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NEW SPINE (LUMBAR) PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of visit: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Marital Status: _____

Home Address: _____

Home phone number: _____ Mobile Number: _____ Male Female

Family Doctor Name and Address: _____

Medical Insurance: VHI Aviva Laya Glo Healthcare Garda ESB POMA Self-Pay

Plan type: _____ Policy Number: _____

Who referred you? _____

What is your main problem today? _____

When did your symptoms begin? _____

Are your symptoms the result of an injury? Yes No

If yes, what happened? _____

Is there litigation pending as a result of your pain/injury? Yes No

Have you been treated by anyone for this problem? Yes No If yes, by whom: _____

What investigations have you had to date: X-rays MRI CT Isotope Bone Scan PET Ultrasound

Have you had any treatment to date? Yes No If yes: Medication Physio Injections

MEDICAL HISTORY:

Have you *EVER IN YOUR LIFE* had any of the following problems?

Tick Box *ONLY* if you have a history of the conditions below:

HEART PROBLEMS:

- Chest Pain
- High Blood Pressure
- Irregular Heartbeat
- Valve Disease
- Heart Failure, Heart Attack, Heart Surgery
- Angiogram, Angioplasty (Stenting)

LUNG PROBLEMS:

- Shortness of Breath
- Asthma
- Emphysema/COPD
- Sleep Apnoea

ENDOCRINE PROBLEMS:

- Diabetes
- Thyroid - Hyperthyroidism
- Thyroid - Hypothyroidism

BLADDER OR KIDNEY PROBLEMS:

- Difficulty passing urine
- Urinary tract infections
- Frequency/Urgency

STOMACH OR BOWEL PROBLEMS:

- Ulcers
- Diverticulitis
- Crohn's Disease/Ulcerative Colitis

GENERAL:

- Previous Clots – Lung or Leg
- Epilepsy

CANCER:

- No
- Yes What kind

ARE YOU ALLERGIC TO ANY MEDICATION?

- No
- Yes What happens:

PLEASE LIST ANY **MEDICATION** THAT YOU ARE TAKING NOW (or attach a list):

- | | | |
|----|----|-----|
| 1. | 5. | 9. |
| 2. | 6. | 10. |
| 3. | 7. | 11. |
| 4. | 8. | 12. |

BLOOD THINNING MEDICATION:

Are you taking any of the following medications:

- Pradaxa Xarelto Plavix Warfarin Aspirin

SURGICAL HISTORY

Please list any surgeries that you have had in the past:

SURGERY	SURGEON	LOCATION	DATE
1			
2			
3			
4			
5			
6			
7			

SOCIAL HISTORY

Do you smoke now? Yes No

If Yes, how much? 5/Day 10/Day 20/Day More For How Long? _____

If No, Did you ever smoke? Yes No If Yes, When did you stop? _____

How much did you smoke? 5/Day 10/Day 20/Day More For How Long? _____

Do you drink alcohol? Yes No If Yes, how much in a week? _____

What is your occupation? _____

Where do you live:

House Apartment Nursing Home Assisted living

With whom do you live? _____

FAMILY HISTORY?

Does anyone in your family have a history of arthritis? _____

If so, have they had joint replacement surgery, and what kind? _____

Are your parents deceased? Yes No

If so how did they die:

Mother: Cause: _____ Age _____

Father Cause: _____ Age _____

What is your: HEIGHT? WEIGHT?

PERSON TO CONTACT IN AN EMERGENCY?

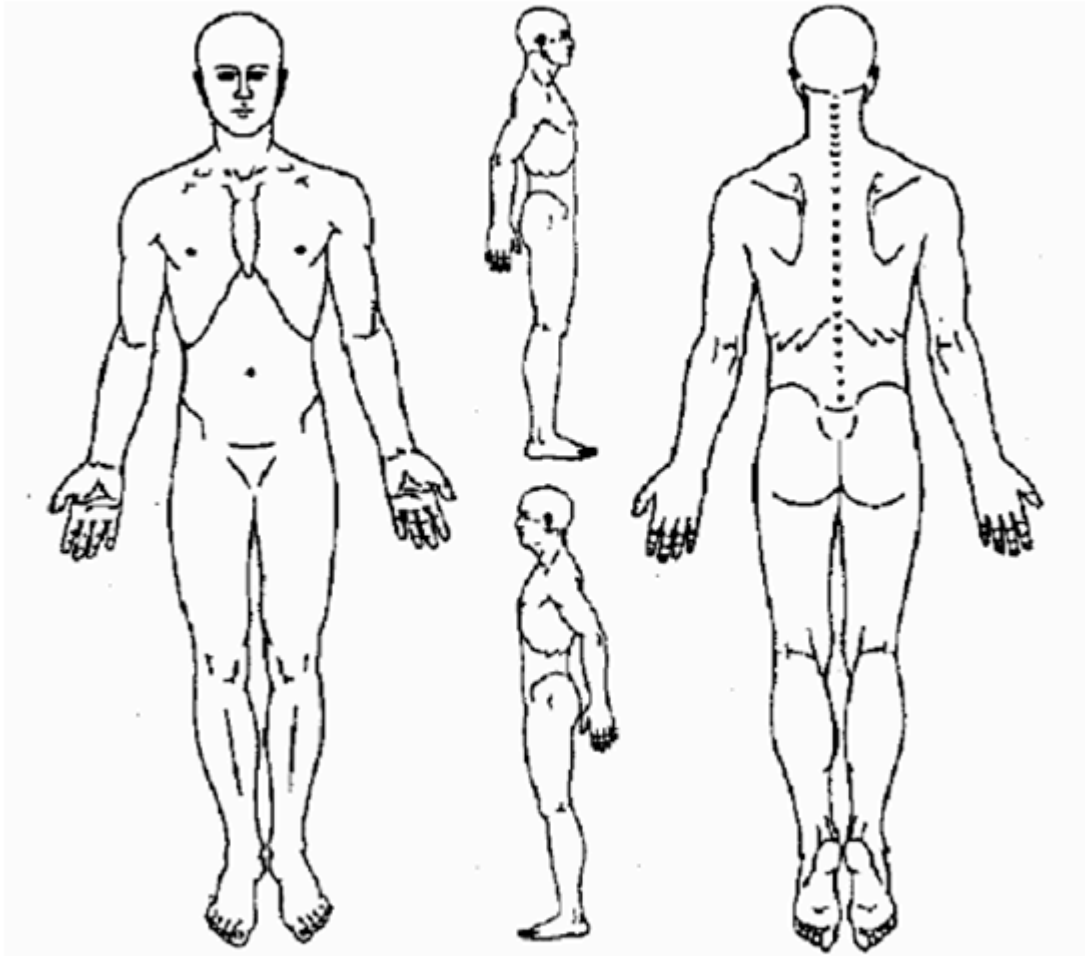
NAME: _____ TEL: _____

NAME: _____ TEL: _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	0 0 0 0 0	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	0 0 0 0 0	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
-----	0 0 0 0 0	^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

Back Pain	<u>0 1 2 3 4 5 6 7 8 9 10</u>
Leg Pain	<u>0 1 2 3 4 5 6 7 8 9 10</u>

Modified Oswestry Low Back Pain Disability Questionnaire

Instructions for completion.

Please answer every question by placing a mark on the line that best describes your condition today. We realise you may that two of the statements describe your condition, but **please mark only the line that most closely describes your current condition.**

1. Pain Intensity

- I can tolerate the pain I have without having to use pain medication.
- The pain is bad, but I can manage without having to take pain medication.
- Pain medication provides me with complete relief from pain.
- Pain medication provides me with moderate relief from pain
- Pain medication provides me with little relief from pain
- Pain medication has no effect on my pain

2. Personal Care (e.g., Washing, Dressing)

- I can take care of myself normally without causing increased pain.
- I can take care of myself normally, but it increases my pain.
- It is painful to take care of myself, and I am slow and careful.
- I need help, but I am able to manage most of my personal care.
- I need help every day in most aspects of my care.
- I do not get dressed, I wash with difficulty, and stay in bed.

3. Lifting

- I can lift heavy weights without increased pain.
- I can lift heavy weights, but it causes increased pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

4. Walking

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can walk only with crutches or a cane.
- I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- I can sit in any chair as long as I like
- I can sit in my favorite chair for as long as I like
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ an hour
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all.

6. Standing

- I can stand as long as I want without increased pain.
- I can stand as long as I want but it increases my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

7. Sleeping

- My sleep is never disturbed by pain.
- I can sleep well only using pain medication.
- Even when I take medication, I sleep less than 6 hours.
- Even when I take medication, I sleep less than 4 hours.
- Even when I take medication, I sleep less than 2 hours.
- Pain prevents me from sleeping at all.

8. Social Life

- My social life is normal and does not increase my pain.
- My social life is normal, but it increases my level of pain.
- Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- Pain prevents me from going out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of my pain.

9. Traveling

- I can travel anywhere without increased pain.
- I can travel anywhere, but it increases my pain.
- My pain restricts my travel over 2 hours.
- My pain restricts my travel over 1 hour.
- My pain restricts my travel to short necessary journeys under 1/2 hour.
- My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment/Homemaking

- My normal homemaking/job activities do not cause pain.
- My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg., lifting, vacuuming).
- Pain prevents me from doing anything but light duties
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores

Please continue on to the next section ↓

Short Form 12 Health Status Questionnaire

Instructions for completion.

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

Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

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

- Excellent** **Very good** **Good** **Fair** **Poor**

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?

- | | 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Climbing several flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

- All of the time** **Most of the time** **Some of the time** **A little of the time** **None of the time**

5. Were limited in the **kind** of work or other activities

- All of the time** **Most of the time** **Some of the time** **A little of the time** **None of the time**

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
 All of the time **Most of the time** **Some of the time** **A little of the time** **None of the time**
7. Didn't do work or other activities as **carefully** as usual
 All of the time **Most of the time** **Some of the time** **A little of the time** **None of the time**
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**

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 the Time | Some of the Time | A Little of the Time | None of the Time |
|---|--------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|
| 9. Have you felt calm and peaceful? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have a lot of energy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. During the <u>past 4 weeks</u> , how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with friends, relatives, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |

For Surgeon use only

Range of Motion:

ROM	R	L
Lumbar Flexion (60°)		
Lumbar Extension(25°)		
Lumbar Lateral Flexion (25°)		
Cervical Flexion (50°)		
Cervical Extension (60°)		
Cervical Lateral Flexion (45°)		
Cervical Lateral Rotation (80°)		

Red Flags:

1. Age <20yrs >55yrs
2. Site.
3. Past Hx. Ca, Steroids, TB, IVDA
4. Night Pain.
5. Weight Loss.
6. Widespread Neurology.
7. Structural Deformity.
8. Abnormal Blood Parameters.
9. Bowel/Urinary Disturbance

Neurology	Motor		Sensory	
	L	R	L	R
C5				
C6				
C7				
C8				
T1				
Reflexes Biceps				
Reflexes Triceps				
Reflexes Supinator				
Reflexes Hoffman				
Scapulohumeral				
Clonus				
Finger Escape				
Spurling's Test				

Neurology	Motor		Sensory	
	L	R	L	R
L2				
L3				
L4				
L5				
S1				
Reflexes KJ				
Reflexes AJ				
Babinski				
Clonus				
Lhermitte's				

Gait: Normal Spastic Unsteady Antalgic Trendelenberg Short Leg
Gait: Heel Walking Toe Walking Dynamic Rhomberg Test Other _____
Alignment: Coronal Balanced Yes No Sagittal Balanced Yes No
Lumbar Lordosis: Present Absent **Scoliosis:** Present Absent
Spinal Rhythm Normal Reversed
Prior incision: Yes No If yes, where? _____ **Skin Condition:** _____
Tender: Yes No If yes, where? _____
Leg Length: Equal Left short _____ mm Right short _____ mmv
Pulses: **Right** DP PT **Left** DP PT
Lasègue's **Right** Degree _____° **Left** Degree _____°
FNST +ve **Right** Yes No **Left** Yes No

XR Analysis: Xrays Date _____

MRI Date: _____

