



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

Main Complaint

What is your main complaint?

Neck Pain

Arm Pain Which Arm? Right Left Both

Both Arms Which arm is worse? Right or Left

If your **Arm pain is worse** than your neck pain, how much percentage % worse?

90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Neck pain is worse** than your arm pain, how much percentage % worse?

90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

Have you had previous cervical spine surgery? Yes No

Surgery Type: Laminectomy Discectomy Fusion Corpectomy Other _____

When? (mo/yr) _____ Where was surgery done? _____

Surgeon's Name: _____

Why was it done?: Neck pain Arm pain Both Neck pain and Arm pain

If arm pain, which arm? Right Left

Did the surgery help? _____

Duration of Symptoms

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

How long have you had the arm 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 Arm Pain travel down your arm? Yes No

If yes, circle the location(s) where the pain travels to:

Shoulder — Upper arm — Elbow — Forearm — Wrist — Hand — Fingers

Stephen E. Hanks, M.D.
Tucson Orthopaedic Institute, P.C.

Last Name _____

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

Did you have pain prior to this accident? Yes No

Description of Pain (circle all that apply)

Arm Pain: Sharp — Dull — Aching — Burning — Stabbing — Electrical

The Arm Pain: Comes and goes or is constant?

On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your arm pain at its **worse** _____? Using the same scale, how bad is the arm pain at its **best** _____? Again, using the same 1 to 10 scale, how bad is your arm pain **usually** _____?

Arm pain wakes you up at night? Yes No

Is the arm pain: Livable or Not Livable?

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

Numbness and Tingling down the arm? Yes No

Arm pain is worse when you cough or sneeze? Yes No

Arm pain improves with placing your arm on top of you head? Yes No

Arm bothers you when reaching overhead (for example, kitchen cabinet) Yes No

Arm bothers you when reaching behind? Yes No

Do you have difficulty with your handwriting? Yes No

Difficulty picking up small coins off a table? Yes No

Trouble buttoning buttons? Yes No

Do your hands feel clumsy? Yes No

Do you have problems with your balance? Yes No

Any recent falls because of poor balance? Yes No

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

The Neck Pain: Comes and goes or is constant?

On a scale of 1 to 10, where 10 is worse pain imaginable, how bad is your neck pain at its **worse** _____? Using the same scale, how bad is the neck pain at its **best** _____? Again, using the same 1 to 10 scale, how bad is your arm pain **usually** _____?

Neck pain wakes you up at night? Yes No

Is the neck pain: Livable or Not Livable?

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

Neck symptoms are improved with? Laying down Sitting Walking

Stephen E. Hanks, M.D.
Tucson Orthopaedic Institute, P.C.

Last Name _____

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

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.

Arm Weakness? Yes No Which arm? Right Left

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 **cervical 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 **neck brace?** Yes No Did it help? Yes No

What **other treatments** have you had? Chiropractic. Massage. TENS unit. Other? _____

Stephen E. Hanks, M.D.
Tucson Orthopaedic Institute, P.C.

Last Name _____

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 _____