Patient Info Sheets for Dr. Lowen, Scott Howell, Caroline Rangel Patients, LUMBAR

PATIENT'S NAME: _____ **DATE:** _____ **D.O.B.** _____

PLEASE CIRCLE AND/OR FILL IN THE ANSWERS TO THE FOLLOWING QUESTIONS

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

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

What is your age? What is your sex? Male Female

What do you do for a living?

Main Complaint

What is your main complaint?

Back Pain Which Side? Right Left Both
Leg Pain Which Leg? Right Left Both
Both legs Which leg is worse? Right or Left

If your **Leg pain is worse** than your back pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Back pain is worse** than your leg pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

Have you had **previous lumbar Spinal Surgery**? Yes No

Surgery Type: Laminectomy Diskectomy Fusion
When? (mo/yr) Where was surgery done?
Surgeon's Name:
Why was it done?: Due to back pain? Due to leg pain? Due to both back and leg pain?
If leg pain, which leg? Right Left
Did the surgery help? For how long?

Duration of Symptoms

How long have you had the back pain?____ years ____months ____weeks ____days
How long have you had the leg pain? ____ years ____months ____weeks ____days

Are the symptoms episodic? Yes No How many episodes per year? _____ episodes/year
The current episode has been present for ____ years ____months ____weeks

Since the onset of the current symptoms, you feel: Better Worse Same
If better, what percentage % better: _____ % better
If worse, how much worse? _____

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

Injury
Were you injured? Yes No What happened?

Motor Vehicle Crash Yes or No
Date of Accident: _____
Did you wear a seat belt? Yes No
You were the: Driver or Passenger. (Front Seat or Back Seat)
Your vehicle was a : _____make _____model
Collided with a : _____make _____model
Collision: Rear End Collision vs Front End Collison vs Side Impact Collision
Your estimated rate of speed High speed ____mph Low speed ____mph
Other vehicle's estimated rate of speed High speed ____mph Low speed ____mph
Damage to you car: Car was totaled. Vs. Car had $ _____ worth of damage.
Did you have pain prior to this accident? Yes No

Description of Pain
Leg Pain: Sharp Dull Aching Burning Stabbing Electrical
The Leg Pain: **Comes and goes** or **is constant?**
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 or Not Livable?
Leg symptoms worsen with: Athletic Activity Walking Standing Sitting Lying Down
Leg symptoms are improved 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
The Back Pain: **Comes and goes** or **is constant?**
Is the back pain excruciating? Yes No Is the back pain agonizing? Yes No
Back pain wakes you at night? Yes No
Is the back pain: Livable or Not Livable?
Back symptoms worsen with: Athletic Activity Walking Standing Sitting Lying Down
Back symptoms are improved with: Lying down Sitting Walking
Restricted in all activities due to the pain? YES NO

Exercise:
Exercise Routine: _____ days per week.
Type of exercise: Treadmill Stationary bike Elliptical machine Swimming Weightlifting
Other types of exercise:
Sports: Tennis Golf Other_____ _____ times per week

Walking: How far can you walk comfortably?
Unlimited 1 – 2 blocks Less than ½ block Not able to walk
How far can you walk before you must stop and sit? _____ (distance)
You can get up and continue walking after _____ minutes of rest.
Do you use an assistive device? Cane Walker Wheelchair
How long have you been using this? _____
Does leaning forward on a grocery cart improve your symptoms? Yes No

Weakness? Yes No Which leg? Right Left
Location: Thigh Knee Calf Ankle Foot drop Knee Buckles
Difficulty stair climbing? Yes No

Bladder Problems:
Incontinent of urine? Yes No Date it started:_____

Treatment for this problem thus far:

What **Medications** have you taken for the **Pain**?
Anti-Inflammatories:
Celebrex, Mobic, Motrin, Ibuprofen, Naprosyn, Relafen, Lodine, Steroid Dosepak, Aleve, Advil, Daypro.
Narcotic Medications:
Percocet, Vicodin, oxycodone, Codeine, OxyContin, Oxy-IR, Lortab.
Other types:
Neurontin, Lyrica, Valium, Soma, Skelaxin, Flexeril, Topamax, Cymbalta, Elavil, Tylenol, Ultracet, Ultram.
Pain Patches:
Duragesic patch, Flector patch, Lidoderm patch.

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 ever had **sacroiliac joint (SI) injections?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you had any **physical therapy?** Yes No
How many times per week? _____ How many weeks? _____
Did the physical therapy help? Yes No
When was your last session of physical therapy? _____ (Date)

Have you used a **back brace?** Yes No Did it help? Yes No
What **other treatments** have you had? Chiropractic. Massage. TENS unit. Acupuncture?
Other? _____

PAST MEDICAL HISTORY: Please circle all that you have.

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

Others:

PAST SURGICAL HISTORY:

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

Other surgeries:

SOCIAL HISTORY:

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

MEDICATIONS: Please list.

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

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.

HEIGHT: _____ **WEIGHT:** _____

REVIEW OF SYSTEMS:
Do you have any of the following?

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? _____