JOHNS HOPKINS
MEDICINE

Johns Hopkins Orthopaedics and Spine Surgery
Greater Washington Region
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 ☐ Internet ☐ 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 answers to the following questions so that we may better serve you.**

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	Right Left Both		
☐ Total Hip Replacement	☐ ☐ ☐	_____	_____
☐ Total Knee Replacement	☐ ☐ ☐	_____	_____
☐ Partial Knee Replacement	☐ ☐ ☐	_____	_____
☐ Core Decompression	☐ ☐ ☐	_____	_____
☐ High Tibial Osteotomy	☐ ☐ ☐	_____	_____
SPINE			
☐ Cervical (neck) Fusion	Levels _____	_____	_____
☐ Cervical Disc Removal/Decompression	Levels _____	_____	_____
☐ Lumbar (lower back) Fusion	Levels _____	_____	_____
☐ Lumbar Disk Removal/Laminectomy	Levels _____	_____	_____
☐ Thoracic (mid back)	Levels _____	_____	_____
☐ Kyphoplasty	Levels _____	_____	_____
☐ Tumor/Infection	Levels _____	_____	_____
SPORTS	Right Left Both		
☐ Knee Arthroscopy	☐ ☐ ☐	_____	_____
☐ Shoulder Arthroscopy	☐ ☐ ☐	_____	_____
☐ Rotator Cuff Repair	☐ ☐ ☐	_____	_____
☐ Total Shoulder Replacement	☐ ☐ ☐	_____	_____
☐ Other	☐ ☐ ☐	_____	_____
TRAUMA (List bone/joint and treatment)	Right Left Both		
_____	☐ ☐ ☐	_____	_____
_____	☐ ☐ ☐	_____	_____

OTHER PAST SURGICAL HISTORY

BREAST
- ☐ Lumpectomy *(left or right side)*
- ☐ Mastectomy *(left or right side)*

CARDIOVASCULAR
- ☐ Pacemaker
- ☐ Coronary artery Bypass
- ☐ Valve replacement

GASTRIOINTESTINAL
- ☐ Hernia repair
- ☐ Resection of large bowel
- ☐ Removal gall bladder

VASCULAR
- ☐ Abdominal aortic aneurysm
- ☐ Femoral Bypass
- ☐ Dialysis shunt
- ☐ Varicose vein stripping

OTHER:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

ALLERGIES

☐ **NO KNOWN ALLERGIES**

MEDICINE	REACTION	GENERAL	REACTION
☐ Aspirin			
☐ Erythromycin		☐ Latex	
☐ NSAIDs		☐ Adhesive	
☐ Penicillin		☐ Other	
☐ 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

Cholesterol Lowering Drugs:
- ☐ Lipitor (Atrovastatin)
- ☐ Pravachol (Pravastatin)
- ☐ Zocor (Simvastatin)

Diuretics (Water Pills):
- ☐ Dyazide (HCTZ + Trim-terrene)
- ☐ 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 (Hydorcodone + Acetaminophen)
- ☐ MS Contin
- ☐ Neurontin
- ☐ Neurontin
- ☐ Oxycodone/Oxycontin
- ☐ Tylenol #3 (Acetaminophen + Codeine)
- ☐ Ultram (Tramadol)

OTHER MEDICATION(S):

_____ _____ _____

_____ _____ _____

FAMILY HISTORY

- ☐ Cancer _____ type
- ☐ Heart Disease _____ type
- ☐ Diabetes _____ Type
- ☐ Other _____

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 your 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

RESPRIRATORY
- ❑ 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.

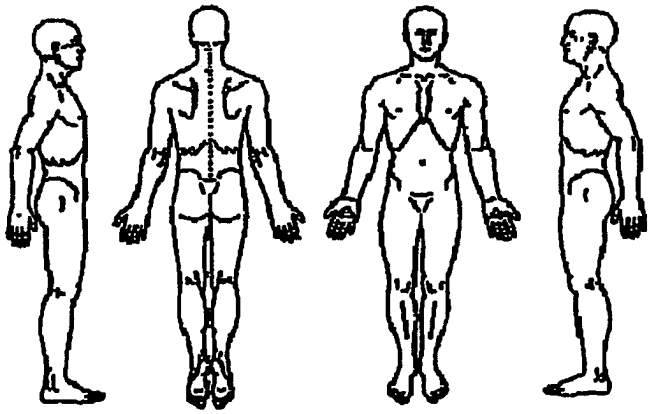
Other problems (please describe): _____

_____

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 <u>recent</u> 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 <u>NOT</u> able to perform the following activities of daily living (check all that apply):

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

TREATMENTS FOR YOUR SPINE TO DATE: (Check all that apply).

- ❑ Physical therapy
- ❑ Facet blocks
- ❑ Epidural steroid injections
- ❑ TENS unit
- ❑ Back injections, not sure what type
- ❑ Spinal surgery *(describe below)*

Date of Spinal Surgery	Title of Spine Operation	Hospital

CURRENT MEDICATIONS FOR PAIN: (Check all that apply):

Narcotics	Narcotic Dose and Frequency	NSAIDs/Tylenol
❑ Vicodin (Hydrocodone/APAP)	_____	❑ Tylenol
❑ Darvocet (Propoxyphene/APAP)	_____	❑ Motrin
❑ Oxycodone (Percocet/Tylox)	_____	❑ Celebrex
❑ Oxycontin	_____	❑ Bextra
❑ Morphine	_____	❑ Vioxx
❑ MS Contin	_____	❑ Advil
❑ Dilaudid	_____	❑ Aleve
❑ Fentanyl (Duragisic)	_____	❑ Ibuprofen
❑ Methadone	_____	❑ Naprosyn
❑ Demerol	_____	❑ Other _____
❑ Other: _____	_____	

If Yes to above, I have been on narcotic pain medications since _____ *(approximate date).*

Muscle Relaxants	Other Related Medications
❑ Soma	❑ Neurontin
❑ Flexeril	❑ Anti-depressant medication
❑ Valium	❑ Anti-anxiety medication
❑ Baclofen	❑ Other: _____
❑ Skelaxin	_____

Completed by: _____ _____
Patient/Guardian Date

This questionnaire has been reviewed with the patient.

_____ _____
Physician/Resident/PA or Nurse's Signature Date

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
COMMUNITY PHYSICIANS

LABEL

JOHNS HOPKINS COMMUNITY PHYSICIANS CONSENT FORM

This form serves three purposes: (1) It says that I want Johns Hopkins Community Physicians to treat me; (2) It says that Johns Hopkins Community Physicians can be paid directly by my health plan; and (3) It says I know that, in some cases, I may have to pay for my treatment.

1) CONSENT FOR TREATMENT

I, or the person who represents me, consent to have Johns Hopkins Community Physicians provide the medical care that the doctor or other health care people who are taking care of me say I need. Unless it is an emergency, they will describe this medical care and any significant risks that may be involved in my care.

2) WHO WILL PAY FOR MY CARE

I know that Johns Hopkins Community Physicians will bill my health plan for the care I receive. I agree that payments from my health plan will go directly to Johns Hopkins Community Physicians.

I know that under Maryland law Johns Hopkins Community Physicians can send me a bill in any of these cases:

(1) When I choose to have care that my health plan covers but I do not get a needed referral or an approval from my health plan.
(2) When I choose not to use my health plan and agree to pay for my care myself.
(3) When my health plan does not include Johns Hopkins Community Physicians for the care I want or need and I agree to pay for my care myself.
(4) When I receive care that is not covered under my health plan.

I know that I must pay for any co-payment or other part of the bill that my health plan says I must pay. I know I may need to pay this before I am treated.

My Signature_____ Date_____

For health care agent / guardian / surrogate / parent (circle one), I, _____, am the representative for the patient as circled above.

Representative's signature: _____

Address: _____ Phone #:_____

_____

_____ _____
Witness Signature/Agency Representative Date

JOHNS HOPKINS
COMMUNITY PHYSICIANS

LABEL

AUTHORIZATION FORM

1. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**
I/we hereby authorize Johns Hopkins Community Physicians, and any of its employees and agents, to release any and all medical records, in its/their possession, which may include psychiatric and addiction information without further authorization, (I) to any other physician or other healthcare provider in order to render patient care, and (II) to my insurance carrier, in order to obtain payment of financial obligations to Johns Hopkins Community Physicians.

2. **AUTHORIZATION TO PAY INSURANCE BENEFITS**
I/we hereby authorize payment directly to Johns Hopkins Community Physicians. I/we understand that I/we am/are financially responsible to Johns Hopkins Community Physicians for charges not covered by this assignment.

3. **GUARANTY OF ACCOUNT**
I/we, the undersigned, accept/s responsibility for any unpaid Johns Hopkins Community Physicians charges incurred during this course of the treatment. These charges will include anything not covered by insurance company coverage, Medicaid, Medicare, or other third party coverage.

   The undersigned further expressly agree/s that if, upon default, this matter is referred to an attorney for collection, the undersigned agree/s to pay all attorney fees and court costs incurred by Johns Hopkins Community Physicians in its efforts to collect the balance due.

4. **MANAGED CARE/HMO ENROLLEES**
I/we understand that if a referral has not been appropriately authorized from my HMO/PCP, I/we will be financially responsible for any charges I/we incur.

5. **MEDICARE AUTHORIZATION (IF APPLICABLE)**
I/we certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I/we authorize any holder of medical or other information about me to release to Social Security Administration and its intermediaries or carriers or any other third party payer, any information needed for this or a related medical claim. I/we request payment of authorized benefits to be made on my behalf and hereby assign the benefits payable for the health care services received to the physicians or organizations providing such services.

6. **RELEASE FROM RESPONSIBILITY FOR VALUABLES**
I/we hereby acknowledge that Johns Hopkins Community Physicians assumes no responsibility for patients' valuables.

I/we certify that the above paragraphs (1-6) have been read in full and understood by the undersigned accept/s the terms and agree/s to be bound thereby.

Witness

Patient/Guarantor/Policy Holder (parent/legal guardian)

Date

For addressograph plate

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Medical Record #: _____

Birth Date: _____

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _____**, confirm that I am the representative for the patient**
(insert your name)
based on the following relationship to the patient:

_____
(state relationship, for example—parent, spouse, guardian)

Representative's Signature: _____ **Date:** _____
(Required)

Address: _____ **Phone:** _____