alaska spine institute

Phone: 907.563.8876
Fax: 907.762.6390
3801 University Lake Drive
Anchorage, AK 99508

Dear Patient:

Enclosed you will find a questionnaire regarding your past medical history and your current concerns. **We ask all our patients to please take the time to complete this questionnaire before your appointment. In the event you are unable to do so, we may need to reschedule your appointment.**

Please review the pre-appointment instructions prior to your appointment, which is scheduled on _____ at _____ with _____, at the _____ facility. Please call our office, before your appointment, to pre-register. The phone number is (907) 563-8876 or toll free 866-637-3422.

On the day of your appointment we ask that you **do not** wear any **lotion, oil or powder.** This may affect the results of the EMG/NCV testing.

Sincerely,

Alaska Spine Institute Providers

Larry Levine, MD
Shawn Johnston, MD
Erik Olson, DO
Hyon Joo, DO

Electrodiagnostic Testing

NAME:_____ **DATE:**_____

DATE OF BIRTH: _____ **AGE:** _____ **SEX: M F**

REFERRING PHYSICIAN: _____

WHEN DID YOUR SYMPTOMS BEGIN? _____

IS THIS WORK RELATED? _____

DESCRIBE YOURCOMPLAINTS:_____

_____

_____

_____

_____

SYMPTOMS ARE WORSENED WITH: _____

_____

SYMPTOMS ARE IMPROVED WITH: ☐ **Rest/Bed** ☐ **Lying down** ☐ **Walking/Standing** ☐ **Time of day**

☐ **Being around people** ☐ **Sexual activity** ☐ **Physical activity** ☐ **Drugs** ☐ **Exercise** ☐ **Other** _____

RECENT PRIOR TESTING:

TEST	WHEN	WHERE
X-RAYS		
CT SCAN/ MRI		
EMG/NCV		
OTHER		

PAST MEDICAL HISTORY:

❑ **Diabetes** ❑ **High blood pressure** ❑ **Hepatitis** ❑ **Thyroid Disease** ❑ **Ulcer**
❑ **Cancer** **If so what kind?**_____ ❑ **Heart Disease** ❑ **Tuberculosis** ❑ **Lung Disease**
❑ **Kidney Disease** ❑ **Arthritis** ❑ **Depression** ❑ **Other Illnesses** _____

Prior Hospitalization:_____

Surgical History (Procedure and Year):_____

_____

TURN PAGE OVER AND COMPLETE OTHER SIDE

FAMILY HISTORY:

❑ **Diabetes** ❑ **High blood pressure** ❑ **Cancer** **If so what kind** _____ ❑ **Heart Disease**
❑ **Depression** ❑ **Disability** ❑ **Chronic pain** ❑ **Stroke** ❑ **Alcoholism** ❑ **Migraine**
❑ **Other** _____

SOCIAL HISTORY: Occupation_____ Currently Working? YES NO

Smoke: YES NO How much? _____ How Long? _____

Alcohol: YES NO How much?_____ How Long?_____

Marital Status ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Separated** ❑ **Widowed** **How long?**_____

MEDICATIONS:_____

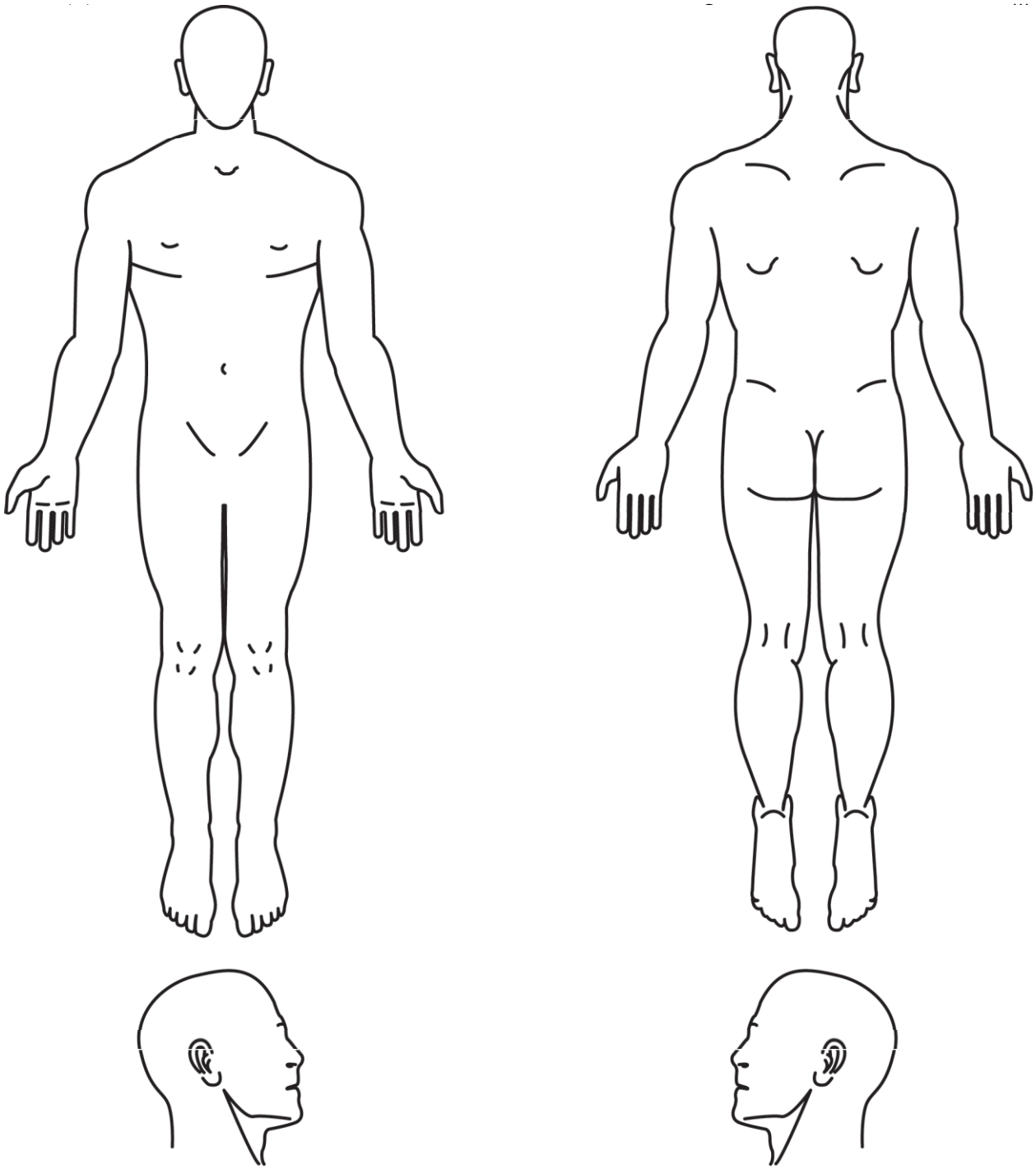
_____

ALLERGIES: _____

YOU MAY USE THE AREA BELOW FOR ANY ADDITIONAL COMMENTS OR INFORMATION THAT YOU FEEL IS IMPORTANT REGARDING YOUR CURRENT MEDICAL CONDITION.

Complete the following diagram drawing the symbols below to show where you have your typical pain

Ache ➢➢ Numbness ■ Pins and Needles ○ Burning Stabbing ///



What is your average pain? Or give a range of your level of pain.
"0" indicates NO PAIN and "10" indicates pain so severe it would cause you to faint or lose consciousness

0 1 2 3 4 5 6 7 8 9 10
|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

Patient Name:_____ Date of Birth:_____

Please review the following list of medical problems and mark any that apply to you *now* or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

Constitutional

- ☐ Recent weight gain: ____ lbs
- ☐ Recent weight loss: ____ lbs
- ☐ Fever or soaking sweats at night
- ☐ Fatigue
- ☐ Weakness/numbness of arms/legs
- ☐ Headaches ≥1-2 times per week
- ☐ Difficulty walking
- ☐ Loss of consciousness/convulsions

Eyes

- ☐ Vision problems not corrected by glasses
- ☐ Glaucoma
- ☐ Eye lens implant
- ☐ Eye prosthesis
- ☐ Contact lenses

Ears, Nose, Throat

- ☐ Chronic stuffy nose or nasal polyps
- ☐ Frequent nosebleeds
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Ear infections
- ☐ Hearing aid
- ☐ Chronic sore throat or tonsillitis
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Dentures or partial plates
- ☐ Capped teeth
- ☐ Loose teeth
- ☐ Orthodontic braces

Cardiovascular

- ☐ Heart murmur
- ☐ Prolapsed mitral valve
- ☐ Heart pacemaker
- ☐ Irregular heartbeat
- ☐ Palpitations or rapid pulse
- ☐ Fainting spells
- ☐ Chest pain or angina on exertion
- ☐ Chest pain or angina at night
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath lying flat
- ☐ Shortness of breath at night
- ☐ Blood clots or pulmonary embolism
- ☐ High blood pressure
- ☐ Low blood pressure

Respiratory

- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Chronic cough
- ☐ Change in amount of phlegm
- ☐ Change in color of phlegm
- ☐ Coughing up blood
- ☐ Collapsed lung
- ☐ Tuberculosis exposure
- ☐ Blueness of your fingernails

Gastrointestinal

- ☐ Ulcers
- ☐ Hiatal hernia or frequent heartburn
- ☐ Ulcerative colitis
- ☐ Diverticulitis
- ☐ Colostomy or other 'ostomy'
- ☐ Hepatitis or yellow jaundice
- ☐ Liver cirrhosis
- ☐ Gallbladder problems
- ☐ Vomiting blood
- ☐ Black, tarry bowel movements
- ☐ Blood in bowel movements
- ☐ Change in bowel habits

Genitourinary

- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Prostate problems
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Do you lose your urine at times

Musculoskeletal

- ☐ Fractures or broken bones
- ☐ Arthritis
- ☐ Difficulty opening mouth wide
- ☐ Scoliosis
- ☐ Spinal column deformity

Integumentary/Dermatologic

- ☐ Skin rash or sores
- ☐ Itching
- ☐ Color change, pigmentation, nodules
- ☐ Pressure ulcers

Neurologic

- ☐ Seizures or convulsions
- ☐ Epilepsy
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple Sclerosis
- ☐ Nerve Injury or Numbness

Psychiatric

- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Mental disorder

Endocrine

- ☐ Diabetes
- ☐ Insulin use
- ☐ Low blood sugar or hypoglycemia
- ☐ Thyroid problems
- ☐ Steroid use

Allergic/Immunologic

- ☐ Herpes exposure
- ☐ AIDS exposure
- ☐ Street drug use

Hematologic

- ☐ Abnormal bleeding problems
- ☐ Anemia or low blood count
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell anemia

Lymphatic

- ☐ Swollen glands or masses in neck, axillae, groin
- ☐ Lymphedema

Others

- ☐ Sexual problems
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Malignant hyperthermia
- ☐ Bad reaction to local anesthetic
- ☐ Down syndrome
- ☐ Cancer or tumor
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Recent acute illness
- ☐ Recent hospitalization
- ☐ Recent surgical operation

Use the back of this page to list any problems not already covered that you consider important

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For women only:

Are you pregnant? ☐ Yes ☐ No
Are menstrual periods normal? ☐ Yes ☐ No
☐ Any vaginal discharge
☐ Bleeding between periods
☐ Bleeding after menopause

Number of pregnancies: _____
Number of deliveries: _____
Date of last menstrual period: _____
Approx date of last pap smear: _____

I have carefully reviewed this checklist and completed it to the best of my knowledge. Date: _____

Signature of Patient, Parent, or Guardian ***Relationship to patient, (if not self)***

Patient Name:_____ Date of Birth:_____

1.) Family History of Substance Abuse: Mark each box that applies

Alcohol	☐
Illegal drugs	☐
Prescription drugs	☐

2.) Personal History of Substance Abuse:

Alcohol	☐
Illegal drugs	☐
Prescription drugs	☐

3.) Age (mark box if between 16 and 45) ☐

4.) History of Preadolescent Sexual Abuse ☐

5.) Psychological Disease

Attention deficit disorder, Obsessive compulsive disorder, Bipolar, Schizophrenia	☐
Depression	☐

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _. 8_. 9_. 10_. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 1 0_. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 1 0_. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _. 8_. 9_. 10_. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0_. 1_. 2_. 3_. 4_. 5_. 6_. 7 _ . 8_. 9_. 10_. Worst Disability

Signature _____ **Please Print** _____

Date _____

Patient Name:_____ Date of Birth:_____