Patient Information Sheets for DR. FERNYHOUGH - Lumbar

PLEASE CIRCLE AND/OR FILL IN THE ANSWERS TO THE FOLLOWING QUESTIONS ON ALL PAGES.

Who referred you to our office?_____Who is your family physician? _____

Other physicians who should receive correspondence about today's visit? _____

Age: ____ Sex: _____ Male Female What do you do for a living? _____

Height _____ Weight _____ Patient's Date of Birth: _____

FOR PHYSICIAN USE ONLY:

For Motor Vehicle Accidents: **Emerg Med Condition? Yes No**

MAIN COMPLAINT: Is your chief complaint?:

Back Pain	Yes		No
Right Leg Pain	Yes		No
Left Leg Pain	Yes		No
Both legs	Yes		No
Which leg is worse?	Right	OR	Left
Are your pains variable?	Yes		No

What is the severity of the back pain? 0 to 10/10?:_____ OR pain ranges from ___/10 to ___/10
Severity of leg pain 0 to 10/10?: _____ OR pain ranges from ___/10 to ___/10
The back pain is worse than the leg pain Yes No
The leg pain is worse than the back pain Yes No
Out of 100%, my pain is _____% back pain, and _____% leg pain.

DURATION OF SYMPTOMS:

How long have you had the back pain?	____ years	____months	____weeks
How long have you had the leg pain?	____ years	____months	____weeks
Are the symptoms episodic?		Yes	No
The current episode has been present for	____ years	____months	____weeks

Since the onset of the current symptoms, you feel better? Yes No
Since the onset of symptoms, do you feel worse? Yes No
If better, what percentage % better: _____ % better
Or, do you feel about the same? Yes No

Does the Leg Pain travel down your leg? Yes No
If yes, circle the location(s) where the pain travels to: (circle)
Buttock Back of Thigh Calf Ankle Foot Toes
Groin Front of Thigh Shin Foot

Was this pain caused by an **INJURY?** Yes No
What happened?

DESCRIPTION OF PAIN: (circle)
LEG PAIN: Sharp Dull Aching Burning Stabbing Electrical
Is the leg pain constant? Yes No
Is the leg pain intermittent (comes and goes)? Yes No
Is the leg pain excruciating? Yes No
Is the leg pain agonizing? Yes No
Leg pain wakes you up at night? Yes No
Is the leg pain livable? Yes No
The leg symptoms worsen with: Activity Walking Standing Sitting Lying Down
The leg symptoms improve with: Lying down Sitting Walking
Pins and Needles Sensation down leg? Yes No
Numbness and Tingling down the leg? Yes No

BACK PAIN: Sharp Dull Aching Burning Stabbing
Is the back pain constant? Yes No
Is the back pain intermittent (comes and goes)? Yes No
Is the back pain excruciating? Yes No
Is the back pain agonizing? Yes No
Back pain wakes you up at night? Yes No
Is the back pain livable? Yes No
The back symptoms worsen with Activity Transitioning up/down from a chair
Walking Standing Sitting Lying Down
The back symptoms improve with: Lying down Sitting Walking Resting/Inactivity
Are you restricted in all activities due to the pain? Yes No
How long can you stand before you have leg pain?: _____ minutes.
How long can you stand before you have back pain?: _____ minutes

EXERCISE ROUTINE?: Yes No
How many days per week? _____
Type of exercise: Treadmill Stationary bike Swimming Weightlifting Walking
Other types of exercise: _____
Sports: Tennis Golf Other? _____

Walking: Are you able to walk? Yes No

How far? Unlimited 1 – 2 blocks Less than ½ block

Do you use an assistive device to help you walk? Yes No

What type: Cane Walker Wheelchair

Does leaning forward on a grocery cart improve your symptoms? Yes No

How far can you walk before you must stop and sit? _____ (distance)

Right leg weakness? Yes No

Left leg weakness? Yes No

Location of weakness? Thigh Knee Calf Ankle Foot drop Knee Buckles

Do you have difficulty stair climbing? Yes No

Does the pain change in quality or location? Yes No

Is the pain constant? Yes No **OR…**

Is the pain intermittent? (comes and goes) Yes No

Do you have incontinence of urine? Yes No Date it started: _____

Do you have incontinence of bowel? Yes No Date it started: _____

PREVIOUS LUMBAR SPINAL SURGERY ?: Yes No

Surgery Type: Laminectomy Discectomy Fusion Other: _____

When? (mo/yr)_____ Where was surgery done? _____

Surgeon's Name:

The surgery was done due to back pain Yes No

The surgery was done due to leg pain Yes No Right Left

Did the surgery help? Yes No

TREATMENT FOR THIS PROBLEM THUS FAR: (circle)

What **MEDICATIONS** have you tried for the pain?

Anti-Inflammatories: Celebrex, Mobic, Motrin, Ibuprofen, Naprosyn, Relafen, Lodine, Steroid Dosepak, Aleve, Advil, Daypro.

Narcotics: Percocet, Vicodin, Norco, Codeine, oxycodone, OxyContin, Oxy-IR, Lortab, Duragesic Patch

Other medications tried for this problem: Neurontin, Lyrica, Valium, Soma, Skelaxin, Flexeril, Topamax, Cymbalta, Elavil, Tylenol, Ultracet, Ultram.

What Medications are you taking **currently** for the **pain**? **What dose and how often**?

1. 4.
2. 5.
3. 6.

Have you ever had **lumbar epidural steroid injections?** Yes No

When? _____ How many? _____ By whom? _____

Did the injections help? Yes No

Have you ever had **lumbar facet injections?** Yes No

When? _____ How many? _____ By whom? _____

Did the injections help? Yes No

Have you had any **physical therapy** for this problem? Yes No
How many times per week? _____ How many weeks? _____
Did the physical therapy help? Yes No

Have you used a **back brace?** Yes No
Did the brace help? Yes No

What **other treatments** have you had? Chiropractic. Massage. TENS unit. Acupuncture.
Other? _____
How many visits/sessions of each of these treatments? _____

Any other physicians seen, chiropractors? What treatments were done? Did it help?

PAST MEDICAL HISTORY: Please circle all that you have.

Diabetes	Heart disease	Atrial fibrillation	Coronary artery disease
Stroke	Hypertension	Kidney disease	Heart Attack _____when?
Depression	Panic/anxiety attacks	Irritable bowel	Cancer _____ type?
Osteoporosis	Migraine headaches	Thyroid problems	Rheumatoid arthritis
Osteopenia	Osteoarthritis	Psoriasis	Stomach ulcers
Asthma	Bronchitis	Lung disease	Parkinson's disease
Gastritis	Colon problems	Prostate problems	Hepatitis _____ type?
HIV	AIDS	TMJ syndrome	Insomnia
Hiatal hernia	Liver disease	Fibromyalgia	Polymyalgia rheumatica
Bone marrow cancer		Bone marrow abnormalities	
Bleeding disorder		Platelet abnormalities or platelet problems	

Any recurrent infections? Yes No **Any fractures of spine or other bones? Yes No**

PAST SURGICAL HISTORY: (Include surgeon's name and year of surgery.)

Pacemaker	Defibrillator implant	Coronary artery bypass graft
Stents-cardiac	Lung cancer surgery	Colon cancer surgery
Stents-aortic	Hip replacement	Breast cancer surgery
Stents-legs	Knee replacement	Knee arthroscopy
Kidney surgery	Spine surgery	Shoulder surgery
Hysterectomy	Gallbladder	Appendectomy
Tonsillectomy		

Other surgeries:

SOCIAL HISTORY:

Do you smoke? Yes No
How many packs per day? _____
Do you drink alcohol ? Yes No
How much per day? _____
Married? Single? Live alone? Live in an Assisted Living Facility? Live in your own home?

MEDICATIONS: Please list.

1. 5.
2. 6.
3. 7.
4. 8.

Others:

Are you currently taking any of the following anticoagulants or anti-platelet medications: (Circle)

Coumadin? Plavix? Aspirin? Baby aspirin? Pradaxa? Xarelto? Aggrenox? Effient? Eliquis? Persantine? ReoPro? Lovenox?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin

Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.

1. 3.
2. 4.

REVIEW OF SYSTEMS:

Do you have any of the following?

Recent weight changes?____ Loss of sensation in perineal/pelvic skin area? _____

Sinus problems? _____	Blurred Vision? _____	Decreased Hearing? _____
Sore Throat? _____	Abnormal Heart Beat? _____	Heart Attack? _____
High Cholesterol? _____	Thyroid Problems? _____	Fatigue? _____
Shortness of Breath? _____	Chest Pain? _____	Abdominal Pain? _____
Constipation? _____	Diarrhea? _____	Nausea? _____
Vomiting? _____	Unexplained Wt. Loss?____	Blood in Stool? ____
Incontinence of Stool? ____	Incontinence of Urine? ____	Problems w/ Urination? ____
Pain in Legs? _____	Swelling in Legs? _____	Poor Circulation in Legs? ___
Depression? _____	Anxiety? _____	

FAMILY HISTORY:

Do you have a positive family history for any of the following?:

Scoliosis? _____ Osteoporosis? _____ Spinal stenosis? _____

Herniated disk _____ Chronic spine pain_____ Back pain _____

Neck pain _____

DR. FERNYHOUGH PATIENTS BACK AND NECK

Were you involved in a **MOTOR VEHICLE ACCIDENT**? YES NO

DATE OF ACCIDENT: _____

Did you have a seatbelt restraint in place? YES NO Did the airbags deploy? YES NO

Did you have loss of consciousness (black-out) YES NO

Were you the driver or passenger?_____ Front seat or back seat? _____

Were you stopped ? YES NO If so, at traffic light or stop sign? _____

Your vehicle was a: _____(Make) _____(Model)

Which collided with a: _____(Make) _____(Model)

Collision: Rear End Collision vs. Front End Collision vs. Side Impact Collision vs "T-Bone" impact. Was impact on driver's or passenger's side? _____

The name of road or intersection in which the accident occurred? _____ City: _____

Estimated speed of your vehicle?: _____ Estimated speed of other vehicle?: _____

The damage to your car: Car was totaled, or sustained $_____ worth of damage
Was your car drivable after the accident? YES NO

Did you go to the hospital or MD or chiropractor immediately after the accident? YES NO
Name of hospital, MD or chiropractor: _____

Did you go by: Ambulance? You drove yourself? Someone else drove you?

Or, if you went later, when and where? _____

When did the pain begin?: Back pain?_____ Leg pain? _____
Neck pain? _____ Arm pain? _____ Headaches? _____

Have you missed work due to the accident? YES NO If yes, how many days? _____

Do you work Part-time or Full-time? (Please circle)

Have you had any medical care yet for this accident? (chiropractor, neurologist, orthopedic surgeon, general practitioner, physical therapy) YES NO If so, describe in detail. _____

Is the pain better, the same, or overall worse since you began treatment? _____

What % better: _____? **OR** What % worse: _____?

Did you have any pain prior to this accident? YES NO

What was your pain score before the accident? Neck (0 to 10 scale): _____ Back (0 to 10 scale):_____

What percentage % of activity can you tolerate since the motor vehicle accident compared to your pre- motor vehicle accident activity level? _____%

Which specific physical activities are you prevented from doing, due to your current pain, that you were able to do before the accident? Examples: Walking, running, sports, gym, weights, work, etc.

Please List: _____

Have you ever had back or neck pain requiring medical care prior to this accident? (circle) YES NO

If yes, when, and what area of your body was treated? _____

Have you had any prior motor vehicle accidents requiring medical care? (circle) YES NO
If so, give date(s): _____