



MANHATTAN ORTHOPAEDICS

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Follow-Up Patient Questionnaire

Today's Date: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Email: _____

Phone: Home: _____ Work: _____ Cell: _____

Change of Address Yes___ No___

Marital Status (Circle One): Single Married Divorced Remarried Widowed Separated

Work Status (Circle One): F/T P/T Not Working Student Disabled Retired

Occupation: _____ Employer: _____ Since? _____

If not working, due to your back pain? _____ Last Date Worked: _____

Tobacco Use: Have you ever smoked? Y / N Number: _____/day Years: _____ If quit, when? _____

Do you get regular exercise? Describe: _____

Medicines: List all medicines that you have taken recently. Include vitamins, aspirin, and nonprescription medicine and *state how long you have been taking them*.

1. _____ Date: _____ 5. _____ Date: _____

2. _____ Date: _____ 6. _____ Date: _____

3. _____ Date: _____ 7. _____ Date: _____

4. _____ Date: _____ 8. _____ Date: _____

Reason for this visit: _____

Chief Complaints

| Do you suffer from? | Yes | No | Since When? |
|--------------------------|-----|----|-------------|
| Neck pain | | | |
| Shoulder pain | | | |
| Arm pain | | | |
| Upper back pain | | | |
| Lower back pain | | | |
| Hip/leg pain | | | |
| Bowel/bladder complaints | | | |
| Any other complaints | | | |

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Which area is the worst? _____

Did your symptoms follow an injury (Circle one)? Y N If yes, where? _____

Circle you least and greatest pain levels over the past two weeks:

(none) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (severe)

Describe your pain (Check all that apply):

- Constant Deep Dull Sharp Intermittent Throbbing
 Stiffness Aching Shooting Cramping Burning Stabbing

When is your pain worse (Check only one)?

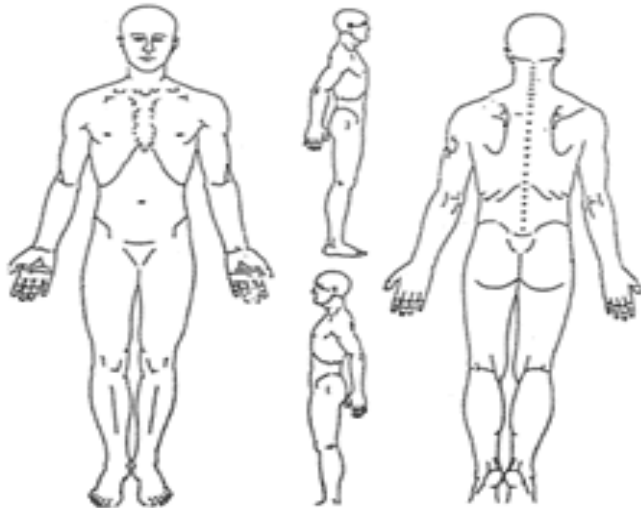
- In the morning At night
 At the end of the shift/day No difference between day and night

What is your pain pattern?

- A single attack of pain Attacks of pain with pain-free intervals
 Continuous pain Continuous pain with attacks of severe pain

For how long can you walk?

- Less than 15 minutes 15 to 30 minutes
 30 to 50 minutes No restrictions



Pain Diagram

Please use the diagrams to indicate where you are experiencing pain and numbness.

Key: Pain xxxxx
 Numbness ooooo

Indicate which activities increase or decrease your pain (Mark **I** for increase; mark **D** for decrease):

- | | | | |
|----------------------------------|-------|-------------------------|-------|
| When I first get out of bed | _____ | Standing | _____ |
| Getting up | _____ | Walking | _____ |
| Sitting | _____ | Bending back | _____ |
| Lying on my back/side | _____ | Lying on stomach | _____ |
| Leaning forwards | _____ | Coughing/sneezing | _____ |
| Lifting/bending forwards | _____ | Twisting | _____ |
| Straining | _____ | Reaching over | _____ |
| Look up/turn head sideways | _____ | Washing/combing hair | _____ |
| Climbing stairs/walking up ramps | _____ | Going down stairs/ramps | _____ |

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Long car rides _____ Other: _____

Please list the most recent studies you have had of your spine:

| Radiology Study | Date | Location |
|------------------------|-------------|-----------------|
| MRI | | |
| CT Scan | | |
| Myleogram | | |
| Bone Scan | | |
| EMG | | |
| X-rays | | |

Most Recent Surgeries

| Year | Operation | Place Hospitalized |
|-------------|------------------|---------------------------|
| | | |
| | | |
| | | |

Did your symptoms improve after surgery? **Y** **N** If yes, how long afterwards? _____

Did you get worse after surgery? **Y** **N** If yes, explain: _____

Were you released back to work after surgery? **Y** **N** If yes, when? _____

Previous Treatment: Put a check next to each type of treatment you have had for you back/neck since your last visit. Then check the column that best describes the treatment's effects.

| <u>Treatment</u> | <u>Dates of treatment</u> | <u>Better</u> | <u>Worse</u> | <u>No Change</u> |
|----------------------|---------------------------|---------------|--------------|------------------|
| Hot/ice packs | _____ | _____ | _____ | _____ |
| Ultrasound | _____ | _____ | _____ | _____ |
| Massage | _____ | _____ | _____ | _____ |
| TENS/Electrical Stim | _____ | _____ | _____ | _____ |
| Toga/ Tai-Chi | _____ | _____ | _____ | _____ |
| Exercises | _____ | _____ | _____ | _____ |
| Traction/DRS | _____ | _____ | _____ | _____ |
| Pool therapy | _____ | _____ | _____ | _____ |
| Biofeedback | _____ | _____ | _____ | _____ |
| Injections | _____ | _____ | _____ | _____ |
| Braces/splints | _____ | _____ | _____ | _____ |
| Medication | _____ | _____ | _____ | _____ |
| Acupuncture | _____ | _____ | _____ | _____ |

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Chiropractic adjustments _____