Midwest Orthopaedic Center, SC

New Patient: Cervical Spine

MIDWEST ORTHOPÆDIC CENTER

❑ Return ❑ Pre-op ❑ 6 week ❑ 3 months ❑ 6 months ❑ 9 months ❑ 12 months ❑ 24 months ❑ ____Years

FOR OFFICE USE – TO BE FILLED OUT BY PHYSICIAN/STAFF

1. VAS: Neck ___ Arms ___ Back ___ Legs ___
2. ODI _____
3. SS _____
4. NDI _____
5. SF-12 _____
6. SF-22 _____
7. TIS _____

Name:_____ Date: _____

Birthdate: _____

A. General Information

1. Internist or family doctor name and address: _____

_____

2. Referring doctor name and full address: _____

_____

If not referred, how did you choose this office? _____

3. Chief complaint (check all that apply): ❑ Neck pain Arm: ❑ pain ❑ numbness ❑ weakness ❑ Back pain Leg: ❑ pain ❑ numbness ❑ weakness ❑ Other
4. Your age: ___ years ___ months
5. Your sex: ❑ male ❑ female
6. How long has your problem been present? _____
7. Has your problem worsened recently? ❑ no ❑ yes — How recently?

_____

8. What started the problem? _____

_____

B. Neck or Arm Pain, numbness or weakness:

1. Note your neck/shoulder/upper back pain by marking a line through the line below. [Average over the last week.]

No pain (_____) Worst pain possible

2. Note your arm/hand pain by marking a line through the line below. [Average over the last week.]

No pain (_____) Worst pain possible

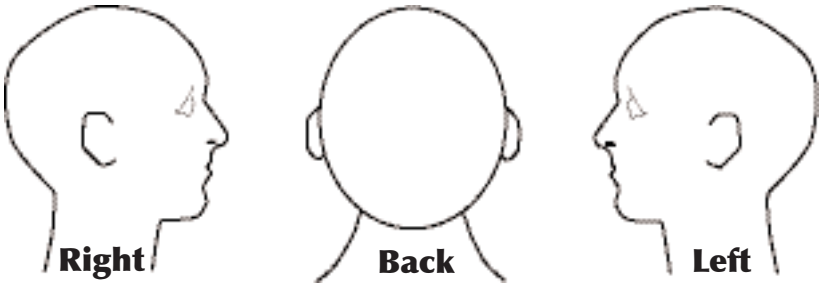
3. There is more pain in the: ❑ left arm/hand ❑ right arm/hand ❑ right and left equally ❑ no pain in the arm/hand
4. The arm pain is present in the (check the following):
   Right: ❑ upper back ❑ forearm ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
   Left: ❑ upper back ❑ forearm ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
5. Raising the arm: ❑ improves the pain ❑ worsens the pain ❑ does not affect the pain
6. Moving the neck: ❑ improves the pain ❑ worsens the pain ❑ does not affect the pain
7. There is: ❑ no weakness of the arms and hands ❑ weakness of the (check the following):
   Right: ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
   Left: ❑ shoulder ❑ upper arm ❑ forearm ❑ hand/finger
8. There is: ❑ no numbness of the arms and hands ❑ numbness of the (check the following):
   Right: ❑ upper arm ❑ forearm ❑ thumb ❑ index finger ❑ long finger ❑ ring finger ❑ small finger
   Left: ❑ upper arm ❑ forearm ❑ thumb ❑ index finger ❑ long finger ❑ ring finger ❑ small finger
9. There (❑ is ❑ is no) difficulty picking up small objects like coins or buttoning buttons.
10. There (❑ is a ❑ is no) problem with balance or tripping frequently.
11. There are (❑ frequent ❑ occasional ❑ no) headaches in the back of the head.

C. Headaches:

1. If you have headaches, how would you describe their intensity and frequency?
   I have (check one) ❑ slight ❑ moderate ❑ severe headaches.
   They come (check one) ❑ infrequently ❑ frequently ❑ almost all the time ❑ I have no headache at all.
2. The headaches are located (check the following):
   ❑ in the back of my neck. ❑ in the back of my head. ❑ at the side of my head/temple area.
   ❑ in the front of my head (near my eyes).
3. How long have you suffered from headaches? ❑ several days ❑ several weeks ❑ several months ❑ greater than 1 year
4. When do the headaches occur most commonly? ❑ morning ❑ afternoon ❑ while at work ❑ evening ❑ no pattern
5. What is your average headache's pain level throughout the day (please check)
   ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
6. How would you describe your pain? ❑ throbbing ❑ squeezing ❑ pressure ❑ dull ❑ stabbing ❑ shooting
7. What medications (either prescription or over-the-counter) do you take for your headaches?_____

_____

8. Please shade the areas below where you experience your discomfort.



D. Additional General Information:

1. Coughing or sneezing (❑ increases ❑ sometimes increases ❑ does not increase) the pain.
2. There is: ❑ no loss of bowel or bladder control ❑ loss of bowel or bladder control since:_____
3. I have: ❑ not missed any work/school due to this problem ❑ missed (how much):_____
4. Treatments have included: ❑ no medicines, therapy, manipulations, injections or braces

Neck	Back		Neck	Back	
❑	❑	Physical therapy, exercise	❑	❑	Anti-inflammatory medications
❑	❑	Massage & ultrasound	❑	❑	Narcotic medication [name below]
❑	❑	Traction			_____
❑	❑	Manipulation	❑	❑	Epidural steroid injections___ times which
❑	❑	Tens unit			relieved the pain for (how long)?_____
❑	❑	Shoulder injections	❑	❑	Trigger point injections___ times which
❑	❑	Braces			relieved the pain for (how long)?_____
❑	❑	Chiropractor	❑	❑	Pain specialist
❑	❑	Acupuncture	❑	❑	Other _____

5. Previous doctors about this problem: ❑ none

Doctor	Specialty	City [if not Peoria]	Treatments

6. Tests done to evaluate your problems, the dates and location where they were done: ❑ none

Test	Neck	Back	#1 Date/Where	#2 Date/Where	#3 Date/Where
Plain x-rays	❒	❒			
Myelogram	❒	❒			
CT Scan	❒	❒			
MRI	❒	❒			
EMGs	❒	❒			
Bone scan	❒	❒			
FCE	❒	❒			
Vascular Studies	❒	❒			
DEXA scan	❒	❒			
Discogram	❒	❒			

E. Medical History: Check all that apply

❑ None apply

❑ Heart attack
❑ Heart failure
❑ High blood pressure
❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Ankylosing spondylitis
❑ Gout
❑ Osteoporosis
❑ Diabetes
❑ Stroke
❑ Seizures
❑ Mental illness
❑ Kidney stones
❑ Kidney failure
❑ Cancer
❑ Lung disease
❑ HIV
❑ AIDS
❑ Tuberculosis
❑ Asthma
❑ Blood clot in leg
❑ Blood clot in lung
❑ Liver trouble
❑ Hepatitis
❑ Thyroid trouble
❑ Bleeding disorders
❑ Anemia
❑ Serious injuries [explain]
❑ Stomach ulcers
❑ Other: _____

F. Surgical History: Previous surgeries — List procedures, surgeon and date. ❑ None

Operation	Surgeon	Date

G. List of medications and dose taken: ❑ none

Medication and Dose	Medication and Dose

H. Allergies: ❑ No known drug allergies

Latex allergy? _____

Food allergy? _____

Medication	Rash	Swelling wheezing or shock	Upset stomach	Unknown reaction	Allergies	Other
	❑	❑	❑	❑		
	❑	❑	❑	❑		
	❑	❑	❑	❑		

I. Social History:

1. Work status: ❑ Homemaker ❑ Retired ❑ Disabled ❑ On leave ❑ Unemployed ❑ Working: ❑ full-time ❑ part-time
   Occupation: _____
2. Marital status: ❑ Married ❑ Single ❑ Co-habitating ❑ Widowed ❑ Divorced
3. Number of living children: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
4. I live: ❑ Alone ❑ With: _____
5. Tobacco use: ❑ Never (skip to #6)
   ❑ Cigar ❑ Chew ❑ Pipe ❑ Cigarettes
   _____ packs per day for _____ years.
   ❑ Quit — When? _____ after smoking _____ packs per day for _____ years (total).
6. Alcohol: ❑ Never or rare
   ❑ Social ❑ Frequently drunk (more than twice a week) ❑ Alcoholic ❑ Recovering alcoholic
7. Drug overuse/abuse: ❑ Never ❑ Currently ❑ In the past
8. Because of this spine problem, I have filed or plan to file:
   ❑ a lawsuit ❑ a worker's compensation claim ❑ neither a lawsuit or a worker's compensation claim
9. Is there a workers compensation dispute? ❑ Yes ❑ No

J. Family History: Check all that apply

❑ None apply

❑ Stroke
❑ Heart trouble
❑ High blood pressure
❑ Diabetes
❑ Arthritis
❑ Gout
❑ Seizures
❑ Spine problems
❑ Mental illness
❑ Kidney trouble or stones
❑ Cancer
❑ Bleeding disorders
❑ Scoliosis
❑ Alcholism
❑ Other: _____

K. Review of Systems: Check all that apply

❑ None apply

❑ Reading glasses
❑ Change of vision
❑ Loss of hearing
❑ Ear pain
❑ Hoarseness
❑ Nosebleeds
❑ Difficulty swallowing
❑ Morning cough
❑ Shortness of breath
❑ Fever or chills
❑ Heart or chest pain
❑ Abnormal heartbeat
❑ Swollen ankles
❑ Calf cramps with walking
❑ Poor appetite
❑ Toothache
❑ Gum trouble
❑ Nausea or vomiting
❑ Stomach pain
❑ Ulcers
❑ Frequent belching
❑ Frequent diarrhea
❑ Frequent constipation
❑ Hemorrhoids
❑ Frequent urination
❑ Burning on urination
❑ Difficulty starting urination
❑ Get up more than once every night to urinate
❑ Frequent headaches
❑ Blackouts
❑ Seizures
❑ Frequent rash
❑ Hot or cold spells
❑ Recent weight change
❑ Nervous exhaustion
❑ Depression
❑ Anxiety

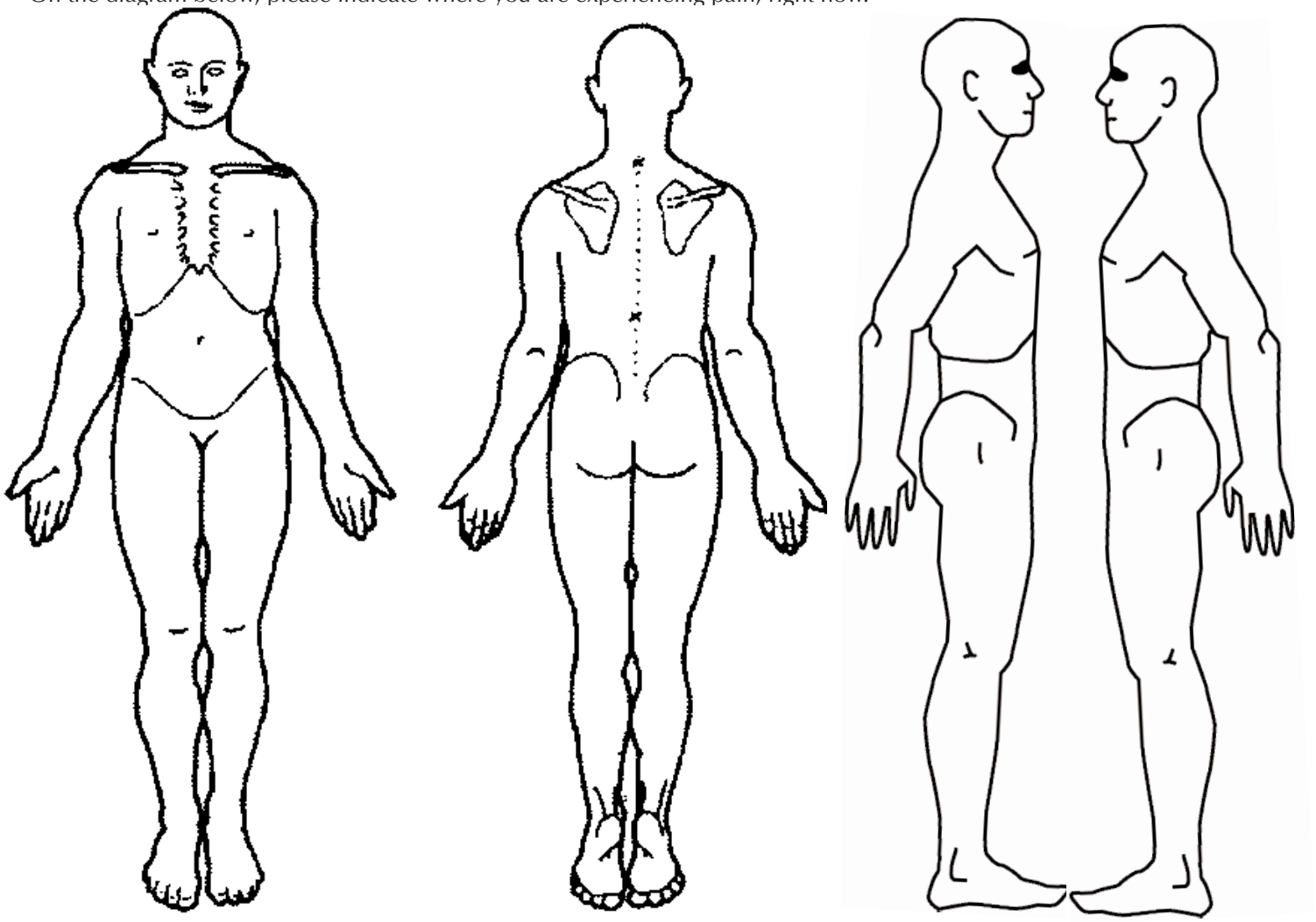
Women only:

❑ *Irregular periods*
❑ *Vaginal discharge*
❑ *Frequent spotting*

❑ Other: _____

L. Pain diagram:

On the diagram below, please indicate where you are experiencing pain, right now.



Patient signature _____ Date _____

Physician signature _____ Date _____