? Circle the number on each of the lines below to indicate your pain.

How bad is your **neck** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **arm** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **middle back** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **low back** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **leg** pain?
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

Please identify which one of the following ratios best describes the amount of pain you feel:

- ☐ 100% Spine pain to 0% Extremity pain
- ☐ 90% Spine pain to 10% Extremity pain
- ☐ 80% Spine pain to 20% Extremity pain
- ☐ 70% Spine pain to 30% Extremity pain
- ☐ 60% Spine pain to 40% Extremity pain
- ☐ 50% Spine pain to 50% Extremity pain
- ☐ 40% Spine pain to 60% Extremity pain
- ☐ 30% Spine pain to 70% Extremity pain
- ☐ 20% Spine pain to 80% Extremity pain
- ☐ 10% Spine pain to 90% Extremity pain
- ☐ 0% Spine pain to 100% Extremity pain

FACTORS OF COMPLAINT

What would you like to happen as a result of this visit?

_____

_____

_____

_____

How / when did your problem begin? (please mark all that apply to your neck / back pain)

- ☐ I don't know how it began
- ☐ It comes and goes
- ☐ I've had it a long time (_____ years)
- ☐ Injury (date of injury_____) on the job? ☐ yes ☐ no
  Please explain how injury happened

  _____

Are you currently in litigation with regards to your back pain?

☐ yes ☐ no

Have you been laid off from your job? ☐ yes ☐ no ☐ N/A

Is your pain worse at night? ☐ yes ☐ no

Does your pain awaken you from sleep? ☐ yes ☐ no

Does coughing affect your pain? ☐ yes ☐ no

Do your legs tire / hurt if you walk too far? ☐ yes ☐ no

If YES, how far can you walk?

☐ less than 1 block ☐1-3 blocks ☐more than 3 blocks

Is this relieved by resting your legs? ☐ yes ☐ no

Is this relieved by bending forward? ☐ yes ☐ no

Bladder Control (urine):

☐ No problem

☐ Can't empty bladder

☐ Loss of urine (accidents)

Bowel Control:

☐ No problem

☐ Constipation

☐ Loss of control (accidents)

How does each of the following affect your pain? (check all that apply)

Sitting	☐ Better	☐ Worse	☐ No change	
Standing	☐ Better	☐ Worse	☐ No change	
Walking	☐ Better	☐ Worse	☐ No change	
Lying down	☐ Better	☐ Worse	☐ No change	
Rising from a chair	☐ Better	☐ Worse	☐ No change	
Physical activity	☐ Better	☐ Worse	☐ No change	
Heat	☐ Better	☐ Worse	☐ No change	☐ Don't know
Cold	☐ Better	☐ Worse	☐ No change	☐ Don't know
Massage	☐ Better	☐ Worse	☐ No change	☐ Don't know

PREVIOUS TREATMENT

Previous treatments for this CURRENT back/neck pain

Chiropractic care	☐better	☐worse	☐no change
Physical Therapy	☐better	☐worse	☐no change
Injections	☐better	☐worse	☐no change
Psychiatric Consultation	☐better	☐worse	☐no change
Other:_____	☐better	☐worse	☐no change

_____

Please mark the timeframe for any tests that were performed for this CURRENT back/neck pain

	<6 months	6-12 months
X-ray	☐	☐
MRI scan	☐	☐
CT scan	☐	☐
Myelogram	☐	☐
Discogram	☐	☐
EMG/NCV (nerve test)	☐	☐

Have you ever had surgery ON YOUR NECK or BACK?

☐ Yes ☐ No **If YES, complete the following:**

1) Type of surgery: _____

Date_____ Surgeon_____

Did it make your pain ☐ better ☐ worse ☐ no change?

2) Type of surgery: _____

Date_____ Surgeon_____

Did it make your pain ☐ better ☐ worse ☐ no change?

3) Type of surgery: _____

Date_____ Surgeon_____

Did it make your pain ☐ better ☐ worse ☐ no change?

Other Neck / Spine issues not related to today's visit?

_____

_____

_____

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GENERAL MEDICAL HISTORY

Check all the conditions below that you currently have or have had in the past. If NONE check ☐

☐ Heart attack ☐ Heart murmur ☐ Angina ☐ High blood pressure ☐ Stroke ☐ Varicose Veins ☐ Stomach ulcers ☐ Duodenal problems ☐ Anemia	☐ Colong problems ☐ Diabetes ☐ Hepatitis ☐ Cirrhosis ☐ Kidney Stones ☐ Kidney infection ☐ Degenerative arthritis ☐ Rheumatoid arthritis ☐ Bleeding tendency	☐ Gout ☐ Anxiety ☐ Depression ☐ Emphysema ☐ Tuberculosis ☐ Chronic bronchitis ☐ Frequent pneumonia ☐ Asthma ☐ Sexual difficulty	☐ Enlarged prostate ☐ Menstrual problems ☐ Caner: Type _____ ☐ Osteoporosis Have you used: ☐ Immunosuppression ☐ Corticosteroids ☐ Other: _____

List any major surgeries you have had, other than your neck or back:

☐ Unremarkable ☐ Abdominal Surgery ☐ Amputation ☐ AV Fistula creation ☐ AV Graft ☐ Aortic Valve replacement ☐ Appendectomy ☐ Bilateral Aorto-femoral bypass ☐ Back surgery ☐ Bronchoscopy ☐ CABG (heart bypass) ☐ Carotid Endarterectomy ☐ Carpal Tunnel ☐ Cataract ☐ Cholecystecomy (GallBladder)	☐ Colon resection ☐ Craniotomy ☐ D&C ☐ Gastric Bypass ☐ Hemorrhoid ☐ Hysterectomy ☐ Total hip arthroplasty ☐ Interventional pain procedures ☐ Knee arthroscopy ☐ Knee Surgery ☐ Total Knee arthroplasty ☐ Kyphoplasty ☐ Left Aorto-femoral bypass ☐ Mastectomy	☐ Mitral Valve Replacement ☐ Nephrectomy (native) ☐ Nephrectomy (transplant) ☐ Pacemaker ☐ Parathyroidectomy ☐ Peumonectomy ☐ Prostatectomy ☐ PTCA (heart stent) ☐ Right Aorto-femoral bypass ☐ Rotator Cuff repair ☐ TURP ☐ Tonsillectomy ☐ Tunneled dialysis cathether ☐ UPPP	☐ Urinary incontinence (sling) ☐ Vertebroplasty ☐ Anesthesia Problem: NO ☐ Anesthesia Problem: YES ☐ Surgical Complication: NO ☐ Surgical Complication: YES ☐ Post-operative delirium

Do you take any medication, including herbals, over the counter, and prescription? **NONE TAKEN ☐**

Medication	Taken for	Dose / how often taken	Doctor (if prescribed)

Are you allergic to any medications? ☐ yes ☐ no
If YES, please list:

FAMILY MEDICAL HISTORY

☐ **I do not know the medical history of my biological parents or other family members.** (Go on to next section)	**Mother:** ☐ Alive age:_____ ☐ Deceased at age:_____ Due to _____	**Father:** ☐ Alive age:_____ ☐ Deceased at age:_____ Due to _____	Number of living brothers/sisters:_____ Number of deceased brothers/sisters:_____ cause(s):_____

Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

Check all that apply

☐ Hear Trouble
☐ Kyphosis
☐ Stroke
☐ Back Problems
☐ Arthritis
☐ Diabetes
☐ Cancer
☐ None of these
☐ Lung Disease
☐ Osteoporosis
☐ Don't know
☐ High Blood Pressure
☐ Scoliosis
☐ Other:_____

SOCIAL HISTORY

Marital Status
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Widow / widower

Education
Highest level completed:
- ☐ Grammar School
- ☐ High School
- ☐ College
- ☐ Post - graduate

Smoking
- ☐ Current every day smoker (see A below)
- ☐ Current some day smoker (see A below)
- ☐ Former smoker (see B below)
- ☐ Never smoked

A)
Year Started: _____
Cigarettes _____ packs / day
Cigars _____ # per week
Smokeless / chewing _____ amount / day

B)
I quit smoking in / around the year _____ ,

But I smoked _____ packs/day for _____ years.

Alcohol
Do you drink:
- ☐ Beer? ☐ yes ☐ no ____ #/day
- ☐ Wine? ☐ yes ☐ no ____ #/day
- ☐ Hard liquor? ☐ yes ☐ no ____ #/day

Frequency of drinking:
- ☐ never
- ☐ rarely
- ☐ socially (# per week _____)
- ☐ daily (# per day _____)

Do you have a history of heavy drinking?
☐ yes ☐ no

Effect of your neck/back pain on your lifestyle

I describe my home setting as supportive of me during this time ☐ yes ☐ no
I describe my work setting as supportive of me during this time ☐ yes ☐ no
My pain has affected my interaction with my family and friends ☐ yes ☐ no
The changes in my lifestyle due to my problem have been difficult for me ☐ yes ☐ no

Ability to enjoy life:
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Please indicate your <u>current work status</u>
- ☐ Working full time
- ☐ Working part time
- ☐ Seeking employment
- ☐ Not working by choice (retired, homemaker, student, etc.)
- ☐ Physically unable to work **due to** neck/back pain
- ☐ Physically unable to work **not due to** neck/back pain

<u>Before</u> having neck/back pain, did you normally work:
☐ full time ☐ part time ☐ neither

What is your usual occupation?
_____

Do you like your work situation?
☐ yes ☐ no ☐ N/A

Has your pain affected your ability to do your job or any other daily activities? ☐ yes ☐ no
If YES, please explain_____

Is there anything we have failed to ask that you believe is important for us to know? ☐ yes ☐ no
If YES, please explain_____

REVIEW OF SYSTEMS

Have you seen a primary care physician within the past year? ☐ yes ☐ no

Do you have any of the following?

General:

Recent weight loss of more than 10 lbs?	☐ yes ☐ no
Recent weight gain of more than 10 lbs?	☐ yes ☐ no
Fever?	☐ yes ☐ no
Chills?	☐ yes ☐ no
Night sweats?	☐ yes ☐ no

Cardiovascular:

Chest pain	☐ yes ☐ no
Shortness of breath	☐ yes ☐ no

Respiratory:

Wheezing	☐ yes ☐ no
Pneumonia	☐ yes ☐ no
Chronic cough	☐ yes ☐ no

Gastrointestinal:

Abdominal pain	☐ yes ☐ no
Nausea	☐ yes ☐ no
Vomiting	☐ yes ☐ no
Diarrhea	☐ yes ☐ no
Liver problems	☐ yes ☐ no

Skin:

Open sores	☐ yes ☐ no
New moles	☐ yes ☐ no
Poor healing	☐ yes ☐ no
Skin infection	☐ yes ☐ no

Endocrine:

Thyroid problems	☐ yes ☐ no

Genitourinary:

Abnormal kidney function	☐ yes ☐ no
Pain with urination	☐ yes ☐ no
Frequent urinary infections	☐ yes ☐ no

Mental health:

Sleep disturbances	☐ yes ☐ no
Feeling of hopelessness	☐ yes ☐ no

Nervous system:

Headaches	☐ yes ☐ no
Tremors	☐ yes ☐ no
Poor speech	☐ yes ☐ no
Changes in vision	☐ yes ☐ no

Bones/Joints:

Shoulder pain	☐ yes ☐ no
Wrist/hand pain	☐ yes ☐ no
Hip pain	☐ yes ☐ no
Knee pain	☐ yes ☐ no
Lupus	☐ yes ☐ no
Muscle weakness	☐ yes ☐ no
Fibromyalgia	☐ yes ☐ no

Hematologic/Oncologic:

Easy bruising	☐ yes ☐ no
Blood thinning medications	☐ yes ☐ no
Blood transfusions	☐ yes ☐ no
Organ transplant	☐ yes ☐ no