**ORTHOPAEDIC SURGERY**
at The GW Medical Faculty Associates

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Welcome to Orthopaedics!

In an effort to make your visit with us at the Department of Orthopaedic Surgery as efficient as possible, please be sure to bring the following to your upcoming appointment:

- Completed patient history forms (attached)
- Government Issued Photo ID
- Current Insurance Card
- Referral (check with your insurance company to see if one is required for a specialty appointment)
- Any reports from prior surgery
- Any reports and images from prior imaging studies (X-rays, MRI, CT scans, etc.)

We look forward to seeing you at your upcoming appointment!

If you have any questions, please feel free to contact our office at 202.741.3309.

Sincerely,

The Department of Orthopaedic Surgery

**Lumbar Spine Questionnaire**

Name: _____ Age:____ Occupation: _____

Name of physician/person who referred you: _____

**Main problem (include date of onset, describe any injury/accident):**

| |
|---|
| |

Was injury work related? ◉ Yes ○ No
Do you have leg pain? ○ Yes ◉ No

Which leg is more painful? ◉ Right ○ Left

Please describe how much back/leg pain you are experiencing.

| | | | | |
|---|---|---|---|---|
| ○ 100% back 0% leg | ○ 75% back 25% leg | ○ 50% back 50% leg | ○ 25% back 75% leg | ○ 0% back 100% leg |

Have you had any bowel/bladder problems? ○ Yes ○ No

**Please check all that apply:**

Pain level/character:
- ☐ none
- ☐ mild
- ☐ moderate
- ☐ severe
- ☐ electrical
- ☐ dull
- ☐ sharp
- ☐ burning
- ☐ occasional pain
- ☐ constant pain
- ☐ pain with activities
- ☐ night pain
- ☐ pain improving
- ☐ pain worsening
- ☐ no change

Worsens with:
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ bending
- ☐ lifting
- ☐ other_____

Improves with:
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ stretching
- ☐ lying down
- ☐ ice
- ☐ heat
- ☐ other_____

Physical therapy: ○ Yes ○ No Please list dates: _____

○ Helped a lot ○ Helped a little ○ No help ○ Made pain worse

Epidural injections: ○ Yes ○ No How many?_____ Dates:_____

○ Helped a lot ○ Helped a little ○ No help ○ Made pain worse

**List current medications you take for your pain. Please indicate if they help.**

| |
|---|
| |

**Have you seen any other doctors for your problem?** ○ Yes ○ No

Name: _____Date:_____
Diagnosis: _____
Recommendation: _____

Name: _____Date:_____
Diagnosis: _____
Recommendation: _____

**Have you had any studies (XRay, MRI, CT, myelogram)? List study and date.**

| |
|---|
| |

Height: Weight:

List any medical conditions current or past, including psychiatric (use back of page if necessary):

List all past surgeries and dates (use back of page if necessary):

List all medications you take including dose and times (use back of page if necessary):

List any drug allergies:_____

Smoking (check one): ○ None ○ ½ pk/day ○ 1 pk/day ○ 2 pk/day ○ > 2 pk/day
○ Quit, last smoked_____

Alcohol (check one): ○ Never ○ 1 day/year ○ 1 day/month ○ 1day/wk ○ 3 days/wk
○ 5 days/wk ○ Every day

Work History: What type of job? Describe your duties.

What activities (sports/hobbies) do you enjoy?

Family History: relatives with problems? (diabetes, high blood pressure, cancer, heart problems)

Do you have or have you been treated for any of the following (check all that apply):

**General**
- ☐ Weight loss
- ☐ Weight gain
- ☐ Decreased appetite
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats

**Skin**
- ☐ Rashes
- ☐ Itching
- ☐ Skin color changes

**HEENT**
- ☐ Headaches
- ☐ Blurred vision
- ☐ Ringing in ears
- ☐ Bloody noses
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Pituitary problems

**Heart/Lungs**
- ☐ Coughing
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Chest pain
- ☐ Palpitations
- ☐ Coronary disease
- ☐ Hypertension
- ☐ Heart attack
- ☐ Stroke
- ☐ Leg swelling

**GI**
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Constipation
- ☐ Blood in stool
- ☐ Dark tarry stool
- ☐ Yellow jaundice
- ☐ Diabetes
- ☐ Liver problems

**GU**
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Urinary urgency
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Impotence
- ☐ Sexual dysfunction

**Neuro**
- ☐ Seizures
- ☐ Fainting
- ☐ Dizziness/spinning
- ☐ Balance problems

**Hematologic**
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Leukemia

**Psychiatric**
- ☐ Depression
- ☐ Bipolar
- ☐ Paranoia
- ☐ Schizophrenia

**Other**
- ☐ HIV/AIDS
- ☐ Hepatitis

**Visual Analogue Scale**

NAME: _____ DATE: _____

SURGEON NAME: _____

FOLLOW UP:

- ○ PreOp
- ○ Immediate PostOp
- ○ 6 weeks
- ○ 3 months
- ○ 6 months
- ○ 12 months
- ○ 24 months
- ○ Other (specify): _____

**Please circle the number that best describes the question being asked.**

NOTE: Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference

EXAMPLE:

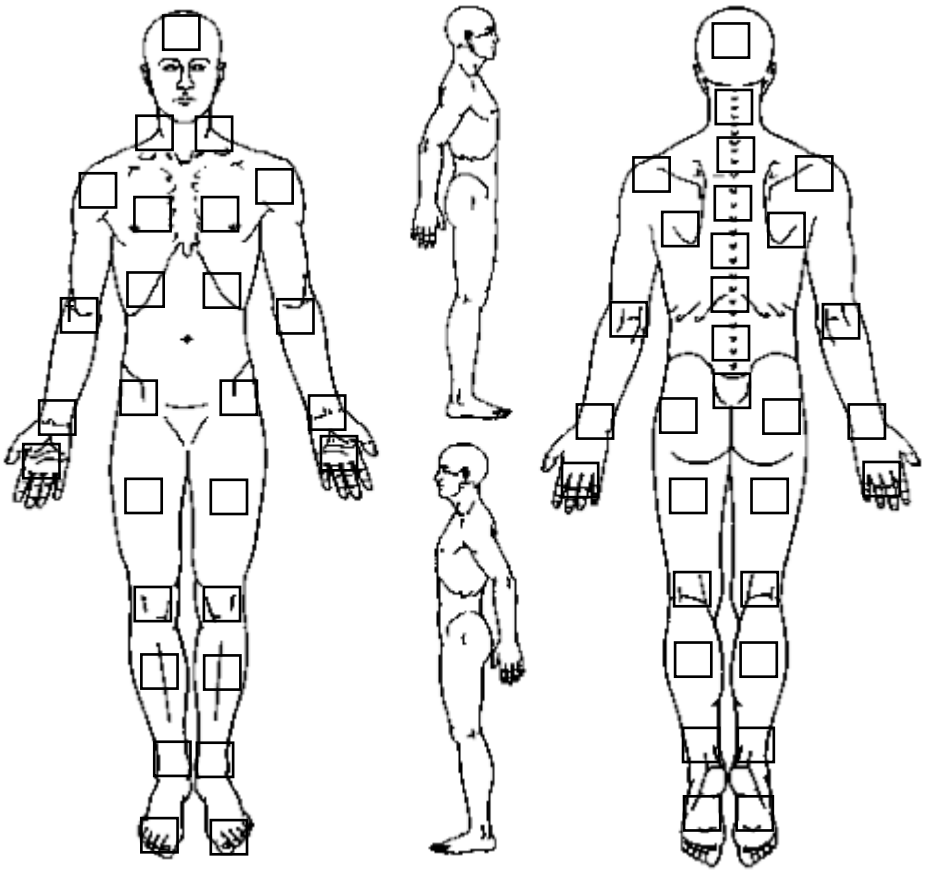
no pain 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 **X** 6 ____ 7 ____ 8 ____ 9 ____ 10 worst possible pain

1. ARM or LEG PAIN

no pain 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 worst possible pain

2. NECK or BACK PAIN

no pain 0 ____ 1 ____ 2 ____ 3 ____ 4 ____ 5 ____ 6 ____ 7 ____ 8 ____ 9 ____ 10 worst possible pain



A = ACHE B= BURNING N= NUMBNESS

P= PINS & NEEDLES S= STABBING O= OTHER