Thank you for taking the time to fill out our forms. The following list will allow us to send letters to the appropriate people.

Please let us know the following:

Who is your primary care physician:

_____

Who is your pain management doctor:

_____

Who referred you?

_____

Who is your neurologist:

_____

Health Questionnaire

Name _____ ***Age*** _____ ***Date*** _____

Address _____ ***Phone*** _____

Past Illness History *Have you ever had:*

Childhood

Measles	No	Yes	Rheumatic fever	No	Yes
Mumps	No	Yes	Heart Disease	No	Yes
Chicken Pox	No	Yes	Tuberculosis	No	Yes
Diabetes	No	Yes	Venereal Disease	No	Yes
Strokes	No	Yes	Congenital Abnormalities	No	Yes
Cancer	No	Yes	Other serious illnesses _____		

Adult

Have you had any serious illness? If so, for what? _____

Have you ever been hospitalized ? If so, for what? _____

Have you been under medical care? If so, for what _____

Operations

Have you had any surgeries? **No** **Yes**

List surgeries and dates _____

Injuries

Have you had any broken bones?	No	Yes
Have you had any head concussions or injuries?	No	Yes
Have you ever lost consciousness?	No	Yes

FAMILY HISTORY	If Living: Age	Health	If Deceased: Age (at death) & Cause		Has any blood relative ever had:		
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother/Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
Husband/Wife					Stroke	No	Yes
Son/Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding Tendency	No	Yes
					Gout or other Arthritis	No	Yes

Social History:

Circle One: Single Married Separated Divorced Widowed

Are you living with your husband or wife?..... **No** **Yes**

Is your sex life satisfactory?..... **No** **Yes**

Do you have dependents at home?..... **No** **Yes**

Alcoholic beverages? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Smoking: ☐ Currently smoke _____ packs/day ☐ Smoked, but quit _____ years ago ☐ Never smoked

Employment: ☐ Full time ☐ Part time ☐ Self employed ☐ Unemployed, but looking for work
☐ Retired ☐ Homemaker ☐ Student

If working, what is your job? _____

Are you exposed to fumes, dusts or solvents? **No** **Yes**

How much time have you lost from work because of your health during the past... ...six months? _____
...one year? _____
...five years? _____

Continued on reverse...

SYSTEMIC REVIEW: Do you have any of the following?				
General:			Genitourinary:	
Recent weight change?	No Yes		Loss of urine	No Yes
Good general health most of your life?	No Yes		Frequent urination	No Yes
Head-eye-ear-nose-throat:			Night time urination	No Yes
Eye disease or injury	No Yes		Burning or painful urination	No Yes
Do you wear glasses?	No Yes		Blood in urine	No Yes
Double vision	No Yes		Kidney trouble	No Yes
Headaches	No Yes		Kidney stones	No Yes
Glaucoma	No Yes		Bright's disease	No Yes
Itching eyes or nose	No Yes		Locomotor-Musculoskeletal:	
Sneezing or runny nose	No Yes		Varicose veins	No Yes
Nosebleeds	No Yes		Weakness of muscles or joints	No Yes
Chronic sinus trouble	No Yes		Any difficulty in walking	No Yes
Ear disease	No Yes		Any pain in calves or buttocks when walking	No Yes
Impaired hearing	No Yes		...relieved by rest?	No Yes
Dizziness or transient unconscious episodes	No Yes		Neuro-psychiatric:	
Neck			Have you ever had psychiatric care?	No Yes
Stiffness	No Yes		Have you been advised to see a psychiatrist?	No Yes
Thyroid trouble	No Yes		Do you have, or ever had, fainting spells?	No Yes
Enlarged glands			Convulsions	No Yes
Respiratory:			Paralysis	No Yes
URI (cold) now	No Yes		Hematological:	
Spitting up blood	No Yes		Are you slow to heal after cuts?	No Yes
Chronic or frequent cough	No Yes		Blood disease	No Yes
Asthma or wheezing	No Yes		Anemia	No Yes
Difficulty breathing	No Yes		Phlebitis	No Yes
Any trouble with lungs	No Yes		Excessive bleeding after tooth extraction or surgery?	No Yes
Pleurisy or pneumonia	No Yes		Have you had abnormal bruising or bleeding?	No Yes
Cardiovascular			Allergic:	
Chest pain or angina pectoris	No Yes		Any allergies, including medication?	No Yes
Shortness of breath walking or lying down	No Yes		Endocrine:	
Difficulty walking two blocks	No Yes		Thyroid disease	No Yes
Heart trouble or heart attacks	No Yes		Hormonal therapy	No Yes
High blood pressure	No Yes		Change in hat or glove size	No Yes
Swelling of hands, feet or ankles	No Yes		Change in hair growth	No Yes
Awakening in the night smothering	No Yes		Has your skin been colder or dryer than before?	No Yes
Heart murmur	No Yes		Skin	
Gastrointestinal			Skin disease	No Yes
Peptic ulcer (stomach or duodenal)	No Yes		Jaundice	No Yes
Vomiting blood or food	No Yes		Hives, eczema or rash	No Yes

Gallbladder disease	No Yes		Frequent infection or boils	No	Yes
Liver trouble	No Yes		Abnormal pigmentation	No	Yes
Hepatitis	No Yes		Gynecological:		
Painful bowel movements	No Yes		Any pain with your periods?	No	Yes
Bleeding with bowel movements	No Yes		Age periods started _____		
Black stools	No Yes		How long do periods last? _____		
Hemorrhoids or piles	No Yes		Number of pregnancies _____		
Recent change in bowel habits	No Yes		Number of miscarriages _____		
Frequent diarrhea	No Yes		Date and results of last cancer smear _____		
Heartburn or indigestion	No Yes		Frequency of periods; every _____ days		
Cramping or pain In the abdomen	No Yes		Number of children _____ Ages _____		
Does food stick in throat?	No Yes		Date of first day of last period _____		

ALLERGIES AND SENSITIVITIES

	Circle one			What other drugs or food?
Penicillin or other antibiotics	Yes	No	Don't know	_____
Morphine, codeine, Demerol or other narcotics	Yes	No	Don't know	_____
Novocain or other anesthetics	Yes	No	Don't know	_____
Aspirin, Empirin or other pain remedies	Yes	No	Don't know	_____
Sulfa drugs	Yes	No	Don't know	_____
Tetanus antitoxin or other serums	Yes	No	Don't know	_____
Adhesive tape	Yes	No	Don't know	_____
Iodine or merthiolate	Yes	No	Don't know	_____
Any other drug or medication	Yes	No	Don't know	_____
Any foods, such as eggs, milk or chocolate	Yes	No	Don't know	_____
Drugs Recently Taken During the past six months, has patient taken:				
Cortisone	Yes	No	Don't know	
ACTH	Yes	No	Don't know	
Anticoagulants	Yes	No	Don't know	
Tranquilizers	Yes	No	Don't know	
Hypotensives (high blood pressure medication)	Yes	No	Don't know	
Aspirin	Yes	No	Don't know	
Has the patient ever received treatment for asthma, rheumatism or rheumatic fever?	Yes	No	Don't know	

Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor _____ Date _____ Signature of patient _____

MEDICATIONS AND ALLERGIES

Please list any medications you are currently taking and bring this form with you to your appointment.

If you are not taking any medication, write "n/a" below.

MEDICATION	AMOUNT	FREQUENCY

ALLERGIES	TYPE OF REACTION

Orange County Neurosurgical Associates

Spine Health Questionnaire

Name:_____ **DATE:**_____

1. What is the main purpose of your visit?

2. Describe your problem
   a. Date of onset
   b. Aggravating factors
   c. Alleviating factors
   d. If you have pain, is it constant/intermittent, dull, sharp or burning?
   e. Rate your average pain level on a scale of 0 to 10
   i. 0 no pain ----------10 worst
   ii. Aggravated by-Standing/walking/sitting/lying down
   f. Do you have weakness in the arms or legs?
   g. Do you have numbness/tingling in the arms or legs?
   h. Other MD's recommendations

   i. Have you had spinal surgery?

   j. Have you had Epidural steroid injections? How many?

   k. Have you had other treatments?

3. Is your problem related to an accident?
   a. Are you involved in any active litigation?

OSWESTRY TEST

Patient's Name: _____ Date: _____

Check (✓) 1 box from each section:

SECTION 1: PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use pain killers (0 points)
- ☐ The pain is bad, but I manage without taking pain killers (1 point)
- ☐ Pain killers give complete relief from pain (2 points)
- ☐ Pain killers give moderate relief from pain (3 points)
- ☐ Pain killers give very little relief from pain (4 points)
- ☐ Pain killers have no affect on the pain, and I do not use them (5 points)

SECTION 2: PERSONAL CARE

- ☐ I can look after myself normally without causing extra pain (0 points)
- ☐ I can look after myself normally, but it causes extra pain (1 point)
- ☐ It is painful to look after myself, and I am slow and careful (2 points)
- ☐ I need some help, but manage most of my personal care (3 points)
- ☐ I need help every day in most aspects of self-care (4 points)
- ☐ I do not get dressed, wash with difficulty and stay in bed (5 points)

SECTION 3: LIFTING

- ☐ I can lift heavy weights without extra pain (0 points)
- ☐ I can lift heavy weights, but it gives extra pain (1 point)
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage, if they are conveniently positioned (for example: on a table) (2 points)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned (3 points)
- ☐ I can lift only very light weights (4 points)
- ☐ I cannot lift or carry anything at all (5 points)

SECTION 4: WALKING

- ☐ Pain does not prevent me walking any distance (0 points)
- ☐ Pain prevents me walking more than 1 mile (1 point)
- ☐ Pain prevents me walking more than .05 miles (2 points)
- ☐ Pain prevents me walking more than 0.25 miles (3 points)
- ☐ I can only walk using a stick or crutches (4 points)
- ☐ I am in bed most of the time, and have to crawl to the toilet (5 points)

SECTION 5: SITTING ("Favorite Chair" includes a recliner)

- ☐ I can sit in any chair as long as I like (0 points)
- ☐ I can only sit in my favorite chair as long as I like (1 point)
- ☐ Pain prevents me from sitting more than 1 hour (2 points)
- ☐ Pain prevents me from sitting more than 0.5 hours (3 points)
- ☐ Pain prevents me from sitting more than 10 minutes (4 points)
- ☐ Pain prevents me from sitting at all (5 points)

SECTION 6: STANDING (Remember, standing is NOT walking)

- ☐ I can stand as long as I want without extra pain (0 points)
- ☐ I can stand as long as I want, but it gives me extra pain (1 point)
- ☐ Pain prevents me from standing for more than 1 hour (2 points)
- ☐ Pain prevents me from standing for more than 30 minutes (3 points)
- ☐ Pain prevents me from standing for more than 10 minutes (4 points)
- ☐ Pain prevents me from standing at all (5 points)

SECTION 7: SLEEPING

- ☐ Pain does not prevent me from sleeping well (0 points)
- ☐ I can sleep well only by using tablets (1 point)
- ☐ Even when I take tablets I have less than 6 hours sleep (2 points)
- ☐ Even when I take tablets I have less than 4 hours sleep (3 points)
- ☐ Even when I take tablets I have less than 2 hours sleep (4 points)
- ☐ Pain prevents me from sleeping at all (5 points)

SECTION 8: SEX LIFE (by pain = for fear of causing pain)

- ☐ My sex life is normal and causes no extra pain (0 points)
- ☐ My sex life is normal, but causes some extra pain (1 point)
- ☐ My sex life is nearly normal, but is very painful (2 points)
- ☐ My sex life is severely restricted by pain (3 points)
- ☐ My sex life is nearly absent because of pain (4 points)
- ☐ Pain prevents any sex life at all (5 points)

SECTION 9: SOCIAL LIFE

- ☐ My social life is normal, and gives me no extra pain (0 points)
- ☐ My social life is normal, but increases the degree of pain (1 point)
- ☐ Pain has no significant affect on my social life, apart from limiting energetic interests, such as dancing (2 points)
- ☐ Pain has restricted my social life, and I do not go out as often (3 points)
- ☐ Pain has restricted my social life to my home (4 points)
- ☐ I have no social life because of pain (5 points)

SECTION 10: TRAVELING

- ☐ I can travel anywhere without extra pain (0 points)
- ☐ I can travel anywhere, but it gives me extra pain (1 point)
- ☐ Pain is bad, but I manage journeys over 2 hours (2 points)
- ☐ Pain restricts me to journeys of less than 1 hour (3 points)
- ☐ Pain restricts me to short necessary journeys under 30 minutes (4 points)
- ☐ Pain prevents me from traveling, except to the doctor or hospital (5 points)