



Johns Hopkins Orthopaedics & Spine Surgery at Good Samaritan Hospital

New Spine Patient Questionnaire

Date: _____ Orthopaedic Surgeon: _____

Patient's Name: _____ GENDER: Female Male
(Last) (First) (MI)

Social Security #: _____ Date of Birth: _____ Height: _____ Weight: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient's E-mail: _____ Married Single Widowed

Employer: _____ Occupation: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

(Please do not leave the following fields blank.)

Referring Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Primary Care Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

How did you hear about us?

- Physician Seminar Newspaper Television Friend/Relative
 Internet Our Website Google Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Insurance Cert. #: _____ Plan Type: _____ Group #: _____

Guarantor/Member's Name: _____

Guarantor's relationship to patient: Husband Wife Parent

Subscriber's Social Security Number: _____ Date of Birth: _____

Address (on back of card): _____

SECONDARY INSURANCE: _____

Insurance Cert. #: _____ Plan Type: _____ Group #: _____

Guarantor/Member's Name: _____

Guarantor's relationship to patient: Husband Wife Parent

Subscriber's Social Security Number: _____ Date of Birth: _____

Address (on back of card): _____

***PLEASE* circle/answer the following questions so that we may serve you better.**

PAST MEDICAL HISTORY

BRAIN

- TIA (transient ischemic attack)
- Stroke

ENDOCRINE

- Insulin dependent diabetes
- Non-insulin dependent diabetes
- Hypercholesterolemia
- Hypothyroidism
- Severe Osteoporosis

HEART

- Coronary artery disease
- Myocardial infarction (heart attack)
- Hypertension/High Blood Pressure

INFECTIOUS

- HIV
- Hepatitis
- Cellulitis
- Syphilis
- Joint infection

KIDNEY

- Chronic renal failure

LUNG

- Pulmonary embolism
- Chronic bronchitis
- Asthma
- COPD

MUSCULOSKELETAL

- Low back pain
- Sciatica
- Spinal Stenosis
- Degenerative disk disease
- Juvenile Rheumatoid Arthritis
- Lupus
- Rheumatoid Arthritis
- Psoriasis
- Osteoarthritis
- Severe Osteoporosis

CANCER

Type: _____

PSYCHIATRIC

- Alcohol abuse
- Major depression
- Anxiety disorder
- Bipolar disorder
- Schizophrenia

STOMACH AND INTESTINE

- GERD/Reflux
- Gastric ulcer
- Irritable Bowel Syndrome

VASCULAR

- DVT
- Phlebitis
- Sickle cell anemia

OTHER:

1. _____
2. _____
3. _____

PAST ORTHOPAEDIC SURGICAL HISTORY

PAST SURGERIES	SIDE/LOCATION	Year	NAME OF SURGEON																		
JOINT REPLACEMENT <input type="checkbox"/> Total Hip Replacement <input type="checkbox"/> Total Knee Replacement <input type="checkbox"/> Partial Knee Replacement <input type="checkbox"/> Core Decompression <input type="checkbox"/> High Tibial Osteotomy	<table border="0"> <tr> <td><u>Right</u></td> <td><u>Left</u></td> <td><u>Both</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>Right</u>	<u>Left</u>	<u>Both</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	 	
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SPINE <input type="checkbox"/> Cervical (neck) Fusion <input type="checkbox"/> Cervical Disc Removal/Decompression <input type="checkbox"/> Lumbar (lower back) Fusion <input type="checkbox"/> Lumbar Disk Removal/Laminectomy <input type="checkbox"/> Thoracic (mid back) <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Tumor/Infection	Levels _____ Levels _____ Levels _____ Levels _____ Levels _____ Levels _____	 	 																		
SPORTS <input type="checkbox"/> Knee Arthroscopy <input type="checkbox"/> Shoulder Arthroscopy <input type="checkbox"/> Rotator Cuff Repair <input type="checkbox"/> Total Shoulder Replacement <input type="checkbox"/> Other	<table border="0"> <tr> <td><u>Right</u></td> <td><u>Left</u></td> <td><u>Both</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>Right</u>	<u>Left</u>	<u>Both</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	 	
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TRAUMA (List bone/joint and treatment) _____ _____	<table border="0"> <tr> <td><u>Right</u></td> <td><u>Left</u></td> <td><u>Both</u></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<u>Right</u>	<u>Left</u>	<u>Both</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	 	 									
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OTHER PAST SURGICAL HISTORY

BREAST <input type="checkbox"/> Lumpectomy (<i>left or right side</i>) <input type="checkbox"/> Mastectomy (<i>left or right side</i>)	GASTROINTESTINAL <input type="checkbox"/> Hernia repair <input type="checkbox"/> Resection of large bowel <input type="checkbox"/> Removal gall bladder	OTHER: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____
CARDIOVASCULAR <input type="checkbox"/> Pacemaker <input type="checkbox"/> Coronary artery Bypass <input type="checkbox"/> Valve replacement	VASCULAR <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Femoral Bypass <input type="checkbox"/> Dialysis shunt <input type="checkbox"/> Varicose vein stripping	

ALLERGIES

NO KNOWN ALLERGIES

<u>MEDICINE</u>	<u>REACTION</u>	<u>GENERAL</u>	<u>REACTION</u>
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Erythromycin	_____	<input type="checkbox"/> Adhesive	_____
<input type="checkbox"/> NSAIDs	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Penicillin	_____		
<input type="checkbox"/> Sulfa	_____		

MEDICATION INFORMATION

(Please circle the medications you are taking.)

High Blood Pressure:

- Accupril (Quinapril)
- Atenolol
- Capoten (Captopril)
- Cardizem (Diltiazem)
- Cardura (Doxazosin)
- Cozaar (Losartan)
- Diovan (Valsartan)
- Vasotec (Enalapril)
- Zestril (Lisinopril)
- Lopressor/Toprol (Metoprolol)
- Lotensin (Benazepril)
- Norvasc (Amlodipine)
- Procardia (Nifedipine)

Heart Medication:

- Lanoxin (Digoxin)
- Nitroglycerin

Blood Thinners:

- Aspirin
- Coumadin (Warfarin)
- Plavix

OTHER MEDICATION(S):

Cholesterol Lowering Drugs:

- Lipitor (Atrovastatin)
- Pravachol (Pravastatin)
- Zocor (Simvastatin)

Diuretics (Water Pills):

- Dyazide (HCTZ + Furosemide)
- Lasix (Furosemide)
- Hydrochlorothiazide (HCTZ)

Diabetes:

- Glucophage (Metformin)
- Glucotrol (Glipizide)
- Insulin (Humulin)

Gastrointestinal (Stomach):

- Nexium (Esomeprazole)
- Prevacid (Lansoprazole)
- Prilosec (Omeprazole)
- Zantac (Ranitidine)

Rheumatology:

- Methotrexate
- Plaquenil
- Prednisone

NSAIDs:

- Advil/Motrin (Ibuprofen)
- Aleve (Naproxen or Naprosyn)
- Bextra
- Celebrex
- Mobic

Pain:

- Davocet (Acetaminophen + Propoxyphene)
- Dilaudid
- Duragesic Patch (Fentanyl Patch)
- Endocet/Percocet/Tylox (Oxycodone + Acetaminophen)
- Lortab/Vicodin (Hydrocodone + Acetaminophen)
- MS Contin
- Neurontin
- Neurontin
- Oxycodone/Oxycontin
- Tylenol #3 (Acetaminophen + Codeine)
- Ultram (Tramadol)

FAMILY HISTORY

<input type="checkbox"/> Cancer	<input type="checkbox"/> Other
_____	_____
type	
<input type="checkbox"/> Heart Disease	
_____	_____
type	
<input type="checkbox"/> Diabetes	
_____	_____
Type	

SOCIAL HISTORY

Occupation:

- Employed
- Unemployed
- Student
- Work from home
- Retired

Marital Status:

- Single
- Married
- Separated
- Divorced
- Widowed

Athletics:

- Professional
- Amateur
- Recreational
- None
- Sport _____

Exercises:

- Daily
- Weekly
- Rarely
- Never
- Type _____

SMOKING HISTORY

_____ I have never smoked.

Do you currently smoke?

- No
- Yes

How long have you smoked? _____

I currently smoke:

- ¼ pack,
- ½ pack,
- ¾ pack,
- 1 pack
- 2 packs per day.

I quit smoking:

- less than 1 year ago
- more than 1 year ago
- more than 5 years ago

I formerly smoked:

- ¼ pack,
- ½ pack,
- ¾ pack,
- 1 pack
- 2 packs per day.

What type of tobacco did you smoke:

- Cigarettes
- Cigars
- Pipe

ALCOHOL HISTORY

Do you currently drink alcohol?

- No
- Yes

If yes, what type of alcoholic beverages do you usually drink?

- Beer
- Wine
- Hard Liquor (such as whiskey, scotch, gin or vodka)

I CURRENTLY DRINK

- Less than one per month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

I USED TO DRINK

- Less than one per month
- 2-4 times per month
- 2-3 times a week
- 4-5 times a week
- 6 or more times a week

How many drinks did you have on a typical day when you are/were drinking?

- 1-2 drinks
- 3-4 drinks
- 5-6 drinks or more

OTHER SUBSTANCES

_____ I have never used drugs

Do you currently use recreational drugs?

- No
- Yes

Have you used:

- Marijuana
- Cocaine
- Heroin
- Other _____

Have you ever developed an addiction to pain medicine?

- No
- Yes

REVIEW OF SYSTEMS

Please mark any symptoms that you are currently experiencing.

GENERAL

- Good general health
- Chills
- Feeling tired all the time
- Dizziness
- Loss of appetite
- Fever
- Night sweats
- Weight gain of more than 10 lbs
- Weight loss of more than 10 lbs

SKIN

- No problems
- Dryness
- Excessive sweating
- Rash

HEENT

- Blurry vision
- Sinusitis
- Fainting
- Headache

NECK

- Difficulty swallowing

RESPIRATORY

- Chest pain
- Shortness of breath
- Chronic cough
- Wheezing

CARDIOVASCULAR

- Chest pain
- Swelling in legs
- Night cramps
- Palpitations
- Phlebitis
- Skipped heartbeats

GASTROINTESTINAL

- Anorexia
- Constipation
- Diarrhea
- Heartburn

MALE GENITOURINARY

- Hesitancy
- Incontinence

NEUROLOGICAL

- Dizziness
- Headaches
- Incontinence stool
- Incontinence urine
- Loss of balance

PSYCHIATRIC

- Anxiety
- Change in sleep pattern
- Depression

ENDOCRINE

- Frequent urination
- Appetite changes
- Cold intolerance

HEMATOLOGY

- Anemia
- Easy bruising
- Enlarged lymph nodes
- Prolonged bleeding
- Spontaneous bleeding

SUMMARY

- All Other Systems Negative

Please complete this section regarding your current condition. Your careful answers will help us to understand your problem and design the best treatment program for you.

CHARACTERISTICS OF PAIN:

How long have you had your current problem?

_____ weeks _____ months _____ years

Below, **CIRCLE THE #1 PROBLEM** for which you are seeking treatment.

- Low back or buttock pain
- Right leg pain
- Left leg pain
- Pain in both legs
- Right leg numbness
- Left leg numbness
- Numbness in both legs
- Difficulty walking
- Neck pain
- Right arm pain
- Left arm pain
- Pain in both arms
- Right arm numbness
- Left arm numbness
- Numbness in both arms
- Other:

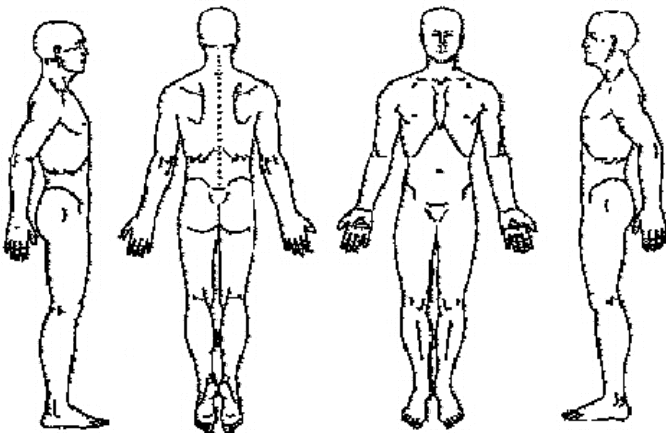
Above, **UNDERLINE THE #2 PROBLEM** for which you are seeking treatment.

Other problems (please describe): _____

WHERE IS YOUR PAIN NOW?

On the diagram below, place an **X** in the area(s) you feel the most pain. Place an **O** on the body diagram where you feel numbness or tingling.

Right Back Front Left



PAIN IS BEST DESCRIBED AS:

- Dull ache
- Sharp
- Burning
- Electric shock

ONSET OF PAIN: How did your current symptoms start?

- Injury at work _____ date of injury, at work
- Injury, not at work _____ date of injury, not at work
- Motor vehicle accident _____ date of accident
- Undetermined
- Other: _____

SEVERITY OF PAIN: In general, what is the intensity of your pain (*circle one*)?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worse Possible Pain**

In general, how is this problem affecting your life (please check one)?

- Nuisance
- Minor problem
- Major problem
- Catastrophe

TIMING OF PAIN: How often do you have your pain (please check one)?

- Occasionally (less than 30% of the time)
- Intermittently (30-60% of the time)
- Nearly constantly (60 to 95% of the time)
- Constantly (100% of the time)

RELIEVING AND AGGRAVATING FACTORS:

How do the following affect you pain (please check one for each item):

	IMPROVES PAIN	NO CHANGE	WORSENS PAIN
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
COUGHING/SNEEZING			
BOWEL MOVEMENTS			

Have you had any recent change in bowel or bladder habits?

- No
- Yes Please describe: _____

ACTIVITIES AND YOUR PAIN:

How many blocks can you walk?

- Less than a block
- 1-2 blocks
- 2-5 blocks
- 5-10 blocks
- Greater than 10 blocks

How often during the day do you lie down because of pain?

- Never
- Seldom
- Sometimes
- Often
- Constantly

To assist walking, I use a:

- Cane
- Walker
- Wheelchair
- No assistance device

I am NOT able to perform the following activities of daily living (check all that apply):

- Doing yard work or shopping
- Socializing with friends
- Performing household chores
- Participating in recreational activities
- Going to work
- Exercising

**Johns Hopkins Orthopaedics
at Good Samaritan Hospital**
5601 Loch Raven Boulevard
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Baltimore, MD 21239
443-444-4730/Fax 443-444-4752
jhortho@jhmi.edu
www.hopkinsorthogsh.com



Referral Policy

Dear Patient;

If your health insurance plan is one which requires that you obtain a referral in order for you to see a specialist healthcare provider, please be sure to bring it with you for your scheduled visit with us. You may also have your Primary Care Physician fax it directly to our office using the above fax number.

In today's healthcare environment, the need to obtain a referral can be very confusing and frustrating. Please contact your Primary Care Physician before your appointment with us so you can determine with certainty whether or not you will need to obtain a referral.

If we have not received the necessary referrals by the time of your visit, then it will be necessary to:

1. Reschedule your appointment for a later date or
2. Pay for your visit and submit the insurance paperwork yourself.

Rescheduling appointments is disruptive for everyone and we would prefer not to take that action.

We thank you very much for your cooperation in this matter. Please let us know if you have any questions.

Sincerely,

Johns Hopkins Orthopaedic and Spine Surgery
at Good Samaritan Hospital

**Johns Hopkins Orthopaedics
at Good Samaritan Hospital**
5601 Loch Raven Boulevard
Smyth Building, Suite G-1
Baltimore, MD 21239
443-444-4730/Fax 443-444-4752
jhortho@jhmi.edu
www.hopkinsorthogsh.com



Dear Patients and Family Members:

Effective January 1, 2009 the Department of Orthopaedic Surgery at Johns Hopkins instituted a policy, charging a fee of \$25.00 per form/letter that is to be completed by the patient's surgeon. This fee would apply to following:

Disability Forms

FMLA Forms

Home and Hospital Teaching Forms

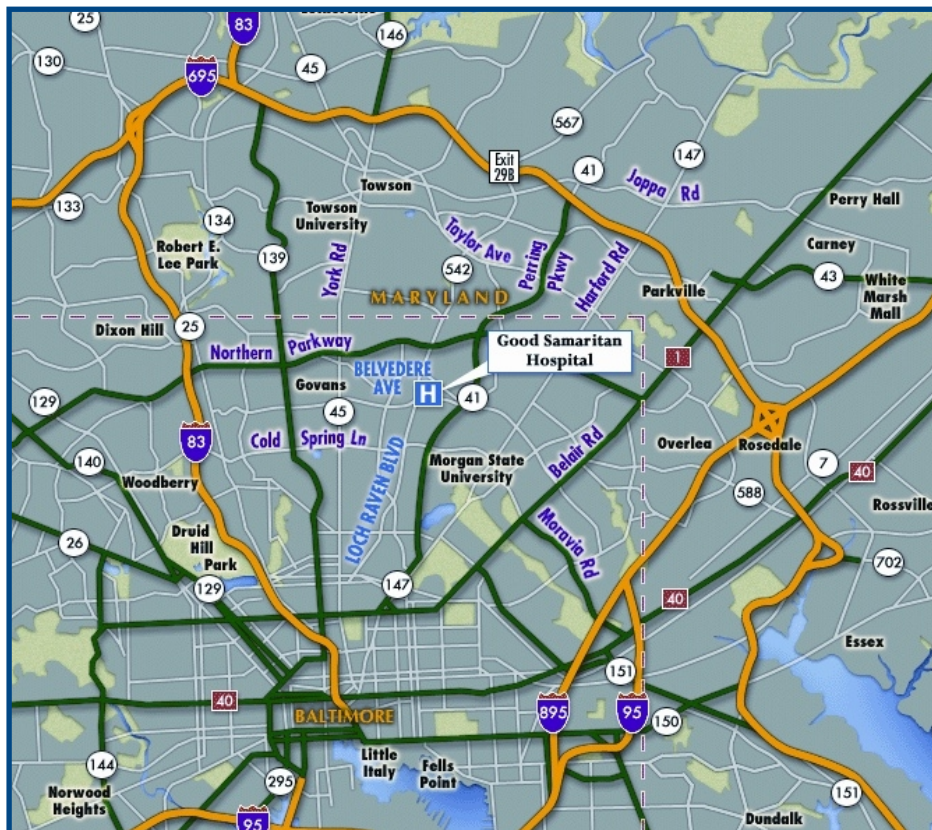
Special Request Letters

The advance fee of \$25.00, payable in cash, check or money order, is required to process any of the forms. Checks should be made payable to the Department of Orthopaedic Surgery and mailed directly to our office. All forms will be completed within 10 days of receiving payment. As a courtesy to our surgical patients, one form will be completed at no charge, per surgery (this does not apply to FMLA or Disability forms). All disability forms subsequent to the initial Disability form will be completed at no charge.

If you have an questions, please do not hesitate to contact us.

Thank You,

Johns Hopkins Orthopaedic and Spine Surgery



Directions to Good Samaritan Hospital

From the NORTHEAST:

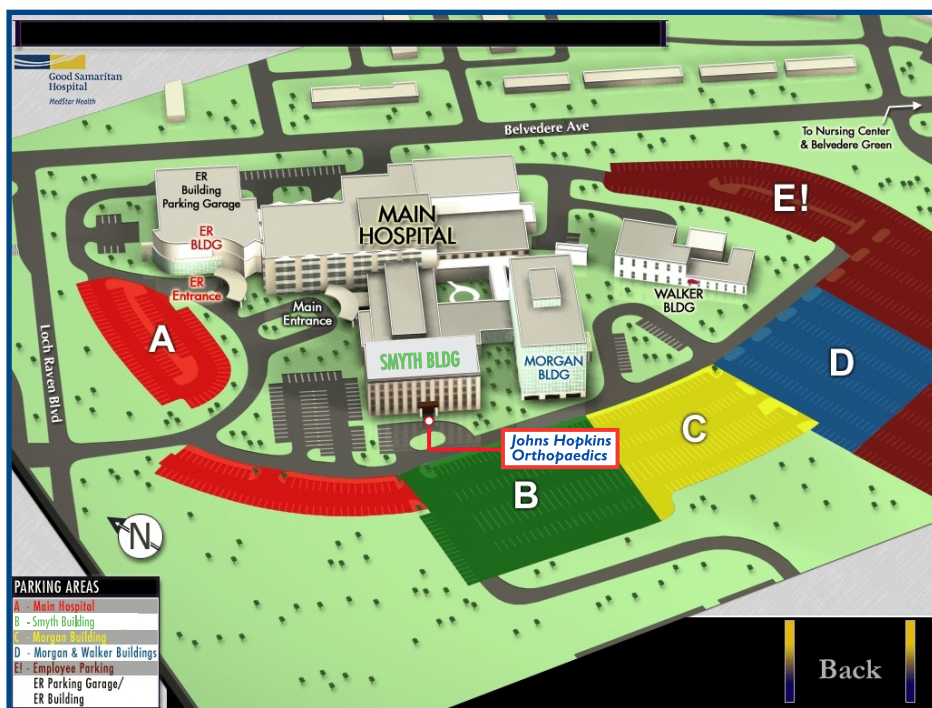
Take I-695 to Loch Raven Boulevard, South. Alternately, take either Harford Road, Perring Parkway, or Belair Road South, make a right onto Northern Parkway and then a left onto Loch Raven Boulevard. Cross over Belvedere Avenue and take a left into the Hospital driveway.

From the NORTHWEST:

Take I-695 to I-83 South. Exit onto Northern Parkway, East. Turn right at Loch Raven Boulevard Exit 29B. Cross over Belvedere Avenue and take a left into the Hospital driveway.

From the SOUTH:

Take I-95 North through the Fort McHenry Tunnel to Exit 60, Moravia Road. Moravia turns into Cold Spring Lane after Harford Road. Proceed on Cold Spring and go right onto Loch Raven Boulevard. Cross over to Woodbourne Avenue and take a right into the Hospital driveway.



Location:

Our main office is located in Suite G-1.

- Proceed through the front door of the Smyth Building.
- We are the first door on the LEFT after the elevator
- Please note our directory and The Johns Hopkins sign on the right side of the door.

Suite 204:

- Proceed through the front door of the Smyth Building.
- Take the elevator on your LEFT to the 2nd floor.
- Make a RIGHT out of the Elevator.
- Follow Signs to Suite 204