USC
UNIVERSITY
HOSPITAL

USC Center for Spinal Surgery
Online Consultation Form

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

Date_____ Referring Doctor/Primary Doctor_____

Name_____ Age_____

Chief Complaint_____ Date of Injury_____

Injured at_____ County of_____ Time of Injury_____

When did the symptoms originally begin?_____

Did your pain start gradually?_____ Suddenly?_____

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.)_____

What treatments in the past have made your pain better?_____

What treatments in the past have made your pain worse?_____

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

Are you currently working? ____no ____yes → what type_____
____Full Duty _____Modified Duty →_____

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

WORK COMP INFORMATION
Employer at time of injury_____ Length of time on job_____

Job description_____ Job title_____

Movements required for your job:

___twisting	___pushing	___pulling	___sitting
___standing	___stooping	___crawling	___lift____pounds
___bending	___crouching	___climbing stairs	___grasping
___balancing	___squatting	___kneeling	___climbing ladders
___reaching above shoulders		___repeated wrist/hand movements	

Sitting time_____ Standing time_____ Machines used_____

Describe how you were injured_____
_____
_____
If work comp, who is your attorney?_____
If work comp, who is your case manager?_____

MEDICAL/SURGICAL HISTORY

Have you had spine surgery in the past?_____ How many?_____

Please list types of spine surgeries and dates/doctor/hospital of surgeries:

1._____
2._____
3._____
4._____
5._____

Please list all medical problems:_____

___high blood pressure ___rheumatoid arthritis
___thyroid ___stroke ___diabetes ___heart attack
___asthma ___stomach ulcer ___cancer →what type_____
___seizure ___kidney stones ___blood clots in leg or lungs

Please list other previous surgeries/year:_____

___Tonsils	___head/neck cancer	___brain surgery
___appendectomy	___cardiac/heart	___lung cancer
___ulcer	___gall bladder	___kidney
___bladder	___abdominal cancer	___prostate
___hernia	___hysterectomy	___hip/knee replacement
___shoulder	___peripheral vascular	___knee
___ankle	___elbow	___wrist
___c-section	___melanoma	___hand
___foot	___hip fracture	___infection

Current medications:_____

Have you tried Anti-inflammation medications (ibuprofen, etc.)_____
Does it help?_____ Does it upset your stomach?_____

Allergies:_____

Are you married?_____ Children?_____
Who do you live with at home?_____
Do you smoke?_____ How much? (pack/day)_____
Do you drink alcohol?_____ How much?_____

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

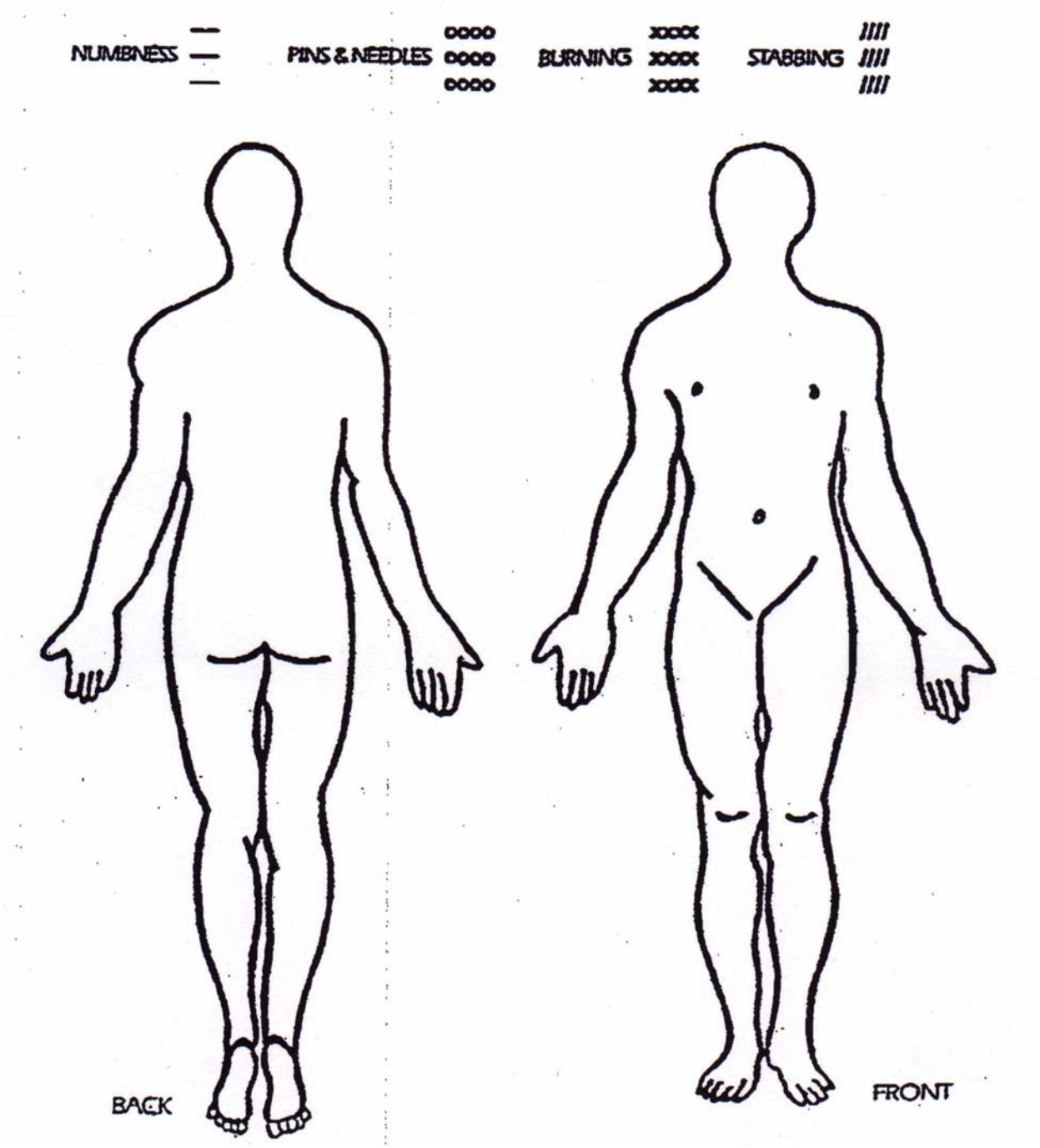
other:_____

Who referred you to this office?_____

What other doctors have seen you and/or treated you for this problem?_____
_____

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_____

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.



SPINE EXAMINATION

Constitutional:
Appearance: Do you have fever, chills, or night sweats?_____
Weight_____

Skin:Do you have any open skin wounds? If yes, please describe._____
_____

Musculoskeletal:
Do you have a spinal deformity, such as a curved spine or hunched back? If yes, please describe._____

Are you able to walk normally?_____
For a long distance?_____
How far?_____
Does sitting down relieve your pain?_____

Is it sore or painful if someone pushes on your back/spine? If so, where at?
_____

ROM:Can you turn your neck side to side all the way?_____
Can you bend your your neck to look down at the floor normally?_____
Can you bend your your neck to look up at the ceiling normally?_____

ROM:Can you bend your back side to side normally?_____
Can you bend you're your back to touch the floor normally?_____
Can you bend your your back to look up at the ceiling normally?_____

Do you have problems bending your Shoulder, Elbow, or Wrist?_____

Do you have problems bending your Hip, Knee, or Ankle?_____

Neurologic:
Arms and Hands
Do you have normal strength in all of your arm and hand muscles? If not, which ones are weak?_____

Do you have normal feeling (sensation) everywhere in your arms, hands, and fingers?
If not, which areas have abnormal sensation or loss of feeling? (eg. Side of arm, etc)
_____

Legs and Feet
Do you have normal strength in all of your leg and foot muscles? If not, which ones are weak?_____

Do you have normal feeling (sensation) everywhere in your legs, feet, and toes?
If not, which areas have abnormal sensation or loss of feeling? (eg. Top of foot, etc)
_____

Please send completed form and imaging studies (actual films-x-rays, MRI's, etc) to:

Mark J. Spoonamore, M.D.
c/o Online Consultation
USC Center for Spinal Surgery
1450 San Pablo Street, Suite 5100
Los Angeles, CA 90033

Patient Information

Patient Name_____

Address:_____

_____

Telephone Number:_____

Best Time to Call:_____

Address to mail x-ray films back to if not same as above:

_____

_____

_____