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BACK QUESTIONNAIRE

Dear Patient:

Since this is your first visit to our office, we would appreciate you filling out this questionnaire so that we can obtain the most accurate medical and orthopaedic history possible.

We thank you in advance for your patience in completing this document.

Sincerely,

Carlos J. Lavernia, M.D., F.A.A.O.S.

[Office Forms\Back-Eng]

Patient Name: _____ Date: _____

DEMOGRAPHIC INFORMATION

Please answer ALL questions as complete as possible. Thank you.

Last Name: _____ **Maiden Name:** _____

First Name, Middle Initial: _____ **Sex:** ☐ Male ☐ Female

Birthplace: _____ **Date of Birth:** _____

Marital Status: _____ **Husband/Wife's Name:** _____

☐ Single ☐ Widowed
☐ Married ☐ Divorced/Separated ☐ Significant Other

Local Address (City, State, Zip Code): _____

Permanent Address (if different from above): _____

Home Phone No.: _____ **Work Phone No.:** _____

Cellular Phone No.: _____ **Beeper No.:** _____

Social Security No.: _____ **Driver 's License No. and State issued in:** _____

Occupation:

☐ Professional _____ ☐ Employed ☐ Self-employed ☐ Disabled
☐ Retired _____ ☐ Unemployed ☐ Student ☐ Homemaker
☐ Other: _____

Level of Education:

☐ Elementary _____ (# of years)
☐ High School _____ (# of years)
☐ College _____ (# of years)
☐ Graduate Degree _____ (# of years) ☐ Masters ☐ PhD ☐ MD ☐ JD

Race:

☐ Black ☐ White ☐ Native-American ☐ Asian ☐ Other: _____

Ethnicity:

☐ African-American ☐ Caucasian ☐ Hispanic/Hispanic descent (specify): _____
☐ Asian/Pacific Islander ☐ Arabic ☐ Native American ☐ Other: _____

Religion (mark only one):

☐ Catholic ☐ Jewish ☐ Protestant ☐ Muslim ☐ Jehovah's Witness
☐ Christian (specify): _____ ☐ Other: _____

Nearest Relative *NOT LIVING WITH YOU*:

Relationship:

Address: _____ **City:** _____

State, Country: _____ **Zip Code:** _____

Home Phone No.: _____ **Work Phone No.:** _____

Closest Friend *NOT LIVING WITH YOU*: _____ **Home Phone No.:** _____

_____ **Work Phone No.:** _____

If you are disabled, is the disability work-related?: ☐ Yes ☐ No

If you are unemployed, when was the last date you worked: ____/____/____

Is this is Worker's Compensation case?: ☐ Yes ☐ No

If YES, please provide the following information:

Name of Insurance Co.: _____

Adjuster's Name: _____

Phone No.: _____ **Case No.:** _____

Name of Employer: _____ **Work Phone No.:** _____

Employer's Address (City, State, Zip Code): _____

Is this a Litigation case?: ☐ Yes ☐ No

If YES, please provide the Attorney's Name: _____

Phone No.: _____ **Case No.:** _____

Referral Information:

☐ Primary physician ☐ Another physician ☐ Internet ☐ Jackson Memorial Hospital

☐ Attorney ☐ **International Center** from→ ☐ Cedars Medical Center ☐ University of Miami

☐ Yellow Pages ☐ Another patient (name): _____

Referring Physician: _____ **Phone No.:** _____

Primary Care Physician: _____ **Phone No.:** _____

Patient Name: _____ **Date:** _____

CURRENT PROBLEM

Please check off the box on ALL that apply:

Age: _____

Back: _____ **Lower Back** _____ **Upper Back**

When did your pain begin?:

_____ days _____ weeks _____ months _____ years

Did your pain start because of (check off the box on ALL that apply):

☐ Twisting injury ☐ Fracture ☐ Contusion
☐ Spontaneously ☐ Fall ☐ Car accident ☐ Other: _____

When did your current pain start getting worse?:

_____ days _____ weeks _____ months _____ years

Do you feel any (check off all that apply):

☐ Pain ☐ Locking
☐ Swelling ☐ Loss of motion
☐ Weakness ☐ Aching
☐ Numbness ☐ Giving out

How is your (pain most of the time)? (ANSWER ONLY ONE):

☐ None
☐ Mild or occasional
☐ Only when standing
☐ Only when walking or climbing stairs
☐ Moderate-severe when weight bearing; unable to do any activity
☐ Severe, even at night
☐ Intense and permanent

How is your pain at night? (ANSWER ONLY ONE):

☐ None ☐ Continuous ☐ Intermittent

How is the pain with no activity (at rest)? (ANSWER ONLY ONE):

☐ None ☐ Mild ☐ Moderate ☐ Moderate-Severe ☐ Severe

What is the character of your pain? (ANSWER ONLY ONE):

☐ Sharp ☐ Dull

Symptoms are worsened by? (Mark ALL that apply):

☐ Walking ☐ Stairs
☐ Standing ☐ Lifting
☐ Sitting ☐ Carrying

Symptoms are improved by? (Mark *ALL* that apply):

- ☐ With nothing (no improvement)
- ☐ Walking
- ☐ Physical therapy
- ☐ Ice
- ☐ Rest
- ☐ Exercise
- ☐ Medications/Pills (specify which brand): _____

Please choose the sentence that best describes your activity level:

- ☐ Wholly inactive; dependent on others; cannot leave the resident.
- ☐ Mostly inactive; very restricted to minimum activities of daily living.
- ☐ Sometimes participates in mild activities as walking, limited housework & limited shopping.
- ☐ Regularly participates in mild activities.
- ☐ Sometimes participates in moderate activities such as swimming; can do unlimited housework or shopping.
- ☐ Regularly participates in moderate activities.
- ☐ Regularly participates in very active events, such as bicycling; and can lift up to 50 pounds.
- ☐ Regularly participates in very active events, such as bowling or golf.
- ☐ Sometimes participates in impact sports such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking; can lift more than 50 pounds.
- ☐ Regularly participates in impact sports.

Walking tolerance (ANSWER ONLY ONE):

- ☐ Unlimited
- ☐ 6 to 20 blocks
- ☐ 2 to 5 blocks
- ☐ Less than 2 blocks
- ☐ Indoors only
- ☐ Unable

How long can you walk at one time *WITHOUT* support? (*WITHOUT* a cane, crutch, or walker? (ANSWER ONLY ONE):

- ☐ Over an hour
- ☐ 31 to 60 minutes
- ☐ 11 to 30 minutes
- ☐ 2 to 10 minutes
- ☐ Less than 2 minutes, or indoors only.
- ☐ I am unable to walk *WITHOUT* support.

How do you climb stairs? (ANSWER ONLY ONE):

- ☐ Normally, without using the rail, one foot over the other, one foot on each step.
- ☐ Normally, but using the rail, one foot over the other, one foot on each step.
- ☐ Both feet on each step, taking only one step at a time.
- ☐ I am unable to climb stairs.

What level of support do you use? (ANSWER ONLY ONE):

- ☐ 1. None
- ☐ 2. A cane occasionally
- ☐ 3. A cane most of the time
- ☐ 4. A cane all the time
- ☐ 5. One crutch all the time
- ☐ 6. Two canes or two crutches
- ☐ 7. A walker
- ☐ 8. Unable to walk

If you answered 3, please specify:

- ☐ A long time with a cane, short time without a cane.
- ☐ I use one cane for less than one (1) hour, but it is difficult without a cane.

Do you limp when walking *WITHOUT* support? (*WITHOUT* a cane, crutch, or walker?) (ANSWER ONLY ONE):

- ☐ No limp
- ☐ Slight limp
- ☐ Moderate limp
- ☐ Severe limp
- ☐ I am unable to walk without support.

Car access (mark only the one that best describes you):

- ☐ I can get in and out of a car easily.
- ☐ It is difficult for me to get in and out of a car.
- ☐ I am unable to get in and out of a car.

Which of the following statements best describes your work situation during the past month? (ANSWER ONLY ONE):

- ☐ Working full-time
- ☐ Working part-time
- ☐ Unemployed because of my health
- ☐ Unemployed, looking for work
- ☐ Retired or quit work because of hip or knee problems
- ☐ Retired for reasons unrelated to my hip or knee
- ☐ Homemaker, full-time
- ☐ Student, full-time

Do you have difficulty putting your shoes and socks on the *SPECIFIED FOOT*? (ANSWER ONLY ONE IN EACH COLUMN):

Left Right

- | | | |
|--------------------------|--------------------------|--------------------|
| ☐ | ☐ | No difficulty |
| ☐ | ☐ | Slight difficulty |
| ☐ | ☐ | Extreme difficulty |
| ☐ | ☐ | Unable to do so |

How do you arise from a chair to a standing position? (ANSWER ONLY ONE):

- ☐ I can stand up from a chair without using my arms to push off.
- ☐ I have to use my arms to push off when standing up from a chair.
- ☐ I am unable to stand up from a chair without someone's help.

Have you had previous **JOINT INJECTIONS?**: ☐ Yes ☐ No

If **YES**, please indicate the number of injections: ____

Was the injection: ☐ Helpful ☐ Not helpful

If **HELPFUL**, for how long?: ____ days ____ weeks ____ months ____ years

When was your **LAST INJECTION?**: ____ days ____ weeks ____ months ____ years

Have you ever had **PHYSICAL THERAPY?**: ☐ Yes ☐ No

If **YES**, was the physical therapy: ☐ Helpful ☐ Not helpful

Please mark with “C” ALL medications that you are currently taking for this pain and mark with a “P” the ones you have taken in the past for this pain:

____ ANSAID	____ DILAUDID	____ PREDNISONE
____ ARTHROTEC	____ FELDENE	____ RELAFEN
____ ASPIRIN	____ GOLD	____ STEROIDS
____ BEXTRA	____ INDOCIN	____ TALWIN
____ BUTAZALIDIN	____ MECLOMEN	____ TOLECTIN
____ CELEBREX	____ MORPHINE	____ TRILISATE
____ CLINORIL	____ MOTRIN	____ TYLENOL
____ CODEINE	____ NALFON	____ TYLENOL #3
____ DARVON	____ NAPROSYN	____ TYLOX
____ DAYPRO	____ PERCODAN	____ VIOXX
____ DEMEROL	____ PLAQUENIL	____ VOLTAREN

Other anti-inflammatory or analgesic drugs not mentioned above:

Have you taken **STEROIDS** in the past? ☐ Yes ☐ No

If **YES**, name of steroid(s) used: _____

Reason or medical condition for using steroids: _____

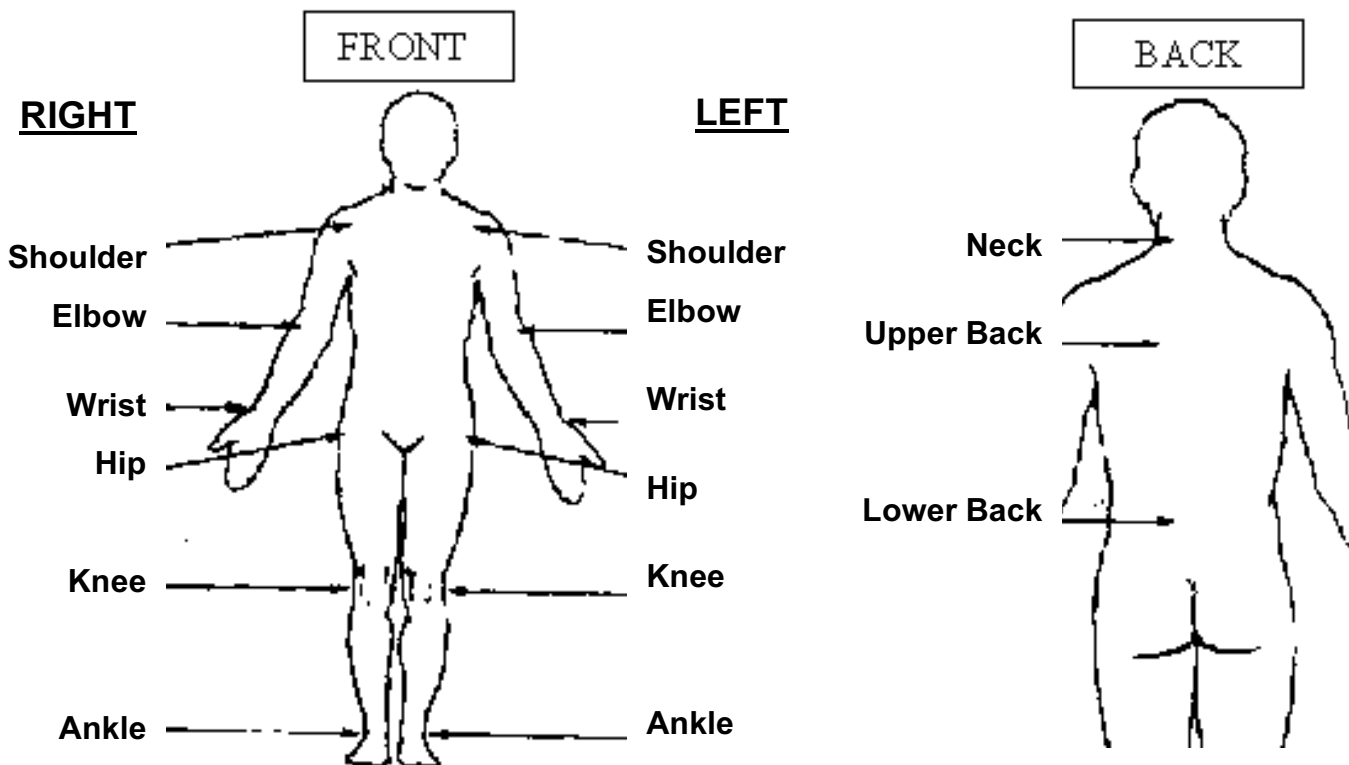
Dosage used: _____ mg. . . . for . . . ____ days ____ weeks ____ months ____ years

TESTS that you have had done (for your *CURRENT PROBLEM*):

- ☐ Plain x-rays
- ☐ Nerve tests
- ☐ C.A.T. scan
- ☐ Bone scan
- ☐ Fluid analysis

- ☐ Blood tests
- ☐ Arthrogram
- ☐ Diagnostic arthroscopy
- ☐ M.R.I.
- ☐ Other: _____

Circle additional areas where you feel significant pain:



Please list other **ORTHOPAEDIC SURGEONS** that you have seen:

First and Last Name: _____

Phone No.: _____ City & State: _____

First and Last Name: _____

Phone No.: _____ City & State: _____

Did they recommend surgery?: ☐ Yes ☐ No

What type of surgery was recommended?: _____

SOCIAL HISTORY/HOUSING:

You live with: ☐ Wife/Husband ☐ Friends
☐ Girlfriend/Boyfriend ☐ Relatives
☐ Other: _____

You live in a: ☐ House ☐ Nursing Home
☐ Apartment: ☐ Assisted Living Facility
(What floor? ____)

Other: _____

Are there any stairs in your house, apartment, etc.?: ☐ Yes ☐ No

Is there an elevator in your house, apartment, etc?: ☐ Yes ☐ No

In case you need surgery, who will take care of you where you live?

☐ My relatives ☐ My son/daughter
☐ My husband/wife ☐ Significant other ☐ Other: _____

FAMILY HISTORY: Has anyone in your family had history of any of the following?:

Condition/Disease:

Avascular Necrosis (AVN)

☐ Yes ☐ No ☐ Do not know

Cancer (CA)

☐ Yes ☐ No ☐ Do not know

Diabetes (DM)

☐ Yes ☐ No ☐ Do not know

Heart Disease (CAD)

☐ Yes ☐ No ☐ Do not know

High Cholesterol

☐ Yes ☐ No ☐ Do not know

Blood Clotting Disorders (HTN)

☐ Yes ☐ No ☐ Do not know

Hypertension/High Blood Pressure (HTN)

☐ Yes ☐ No ☐ Do not know

Osteoarthritis (OA)

☐ Yes ☐ No ☐ Do not know

Rheumatoid Arthritis (RA)

☐ Yes ☐ No ☐ Do not know

Systemic Lupus Erythematosus (SLE)

☐ Yes ☐ No ☐ Do not know

Stroke

☐ Yes ☐ No ☐ Do not know

Relationship:

Additional Comments: _____

ALLERGIES: Please write the medication(s) or food(s) you are allergic to in the appropriate spaces:

☐ Pollen

☐ Medicines: _____

☐ Food: _____

☐ Other: _____

☐ No known allergies

Please list *ALL* the medications you are currently taking, the dosage, and for how long you have been taking them:

EXAMPLE: 1. Coumadin, 5 mg., every day, for 2 weeks

2. Percocet, 1 tab, every 6 hours, for 7 days

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

HABITS: Do you drink any **CAFFEINATED BEVERAGES?** (This includes **COFFEE, CHOCOLATE, TEA, SODAS**, etc):

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Approximately how many number of cups of coffee/tea do you drink daily?
_____ cups of coffee _____ cups of tea

Do you drink any ALCOHOLIC BEVERAGES? (This includes **BEER, WINE, RUM, WHISKEY**, etc):

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Approximately how many numbers of drinks do you drink daily?
_____ (# of drinks) (Type of drink): _____

_____ (# of drinks) (Type of drink): _____

Do you smoke or use TOBACCO in any form? (**INHALED, CHEWED**, etc):

NOW: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

PAST: ☐ Never ☐ Occasionally ☐ Moderately ☐ Heavily

Approximately how many packs do you smoke daily?
_____ (# of packs) For how long? _____

GENERAL MEDICAL CONDITION:

Please mark **ALL THE BLANKS** that apply and explain, if necessary:

Height: ____ FEET ____ INCHES Weight: ____ LBS.

A. General health:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

B. Head:

- ☐ Headaches
- ☐ Past injury
- ☐ Other: _____

C. Neck:

- ☐ Stiffness
- ☐ Pain
- ☐ Arthritis
- ☐ Other: _____

D. Skin:

- ☐ Infections
- ☐ Boils
- ☐ Psoriasis/Rashes
- ☐ Other: _____

E. Eyes:

- | | | | |
|--|--------------------------------|-------------------------------|-------------------------------|
| ☐ Blindness: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Glasses or Contact Lenses | | | |
| ☐ Glaucoma | | | |
| ☐ Blurred Vision: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Cataracts: | ☐ Right | ☐ Left | ☐ Both |
| ☐ Other: _____ | | | |

F. Constitution:

- ☐ Fever
- ☐ Chills
- ☐ Malaise
- ☐ Weight Loss

- G. Ears:**
- ☐ Hearing Loss: ☐ Right ☐ Left ☐ Both
- ☐ Hearing aid
- ☐ Ringing/Buzzing
- ☐ Infection
- ☐ Other: _____

- H. Nose and Throat:**
- ☐ Bleeding
- ☐ Hoarseness
- ☐ Polyps
- ☐ Sinus trouble
- ☐ Trouble swallowing
- ☐ Other: _____

- I. Respiratory System Throat:**
- ☐ Asthma
- ☐ Wheezing
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Pain on breathing
- ☐ Tuberculosis
- ☐ Other: _____

- J. Cardiovascular System:**
- ☐ Chest pain
- ☐ Heart disease (INFARCTS, ARRHYTHMIAS, DEFECTS, etc.) **Date:** _____
- ☐ Leg cramps: ☐ at night ☐ while walking
- ☐ Heartbeat: ☐ irregular ☐ fast
- ☐ Blood pressure: ☐ high ☐ low
- ☐ Cold fingers/toes
- ☐ Sweating fingers/toes
- ☐ Other: _____

- K. Bleeding:**
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Bruise easily
- ☐ Prolonged bleeding after shaving
- ☐ Other: _____

L. Stomach and Bowel:

- ☐ Ulcer
- ☐ Loss of appetite
- ☐ Swelling
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colitis
- ☐ Nausea/Vomiting
- ☐ Pain
- ☐ Change in bowel habits
- ☐ Gallbladder problems
- ☐ Pancreatitis
- ☐ Bleeding
- ☐ Other: _____

M. Urinary System

- ☐ Leakage
- ☐ Back pain
- ☐ Sores on genitalia
- ☐ Discharge/drainage
- ☐ Strong urine
- ☐ Bloody urine
- ☐ Frequent urination
- ☐ Nighttime urination
- ☐ Trouble urinating (starting, stopping)
- ☐ Urinary infections
- ☐ Other: _____

N. Metabolic:

- ☐ Diabetes
- ☐ Hypoglycemia (low blood sugar)
- ☐ Thyroid trouble
- ☐ High Cholesterol
- ☐ Other: _____

O. Neurological System/Headaches:

- ☐ Seizures (epilepsy)
- ☐ Paralysis
- ☐ Fainting
- ☐ Stroke
- ☐ Numbness
- ☐ Balance problems
- ☐ Other: _____

P. Psychological:

- ☐ Nervous breakdown
- ☐ Crying frequently
- ☐ Tension
- ☐ Feeling BLUE
- ☐ Anxious
- ☐ Stress-prone
- ☐ Insomnia
- ☐ Psychosis
- ☐ Exhausted
- ☐ Other: _____

Q. Prior diseases or infections:

- ☐ Hepatitis
- ☐ Sexually transmitted: (Syphilis, AIDS, herpes, others...)
- ☐ Cancer: (what type): _____
- ☐ Infections: (what type): _____
- ☐ Other: _____

R. Female History:

- ☐ Menopause
- ☐ Menstruating: (If yes, please indicate date of last menstruation: _____)
- ☐ Birth control pills
- ☐ Intra Uterine Device (I.U.D.)

S. Number of pregnancies: _____

T. Number of live births: _____

U. Prior surgeries: (Please specify the procedure and date the surgery was done.)

- | | | | | |
|--|-------|--------------------------------|-------------------------------|-------------------------------|
| ☐ Back fusion | _____ | | | |
| ☐ Brain surgery | _____ | | | |
| ☐ Thyroid surgery | _____ | | | |
| ☐ Heart bypass surgery | _____ | | | |
| ☐ Bowel removal | _____ | | | |
| ☐ Kidney removal | _____ | | | |
| ☐ Hysterectomy | _____ | | | |
| ☐ Kidney stones | _____ | | | |
| ☐ Lumbar disc removal | _____ | | | |
| ☐ Chest surgery | _____ | | | |
| ☐ Cataract removal: | _____ | ☐ Right | ☐ Left | ☐ Both |
| ☐ Stomach removal | _____ | | | |
| ☐ Colostomy | _____ | | | |
| ☐ Gallbladder removal | _____ | | | |
| ☐ Caesarian section | _____ | | | |
| ☐ Appendectomy | _____ | | | |
| ☐ Prostate removal | _____ | | | |
| ☐ Balloon angioplasty | _____ | | | |
| ☐ Bladder repair | _____ | | | |
| ☐ Hemorrhoidectomy | _____ | | | |
| ☐ Tubal ligation | _____ | | | |
| ☐ Vascular surgery | _____ | | | |
| ☐ Vein ligation/stripping | _____ | | | |
| ☐ Inguinal hernia repair: | _____ | ☐ Right | ☐ Left | ☐ Both |
| ☐ Other: | _____ | | | |

In any of the above surgeries, did you ever have complications with?:

- ☐ Anesthesia ☐ Blood clots ☐ Infection

The following information is *VOLUNTARY, STRICTLY CONFIDENTIAL*, and used for *RESEARCH PURPOSES ONLY*:

Your annual income is:

- ☐ Less than \$13,000
☐ From \$13,001 to \$19,999
☐ From \$20,000 to \$39,999
☐ From \$40,000 to \$59,999
☐ From \$60,000 to \$79,999
☐ From \$80,000 to \$99,999
☐ More than \$100,000
☐ Prefer not to answer