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

Cervical 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
Your dominant hand:	Left	Right
Which arm is more painful?	Left	Right

Do you have any of the following:

Neck pain:	Yes	No	Difficulty writing	Yes	No
Arm pain:	Yes	No	Difficulty walking:	Yes	No
Arm weakness:	Yes	No	Balance problems:	Yes	No
Hand clumsiness:	Yes	No	Bowel/bladder problems:	Yes	No

Please check all that apply:

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

Worsens with: overhead activities repetitive motions lifting
other______________________________

Improves with: rest stretching ice heat
other_________________________________

Physical therapy: yes no How many sessions? _______________
helped a lot helped a little no help made pain worse

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:__________ Name: _______________________Date:__________
Diagnosis: __________________________________ Diagnosis: __________________________________
Recommendation: ____________________________ 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 last page if necessary):

List all past surgeries and dates (use last 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

Please provide any additional information:

Visual Analogue Scale

NAME: ____ DATE: ____________________

SURGEON NAME: ____

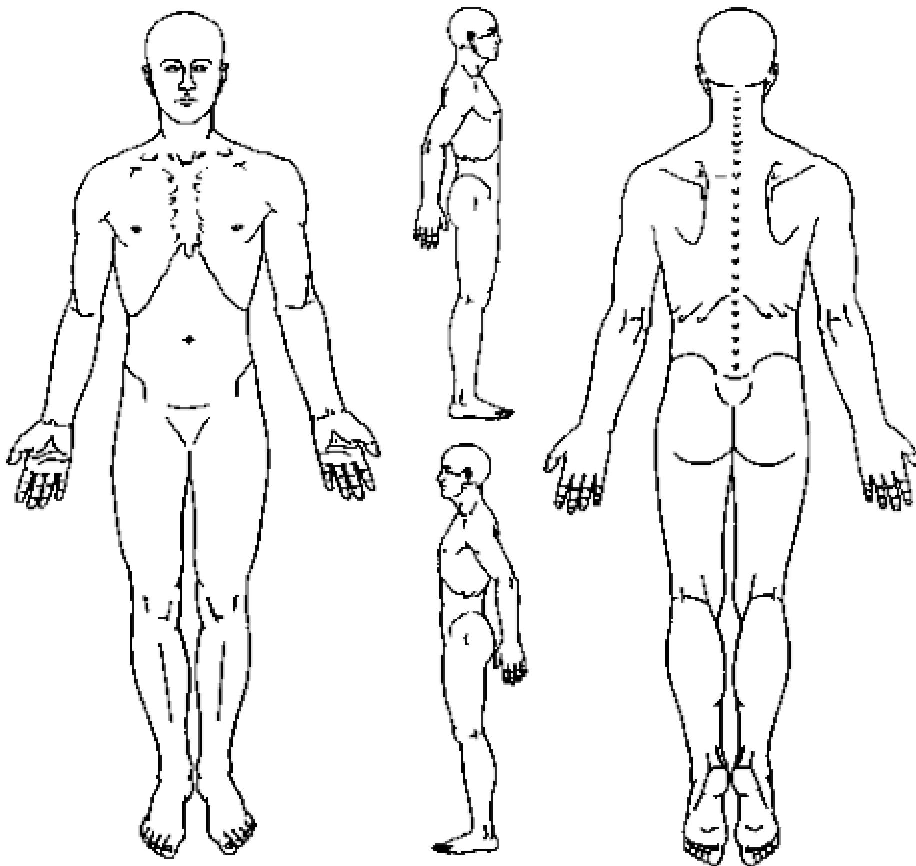
FOLLOW UP:	PreOp	6 months
	Immediate PostOp	12 months
	6 weeks	24 months
	3 months	Other (specify): ________________

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