UC San Diego
MEDICAL CENTER

ORTHOPAEDIC NEW PATIENT QUESTIONNAIRE

Please complete this Questionnaire. It is designed to give us information about your health that will allow us to better understand and assist you.

Patient Label Here

CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

❒ Back Pain ❒ Leg Pain ❒ Neck Pain ❒ Arm Pain

❒ Other_____

How long has this been a problem?

❒ Less than 2 months ❒ 2-6 months ❒ 6-12 months ❒ Greater than 1 year

Further Comments:

_____

_____

Have you been treated by any other medical professional for this condition? ❒ Yes ❒ No

If yes, please list:_____

_____

What treatments have you had for this problem? (Check all that apply)

❒ Chiropractic Care ❒ Acupuncture ❒ Nothing ❒ Injections (epidurals, nerve blocks trigger points, etc)

❒ Physical Therapy (Check all that apply)

❒ Stretching ❒ Strengthening ❒ Traction ❒ Iontophoresis/Topical Steroid ❒ TENS

❒ Massage ❒ Ultrasound ❒ Heat/Ice ❒ Therapeutic Ball

❒ Other (Herbal, homeopathic remedies)_____

Have you had any other tests for this problem? ❒ Yes ❒ No

❒ X-Ray ❒ MRI ❒ Discography ❒ CT Scan ❒ Electromyogram

❒ CT/Myelogram ❒ Bone Scan ❒ Other (Please specify): _____

_____

Current problem is the result of a(n): (Check all that apply)

❒ Injured at work ❒ Auto accident ❒ Sports ❒ No apparent cause

❒ Other:_____

Current problem began:

❒ Suddenly ❒ Gradually ❒ Lifting ❒ Twisting ❒ Fall

❒ Bending ❒ Pulling ❒ Other_____

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What makes the pain worse?

❒ During exercise ❒ Prolonged sitting ❒ Prolonged standing ❒ Walking
❒ Bending forward ❒ Bending backward ❒ Pushing ❒ Pulling
❒ Squatting ❒ Pain at night ❒ Other_____

What reduces your pain?

❒ Lying down ❒ Sitting ❒ Standing ❒ Walking
❒ Medication ❒ Shifting/changing positions ❒ Nothing
❒ Other_____

PAST MEDICAL HISTORY

Spine Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or Past Illnesses:

Date	Illness or Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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Medication Allergies/Reactions Are you allergic to latex? ❒ Yes ❒ No

_____

_____

_____

_____

_____

Medication and Dosage: (Include Over-the-Counter, presecription, herbal, homeopathic)		
1 Medication	Strength	How taken?
2		
3		
4		
5		
6		
7		
8		
9		
10		

SOCIAL HISTORY

Age: _____

Occupation:_____

Are you? ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Domestic partner

Are you working? ❒ Full time ❒ Part time ❒ Disabled ❒ Retired ❒ Not working

Do you exercise? ❒ Daily ❒ Weekly ❒ Monthly ❒ Rarely ❒ Never

Type of exercise / activity:_____

Do you have children? Yes ❒ No ❒ How many? _____

Do you live alone? Yes ❒ No ❒

Do you have any stairs? Yes ❒ No ❒

Do you smoke? Yes ❒ No ❒

Use other nicotine products? Yes ❒ No ❒

Which product do you use? Yes ❒ No ❒

Have you quit smoking? Yes ❒ No ❒

Drink alcohol? Yes ❒ No ❒

Is there any litigation pending? ❒ Lawsuit ❒ Workers ❒ Disability ❒ Social Security Claim

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FAMILY HISTORY

Do you have a family history of:

Arthritis	❒ Yes	❒ No	Blood clots/excessive bleeding	❒ Yes	❒ No
Tuberculosis	❒ Yes	❒ No	Hypertension	❒ Yes	❒ No
Diabetes	❒ Yes	❒ No	Adverse reaction to anesthesia	❒ Yes	❒ No
Cancer	❒ Yes	❒ No	Mental health disorders	❒ Yes	❒ No
Cardiac disorders	❒ Yes	❒ No	Other_____		

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

			Please describe all YES answers
Skin	❒ Yes	❒ No	_____
Ears, Nose, Throat	❒ Yes	❒ No	_____
Cardiac/High Blood Pressure	❒ Yes	❒ No	_____
Lung (asthma, infection)	❒ Yes	❒ No	_____
Stomach/Digestion	❒ Yes	❒ No	_____
Bladder/Bowel problems	❒ Yes	❒ No	_____
Hematologic/Bleeding problems	❒ Yes	❒ No	_____
Diabetes	❒ Yes	❒ No	_____
Cancer	❒ Yes	❒ No	_____
Musculoskeletal	❒ Yes	❒ No	_____
Neurological	❒ Yes	❒ No	_____
Psychiatric problems	❒ Yes	❒ No	_____
Reproductive/Sexual problems	❒ Yes	❒ No	_____
Fever/Chills	❒ Yes	❒ No	_____
Night sweat	❒ Yes	❒ No	_____
Night pain	❒ Yes	❒ No	_____
Unexpected weight loss	❒ Yes	❒ No	_____

Reviewed By:_____ Date/Time:_____

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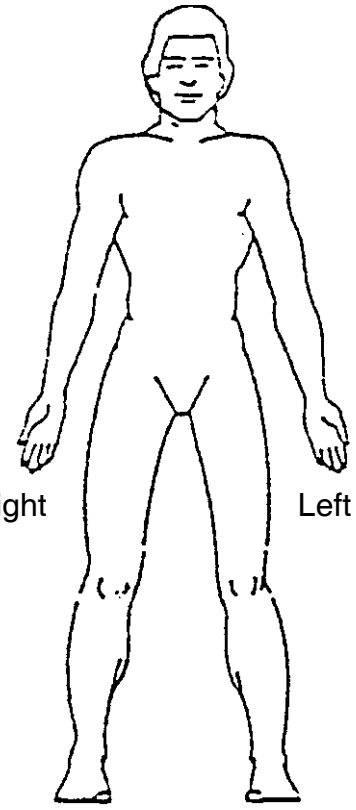
WHERE IS YOUR PAIN NOW?

Mark the areas on your body diagram where you feel the described sensations using the symbols shown below.. Please indicate the percentage of pain that you currently feel in your legs, arms, neck and back in the given table.

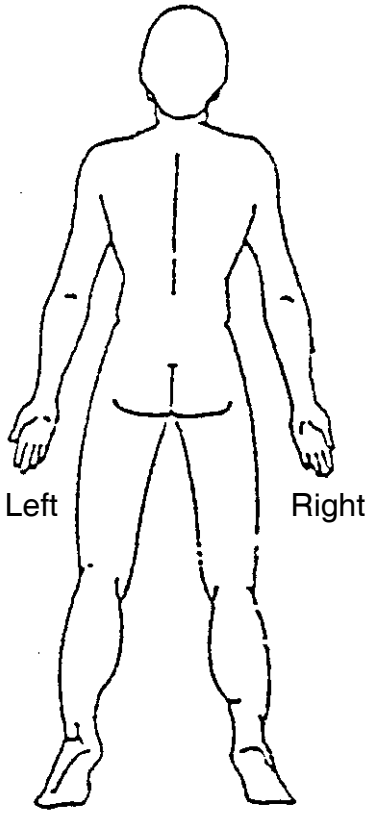
ACHE	NUMBNESS	PINS AND NEEDLES	BURNING	STABBING
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///
AAA	OOO	---	XXX	///

Front



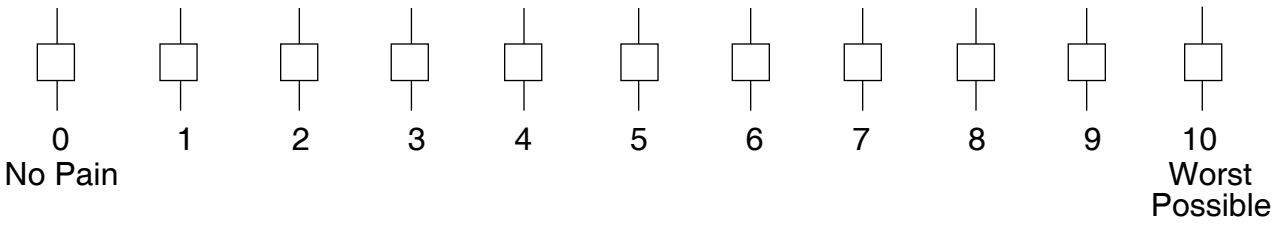
Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total		%
Must add up to 100%		

Back



Grade your overall PAIN

Please place an X in the box that most accurately describes your degree of pain now.



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ORTHOPAEDIC NEW PATIENT QUESTIONNAIRE

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SF-12® Health Survey

This survey asks for your views about your health. Your information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Good	Very Good	Fair	Poor
☐	☐	☐	☐	☐

The following questions are about activities you might do during a typical day. Does you health *now* limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, Limited a little	No, not Limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐	☐	☐
3. Climbing several flights of stairs	☐	☐	☐

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

4. Accomplished less than you would like	Yes ☐	No ☐
5. Were limited in the **kind** of work or other activities	Yes ☐	No ☐

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

6. **Accomplished less** than you would like	Yes ☐	No ☐
7. Didn't do work or activities as carefully as usual	Yes ☐	No ☐

---

8. During the *past 4 weeks*, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

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These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the *past 4 weeks*....

	All of the time	Most of time	A good bit of time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11. Have you felt downhearted or blue?	☐	☐	☐	☐	☐	☐

12. During the *past 4 weeks*, how much of the time have your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

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Oswestry Disability Index 2.0

Check one of the following boxes: ❒ Prior to Surgery ❒ After Surgery

Could you please complete this questionnaire? It is designed to give us information as to how your spine trouble has affected your ability to manage in everyday life.

Please answer every section. Mark **one box only** in each section that most closely describes you ***today***

Section 1: Pain Intensity

1. ❒ I have no pain at the moment.
2. ❒ The pain is very mild at the moment.
3. ❒ The pain is moderate at the moment.
4. ❒ The pain is fairly severe at the moment.
5. ❒ The pain is very severe at the moment.
6. ❒ The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, dressing, etc)

1. ❒ I can look after myself normally without causing extra pain.
2. ❒ I can look after myself normally but it is very painful.
3. ❒ It is painful to look after myself and I am slow and careful.
4. ❒ I need some help but manage most of my personal care.
5. ❒ I need help every day in most aspects of self-care.
6. ❒ I do not get dressed, I wash with difficulty and I stay in bed.

Section 3: Lifting

1. ❒ I can lift heavy weights without extra pain.
2. ❒ I can lift heavy weights but it gives extra pain.
3. ❒ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table
4. ❒ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
5. ❒ I can lift only very light weights.
6. ❒ I cannot lift or carry anything at all.

Section 4: Walking

1. ❒ Pain does not prevent me from walking any distance.
2. ❒ Pain prevents me from walking more than one mile.
3. ❒ Pain prevents me from walking more than a quarter of a mile.
4. ❒ Pain prevents me walking more than 100 yards.
5. ❒ I can only walk using a stick or crutches.
6. ❒ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting

1. ❒ I can sit in any chair as long as I like.
2. ❒ I can sit in my favorite chair as long as I like.
3. ❒ Pain prevents me from sitting for more than one hour.
4. ❒ Pain prevents me from sitting for more than half an hour.
5. ❒ Pain prevents me from sitting for more than half an hour.
6. ❒ Pain prevents me from sitting at all.

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Section 6: Standing

1. ❒ I can stand as long as I want without extra pain.
2. ❒ I can stand as long as I want but it gives me extra pain.
3. ❒ Pain prevents me from standing for more than one hour.
4. ❒ Pain prevents me from standing for more than half an hour.
5. ❒ Pain prevents me from standing for more than 10 minutes.
6. ❒ Pain prevents me from standing at all.

Section 7: Sleeping

1. ❒ My sleep is never disturbed by pain.
2. ❒ My sleep is occasionally disturbed by pain.
3. ❒ Because of pain I have less than 6 hours sleep.
4. ❒ Because of pain I have less than 4 hours sleep.
5. ❒ Because of pain I have less than 2 hours sleep.
6. ❒ Pain prevents me from sleeping at all.

Section 8: Sex life (if applicable)

1. ❒ My sex life is normal and causes no extra pain.
2. ❒ My sex life is normal but causes some extra pain.
3. ❒ My sex life is nearly normal but it is very painful.
4. ❒ My sex life is severely restricted by pain.
5. ❒ My sex life is nearly absent due to pain.
6. ❒ Pain prevents any sex life at all.

Section 9: Social Life

1. ❒ My social life is normal and causes me no extra pain.
2. ❒ My social life is normal but increases the degree of pain.
3. ❒ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., sports, etc.
4. ❒ Pain has restricted my social life and I do not go out as often.
5. ❒ Pain has restricted social life to my home.
6. ❒ I have no social life because of pain.

Section 10: Traveling

1. ❒ I can travel anywhere without pain.
2. ❒ I can travel anywhere but it gives extra pain.
3. ❒ Pain is bad but I manage journeys over 2 hours.
4. ❒ Pain restricts me to journeys less than one hour.
5. ❒ Pain restricts me to short necessary journeys less than 30 minutes.
6. ❒ Pain prevents me from traveling except to receive treatment.

_____ _____

Patient Signature Date/Time