



Stephen E. Hanks, M.D.
 Spine Surgery, Including Tumor, Trauma and
 Degenerative Disorders of the Spine
 Tucson Orthopaedic Institute, P.C.

Last 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? _____

What is your age? _____ What is your sex? Male Female

What do you do for a living? _____

Main Complaint

What is your main complaint?

- _____ **Back Pain**
- _____ **Leg Pain** Which Leg? Right Left Both
- _____ **Both Legs** Which leg is worse? Right or Left

If your **Leg pain is worse** than your back pain, how much percentage % worse?
 90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Back pain is worse** than your leg pain, how much percentage % worse?
 90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

Have you had **previous Spinal Surgery**? Yes No
 Surgery Type: Laminectomy Discectomy Fusion
 When? (mo/yr) _____ Where was surgery done? _____
 Surgeon's Name: _____
 Why was it done?: Due to back pain Due to leg pain Due to both back and leg pain
 Did the surgery help? _____ For how long? _____

Duration of Symptoms

How long have you had the back pain? _____ years _____ months _____ weeks
 How long have you had the leg pain? _____ years _____ months _____ weeks

Are the symptoms episodic? Yes No How many episodes per year? _____ episodes/year
 The current episode has been present for _____ years _____ months _____ weeks

Since the onset of the current symptoms, you feel: Better Worse Same
 If better, what percentage % better: _____ % better

Does the Leg Pain travel down your leg? Yes No

- If yes, circle the location(s) where the pain travels to:
 Shoulder — Upper arm — Elbow — Forearm — Wrist — Hand — Fingers
 Buttock — Back of Thigh — Calf — Ankle — Foot — Toes
 Groin — Front of Thigh — Shin — Foot

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Injury

Were you injured? Yes No What happened? _____

Motor Vehicle Crash Yes No

Date of Accident: _____

Did you wear a seat belt? Yes No

You were the: Driver or Passenger. (Front Seat or Backseat)

Collision: Rear End Collision vs. Front End Collision vs Side Impact Collision

Speed Estimate: High Speed Low Speed

Did you have pain prior to this accident? Yes No

Description of Pain

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

The Leg Pain: **Comes and goes** or **is constant?**

On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your leg pain at its **worse** _____?

On the same scale, how bad is the leg pain at its **best** _____?

Once again, using the same 1 to 10 scale, how bad is your leg pain **usually** _____?

Leg pain wakes you up at night? Yes No

Is the leg pain: Livable or Not Livable?

Leg symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down

Leg symptoms are improved with: _____ Lying down _____ Sitting _____ Walking

Numbness and Tingling down the leg? Yes No

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

The Back Pain: **Comes and goes** or **is constant?**

On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your back pain at its **worse** _____?

On the same scale, how bad is the back pain at its **best** _____?

Once again, using the same 1 to 10 scale, how bad is your back pain **usually** _____?

Back pain wakes you up at night? Yes No

Is the back pain: Livable or Not Livable?

Back symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down

Back symptoms are improved with? Laying down Sitting Walking

Exercise:

Exercise Routine: _____ days per week.

Type of exercise: Treadmill Stationary bike Swimming Weight lifting

Other types of exercise: _____

Sports: Tennis Golf Other: _____ _____ times per week

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Walking: (Again, please circle, fill in blanks, etc.)

Unlimited 1-2 blocks Less than ½ 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)
You can get up and continue walking after _____ minutes of rest.

Weakness? Yes No Which leg? Right Left
Location: Thigh Knee Calf Ankle Foot drop Knee buckles
Difficulty stair climbing? Yes No

Bladder Problems:
Incontinent of urine? Yes No Date it started: _____

Treatment for this problem thus far:

What **Medications** have you taken for the Pain?

Anti-Inflammatories:

Celebrex, Vioxx, Bextra, Mobic, Motrin, Ibuprofen, Naprosyn, Relafen, Daypro, Lodine, Tylenol, Steroid Dosepak, Aleve, Advil.

Narcotic Medications:

Percocet, Vicodin, Darvocet, Codeine, OxyContin, Oxy-IR, Lortab, Duragesic Patch

Other Types:

Neurontin, Zanaflex, Ultram, Valium, Soma, Skelaxin, Flexeril, Topamax

What Medications are you taking **currently** for the pain? **What dose and how often?**

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

Have you ever had **lumbar epidural steroid injections?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you had any **physical therapy?** Yes No
How many times per week? _____ How many weeks? _____
Did the 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? _____

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PAST MEDICAL HISTORY: Please circle all that you have.

Diabetes	Heart Disease	Atrial fibrillation	Coronary artery disease
Stroke	Hypertension	Kidney disease	Heart attack _____ when?
Fibromyalgia	Depression	Panic/anxiety attacks	Cancer _____ type?
Osteoporosis	Migraine headaches	Thyroid problems	Rheumatoid arthritis
Osteopenia	Osteoarthritis	Psoriasis	Stomach ulcers
Asthma	Bronchitis	Lung disease	Parkinson's disease
Gastritis	Colon problems	Prostate problems	Hepatitis _____ type?
HIV	AIDS	TMJ syndrome	Insomnia
Hiatal hernia	Liver disease	Irritable bowel syndrome	

Others:

PAST SURGICAL HISTORY:

Pacemaker	Defibrillator implants	Coronary artery bypass graft
Stents	Lung cancer surgery	Colon cancer surgery
Kidney surgery	Spine surgery	Breast cancer surgery
Hysterectomy	Gallbladder	

Other surgeries:

SOCIAL HISTORY:

Do you smoke? No Yes _____ How many packs per day?
Do you drink alcohol? No Yes _____ How much per day?
Married Single Live alone? In an Assisted Living Facility? In your own home?

MEDICATIONS: Please list

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Others:

Are you currently taking: Coumadin? Plavix?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin.

Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.

1.	3.
2.	4.

HEIGHT _____ WEIGHT _____