THE METROPOLITAN NEROSURGERY GROUP LLC

FOLLOW UP QUESTIONNAIRE

DATE: _____/_____/_____

FIRST NAME_____ **LAST NAME**_____ D.O.B._____ POST OP. (within 3 months of surgery) ☐ YES ☐ NO LAST VISIT DATE: _____ MOST RECENT SURGERY DATE: _____ Type:_____ _____	Primary Care Physician:_____ PCP Tel: _____Fax:_____ Address:_____ _____ _____ Please list all physicians we should send today's visit note to: _____ _____ _____ _____

HAS YOUR INSURANCE CHANGED RECENTLY?_____
IF YES, PLEASE PROVIDE OUR OFFICE A COPY.

ADDRESS: P.O. BOX:_____ or: STREET ADDRESS:_____ CITY:_____STATE:_____ZIP:_____

HOME PHONE:	CELLULAR:	EMAIL:

Preferred Pharmacy Name and Address:	Pharmacy phone no:

Height: _____'_____"	**Weight:** _____**lbs.**	**BP** (leave for staff): _____ /_____	**HR** (leave for staff): _____ / min

List the 3 top concerns that you would like to discuss today:

1_____
_____
_____

2_____
_____
_____

3_____
_____
_____

Imaging, tests or reports brought for review today:

1_____**2**_____

3_____**4**_____

NEUROSURGICAL HISTORY

PLEASE LIST ALL BRAIN OR SPINAL PROCEDURES IN CHRONOLOGICAL ORDER:

SURGERY:	APROXIMATE DATE:	SURGEON:

SYMPTOMS

PLEASE LIST WHAT SYMPTOMS ARE IMPROVED SINCE YOUR LAST VISIT OR SURGERY:

_____
_____
_____
_____

PLEASE LIST WHAT SYMPTOMS ARE UNCHANGED SINCE YOUR LAST VISIT OR SURGERY:

_____
_____
_____
_____

PLEASE LIST WHAT SYMPTOMS ARE WORSE SINCE YOUR LAST VISIT OR SURGERY:

_____
_____
_____
_____

PAIN

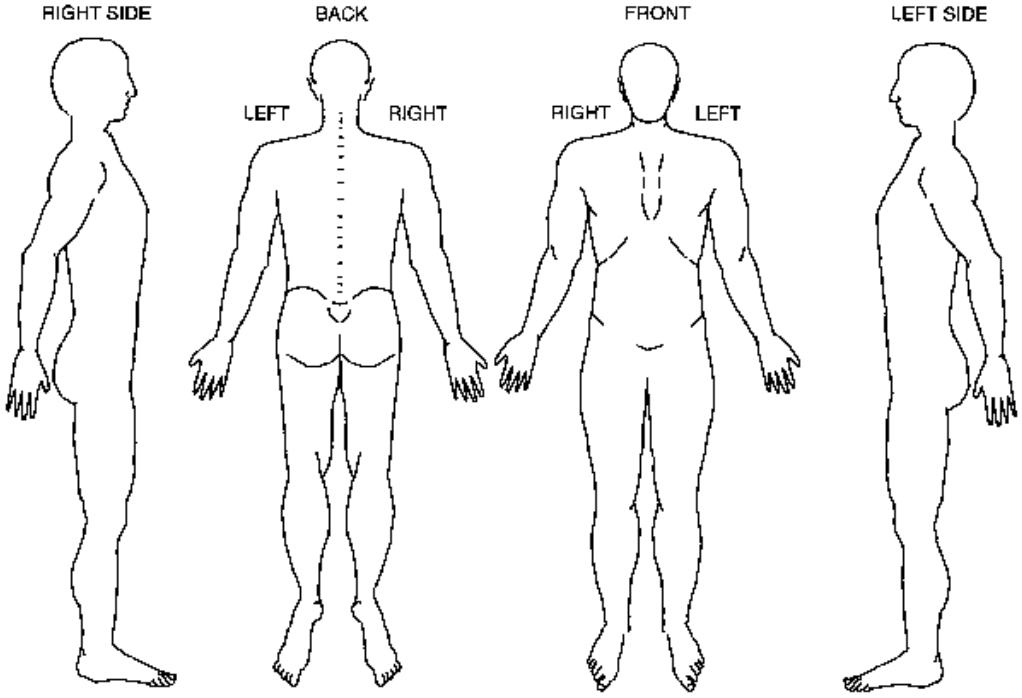
Overall average pain level (0-10): _____

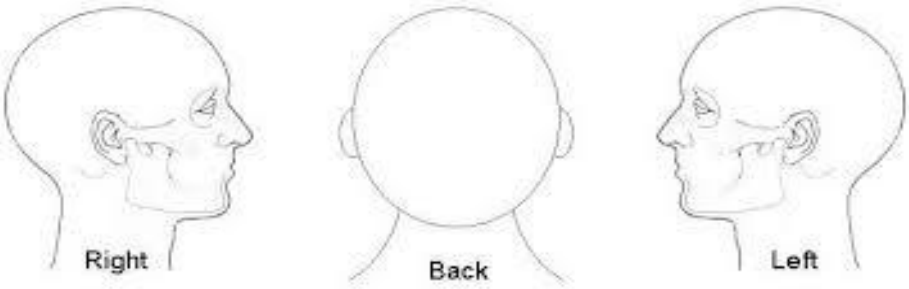
On a scale from 0-10 what is your worst pain level? _____ How often?_____

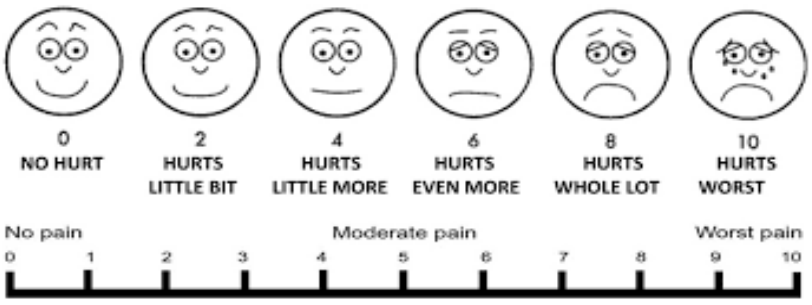
On a scale from 0-10 what is your best pain level? _____ How often?_____

PAIN ASSESSMENT:

Using the diagrams below, please indicate pain location, type, frequency and intensity.







PAIN TYPE:

+ aching **↓↓ pins and needles**

♯ numb **● dull/throb**

▼sharp **≈ nerve pain**

FREQUENCY

© continuous

≠ on and off

PLEASE LIST ANY CONSERVATIVE TREATMENTS THAT YOU HAVE TRIED SINCE LAST VISIT:

PHYSICAL THERAPY:
Length of treatment and frequency:_____
Does your physical therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OCCUPATIONAL THERAPY:
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

OTHER TYPES OF THERAPY (aqua, massage, dry needling, acupuncture, etc):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Does your therapist specialize in EDS/Hypermobility?_____
Describe your response to treatment:_____
_____
_____

NERVE BLOCKS AND EPIDURAL INJECTIONS: Date(s):_____
Type of block/injection_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES/TREATMENTS (BACLOFEN PUMP, TENS UNIT, etc.):
Type of procedure/treatment:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

BRACES: Type of brace:_____
Length of treatment and frequency:_____
Describe your response to treatment:_____
_____
_____

OTHER PROCEDURES, TREATMENTS OR MEDS (e.g. medications you have tried in the past for related symptoms, such as neurogenic bladder, chronic constipation/gastroparesis, nausea, POTS, etc).
_____
_____
Length of treatment and frequency:_____
Describe your response to treatment: _____

PLEASE LIST ALL MEDICATIONS THAT YOU HAVE TRIED FOR PAIN SINCE LAST VISIT:

NARCOTIC PAIN MEDICATIONS (e.g.: Oxycodone, Oxycontin, Dilaudid, Morphine Sulfate, Fentanyl patches, Percocet, Methadone, Marinol, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

ORAL CORTICOSTEROIDS (e.g.: Medrol, Solucortef, Cortisone, Prednisone, Prednisolone, Methylprednisolone, Decadron, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

N.S.A.I.D.S (e.g.: Aspirin [Bufferin, Bayer, and Excedrin], Ibuprofen [Advil, Motrin, Nuprin], Ketoprofen [Actron, Orudis], Naproxen [Aleve], Daypro, Indocin, Lodine, Naprosyn, Relafen, Vimovo, Voltaren, Celebrex, Ketorolac, etc)

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Drug			
Dose			
Frequency			
Length of treatment			
Response to treatment			
Are you still taking it?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

OTHER MEDICATIONS (please print)

Nr.	Medication	Dose	Frequency	Prescribing Physician	Since (year)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					

ALLERGIES

Nr.	Allergen	Reaction	Mild	Moderate	Severe
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Indicate severity using number scale | 1 = None or Minimal | 2 = Mild | 3 = Moderate | 4 = Severe | 5 = Incapacitating

NEUROLOGICAL						**MUSCULOSKELETAL**					
Hyperaccusis/sensitivity to noise	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Neck pain on bumpy roads	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Ringing in the ears	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Muscle pain at rest	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Loss of hearing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Cramps/stiff muscles	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Balance disorder	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Pain in legs while walking	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Vertigo (room spinning around)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Back pain standing/walking	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Dizziness/ightheadedness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Back pain when lying down	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Shaking episodes	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Back pain walking up incline	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Seizures	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Lower back pain	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Tremos	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Sacral pain	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Headache	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Sleep with knees bent	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Neck pain	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	**CARDIOVASCULAR/AUTONOMIC NERVOUS SYSTEM**					
Loss of consciousness/syncope	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Feeling heart beats/palpitations	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Concentration difficulties	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Chest tightness/pain at rest	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Memory loss	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Chest pain on exertion	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Blurred vision	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Shortness of breath at night	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Double vision	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Shortness of breath at rest	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Teichopsia (vision flashes)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Shortness of breath on exertion	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Photosensitivity (light sensitivity)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Fingers change color	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Foreign body sensation in eye	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Excessive sweating	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Hyperolfaction (sensitive to smell)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Heat intolerance	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Facial numbness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Fever	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Paresthesia/tingling/sensory loss	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Changes in sleep pattern	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Leg weakness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Abnormally dilated pupils	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Arm weakness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	**GASTROINTESTINAL**					
Nausea/vomiting	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Abdominal pain	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Poor coordination	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Bloating	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Speech difficulty	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Constipation	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Hoarseness	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Heart burn	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Choking	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Diarrhea	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Difficulty swallowing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Black stool/blood in stool	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
CONSTITUTIONAL						Loss of bowel control	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Fatigue	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	**GENITOURINARY**					
Rashes	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Burning with urination	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Easily bruised	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Increased frequency / urination	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Joint pain	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Loss of bladder control	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Poor wound healing	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Nocturia (urination at night)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Frequent infections	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Difficulty initiating stream	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Anemia	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Unable to empty bladder	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Excessive bleeding	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Scoliosis	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Change in appetite	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	**PSYCHIATRIC**					
Weight loss	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Depression	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Swollen lymph nodes	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	Anxiety/panic	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Thyroid disorder	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐						
Hair loss	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐						

NAME: _____

STANDING TIME (Please choose one)

- ☐ **0** - On most occasions, I can stand as long as necessary without experiencing orthostatic symptoms
- ☐ **1**- On most occasions, I can stand *more than 15 minutes* before experiencing orthostatic symptoms
- ☐ **2**- On most occasions, I can stand *5-14 minutes before* experiencing orthostatic symptoms
- ☐ **3**- On most occasions, I can stand *1-4 minutes before* experiencing orthostatic symptoms
- ☐ **4**- On most occasions, I can stand *less than 1 minute before* experiencing orthostatic symptoms

ORTHOSTATIC (Please choose one)

1. **Frequency of orthostatic symptoms**
   - ☐ 0- I *never or rarely* experience orthostatic symptoms when I stand up
   - ☐ 1- I *sometimes* experience orthostatic symptoms when I stand up
   - ☐ 2- I *often* experience orthostatic symptoms when I stand up
   - ☐ 3- I *usually* experience orthostatic symptoms when I stand up
   - ☐ 4- I *always* experience orthostatic symptoms when I stand up
2. **Severity of orthostatic symptoms**
   - ☐ 0- I *do not* experience orthostatic symptoms when I stand up
   - ☐ 1- I experience *mild* orthostatic symptoms when I stand up
   - ☐ 2- I experience *moderate* orthostatic symptoms when I stand up and *sometimes* have to sit back down for relief
   - ☐ 3- I experience *severe* orthostatic symptoms when I stand up and *frequently* have to sit back down for relief
   - ☐ 4- I experience *severe* orthostatic symptoms when I stand up and *regularly faint* if I do not sit back down
3. **Conditions under which orthostatic symptoms occur**
   - ☐ 0- I *never or rarely* experience orthostatic symptoms under any circumstances
   - ☐ 1- I *sometimes* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - ☐ 2- I *often* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - ☐ 3- I *usually* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - ☐ 4- I *always* experience orthostatic symptoms when I stand up; the specific conditions do not matter
4. **Activities of daily living**
   - ☐ 0- My orthostatic symptoms *do not interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - ☐ 1- My orthostatic symptoms *mildly interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - ☐ 2- My orthostatic symptoms *moderately interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - ☐ 3- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - ☐ 4- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)/ *I am bed or wheelchair bound because of my symptoms*

WOOD MENTAL FATIGUE INVENTORY

In the last month, have you been bothered by each of the following? (Please check the most appropriate box)

	Not at All	A Little	Some-what	Quite A Lot	Very Much
Spells of confusion	○	◉	○	○	○
Thoughts getting mixed up	○	○	○	○	○
Poor Concentration	○	○	○	○	○
Difficulty making decisions	○	○	○	○	○
Poor memory for recent events	○	○	○	○	○
Can't take things in when speaking to people ( )		○	○	○	○
Thoughts are slow **(CONTINUED)**	○	○	○	○	○
Muzzy or foggy head	○	○	○	○	○
Can't find the right words	○	○	○	○	○
Scoring for each item:	**0**	**1**	**2**	**3**	**4**

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Circle One Number on Each Line)

	Yes, Limited a Lot (1)	Yes, Limited a Little (2)	No, Not limited at All (3)
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1 ☐	2 ☐	3 ☐
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1 ☐	2 ☐	3 ☐
Lifting or carrying groceries	1 ☐	2 ☐	3 ☐
Climbing several flights of stairs	1 ☐	2 ☐	3 ☐
Climbing one flight of stairs	1 ☐	2 ☐	3 ☐
Walking more than a mile	1 ☐	2 ☐	3 ☐
Walking several blocks	1 ☐	2 ☐	3 ☐
Walking one block	1 ☐	2 ☐	3 ☐
Bathing or dressing yourself	1 ☐	2 ☐	3 ☐

OTHER PERTINENT INFORMATION YOU WOULD LIKE TO ADD:

Submit Form

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