LUMBAR SPINE APPOINTMENT

Stephen E. Hanks, M.D.
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. 4.
2. 5.

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: