USC
UNIVERSITY
HOSPITAL

USC Center for Spinal Surgery
Follow-up Patient History Form

Please take the time to answer all questions that apply to your problem as completely as possible. Thank You.

Date_____

Name_____ Age_____

Chief Complaint_____ Date of Injury_____

What has happened since your last exam?_____

Have you had any recent tests or X-rays? _____Yes _____No
What tests? ____MRI ____CT scan _____Bone Scan Other_____

Are your symptoms now worse?_____ Better?_____ No Change?_____

What is the degree of pain that you are currently experiencing:
____none ____mild ____moderate ____severe

What is your pain on a scale of 1-10, with 10 being the worst pain?_____

How often do you experience the pain: ____intermittent _____constant

Describe the quality of your pain (i.e. dull, burning, sharp, etc.)_____

What is your back pain to leg pain ratio? (i.e. 100% back/0% leg)?
____100/0 ____90/10 ____80/20 ____70/30 ____60/40 ____50/50

____40/60 ____30/70 ____20/80 ____10/90 ____0/100

What is your neck pain to arm pain ratio? (i.e. 100% neck/0% arm)?
____100/0 ____90/10 ____80/20 ____70/30 ____60/40 ____50/50

____40/60 ____30/70 ____20/80 ____10/90 ____0/100

Where is your pain located?

____neck ____neck and arm(s) R or L ____arm(s) only- R or L

____back ____back and leg(s) R or L ____leg(s) only- R or L

What aggravates your pain? (standing, sitting, etc.)_____

What relieves your pain? (lying down, sitting, etc.)_____

Do you have night pain?_____ Does it wake you up from sleep?_____

Do you have numbness? If so, where?_____

Do you have weakness? If so, where?_____

Do you have any bowel or bladder problems?_____
_____incontinence _____constipation _____hesitancy

Are there any associated signs or symptoms (i.e. nausea, loss of balance, etc.)_____

Have you been in a physical therapy program? ____Yes ____No
When/Where/How often?_____ Did it help you?_____

Have you been wearing a back brace? ___Yes ___No
How long?_____ How many hours per day?_____
Does it help you? ___Yes ___No

What medications are we currently prescribing for you?_____

What other medications are you taking?_____

WORK INFORMATION
Are you currently working? ____No ____Yes → What type_____
_____Full Duty _____Modified Duty →_____

Date last worked_____Are you able to perform your usual duties?_____

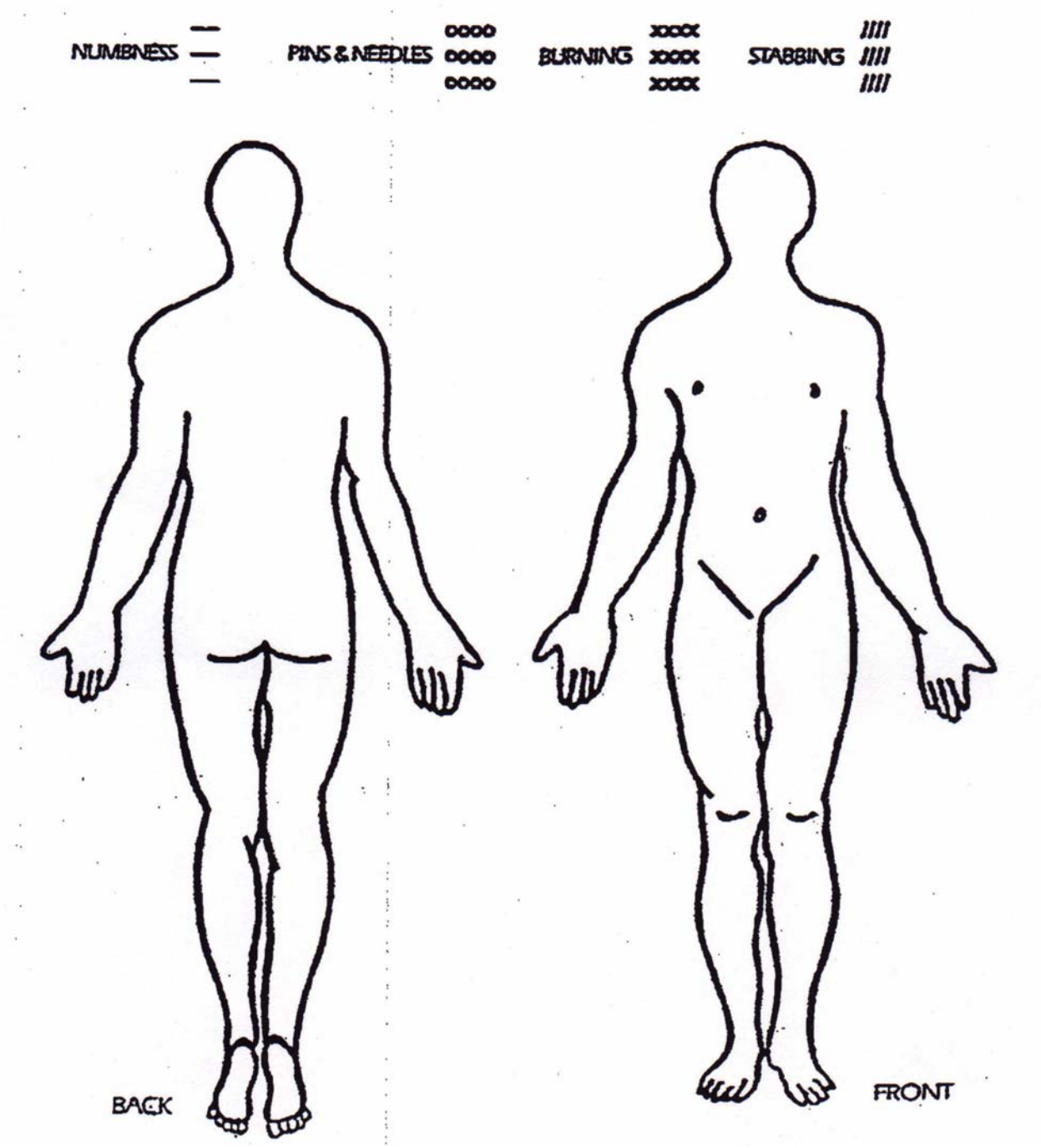
Since your last exam, have you developed any of the following symptoms?

Review of symptoms:

___fever	___chills	___sore throat
___weight loss	___night sweats	___headaches
___blurred vision	___double vision	___coordination loss
___fainting	___shortness of breath	___chest pain
___palpitations	___dizziness	___loss of consciousness
___bloody stools	___stomach pain	___diarrhea
___tarry stools	___light color stools	___pain in joints
___joint swelling	___bloody urine	___severe stiffness

other:_____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw your face.



-----Patients, please do not write below this line-----

SPINE EXAMINATION

Appearance_____ Weight_____
Alignment/Scoliosis/Rib Hump_____

Gait_____ Heel/Toe Walk_____
Tandem_____ Heel/Toe Raise_____
Myelopathy_____
Cranial nerves:_____
Skin/Incisions:___normal/intact ___healed ___healing other_____

Palpation: ____nontender ____tender → _____
Carotid bruit_____
ROM: Neck- Flexion_____ Ext_____ Rot_____ Lat Flexion_____

Back- Flexion____/90 Extension____/30 Sidebending/Rotation_____

Shoulder/Elbow/Wrist ROM___Normal ___Abnormal →_____
Hip/Knee/Ankle ROM ___Normal ___Abnormal →_____
Strength:

	C5	C5, C6	C7	C6	C7	C8	T1
	D	**B**	**T, ECU**	**WE/ECRL/L**	**WF/FCR**	**FF/FDSP/FCU**	**IO**
R							
L							
	L1,**L2**	L2,L3,L4	L3	L4	L5	L5	S1
	HF/IP	**HADD**	**Q**	**TA**	**EHL, EDL**	**HABD**	**GS,FHL,HE**
R							
L							

Sensory: ____intact _____not intact →location_____
Vibratory: ____intact _____not intact →location_____
Pulses: RUE_____ LUE_____ RLE_____ LLE_____

DTR:

	Biceps	Triceps	Brachiorad	Knee	Ankle
R	_____	_____	_____	_____	_____
L	_____	_____	_____	_____	_____

Cross adductor_____ Tibialis_____ Abdominal_____

Special Tests: Babinski_____ Clonus_____
Hoffmans_____ Sh Abd Test_____ Adsons_____ Spurling_____
SLR_____ Leseague_____ CRAM_____ FABER_____
Rectal Exam_____ BCR_____

XRAY/MRI Findings:_____

DIAGNOSIS:_____

RECOMMENDATIONS: 1._____
2._____
3._____