

Name:
DOB:
Today's Date:

Samuel K. Cho, M.D.
NEW PATIENT QUESTIONNAIRE FOR SPINE SURGERY

Please answer all questions completely.

It is in your best interest and will assist your doctor with your care.

NAME: Today's Date:
Date of Birth: Age: Sex: Height: ft in Weight: lbs

Primary Doctor Name and Address: Referring Doctor Name and Address:

A. 1. Why are you seeing the doctor today?

- (Please check all that apply)
Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)
Neck pain Arm: Pain Numbness Weakness
Back pain Leg: Pain Numbness Weakness

2. How long has the pain/problem been present?

3. Has the pain/problem worsened recently? No Yes, how recently?

4. What started the pain/problem?

5. Quality of the pain Sharp Burning Dull Aching

6. How severe is the pain at the location described above?

- No Pain Mild Moderate Severe

7. What makes the pain/problem better?

8. What makes the pain/problem worse?

9. Is the pain (check all that apply): Continuous Activity related Night pain Unpredictable

10. Coughing or sneezing Increases Sometimes increases Does not increase the pain.

11. There is No loss of bowel or bladder control Loss of bowel or bladder control since

12. Did this problem start at work?

13. Have you already filed or will you file a Workers' Compensation claim?

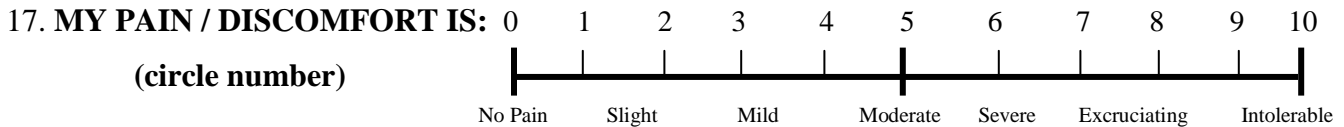
14. Have you missed work because of this problem?

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15. Treatments have included:  No medicines, therapy, manipulations, injections, or braces
- |                          |                          |                            |                          |                          |   |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---|
| <b>Neck</b>              | <b>Back</b>              |                            | <b>Neck</b>              | <b>Back</b>              |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical therapy, exercise | <input type="checkbox"/> | <input type="checkbox"/> | Anti-inflammatory medications   |
| <input type="checkbox"/> | <input type="checkbox"/> | Massage & ultrasound       | <input type="checkbox"/> | <input type="checkbox"/> | Narcotic medication   |
| <input type="checkbox"/> | <input type="checkbox"/> | Traction                   | <input type="checkbox"/> | <input type="checkbox"/> | Epidural steroid injections _____ times which relieved the pain for (how long)? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Manipulation               |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tens Unit                  | <input type="checkbox"/> | <input type="checkbox"/> | Trigger point injections _____ times which relieved the pain for (how long)? _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder injections        |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | Braces                     | <input type="checkbox"/> | <input type="checkbox"/> | Other _____   |

16. Generally speaking, are your symptoms getting better or worse? (Fill in **one** circle)
- Getting much better     
  Getting somewhat better     
  Staying about the same  
 Getting somewhat worse     
  Getting much worse



**B. For patients with NECK OR ARM problems: DON'T DO IF BEING SEEN FOR A BACK PROBLEM**

- What % of your pain is neck pain and what % is arm pain? (check appropriate box)
 

<input type="checkbox"/> Neck 0%, Arm 100%	<input type="checkbox"/> Neck 10%, Arm 90%	<input type="checkbox"/> Neck 25%, Arm 75%	<input type="checkbox"/> Neck 40%, Arm 60%
<input type="checkbox"/> Neck 50%, Arm 50%	<input type="checkbox"/> Neck 60%, Arm 40%	<input type="checkbox"/> Neck 75%, Arm 25%	<input type="checkbox"/> Neck 90%, Arm 10%
<input type="checkbox"/> Neck 100%, Arm 0%			
- There is:  No arm pain       Arm pain is as follows (check the following):
  - Right 0%, Left 100%   
  Right 10%, Left 90%   
  Right 25%, Left 75%   
  Right 40%, Left 60%  
 Right 50%, Left 50%   
  Right 60%, Left 40%   
  Right 75%, Left 25%   
  Right 90%, Left 10%  
 Right 100%, Left 0%
  - The arm pain is present in the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Upper back	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand/finger
<b>Left:</b>	<input type="checkbox"/> Upper back	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand/finger
- Raising the arm:  Improves the pain     Worsens the pain     Does not affect the pain
- Moving the neck:  Improves the pain     Worsens the pain     Does not affect the pain
- There is:  No weakness of the arms and hands       Weakness of the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand/finger
<b>Left:</b>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand/finger
- There is:  No numbness of the arms and hands       Numbness of the (check the following):
 

<b>Right:</b>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thumb	<input type="checkbox"/> Index finger	<input type="checkbox"/> Long finger	<input type="checkbox"/> Ring finger	<input type="checkbox"/> Small finger
<b>Left:</b>	<input type="checkbox"/> Upper arm	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thumb	<input type="checkbox"/> Index finger	<input type="checkbox"/> Long finger	<input type="checkbox"/> Ring finger	<input type="checkbox"/> Small finger
- There (  is     is no) difficulty picking up small objects like coins or buttoning buttons.
- There (  is     is no) problem with balance or tripping frequently.
- There are: (  Frequent     Occasional     No) headaches in the back of the head.

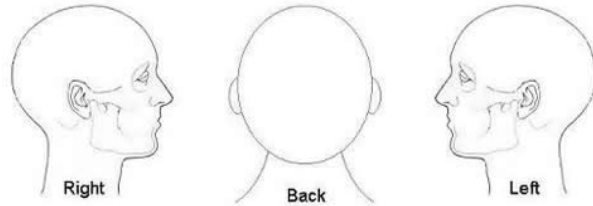
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**10. Patients with HEADACHES.**

- a. 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
- b. The headaches are located (check the following):  
 In the back of my neck  In the back of my head  
 The side of my head/temple area  In the front of my head (near my eyes)
- c. How long have you suffered from headaches?  Several days  Several weeks  
 Several months  Greater than 1 year
- d. When do the headaches occur most commonly?  
 Morning  Afternoon  While at work  Evening  No pattern
- e. What is your average headache pain level throughout the day? (please circle)  
**0 1 2 3 4 5 6 7 8 9 10**
- f. How would you describe your pain?  Throbbing  Squeezing  Pressure  
 Dull  Stabbing  Shooting
- g. What medications (either prescription or over-the-counter) do you take for your headaches?  
 \_\_\_\_\_

h. Please shade in the areas where you experience your discomfort.



**C. For patients with BACK OR LEG Problems: DON'T DO IF BEING SEEN FOR A NECK PROBLEM**

- 1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box)  
 Back 0%, Leg 100%  Back 10%, Leg 90%  Back 25%, Leg 75%  Back 40%, Leg 60%  
 Back 50%, Leg 50%  Back 60%, Leg 40%  Back 75%, Leg 25%  Back 90%, Leg 10%  
 Back 100%, Leg 0%
- 2. There is:  No leg pain  Leg pain as follows (check the following):  
 a.  Right 0%, Left 100%  Right 10%, Left 90%  Right 25%, Left 75%  Right 40%, Left 60%  
 Right 50%, Left 50%  Right 60%, Left 40%  Right 75%, Left 25%  Right 90%, Left 10%  
 Right 100%, Left 0%  
 b. The pain is present in the (check the following):  
**Right:**  Buttock  Thigh-front  Thigh-back  Calf  Foot  
**Left:**  Buttock  Thigh-front  Thigh-back  Calf  Foot
- 3. There is:  No weakness of the legs  Weakness of the (check the following):  
**Right:**  Thigh  Calf  Ankle  Foot  Big toe  
**Left:**  Thigh  Calf  Ankle  Foot  Big toe
- 4. There is:  No numbness of the legs  Numbness of the (check the following):  
**Right:**  Thigh  Calf  Foot  
**Left:**  Thigh  Calf  Foot

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

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5. The worst position for the pain is:  Sitting  Standing  Walking
6. How many minutes can you stand in one place without pain?  0-10  15-30  30-60  60+
7. How many minutes can you walk without pain?  0-10  15-30  30-60  60+
8. Lying down:  Eases the pain  Does not ease the pain  Sometimes eases the pain
9. Bending forward:  Increases the pain  Decreases the pain  Doesn't affect the pain

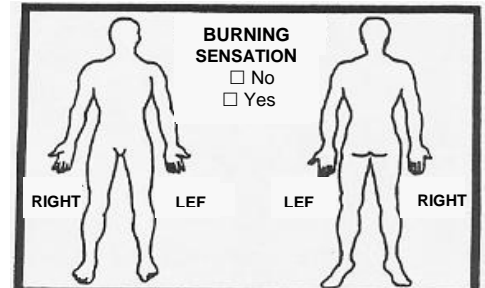
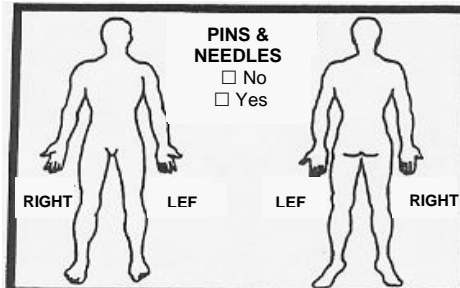
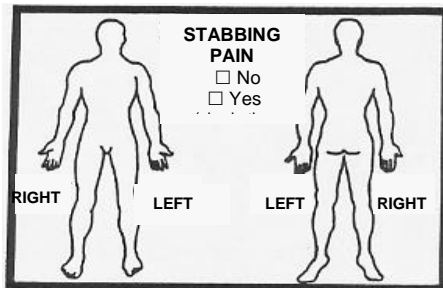
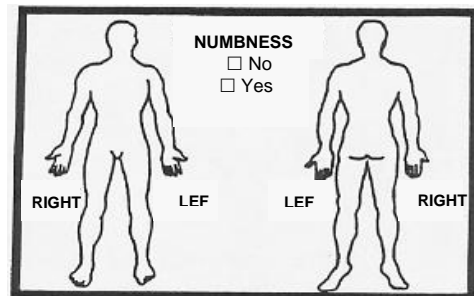
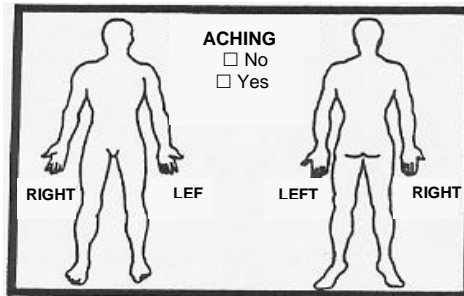
In the past week, how often have you suffered: (Please circle the number that applies)

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
10. Low back and/or buttock pain.....	1	2	3	4	5	6
11. Leg pain.....	1	2	3	4	5	6
12. Numbness or tingling in leg and/or foot	1	2	3	4	5	6
13. Weakness in leg and/or foot.....	1	2	3	4	5	6

In the past week, how bothersome have these symptoms been? (Please circle the number that applies)

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
14. Low back and/or buttock pain.....	1	2	3	4	5	6
15. Leg pain.....	1	2	3	4	5	6
16. Numbness or tingling in leg and/or foot... 1	1	2	3	4	5	6
17. Weakness in leg and/or foot.....	1	2	3	4	5	6

Please fill in the drawings:  
 (SHADE THE AREAS)



**D. For patients with SPINAL DEFORMITY/ BACK CURVATURE.**

1. How was your spinal deformity discovered? \_\_\_\_\_
2. Do you know your current curve measurement(s)? \_\_\_\_\_
3. Reason(s) for seeking treatment at this time:  progressive deformity  pain  can't stand straight  
 don't like the appearance of my back/waistline  Other: \_\_\_\_\_

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**PAST MEDICAL HISTORY:** *Check all that apply*       *None Apply*

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Rheumatoid arthritis  | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Heart failure       | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> ADHD              |
| <input type="checkbox"/> Abnormal heartbeat  | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Seizures          |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid        | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Migraine          |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Cirrhosis             | <input type="checkbox"/> Cerebral palsy    |
| <input type="checkbox"/> Blood clots in leg  | <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Hepatitis (A, B or C) | <input type="checkbox"/> Downs syndrome    |
| <input type="checkbox"/> Blood clots in lung | <input type="checkbox"/> Hiatal hernia  | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Spina bifida      |
| <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Bleeding disorder     | <input type="checkbox"/> Neurofibromatosis |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Kidney stones  | <input type="checkbox"/> Anemia                |  |
- Neuropathy:    Hands or    Feet  
 Cancer: \_\_\_\_\_ (type/treatment)  
 Diabetes: year diagnosed \_\_\_\_\_

Currently controlled with    insulin    oral medications    diet

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:**       *No Prior Surgery*

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia?    No       Yes

If YES, have you had any problems related to this?    No    Yes

Please explain any problems related to general anesthesia: \_\_\_\_\_

**MEDICATIONS (prescribed and over the counter):**       *I take no medications*

Name of Medication	Dose	Reason

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**ALLERGIES TO MEDICATIONS:**       *No Allergies*

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

**METAL ALLERGIES:**    *No Allergies*    Yes \_\_\_\_\_ (List Metals)

**SOCIAL HISTORY:**

Work status:

- Working  
  Homemaker  
  Unemployed  
  Disabled  
  On leave  
  Retired  
  Student

Occupation \_\_\_\_\_

Marital Status:  Single       Married       Divorced       Widowed

Children  No  Yes, How Many? \_\_\_\_\_

Do you live alone? \_\_\_\_\_ If no, who lives with you? \_\_\_\_\_

Are you currently smoking? \_\_\_\_\_ If yes, how many packs a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Have you quit smoking? If so, when did you quit? \_\_\_\_\_ How many years did you smoke? \_\_\_\_\_

How many packs a day did you previously smoke? \_\_\_\_\_ Other forms of tobacco? \_\_\_\_\_

Alcohol Use    Never       Rare       Social       Frequently (more than twice a week)

Alcoholic    Recovering Alcoholic

Illegal Drug Use    Never    In the past    Currently   Types of Drugs \_\_\_\_\_

**FAMILY HISTORY: Check all that apply**    None apply

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Seizure        | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Gout           | <input type="checkbox"/> Kidney problems             | <input type="checkbox"/> Lung problems       | <input type="checkbox"/> Mental Illness    |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Blood clots (legs or lungs) |  |  |

Other: \_\_\_\_\_

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**REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fever            | <input type="checkbox"/> Sleep apnea (snoring) | <input type="checkbox"/> Nausea             |
| <input type="checkbox"/> Chills           | <input type="checkbox"/> Hoarseness            | <input type="checkbox"/> Vomiting           |
| <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Cough                 | <input type="checkbox"/> Diarrhea           |
| <input type="checkbox"/> Weight gain      | <input type="checkbox"/> Trouble swallowing    | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Vision changes   | <input type="checkbox"/> Chest pain            | <input type="checkbox"/> Hemorrhoids        |
| <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Stomach pain       |
| <input type="checkbox"/> Hearing loss     | <input type="checkbox"/> Swollen ankles        | <input type="checkbox"/> Urinary difficulty |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Ear pain         | <input type="checkbox"/> Seasonal allergies    | <input type="checkbox"/> Hyperactivity      |
| <input type="checkbox"/> Nosebleeds       | <input type="checkbox"/> Skin rashes           | <input type="checkbox"/> Memory loss        |
| <input type="checkbox"/> Toothache        | <input type="checkbox"/> Swollen glands        | <input type="checkbox"/> Blackouts          |
| <input type="checkbox"/> Gum problems     | <input type="checkbox"/> Poor appetite         | <input type="checkbox"/> Headache           |

***I have NOT experienced any of the above symptoms in the last 30 days.***

Other: \_\_\_\_\_

**Previous physicians seen for this problem:**

Physician	Specialty	City	Treatment

**X-Rays and Tests for this problem:**

	Results	Date	Location
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Bone Scan			
<input type="checkbox"/> Other			

<p><b>FOR OFFICE USE ONLY</b></p> <p>I have read and confirmed the above information with the patient:</p> <p>Physician Signature: _____ Date: _____</p>
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