

LUMBAR SPINE QUESTIONNAIRE—Dr. Mitsunaga

Please print legibly in black ink. This form will become a part of your medical record.

PART 1: GENERAL INFORMATION

1) Name:

2) Today's Date:

3) Date of birth: Age: Gender: Height: Weight:

4) Which spine surgeon are you being referred to (check one): Kyle Mitsunaga Lance Mitsunaga Morris Mitsunaga None specified

5) Which physician referred you here?

6) Who is your primary care physician?

PART 2: LOW BACK HISTORY

1) What is your **main symptom** (for example: back pain, leg pain/weakness/numbness, trouble walking): _____

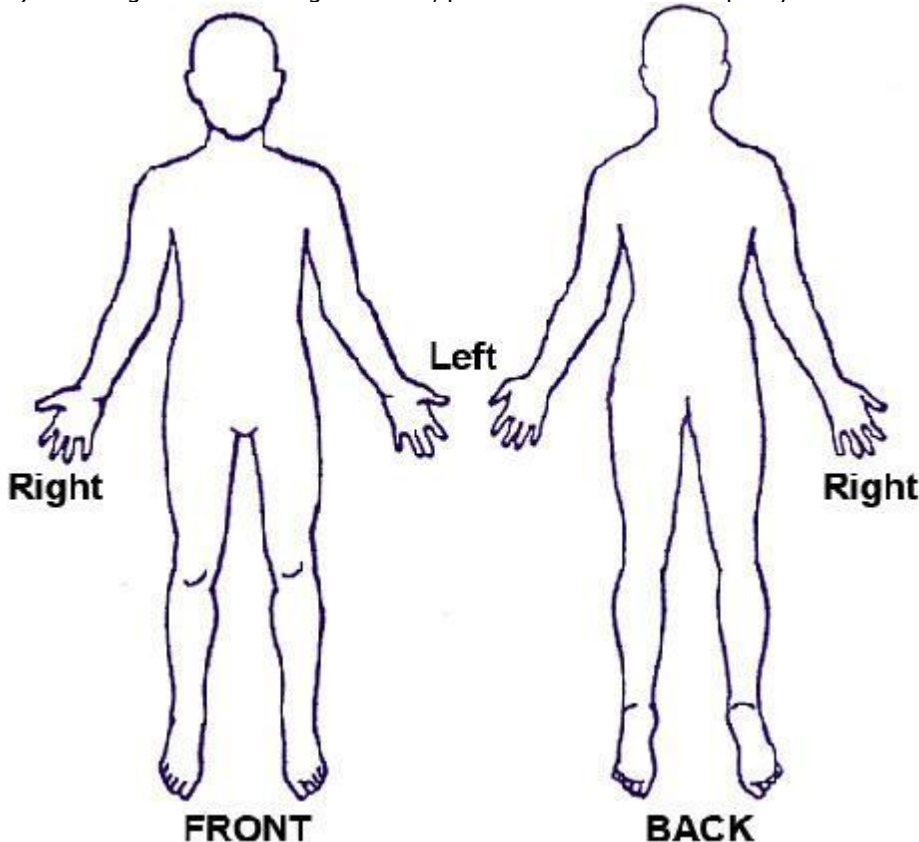
2) Out of 100%, what % of your pain is in your **low back versus your legs**? Back: ____%. Lower leg: ____%.

3) If you have lower extremity pain, what % is in your **left versus your right leg**? Left: ____%. Right: ____%

4) When did you **first start** experiencing this pain (month/year)? _____

5) Where is the pain **located** (for example, low back, left/right groin, buttocks, thigh, calf, foot)? _____

6) Pain diagram: In the diagram below, place an "X" in the exact spots you are feeling pain or numbness



7) How did this pain come on (please select one): All of a sudden Gradually over time

8) Is your pain associated with any **specific injuries or accidents** (such as falling, work-related injury, lifting, twisting, bending, pushing, direct blow, reaching, pulling, car accident)? YES NO If yes, please describe: _____

9) Over the past 2 months, how has your pain **changed**? Getting worse Staying the same Getting Better

10) How would you **describe** this pain: Constant Intermittent Waxes/wanes Central Dull Aching Sharp Burning
Nuisance Throbbing Bearable Unbearable Excruciating Manageable Unmanageable Terrible Other: _____

11) On a scale of 1 to 10, what is your pain level **currently**? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

12) On a scale of 1 to 10, what is the **lowest** your pain ever gets? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

13) On a scale of 1 to 10, what is the **worst** your pain ever gets? Circle one: (none) 0 1 2 3 4 5 6 7 8 9 10 (severe)

14) Have you had any **prior spine surgeries**? Yes No If yes, please list the 3 most recent spine surgeries:

1. Date: _____ Surgeon: _____ Part of spine: Cervical Thoracic Lumbar
Type of procedure: Fusion Laminectomy/decompression Microdiscectomy

2. Date: _____ Surgeon: _____ Part of spine: Cervical Thoracic Lumbar
Type of procedure: Fusion Laminectomy/decompression Microdiscectomy

3. Date: _____ Surgeon: _____ Part of spine: Cervical Thoracic Lumbar.
Type of procedure: Fusion Laminectomy/decompression Microdiscectomy

15) Is your pain **brought on or aggravated** by any of the following? Check all that apply: Coughing Sneezing Bearing down with bowel movement Lying down Sitting Standing Walking Bending over Getting up from seated position Other: _____

16) Is there anything that **relieves** the pain (such as certain positions, activities, medications, ice/heat, etc.): _____

17) How far can you comfortably **walk** (e.g. few feet, 1 block, 1/2 mile, etc)? _____. What is the limiting factor for your walking (e.g. pain, weakness, poor balance, etc.): _____

18) Do you have any **weakness** in your **lower extremities/legs**? Yes No. If yes, which lower extremity? Left Right
Please give 1 or 2 specific examples of when you notice this weakness (such as going up/down stairs, sensation of legs "giving out" or buckling when walking, etc): _____

19) Do you have any **numbness** in your **lower extremities** (e.g. groin, buttocks, thigh, leg/calf, foot, toes)? Yes No
If so, where is the numbness (for example, left/right groin, thigh, leg/calf, foot, toes): _____

20) Do you have any **weakness** in your **upper extremities** (such as your shoulders, elbows, wrists, hand)? Yes No
If yes, please give 1 or 2 specific examples of when you notice this weakness (such as holding onto objects, lifting objects overhead, etc): _____

21) Do you have any **numbness** in your **upper extremities** (e.g. shoulders, arm, forearm, wrist, hand/fingers)? Yes No. If yes, where is the numbness (for example, left/right shoulders, arm, forearm, hand, fingers): _____

22) Do you have any trouble with your **gait or balance**? Yes No If so, please describe in 1 or 2 sentences: _____

23) Do you have any **trouble standing upright**? (for example, do you feel yourself leaning too far forward, too far to the left or right?) Yes No If yes, please describe: _____

24) To what degree are your back/leg problems affecting your **quality of life**? Significantly Moderately Minimally Not at all
Please give an example of how your quality of life is being affected (for example, are there certain recreational/social activities you enjoy but are no longer able to do?) _____

25) Do you have trouble with any **day to day activities** such as going to work, dressing, cooking, cleaning, driving? Yes No.
If yes, please give examples of some of the activities you find most difficult:

26) Do you use any of the following **assistive devices** (check all that apply): Canes Walkers Wheelchairs
If so, how long have you been using this device?

27) Which of the following treatments have you tried that you found **helpful**? Please circle any that apply:

Opiates: Tylenol #3, hydrocodone, oxycodone, Norco, Percocet, Vicodin, morphine, oxycontin, tramadol, methadone.

Neuropathic agents: Lyrica (pregabalin), Neurontin (gabapentin), Cymbalta (duloxetine), Pamelor/Aventyl (nortriptyline)

Topical agents: Salonpas, Lidoderm patch, fentanyl patch.

Anti-inflammatories: Mobic (meloxicam), Motrin, Aleve, ibuprofen, naproxen.

Muscle relaxants: Flexiril (cyclobenzaprine), temazepam, tizanidine, Valium (diazepam), skelaxin (metaxalone).

Steroids (such as Medrol dosepak, methylprednisolone)

Other medications:

PHYSICAL THERAPY

What did the therapy include? Home exercise program Massage Traction Electrical stimulation Ultrasound Paraffin

Therapeutic Taping Heat/thermal agents Ice Iontophoresis Postural education/ergonomics Strengthening

stretching/range of motion Exercises Weight loss Core strengthening Aquatic therapy Balance/proprioception Gait training

Aerobic exercises such as: _____

Home exercises/stretching/therapy

Lumbar epidural steroid injections:

How many have you undergone?

When was the most recent one performed (Month/year):

Which doctor performed this injection?

What % of your pain is relieved with the injections?

How long does the benefit last?

Miscellaneous Lumbar brace TENS unit Chiropractor Acupuncture Weight loss Pool therapy

Activity modification Inversion table Massage

Other treatments you have found helpful:

28) Which of the following treatments have you tried that you found **NOT helpful**? Please check/circle any that apply:

Opiates: Tylenol #3, hydrocodone, oxycodone, Norco, Percocet, Vicodin, morphine, oxycontin, tramadol, methadone.

Neuropathic agents: Lyrica (pregabalin), Neurontin (gabapentin), Cymbalta (duloxetine), Pamelor/Aventyl (nortriptyline)

Topical agents: Salonpas, Lidoderm patch, fentanyl patch.

Anti-inflammatories: Mobic (meloxicam), Motrin, Aleve, ibuprofen, naproxen.

Muscle relaxants: Flexiril (cyclobenzaprine), temazepam, tizanidine, Valium (diazepam), skelaxin (metaxalone).

Steroids (such as Medrol dosepak, methylprednisolone)

Other medications:

PHYSICAL THERAPY

What did the therapy include? Home exercise program Massage Traction Electrical stimulation Ultrasound Paraffin

Therapeutic Taping Heat/thermal agents Ice Ionto/phonophoresis Postural education/ergonomics Strengthening

stretching/range of motion Exercises Weight loss Core strengthening Aquatic therapy Balance/proprioception Gait training

Aerobic exercises such as: _____

Home exercises/stretching/therapy

Lumbar epidural steroid injections:

How many have you undergone?

When was the most recent one performed (Month/year):

Which doctor performed this injection?

What % of your pain is relieved with the injections?

How long does the benefit last?

Miscellaneous Lumbar brace TENS unit Chiropractor Acupuncture Weight loss Pool therapy

Activity modification Inversion table Massage

Other treatments you have found *NOT* helpful:

29) Do you have any **bowel control issues** (such as incomplete emptying of your bowels when you try to have a bowel movement, or bowel incontinence) Yes No? If so, please describe the nature of this problem and how long it has been going on:

30) Do you have any **bladder control issues**? (such as incomplete emptying of your bladder when you try to urinate, or urinary incontinence) Yes No? If so, please describe the nature of this problem and how long it has been going on:

31) Do you feel **generally well**? Yes No

32) Have you had any **unintentional weight loss** Yes No? If yes, how much weight have you lost?: _____ pounds. Over what period did you lose this weight? _____

33) Have you had any of the following symptoms recently (select any that apply)? Fevers Chills Night sweats Night pain

34) Is there a **workers compensation claim** for this injury? Yes No

Part 3: Past Medical/Surgical History

1) Check all that apply: Heart disease Heart failure Heart attack Lung disease High blood pressure High cholesterol

Stroke Diabetes Cancer Gastric reflux Ulcer Kidney disease Liver failure Bleeding disorders

Other medical issues: _____

2) Other than spine surgery, please list the **last 5 surgeries** on other parts of your body:

1. Date: _____ Procedure: _____

2. Date: _____ Procedure: _____

3. Date: _____ Procedure: _____

4. Date: _____ Procedure: _____

5. Date: _____ Procedure: _____

3) Please list all of the **medications** that you take:

4) Do you have any **drug allergies**? Yes No. If yes, please list the drug and side effectL

5) **Family history:** Is there anyone in your family with any spine problems? Yes No.
If yes, which family member? _____. If yes, what type of spine problem?

PART 4: SOCIAL HISTORY

1) **Work status:** Homemaker Working Retired Disabled On leave

2) **Occupation:** _____

3) **Marital status:** Single Married Divorced Widowed Cohabiting

3) **# of Children:** _____

4) **Who do you live with?** Alone With someone else. If you live with someone else, who do you live with? _____

5) Do you **smoke**? Yes No. If yes, how many packs per day? _____ packs per day. How many years? _____ years.

6) **Alcohol consumption:** Never or rare Social Frequently drunk (more than twice a week) Alcoholic Recovering alcoholic. If you are a recovering alcoholic, # of years sober: _____

7) **Drug use:** never in the past current IV drug use

8) **Recreations/hobbies:** _____

PART 5: REVIEW OF MEDICAL PROBLEMS (please check all that apply):

General: Fever Chills Weight changes Night pain Night sweats Unintentional weight loss Recent colds or flu

Head/eyes/ears/nose/throat: Eye problems Ear problems Hearing problems vision changes Sore throat Runny nose

Cardiac: Chest pain Heart palpitations Heart attack Cardiac arrhythmias

Respiratory: Cough Wheeze Asthma Lung problems Shortness of breath

Gastrointestinal: Gastric reflex Diarrhea Constipation Intestinal/abdominal problems nausea vomiting

Musculoskeletal: Problems with joints Muscle problems Bone problems

Integument: skin changes hair problems nail problems

Genitourinary: Urinary hesitancy Painful urination Urinary incontinence (loss of bladder control)

Endocrine: Heat or cold intolerance Diabetes

Hematologic: Bleeding problems bruising problems

Neurologic: stroke seizures

Psychiatric: anxiety depression schizophrenia

Other medical problems: _____