LUMBAR SPINE APPOINTMENT

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Spine Surgery, Including Tumor, Trauma and Degenerative Disorders of the Spine

Tucson Orthopaedic Institute, P.C.

NAME ______________________________

Please circle and/or fill in the answers to the following questions on all pages.

Who referred you to our office? ______________________________

Who is your family physician? ______________________________

Other physicians who should receive correspondence about today's visit? ______________________________

Age __________ Gender__________ Occupation ______________________________

Main Complaint: What is your main complaint?

_____ **Back Pain**

_____ **Leg Pain** Right Left

_____ **Both Legs** Which leg is worse? Right Left

Which pain is worse? **Back** **Leg** About Equal

Have you had **previous Lumbar Surgery?** Yes No

Duration of symptoms

How long have you had back pain? ______________________________

How long have you had leg pain? ______________________________

Since the onset of the current symptoms, you feel: Better Worse Same

Does the Leg Pain travel down your leg? Yes No

Where does it start and where does it end? ______________________________

Description of pain

Leg pain (circle all that apply): Sharp Dull Aching Burning Stabbing Electrical

- Leg pain: **constant** or **comes and goes**
- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your leg pain at its:
  Worst ______ Usually ______
- Does the leg pain wake you up at night? Yes No
- Leg symptoms worsen with: Athletic activity Driving Walking Standing Sitting Lying down
- Leg symptoms are improved with: Lying down Sitting Walking Other______________________
- Do you have numbness and/or tingling down the leg? Yes No

Back Pain (circle all that apply): Sharp Dull Aching Burning Stabbing Electrical

- Back pain: **constant** or **comes and goes**
- On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your back pain at its:
  Worst ______ Usually______
- Does the back pain wake you up at night? Yes No
- Back symptoms worsen with: Athletic activity Driving Walking Standing Sitting Lying down
- Back symptoms are improved with: Lying down Sitting Walking Other______________________

Exercise routine: _________days per week. What type of exercise?________________________________

Walking (Again, please circle, fill in the blanks, etc.):
Unlimited 1-2 blocks Less than ½ a block Not able to walk
Assist: Cane Walker Wheelchair Length of time using this? ________________________________
How far can you walk before you must stop and sit?____________(distance)

Bladder problems:
Do you suffer from urinary incontinence? Yes No Date it started: ________________________

Treatment for this problem thus far:
What **Medications** are you **currently** taking for the pain? **What dose and how often?**
1. 3.
2. 4.

Have you ever had **Lumbar Epidural Steroid Injections?** Yes No
When?___________How Many?___________By whom? ____________________________________
Did the injection help? Yes No

Have you undergone any **Physical Therapy** for this condition? Yes No
Did physical therapy help? Yes No
When was your last session of Physical Therapy?______________________ (Date)

Have you used a **back brace?** Yes No Did it help? Yes No
What **other treatments** have you had?
__Chiropractic __Acupuncture __Massage __TENS unit Other__________________________________

SOCIAL HISTORY:
Do you smoke? No Yes____________ How many packs per day?
Do you drink alcohol? No Yes____________ How much per day?

Are you currently taking any blood thinning medications? Yes No
Blood thinner: ______________________

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.
1. 3.
2. 4.

ADDITIONAL INFORMATION:

Patient Signature____ Date: ____________________

Provider Signature____ Reviewed Date:____________