



Dear _____,

This letter contains important information regarding your future appointment with Dr. _____. Following these instructions will help us to be as thorough as possible in evaluating your spine related condition.

Enclosed are forms that you need to complete prior to your appointment and bring with you on the day of your appointment. Not only will this save time, but by filling out the forms at home, you may have better access to information such dates of injuries, dates of tests, names and dosages of medication, etc. Please take time to fill the forms out as completely as you can.

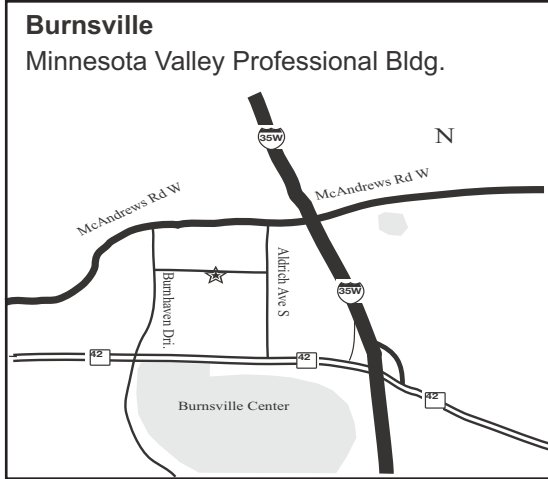
For the day of your appointment your physician will need all **X-rays, MRI scans, CT scans, Bone scans or any other diagnostic studies** such as epidural steroid injection and/or other injection reports, bone density test results and EMG results that you have had done related to your spine problem. This includes both the report and the actual films or disc. *It is your responsibility to make arrangements to get these items to this office for the day of your appointment.* If you have any difficulty obtaining your scans or records, please contact this office prior to your appointment at (952) 456-7000.

If you have not already done so, please contact pre-registration at (952)-512-5603 to pre-register prior to your appointment.

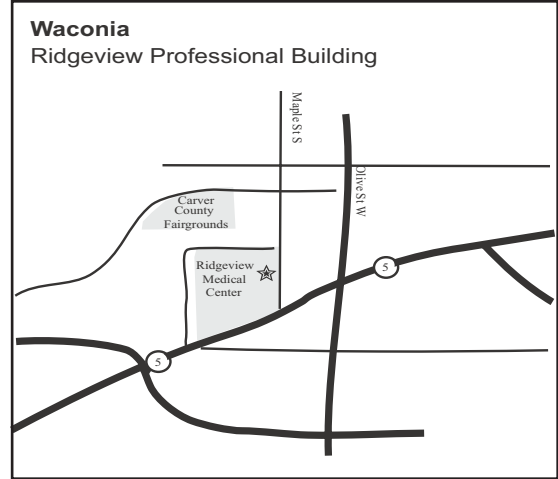
If you are unable to keep your appointment please contact us no later than 24 hours in advance to cancel or reschedule.

Sincerely,

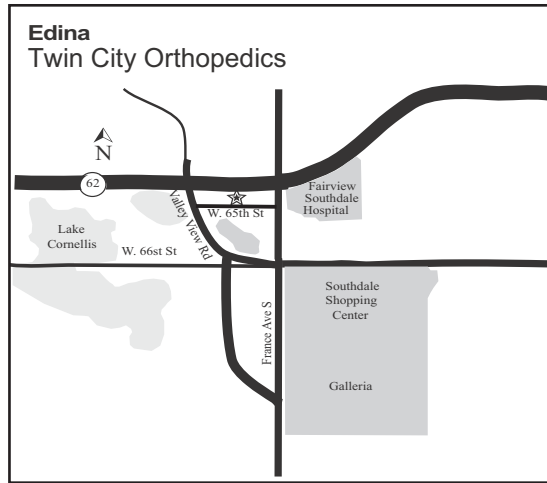
Twin Cities Orthopedics



Burnsville Location
1000 West 140th Street, Suite 201
Burnsville, MN 55337
952-808-3000



Waconia Location
560 South Maple Street
Waconia, MN 55387
952-442-2163



Twin Cities Orthopedics
4010 West 65th Street
Edina, MN 55435
952-456-7000

Your appointment has been scheduled

With: _____

Location: _____

Time and Date: _____

Patient Name: _____
Birthdate ____/____/____
Today's Date ____/____/____

PATIENT HEALTH HISTORY

Please Complete page 1 and 2

Physician you are seeing today _____

Who referred you to our office? _____ Clinic: _____

PAST MEDICAL HISTORY		Do you have a personal history of any of the following: (none or circle)
General	<input type="checkbox"/> None	Cancer Diabetes Thyroid disease Delayed wound healing Malignant hyperthermia Hepatitis AIDS/HIV Difficulty with anesthesia
Heart/Circulation	<input type="checkbox"/> None	MI/Heart attack Blood clots High Blood Pressure Stroke Abnormal Rhythm Pacemaker Bleeding disorders
Lungs	<input type="checkbox"/> None	Asthma Emphysema Oxygen dependence Bronchitis
Gastrointestinal	<input type="checkbox"/> None	Ulcers Appendectomy Gallbladder surgery Crohn's Disease Reflux/GERD
Neuro/Psych	<input type="checkbox"/> None	Depression Anxiety disorder Schizophrenia Seizures Chemical Dep
Musculoskeletal	<input type="checkbox"/> None	Arthritis Gout Fracture Ligament injury/Sprain Fibromyalgia Previous Orthopedic Surgery Bone joint infections
Other		List:

HOSPITALIZATIONS / SURGERIES	YEAR
List all previous hospitalizations and/or surgeries	<input type="checkbox"/> None

MEDICATIONS	
List any medications you are taking and why. Include herbs, inhalers, non-prescription medications <input type="checkbox"/> None	
Dosage/Frequency	Dosage/Frequency

To your knowledge, have you ever taken Prednisone/Cortisone by mouth? yes no don't know

ALLERGIES	
List any medications you are sensitive to and the reaction <input type="checkbox"/> None	

Have you ever had a reaction to: eggs shellfish latex rubber

Do you use tobacco in any form? yes no Quit # ____ years If yes, # per day ____ # of years ____

Do you drink alcohol? yes no Quit # ____ years If yes, # per week ____ # of years ____

Have you ever used recreational drugs? yes no List:

FAMILY HISTORY (Grandparents, parents, siblings)	
Do you have a family history of any of the following? <input type="checkbox"/> None	
<input type="checkbox"/> diseases of muscles, bones, or nervous system	<input type="checkbox"/> difficulty with anesthesia
<input type="checkbox"/> arthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> osteoarthritis	<input type="checkbox"/> diabetes
<input type="checkbox"/> bleeding disorders blood clots	<input type="checkbox"/> infectious diseases
If yes, please explain:	

WORK / SOCIAL HISTORY

Marital status single married separated divorced widowed domestic partner
 Children yes no How many? _____ Ages _____
 Do you live alone with family assisted living nursing home other
 Are you currently working? yes no If no, when did you last work? _____
 Occupation: _____ Employer _____ How long? _____
 Is your regular work? Heavy Medium Light Sedentary
 Are you currently on any work restrictions? yes no If yes, what are they? _____
 Do you exercise or participate in sports on a regular basis? yes no If yes, please explain:

REVIEW OF SYSTEMS (check None or circle any that apply)

General	<input type="checkbox"/> None	recent unexplained weight loss or gain fatigue fever chills night sweating risk factors HIV/AIDS
Eyes	<input type="checkbox"/> None	double vision blurred vision blind spots glasses/contact lenses glaucoma cataracts legally blind
Ears/Nose/Throat	<input type="checkbox"/> None	ringing in ears difficulty hearing use hearing aid deaf (read lips; ASL) frequent nose bleeds hoarseness dry mouth sinus problems dentures/partial plate/braces/caps
Lungs	<input type="checkbox"/> None	chronic cough wheezing shortness of breath pneumonia coughing blood
Heart/Circulation	<input type="checkbox"/> None	chest pain leg swelling hands/feet always cold leg cramps varicose veins easy bruising
Gastrointestinal	<input type="checkbox"/> None	stomach ulcers problems with bowel movements heartburn nausea swallowing problems
Genitourinary	<input type="checkbox"/> None	incontinence painful urination blood in urine trouble starting stream
Reproductive	<input type="checkbox"/> None	pregnant possible pregnancy menopause prostate problems
Musculoskeletal	<input type="checkbox"/> None	joint pain joint swelling stiffness arthritis gout muscle or tendon injuries fractures childhood deformities or braces
Skin	<input type="checkbox"/> None	rashes lumps sores color changes change in hair or nails skin tears easily difficulty healing skin
Neurological	<input type="checkbox"/> None	numbness or tingling weakness pins and needles tremors/shaking seizures dizziness fainting
Endocrine	<input type="checkbox"/> None	thyroid heat or cold intolerance when others are comfortable excessive thirst excessive sweating
Psychiatric	<input type="checkbox"/> None	depression anxiety excessive stress nervousness panic attacks

Patient Signature: _____ **Date** _____

Physician/Non-Physician Signature: _____ **Date** _____

UPDATES OR CHANGES

Date	Remarks	Initial

Spine Pain Questionnaire

Patient Sticker

Patient Name: _____ Date: _____

Referred By: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

What is the reason you are seeing the orthopedic surgeon:

- Evaluation and treatment 2nd opinion Disability rating

History of Current Problems.

1. Date that your back or neck problems started? _____
2. Have you had a similar problem in the past? No Yes If yes, when _____
Please describe: _____
3. Is your current problem the result of a: No injury that you know of Work injury
 Motor vehicle accident Other injury If an injury, give **Date of Injury?** _____
4. Has litigation or claim for compensation been initiated? No Yes
5. Please briefly describe how your current back/neck and/or leg/arm problems first began:

Symptom (Pain) Diagram – Please use the diagrams below to indicate the area of your symptoms and the type of symptoms you are experiencing. Use the appropriate symbol. Include all affected areas.

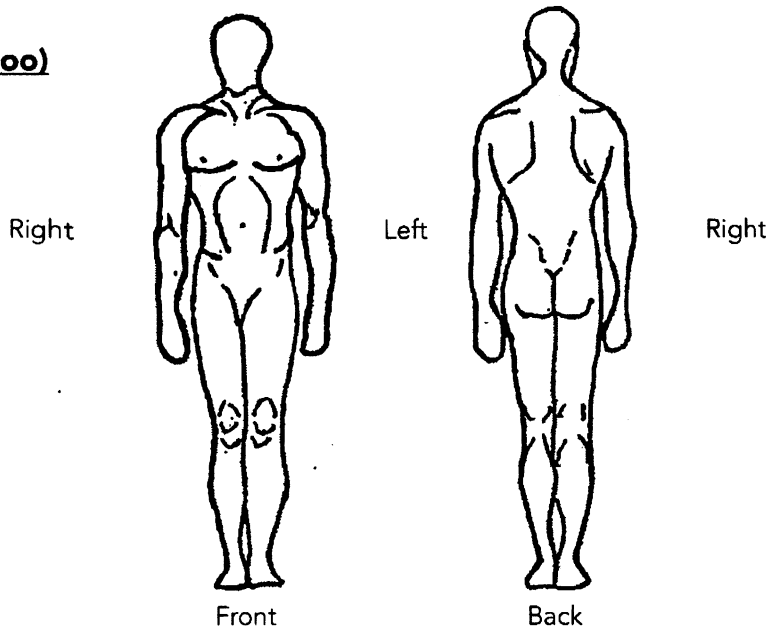
Sharp Pain (///)

Pins/Needles (ooo)

Aching Pain (xxx)

Numbness (+++)

Burning (BBB)



How much of your problem is in your back or leg? **Back** _____ % + **Leg** _____ % = **100%**

If you have pain in your legs, which is worse: Right _____ Left _____ Equal _____

How much of your problem is in your neck or arm? **Neck** _____ % + **Arm** _____ % = **100%**

If you have pain in your arms, which is worse: Right _____ Left _____ Equal _____

Description of Symptoms

Pain Scale: 0 = No Pain 10 = Worst Pain Possible

1. When my pain is at its worst, it is a _____ (Pick a number from the above pain scale).
2. When my pain is at its best, it is a _____ (Pick a number from the above pain scale).
3. Most of the time, my pain is a _____ (Pick a number from the above pain scale).
4. Have you noticed weakness in any muscles since your problem began? No Yes*

*If yes, please describe: _____

5. How far do you estimate you can walk? _____ Feet or _____ Miles or Unlimited

Treatment

What medications are you currently taking for your pain? _____

What medications have you taken in the past for your pain? _____

List the physicians you have seen for this problem. _____

How many times have you been treated by the following professionals?

Physical Therapist: _____ When? _____ Chiropractor: _____ When? _____

Have you had any of the following spinal treatments?

Epidural Steroid Injections Trigger-Point Injections Facet Injections Other: _____

When? _____ When? _____ When? _____ When? _____

Please list any surgeries you have had on your spine?

Date	Surgeon	Procedure
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check any of the following tests or studies you have had and give the date they were done.

- X-Ray _____ CT Scan _____
- MRI Scan _____ EMG Test _____
- Discogram _____ Bone density _____
- Other _____ None of the above

Indicate the severity of your pain today by marking the appropriate lines below with a vertical line.

Back Pain Survey

BACK PAIN:



Check if not applicable

RIGHT LEG PAIN:



Check if not applicable

LEFT LEG PAIN:



Check if not applicable

Neck Pain Survey

NECK PAIN:



Check if not applicable

RIGHT ARM PAIN:



Check if not applicable

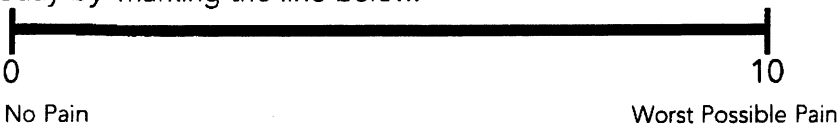
LEFT ARM PAIN:



Check if not applicable

Back/Neck Pain Survey

HIP PAIN: If you had donor bone removed from iliac crest, describe your hip pain today by marking the line below.



Check if not applicable

This survey asks for your views about your health. For each of the following questions, please mark an in the box that best describes your answer.

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

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Excellent | Very Good | Good | Fair | Poor |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

2. The following questions are about activities you might do during a typical day. Does your **health now limit you** in these activities? If so, how much

Yes, very limited Yes, limited a little No, not limited at all

- | | | | |
|---|----------------------------|----------------------------|----------------------------|
| a) Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| b) Climbing <u>several</u> flights of stairs | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

3. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

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

- | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Were limited in the kind of work or other activities | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

4. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of emotional problems** (such as feeling depressed or anxious)?

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

- | | | | | | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a) Accomplished less than you would like | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) Did work or other activities less carefully than usual | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

5. 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 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

6. 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 time **during the past 4 weeks** ...

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

- | | | | | | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| a) have you felt calm or peaceful? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) did you have a lot of energy? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |
| b) have you felt downhearted and depressed? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

7. During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting friends, relatives, etc.)?

- | | | | | |
|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 |

Modified Oswestry Pain Questionnaire

This questionnaire is designed to enable us to understand how much your pain has affected your ability to manage your everyday activities. Please answer each section by marking in each section one box that most applies to you. We realize that you may feel that more than one statement may relate to you, but please **just mark the box that most closely describes your problem.**

Section 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.

Section 2 - Personal Care

- 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 I stay in bed.

Section 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 they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned on a table.
- I can only lift light weights.
- I cannot lift or carry anything at all.

Section 4 - Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile (1 mile = 1.6 km).
- Pain prevents me from walking more than ½ mile.
- Pain prevents me from walking more than ¼ mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

Section 5 - Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than 1 hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

Section 6 - Standing

- I can stand as long as I want without increased pain.
- I have some pain while standing, but it does not increase my pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

Section 7 - Sleeping

- Pain does not prevent me from sleeping well.
- I can sleep well only by 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.

Section 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 pain.

Section 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 ½ hour.
- My pain prevents all travel except for visits to the physician/therapist or hospital.

Section 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 e.g. lifting, vacuuming, etc.
- Pain prevents me from performing anything but light duties.
- Pain prevents me from performing even light duties
- Pain prevents me from performing any job or homemaking chore.