LAKE CUMBERLAND NEUROSURGICAL ASSOCIATES

NAME: AGE: APPOINTMENT DATE:

OCCCUPATION:_____ LAST DAY WORKED: _____

EMPLOYER NAME AND LOCATION: _____

PLEASE CIRCLE ILLNESSES OR CONDITIONS **YOU** HAVE HAD: DIABETES, CANCER, BLEEDING TENDENCIES, HEART DISEASE, STROKE, HIGH BLOOD PRESSURE, TUBERCULOSIS, NERVOUS ILLNESS, GLAUCOMA, ASTHMA, RHEUMATIC FEVER, MRSA.

PLEASE LIST BELOW ANY OF THE FOLLOWING ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **FAMILY MEMBERS**: DIABETES, CANCER, BLEEDING TENDENCIES, HEART DISEASE, STROKE, HIGH BLOOD PRESSURE, TUBERCULOSIS, NERVOUS ILLNESS, GLAUCOMA, ASTHMA, RHEUMATIC FEVER, MRSA:

MOTHER: FATHER:

BROTHERS/SISTERS: CHILDREN:

ARE YOU **ALLERGIC** TO ANY MEDICATIONS [ ] **NO** [ ] **YES**
IF YES, PLEASE LIST:_____

DO YOU USE TOBACCO? [ ] NO [ ] YES TYPE AND AMOUNT:_____

DO YOU USE ALOCHOL? [ ] NO [ ] YES TYPE AND AMOUNT:_____

HEIGHT: WEIGHT: HOW LONG AT THIS WEIGHT?

MARITAL STATUS: [ ] SINGLE [ ] MARRIED [ ] DIVORCED [ ] SEPARATED

PREVIOUS SURGERIES: DATE HOSPITAL SURGEON

_____

_____

_____

CURRENT MEDICATIONS: PLEASE INCLUDE NAME, DOSAGE AND FREQUENCY

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

WORK RELATED INJURY? [ ] NO [ ] YES DATE OF INJURY: _____
MOTOR VEHICLE ACCIDENT? [ ] NO [ ] YES DATE OF ACCIDENT:_____

MAIN COMPLAINT: _____ WHEN DID IT START? _____

HISTORY OF INJURY OR ILLNESS? (PLEASE FILL OUT COMPLETELY)

_____

_____

PLEASE LIST NAME OF REFERRING DOCTOR: _____

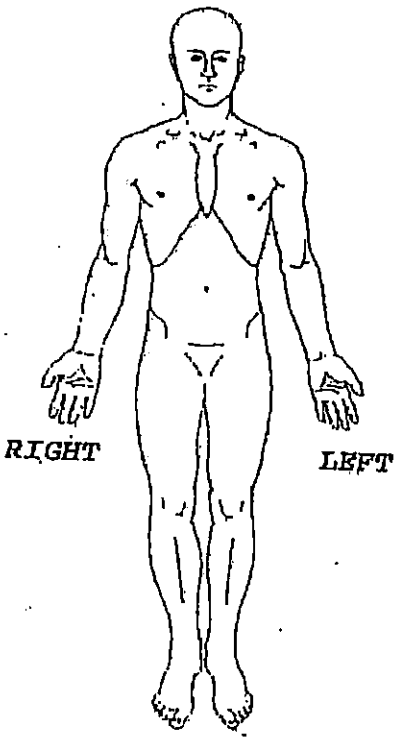
LAKE CUMBERLAND NEUROSURGICAL ASSOCIATES

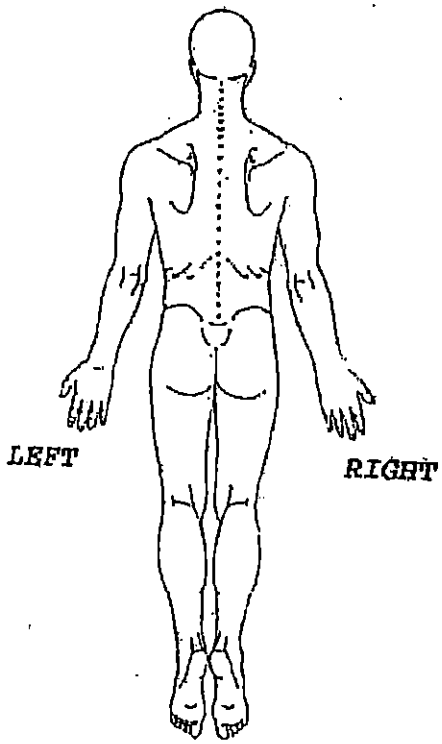
AMR O. EL-NAGGAR, M.D. MAGDY M. EL-KALLINY, M.D.

WHERE IS YOUR PAIN?

USE THE APPROPRIATE SYMBOL TO MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATION. PLEASE INCLUDE ALL AFFECTED AREAS INCLUDING RADIATION.

^^^^	*****	=====	~~~~~	/////
ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING





PLEASE MARK ON THE LINE: ON A SCALE FROM 1-10, HOW BAD IS YOUR PAIN RIGHT NOW?

X _____ X

(0) (10)

NO PAIN WORSE PAIN POSSIBLE

Oswestry Low Back Pain Disability Questionnaire

Instructions

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 – Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. 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 very light weights
- ☐ I cannot lift or carry anything at all

Section 4 – Walking*

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile
- ☐ Pain prevents me from walking more than 1/2 mile
- ☐ Pain prevents me from walking more than 100 yards
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ 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 extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7 – Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9 – Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10 – Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

References

1. Fairbank JC, Pynsent PB. The Oswestry Disability Index. Spine 2000 Nov 15;25(22):2940-52; discussion 52.

Lake Cumberland Neurosurgical Associates
Health History Form
Magdy M. El-Kalliny, M.D. Amr O. El-Naggar, M.D., F.A.C.S

Please complete this form by filling in the 0 beside the correct answer

DATE_____

Social History

Working : 0 FT 0 PT 0 Unemployed 0 Disabled 0 Student
Live With: 0 Spouse 0 Companion 0 Adult child 0 Alone 0 Other
Alcohol: 0 None 0 Occassionally 0 1-2 Daily 0 More than 2 drinks daily
Smoking: 0 Never 0 Quit 0 1 Pack Daily 0 2 Packs Daily 0 More than 2 Packs Daily
Drug Use: 0 Never 0 Quit 0 Still Using

Family History

Mother 0 Alive 0 Deceased
0 Stroke 0 Heart Disease 0 High BP 0 Brain Aneurysms
0 Brain Tumors 0 Parkinson's 0 Tremors 0 Diabetes 0 Cancer
0 Bleeding Tendency 0 TB 0 Rheumatic Fever

Father 0 Alive 0 Deceased
0 Stroke 0 Heart Disease 0 High BP 0 Brain Aneurysms
0 Brain Tumors 0 Parkinson's 0 Tremors 0 Diabetes 0 Cancer
0 Bleeding Tendency 0 TB 0 Rheumatic Fever

Siblings 0 Alive 0 Deceased
0 Stroke 0 Heart Disease 0 High BP 0 Brain Aneurysms
0 Brain Tumors 0 Parkinson's 0 Tremors 0 Diabetes 0 Cancer
0 Bleeding Tendency 0 TB 0 Rheumatic Fever

Children 0 Alive 0 Deceased
0 Stroke 0 Heart Disease 0 High BP 0 Brain Aneurysms
0 Brain Tumors 0 Parkinson's 0 Tremors 0 Diabetes 0 Cancer
0 Bleeding Tendency 0 TB 0 Rheumatic Fever

Review of Systems

Fever	0 Yes	0 No	Weight Loss	0 Yes	0 No	Change in Vision	0 Yes	0 No
Hearing Loss	0 Yes	0 No	Ringing in Ears	0 Yes	0 No	Breathlessness	0 Yes	0 No
Chest Pain	0 Yes	0 No	Blood in Stool	0 Yes	0 No	Joint Pain	0 Yes	0 No
Rash	0 Yes	0 No	Easy Bleeding	0 Yes	0 No	Painful Urination	0 Yes	0 No

Patient Name_____Date of Birth_____Age_____