OKC SPINE & ORTHOPEDIC
www.okcspineortho.com

Charles A. Hogan, MD
Reconstructive Spinal Surgery

North office:
1616 S Kelly Ave
Edmond, OK 73013

South office:
3115 SW 89th St
Oklahoma City, OK 73159

Phone:
405-486-6820

Fax:
405-426-6443

www.okcspineortho.com

Dear Valued Patient,

We are pleased you have selected Dr. Hogan to evaluate and treat your spinal condition. We want to provide you with the best possible care and service before and during your appointment. Our team is always available and we welcome your call. Please ask us to clarify any questions you might have or visit our website.

Your appointment is scheduled in our:

☐ North office:
1616 S Kelly Ave
Edmond, OK 73013

☐ South office:
3115 SW 89th St
Oklahoma City, OK 73159

_____ / _____ / _____
Day Date Time

North office: is located in Edmond on Kelly Ave, north of the Kilpatrick Turnpike. It is south of 15th Street and north of 33rd Street on the east side of the road, in the OSSO building.

South office: is located in southwest Oklahoma City on SW 89th St between I-44 and May Avenue. Is it directly across the street from Community Hospital and Fountain Park Medical Plaza. It is located on the north side of the road, in the OSSO building.

*** IMPORTANT INFORMATION - PLEASE READ CAREFULLY ***

What to bring:

- ☐ Identification (driver's license or state issued ID card)
- ☐ Insurance card(s)
- ☐ Co-pay
- ☐ Completed New Patient Packet
- ☐ **All diagnostic testing/imaging (within the last year) related to your spine, <u>on a disc/CD</u>. Bring the <u>paper reports</u> as well.**
  - Spine X-ray, MRI, CT, CT myelogram, EMG/NCV (nerve test), DEXA (bone density test), etc.
- ☐ Referral from your Primary Care Provider (if required by your insurance)
- ☐ List of current medications
- ☐ Medical records specific to your spine
  - Operative report from ANY prior spine surgery
  - Operative report from any spine pain procedure particularly within the last year
  - Names and phone numbers of any providers currently involved in your care or prescribing medications to you

Tips:

- ☐ Carefully note your appointment location (north office or south office).
- ☐ Complete the secure online portion of your medical history at www.okcspineortho.com ---> patient forms.
- ☐ Dress comfortably (loose fitting clothing/shorts/athletic pants) to allow for the physical exam portion of your visit.
- ☐ We often need to obtain new or additional X-rays during your visit if your disc will not import or if X-rays are too old, low quality, or missing views.
- ☐ All insurance companies, including medicare, require us to collect co-pays **at the time of service**. Our office accepts cash, check, and major credit cards.
- ☐ ***** Failure to bring the imaging on a disc/CD and reports/records to this appointment will result in the postponement of your appointment so as to enhance your time in our office and to ensure your needs are met. ****

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This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature: _____

Patient Name:_____

Date:_____ **Gender:** Male Female

Hand Dominance: R L **Date of Birth:** _____

Current Age: _____ **Height:**_____ **Weight:**_____

Who is with you today?:_____ **Relation:**_____

Who referred you?:_____

Who is your primary care doctor?_____

PAIN DIAGRAM

Mark the location and type of pain on the diagrams. <u>Pay attention to right and left sides.</u> If you have pain into the lower leg, feet, or hands, make sure to note it.

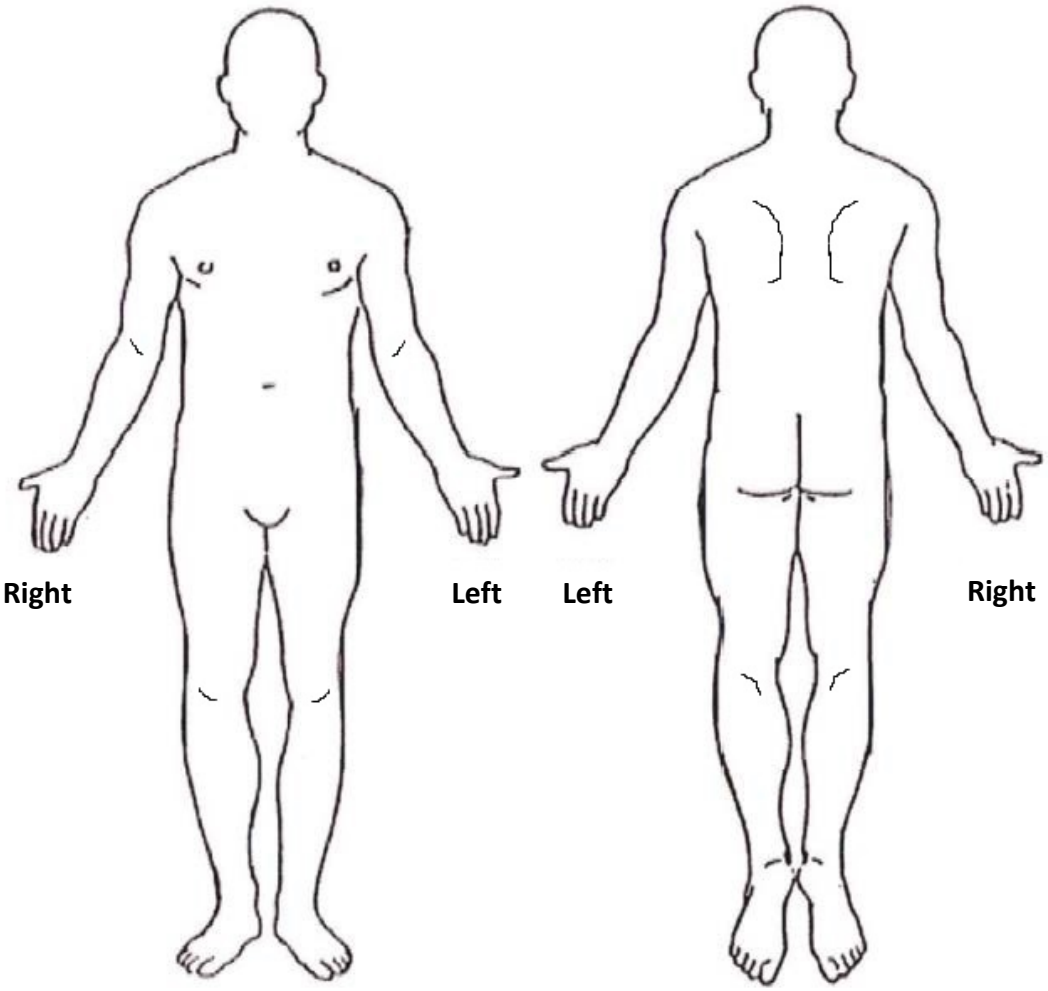
Ache
^^^^^
^^^^^
^^^^^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
====
====
====

Burning
XXXX
XXXX
XXXX

Stabbing
/////
/////
/////



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PAIN DESCRIPTION

Please fill out these forms completely!

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes and fill in the blanks where indicated.

Thank you for helping us get to know you better!

What would you like to happen as a result of this visit?

_____

_____

_____

_____

_____

Carefully read the following definitions	**Definitions**
	Neck Pain – "neck" includes middle of the neck, tops of shoulders by the neck, between upper shoulder blades
	Arm Pain – "arm" includes shoulder, arm, hand, fingers
	Mid back Pain – "mid back" includes pain from the level of the shoulder blades to the bottom of the ribs
	Low back Pain – "low back" includes pain across the lower back, above the beltline
	Leg Pain – "leg" includes areas below the belt line including the buttock, leg, foot, toes

Pain levels should be a total of 100% unless pain is 0%, in which case, please put 0 in the boxes (0% + 0% = 0%)

For a total of 100%, what % is back pain and what % is leg?	**% Low Back Pain**		**% Leg Pain**	
(e.g. 30% low back pain with 70% leg pain)		+		**= 100%**
For a total of 100%, what % is neck pain and what % is arm?	**% Neck Pain**		**% Arm Pain**	
(e.g. 20% neck pain with 80% arm pain)		+		**= 100%**

How bad is your pain? Circle the number on each of the lines below to indicate your pain.

How bad is your **neck** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **arm** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **middle back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **low back** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

How bad is your **leg** pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible

What makes your pain better?

_____

_____

_____

What makes your pain worse?

_____

_____

_____

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FACTORS OF COMPLAINT

How/when did your problem begin? (Please check all that apply to your neck/back pain.)

☐ I don't know how it began ☐ It came on gradually ☐ It came on all of the sudden
☐ Pain comes and goes ☐ Pain is there all the time
☐ I have had it a long time (_____ years)
☐ The recent episode started (_____ weeks _____ months _____ years) ago
☐ It's getting worse over the last (_____ weeks _____ months)
☐ It's actually getting better over the last (_____ weeks _____ months)
☐ Injury (date of injury _____)
Please explain how the injury happened: _____
On the job? ☐ yes ☐ no
In a car accident? ☐ yes ☐ no
☐ Are you currently in litigation with regards to your back pain? ☐ yes ☐ no
☐ Have you been laid off from your job? ☐ yes ☐ no ☐ n/a

If we are seeing you for LEG/BACK PAIN please complete this box.

Do you think your leg pain is related to the pain in your back? ☐ yes ☐ no Explain:_____
Does coughing make your pain worse? ☐ yes ☐ no

My pain is the worst when I am: (CIRCLE) sitting, standing, transitioning sit to stand, lying flat?

Do your LEGS/BUTTOCK get tired or hurt if you walk too far? ☐ yes ☐ no
If YES, How far can you walk? _____
How long can you stand for? _____ minutes
Is this relieved by resting your legs? ☐ yes ☐ no
Is this relieved by bending forward? ☐ yes ☐ no

Do your legs get cold or change color? ☐ yes ☐ no
Do your legs/feet swell? ☐ yes ☐ no
Do you have non-healing sores on your legs/feet? ☐ yes ☐ no ☐ n/a
Have you lost the hair on your legs? ☐ yes ☐ no ☐ n/a
Does dangling your feet over the bed make your legs feel better? ☐ yes ☐ no ☐ n/a
Do you have ED (erectile dysfunction)? ☐ yes ☐ no ☐ n/a
Do your legs feel: (CIRCLE) dull, crampy, heavy, tight, or tired? ☐ yes ☐ no
Do your knees: (CIRCLE) swell, ache, pop, click, or catch? ☐ yes ☐ no

If we are seeing you for ARM/NECK PAIN please complete this box.

Does how you position your neck make your arm/hand/shoulder pain worse? ☐ yes ☐ no ☐ n/a
Does hand or arm pain wake you up at night? ☐ yes ☐ no ☐ n/a
Does hand numbness wake you up at night? ☐ yes ☐ no ☐ n/a
Do you shake your hands to get relief? ☐ yes ☐ no ☐ n/a
My pain is the worst in my: (CIRCLE) neck, shoulder, arm, forearm, hand, fingers, or hard to tell.
Does talking on the phone make the hand/fingers more numb/tingly? ☐ yes ☐ no ☐ n/a
Does resting your hand atop the steering-wheel while driving make your arm/hand/shoulder pain worse? ☐ yes ☐ no ☐ n/a
Do you have worse shoulder pain with holding your arm away from your body or over your head? ☐ yes ☐ no ☐ n/a
Does sleeping on your side make the pain worse? ☐ yes ☐ no ☐ n/a

FACTORS OF COMPLAINT CONTINUED

How does each of the following affect your pain? (check all that apply)

Resting	☐ Better	☐ Worse	☐ No change	
Sitting	☐ Better	☐ Worse	☐ No change	
Lying down flat	☐ Better	☐ Worse	☐ No change	
Walking on flat surfaces	☐ Better	☐ Worse	☐ No change	
Walking up stairs	☐ Better	☐ Worse	☐ No change	
Walking down stairs	☐ Better	☐ Worse	☐ No change	
Rising from a chair	☐ Better	☐ Worse	☐ No change	
Physical activity	☐ Better	☐ Worse	☐ No change	
Bending/Twisting	☐ Better	☐ Worse	☐ No change	
Arching back	☐ Better	☐ Worse	☐ No change	
Heat	☐ Better	☐ Worse	☐ No change	☐ Don't know
Cold	☐ Better	☐ Worse	☐ No change	☐ Don't know
Massage	☐ Better	☐ Worse	☐ No change	☐ Don't know

_____

_____

Bladder Control (urine)

☐ No problem
☐ Can't empty bladder
☐ Loss of urine (accidents) for _____ weeks _____ months _____ years
Only when I: ☐ sneeze ☐ cough ☐ laugh ☐ strain
I've had: ☐ hysterectomy ☐ multiple children ☐ bladder sling ☐ prostate surgery
☐ I see a Urologist/Urogynocologist. Name: _____

Bowel Control

☐ No problem
☐ Constipation
☐ Loss of control (accidents) for _____ weeks _____ months _____ years
☐ I see a GI Doctor. Name:_____

Do you have:

☐ Balance problems from leg weakness?			
☐ Balance problems not from weakness but from lack of coordination?			
☐ Problems handling small objects such as coins?	☐ Both hands	☐ Right hand	☐ Left hand
☐ Problems feeding yourself, dropping things?	☐ Both hands	☐ Right hand	☐ Left hand
☐ Problems with zippers or buttons?	☐ Both hands	☐ Right hand	☐ Left hand
☐ Weakness with grip strength?	☐ Both hands	☐ Right hand	☐ Left hand
☐ Pain that is worse at night?			
☐ Pain that wakes you up from sleep.			

Has your pain affected your ability to do your job or any other daily activities? ☐ Yes ☐ No

If YES, please explain_____

_____

WHAT HAVE YOU TRIED?

Previous treatments for this CURRENT NECK/BACK pain (check all that apply)

☐ Chiropractic care Dates:_____ Where:_____	☐Better	☐Worse	☐No change
☐ Physical therapy Dates:_____ Where:_____	☐Better	☐Worse	☐No change
☐ Spine injections (Also see next page)	☐Better	☐Worse	☐No change
(CIRCLE) Facet injection, Medial branch block (MBB), Radiofrequency ablation (RFA), Epidural injection (ESI)			
☐ Behavioral health consultation. Name:_____	☐Better	☐Worse	☐No change
☐ Pain management. Name:_____	☐Better	☐Worse	☐No change
☐ Had to go to ER for this pain. Date:_____	☐Better	☐Worse	☐No change
Explain:_____			
☐ Avoid activity that causes pain. Explain:_____	☐Better	☐Worse	☐No change
☐ Weight loss. I lost _____ lbs over _____ months _____ years.	☐Better	☐Worse	☐No change
☐ Back or neck brace	☐Better	☐Worse	☐No change
☐ Cane ☐ walker ☐ wheelchair	☐Better	☐Worse	☐No change
For how long?_____			
☐ Heat	☐Better	☐Worse	☐No change
☐ Ice	☐Better	☐Worse	☐No change
☐ TENS	☐Better	☐Worse	☐No change
☐ Massage	☐Better	☐Worse	☐No change
☐ Home exercises and stretches	☐Better	☐Worse	☐No change
Describe:_____			
☐ Dry needling	☐Better	☐Worse	☐No change
☐ Aquatic physical therapy Dates:_____	☐Better	☐Worse	☐No change
☐ Home core strengthening routine	☐Better	☐Worse	☐No change
Describe:_____			
☐ Acupuncture	☐Better	☐Worse	☐No change
☐ Cervical traction	☐Better	☐Worse	☐No change
☐ Inversion table	☐Better	☐Worse	☐No change
Other:_____			

Previous medication for this CURRENT NECK/BACK pain (check all that apply)

☐ Topical (salon pas, biofreeze, icy hot, blu emu, pennsaid, etc.)	☐Better	☐Worse	☐No change
☐ CBD oil	☐Better	☐Worse	☐No change
☐ Tylenol	☐Better	☐Worse	☐No change
☐ Steroid shot in buttocks	☐Better	☐Worse	☐No change
Date:_____			
☐ Steroid pills (medrol dosepak, prednisone, etc.)	☐Better	☐Worse	☐No change
Date:_____			
☐ NSAIDS (ibuprofen, motrin, advil, mobic, aleve, celebrex, etc.)	☐Better	☐Worse	☐No change
☐ Can't take NSAIDS/anti-inflammatory.			
Explain:_____			
☐ Narcotics (codeine, hydrocodone, oxycodone, tramadol, etc.)	☐Better	☐Worse	☐No change
☐ Muscle Relaxer (soma, flexeril, robaxin, zanaflex, norflex, etc.)	☐Better	☐Worse	☐No change
☐ Nerve pain medication (neurontin, lyrica, gabapentin, etc.)	☐Better	☐Worse	☐No change
☐ Tricyclics (amytriptyline, nortryptaline)	☐Better	☐Worse	☐No change
☐ Antidepresssant/pain SSRI (celexa, lexapro, paxil, prozac, zoloft)	☐Better	☐Worse	☐No change
☐ Antidepressant/pain SNRI (cymbalta, effexor, pristiq)	☐Better	☐Worse	☐No change
☐ (CIRCLE) Methadone, belbuca, butrans, suboxone	☐Better	☐Worse	☐No change
Other: _____			
Other: _____			

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SPINE RELATED SURGERIES/PROCEDURES

If you have had ANY prior spine surgery hw pain procedure in the last year, bring the operative report/procedure note.

☐ **If you have never had SURGERY on your spine OR spine INJECTIONS/PROCEDURES/SHOTS (NECK/BACK): Check box & skip page**

Have you ever had *surgery* ON YOUR NECK/BACK?

☐ Yes ☐ No **If YES, complete the following:**

1) Type of surgery: _____

Date:_____ Surgeon:_____

Did it make your pain ☐better ☐worse ☐no change?

2) Type of surgery: _____

Date:_____ Surgeon:_____

Did it make your pain ☐better ☐worse ☐no change?

3) Type of surgery: _____

Date:_____ Surgeon:_____

Did it make your pain ☐better ☐worse ☐no change?

Have you had *shots/pain procedures* FOR YOUR NECK/BACK?

☐ Yes ☐ No **If YES, complete the following:**

1) Type of procedure: _____

Date:_____ Doctor:_____

Did it make your pain ☐ better ☐ worse ☐ no change?

2) Type of procedure: _____

Date:_____ Doctor:_____

Did it make your pain ☐ better ☐ worse ☐ no change?

3) Type of procedure: _____

Date:_____ Doctor:_____

Did it make your pain ☐ better ☐ worse ☐ no change?

AFTER YOUR NECK/BACK surgery

Unexpected events:_____

_____

_____

_____

_____

Did you experience: ☐None of these

☐Longer recovery than expected
☐Anesthesia problem: _____
☐Dural tear/spinal fluid leak
☐Blood clot
☐Arm/leg pain did not get better
☐Neck/back pain did not get better
☐Pain did not get better
☐Numbness in arms/legs did not get better
☐Weakness in arms/legs did not get better
☐Pain got better but worsened again. When?_____
☐Hoarseness
☐Trouble swallowing
☐Weight loss
☐Bowel obstruction/blockage
☐Wound that drained
☐Repeat surgery for wound drainage
☐Repeat surgery for infection
☐Repeat surgery for:_____
☐PICC line and IV antibiotics
☐On long-term oral antibiotic suppression
Name of Infectious Disease doctor:_____
☐New pain in neck/back
☐New pain in arms/legs
☐New numbness in arms/legs
☐New weakness in arms/legs
☐Re-rupture of a disc
☐Failure of bone to fuse together
☐Breakage of the instrumentation (plate/screws/rods)
☐Bowel/bladder problems
☐Surgery did not meet my expectations
Explain:_____
☐Other:_____

MEDICATION & ALLERGIES

List ALL medications that you are currently taking including prescription, over the counter, vitamins, herbals, and supplements. (May attach list)	☐ I currently take no medications

Medication	Dose (mg) / how often taken	Taken for	Doctor (if prescribed)

Allergic reactions including medicines, iodine, intravenous dye, latex, shellfish, etc.	☐ I have no allergies

Medication/Substance	Allergic Reaction

MY PHARMACIES AND SPECIALISTS

My preferred pharmacies	Pharmacy name:_____ Address:_____ Phone number:_____	Mail order pharmacy:_____ _____ Phone number:_____

My medical specialist(s) are: (cardiology, pain management, psychiatry, etc.)	Type of doctor	Doctor's name

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TELL US ABOUT YOU

Marital Status

- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Single
- ☐ Widow / widower

Education

Highest level completed:

- ☐ Grammar School
- ☐ High School
- ☐ College
- ☐ Post - graduate

Children

Number of kids:_____
Ages: _____

Smoking/Tobacco

- ☐ Current every day smoker/tobacco (see A below)
- ☐ Current some day smoker/tobacco (see A below)
- ☐ Former smoker/tobacco user (see B below)
- ☐ Never smoked/used tobacco

A) Year Started: _____

Cigarettes	_____ pack(s) per day
Cigars	_____ # per week
Vape	_____ amount per day
Dip/chew	_____ can(s) per day

B)

I quit tobacco in / around the year _____ ,
But I smoked _____ pack(s) per day for _____ years.
But I dipped _____ can(s) per day for _____ years.

Alcohol/Illicit Drugs

Do you drink: ☐ yes ☐ no

- ☐ Beer? ____ #/day
- ☐ Wine? ____ #/day
- ☐ Hard liquor? ____ #/day

Frequency of drinking:

- ☐ never
- ☐ rarely (# per year_____)
- ☐ occasionally (# per month _____)
- ☐ socially (# per week _____)
- ☐ daily (# per day _____)

Do you have a history of heavy drinking?
☐ yes ☐ no

Do you have a history of drug use?
☐ yes ☐ no
Explain:_____

Effect of your neck/back pain on your lifestyle

I describe my home setting as supportive of me during this time	☐ yes	☐ no
I describe my work setting as supportive of me during this time	☐ yes	☐ no
My pain has affected my interaction with my family and friends	☐ yes	☐ no
The changes in my lifestyle due to my problem have been difficult for me	☐ yes	☐ no

Ability to enjoy life

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Who do you live with? _____

Do you have any religious preferences?_____

What do you enjoy doing in your free time?_____

Please indicate your <u>current work status</u>

- ☐ Working full time Where:_____
- ☐ Working part time Where:_____
- ☐ Seeking employment
- ☐ Not working by choice (retired, homemaker, student, etc.)
- ☐ Physically unable to work **due to** neck/back pain
- ☐ Physically unable to work **not due to** neck/back pain
- ☐ Disabled since:_____ Explain: _____

_____

<u>Before</u> having neck/back pain, did you normally work

☐ full time ☐ part time ☐ neither

What is your usual occupation? _____

Do you like your work situation?

☐ yes ☐ no ☐ N/A

Your job title and brief description of your duties:

_____

_____

Is there anything we have failed to ask that you believe is important for us to know? ☐ yes ☐ no

If YES, please explain: _____

_____