



IMPORTANT: Please fill out this form completely. It contains information that is critical for your consultation. Failure to complete the form will result in a delay in your consultation.

2 WAYS TO COMPLETE:

- 1) This form is designed so you may easily complete it on your computer. You can complete the fields below and save the file to your computer for submission.
- 2) If you prefer, you may instead print out this form and complete it by hand. You will then need to scan the completed document and save it on your computer for submission.

If you are unable to type directly into this document: 1) Save this document to your desktop. 2) Download and install Adobe Acrobat Reader from [HERE](#) (You can skip any "additional offers.") 3) Close this document and reopen it from your desktop. The file should open in the proper version of Adobe Reader and be editable.

PERSONAL DATA

Full Name _____ Birthdate / Age _____

Address _____

Phone _____ Email _____

Height _____ Weight _____ Occupation _____

IF YOU ARE A CANDIDATE FOR SURGERY WHAT MONTH IS BEST FOR YOU?

January February March April May June July

August September October November December

HOW DID YOU LEARN OF US?

Web-site Friend Doctor Referral Book Advertisement

YouTube Facebook Other _____

PAIN HISTORY

Length of time	
Describe numbness, weakness, neurological deficits, leg pain (if any, left/right/both)	
What makes pain worse?	
Walking tolerance (minutes or distance)	
Standing tolerance (minutes)	
Sitting tolerance (minutes)	
Previous spine surgeries	
Other surgeries	
Medications (spine related)	
Medications (other)	
Allergies (medications, metals, etc?)	

Please advise if you are taking Fentanyl or morphine patches. We supply standard pain management but not these specifically. These and other medications that are non-pain related should be brought with the patient.

PERSONAL MEDICAL HISTORY (ANSWER YES/NO. DETAIL IF NECESSARY)

Cardiovascular diseases	
Blood pressure/ hypertension	
Stroke	
Heart trouble	
Irregular heartbeat	
Blood clots/ embolism	
Respiratory system	
Nose throat problem	
Breathing problem	
Chest pain	
Asthma	
Pneumonia	
Tuberculosis	
Hormonal / metabolic diseases	
Diabetes	
Thyroid problem	
Diseases of the nerve system	
Migraine headache	
Nervous breakdown	
Eye problems	
Epilepsy	
Depression	

PERSONAL MEDICAL HISTORY CONTINUED (ANSWER YES/NO DETAIL IF NECESSARY)

Gastrointestinal tract/organs

Stomach problem	
Pyrolysis	
Colitis	
Hepatitis / Jaundice	
Kidney problems	

Infectious diseases

AIDS positive	
Hepatitis	

Blood diseases / Anemia / Transfusion

Bleeding problem	
Transfusion	
Anemia	

Joint / bone diseases

Lupus	
Arthritis	
Back problems (other)	
Osteoporosis	

Cancer

Details	
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HABIT DETAILS (PLEASE NOTE ALL INFORMATION IS STRICTLY CONFIDENTIAL)

	Consumption (daily, weekly, etc.)
Alcohol	
Cigarettes	
Drugs (Cannabis, etc.)	
Homeopathic	
Other	

CASE HISTORY – WORK INVOLVEMENT AND LEISURE TIME ACTIVITIES

The physical strain in job and leisure time plays a major role for orthopedic diagnosis and therapy. This questionnaire will therefore help us to help you.

1. What is the profession you work in? _____

2. Have you had to stop working or change jobs because of your condition? Yes No

If yes, when? _____

What job are you working in at present? _____

3. You are working under these conditions.

Fulltime	<input type="checkbox"/>
Part-time	<input type="checkbox"/>
A few hours per day	<input type="checkbox"/>

4. Is your job physically straining for you? Yes No

Is it associated with monotonous body postures? Yes No

Does your status make it difficult to work? Yes No

5. Do your complaints allow you to do sports? Yes No

If yes, what kind of sports are you doing? _____

Did you do any sports before? Yes No

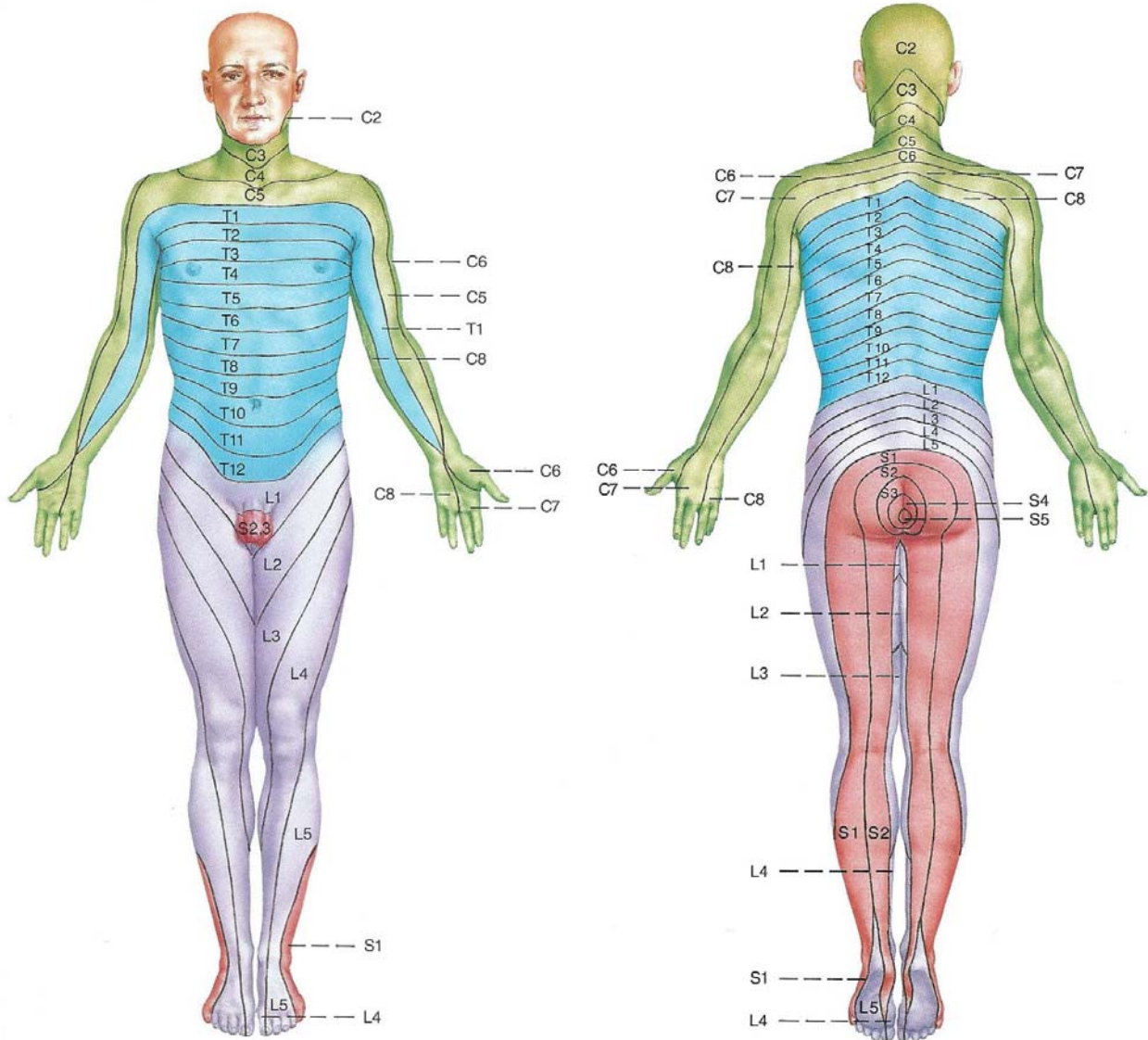
If yes, what kind of sports? _____

6. Will you have someone to support you at home after surgery? Yes No

Who would help you? _____

BODY SCHEME

Please mark the pain area and mark the sensations according to the legend below.



Legend:

n = numbness

t = tingling

w = weakness

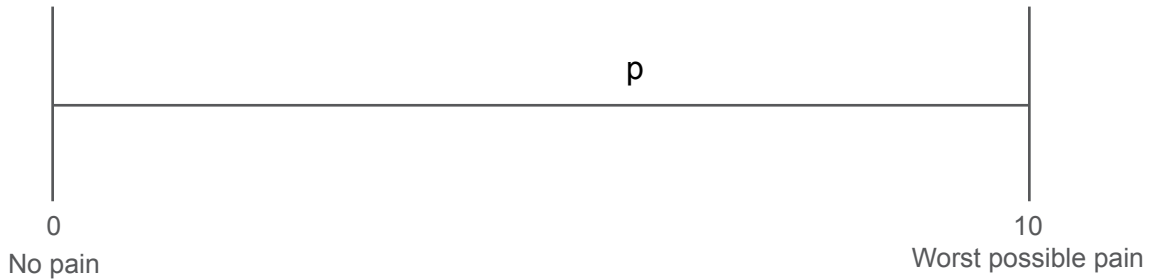
b = burning

VISUAL ANALOGUE SCALE / BACK

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.)?

The visual analog scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

Example:



Back Pain:



Left Leg Pain:



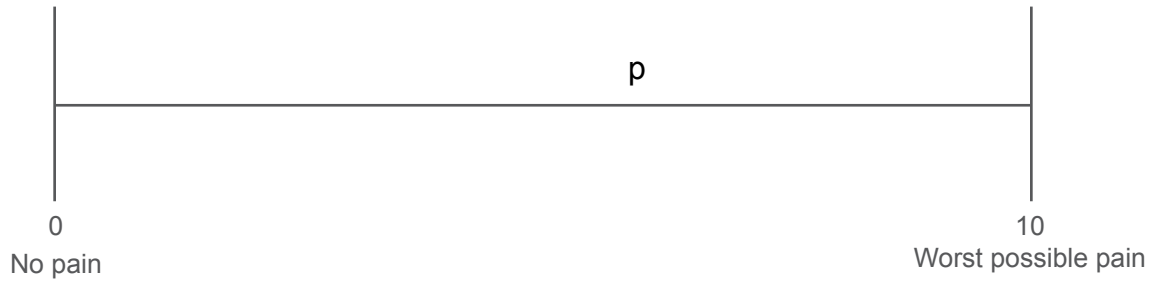
Right Leg Pain:



VISUAL ANALOGUE SCALE / NECK

The visual analogue scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

Example:



Neck Pain:



Left Arm Pain:



Right Arm Pain:



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.)?

This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

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. Compared to one year ago, how would you rate your health in general now?

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Much better now | Somewhat better now | About the same | Somewhat worse now | Much worse now |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. 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, limited a lot | Yes, limited a little | No, not limited at all |
|--|--------------------------|--------------------------|--------------------------|
| a) Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Lifting or carrying groceries | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Climbing several flights of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Climbing one flight of stairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Bending, kneeling, or stooping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Walking more than a mile | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Walking several blocks | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Walking one block | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Bathing or dressing yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. 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?

- | | Yes | No |
|--|--------------------------|--------------------------|
| a) Cut down on the amount of time you spent on work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Accomplished less than you would like | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Were limited in the kind of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Had difficulty performing the work or other activities (for example, it took extra effort) | <input type="checkbox"/> | <input type="checkbox"/> |

5. 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)?

Yes No

- a) Cut down on the **amount of time** you spent on work or other activities
- b) **Accomplished less** than you would like
- c) Didn't do work or other activities as **carefully** as usual

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all Slightly Moderately Quite a bit Extremely

7. How much bodily pain have you had during the past 4 weeks?

None Very mild Mild Moderate Severe Very severe

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

9. 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	A Good Bit of the Time	Some of the time	A little of the time	None of the time
a) Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

11. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a) I seem to get sick a little easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Optional notes:

DIGITAL SIGNATURE: By typing my full name below, I signify that the information on this form is true and correct to my knowledge

Full Name: _____ Date ____ / ____ / _____

IMPORTANT: Please make sure you have filled out this form completely before submission. Incomplete information may delay your consultation.

SAVE THIS FORM: Save this completed form to your computer. Click "File" from the menu at the top of the screen and then "Save As" to save this file in a location where you will easily find it. It is recommended you change the file name to include your name like this: FirstName LastName Patient Data Sheet.

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