LANDSTUHL REGIONAL MEDICAL CENTER
NEUROMUSCULAR & SPINE SERVICES
CMR 402 / CLINIC 9D
APO AE 09180

MEDICAL INFORMATION

ARE YOU PRP? YES ☐ NO☐

WHICH SERVICE ARE YOU SCHEDULE TO SEE TODAY:

☐SPINE & NEUROSURGERY SERVICE

☐PHYSICAL MEDICINE/PAIN CLINIC

☐PHYSICAL MEDICINE/EMG

PATEINT'S NAME: _____ Date of Birth: _____
Last, First MI DD/MM/YY

SEX _____ NAME OF SPONSER_____ RANK _____

SOCIAL SECURITY NUMBER _____DEROS _____
(OF SPONSOR) (FM MBR PREFIX EX. 20/SSN)

SPONSOR'S UNIT _____

SUPERVISOR'S NAME AND NUMBER _____
(OF SPONSER)
MAILING ADDRESS _____

E-MAIL ADDRESS _____ CELL PHONE _____

DUTY PHONE (DSN) _____HOME PHONE _____

WHERE ARE YOUR MEDICAL RECORDS KEPT?_____

MOS/AFC JOB DESCRIPTION _____
(Plain English)

BRANCH OF SERVICE_____

*** Please provide accurate contact information. This will assist us in contacting you concerning your appointments and surgery dates. Thanks**

"This document may contain information covered under the Privacy Act. 5 USC 552 (a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization."

Name _____ **Date**_____

What is your height (inches)?_____ What is your weight? _____

Social History

Do you smoke? Yes or No If yes, how many packs/day? ____ Do you drink alcohol? Yes or No If yes, how much? _____Do you drink or take caffeine pills? Yes or No If yes, how many cups of coffee/day ____ cups of tea/day ____ cans of cola/day? How many caffeine pills/day? _____

When was your last APFT/Fitness test? _____ Did you pass? _____ Do you have a regular exercise regimen? If yes, please describe? _____
_____ Are you on a profile for this current condition? Yes/No If yes, when did you get this profile? _____

Past Medical History

Are you allergic to any medications, contrast dye, iodine, or shellfish? _____ If yes, please list them
_____
Any past spinal surgeries? If yes, identify type of surgery and levels (ex. L5-S1 lumber discectomy May 2, 2003, C5-6 cervical fusion June 2006). _____
_____
Was surgery a success? Yes or No What is your post-so improvement: □10% □ 20% □30% □40% □ 50% □60% □70% □80% □90% □100% □None □Surgery worsened my symptoms
Please list past surgeries performed and any complications? (knee scope Dec. 2002)?
_____
_____
Hospitalized for other reasons? Yes or No If yes, please explained?
_____
_____

Please indicate all treatments you have tried to help your pain.

	Did it help? Yes	No
□Physical Therapy	□	□
□TENS unit	□	□
□Ultrasound	□	□
□Chiropractic	□	□
□Acupuncture	□	□
□Massage	□	□
□Biofeedback	□	□
□Psychology/Counseling	□	□
□Steroid Injections	□	□
□Nerve Blocks	□	□

History of Present Illness

1. When did your current symptoms first start MM/YY? _____
2. Was there an event or injury preceding your symptoms? Please describe.

_____

_____

3. If it was possible to separate your pain from the trunk (neck/low back) from the radiating pain in the (arms/legs) please grade. Trunk =_____% + Extremity = _____% = 100%. Please describe

_____

_____

4. What specific position makes your pain worse? Please describe.

_____

5. What specific position makes your pain better? Is there a decrease in pain while sitting/ standing/ lying on your back (please circle? Describe.

_____

_____

6. How long can you comfortably tolerate the following: Sitting _____ Minutes Standing _____ Minutes Walking_____Minutes
7. What is your average pain on a scale of 1-10? _____

0- no pain
1-2 mild pain, annoying (doesn't limit activity)
3-4 nagging, pain, uncomfortable (can perform activities with rest periods)
5-6 miserable, distressing (unable to do some activities) able to focus
7-8 intense, dreadful (unable to do most activities)
9-10 worst pain possible (unable to do any activities)

8. Do you experience constant pain everyday? Yes or No If no, describe how often it is present (3 times a week for 6 hours)? _____
9. Do you feel your pain is getting a) worse b) better c) staying the same?
10. How much does the pain affect your life a) doesn't affect your life b) place limitations on your life c) taken over your life?
10. What daily activity is most affected? _____
11. Please describe any changes to urination or control of urine? _____

_____

12. Please describe any changes to bowel movement or control of bowel movement.

_____

13. Are you experiencing any sexual dysfunctions (ability to maintain an erection)? (Please do not say N/A due to deployment). Yes or No If yes, please explain _____

_____

14. Please describe any changes with your sleep pattern. _____

_____

15. Do you have any of the following (please identify where completed if they were not done at Landstuhl Regional Medical Center):

X-rays? Yes or No If yes, when completed? _____
EMG? Yes or No If yes, when completed? _____
CT Scan? Yes or No If yes, when completed? _____
MRI? Yes or No If yes, when completed? _____

Review of Systems

Please indicate if you have any of the following medical conditions:

☐Stroke
☐Dizziness
☐Blurry vision
☐Hearing loss
☐Tremors
☐Seizures
☐Headaches
☐Altered taste
☐Memory loss
☐Numbness of hands or feet
☐Weight loss

☐Heart attack
☐Heart failure
☐Palpitations
☐Irregular heart beat
☐High Blood Pressure
☐Chest Pain
☐Shortness of breath
☐Murmurs
☐Cancer

☐Muscle disease
☐Broken bones
☐Fibromyalgia
☐Myopathy

☐Adrenal gland disease
☐Diabetes
☐Thyroid disease
☐Heat intolerance
☐Cold intolerance
☐Pituitary disease

☐COPD
☐Tuberculosis
☐Coughing blood
☐Smoking
☐Asthma
☐Bronchitis
☐Wheezing
☐Emphysema

☐Ulcer
☐Blood in stool
☐Hiatal hernia
☐Pancreatitis
☐Hepatitis
☐Liver disease
☐Diarrhea

☐Blood in urine
☐Kidney Stones
☐Kidney disease

☐Depression
☐Bipolar disease
☐Schizophrenia

☐Easy bruising
☐Anemia
☐Sickle Cell Disease
☐HIV/AIDS

Medication Reconciliation Patient Questionnaire

- **Drug reactions**

Name of Medication	Reaction	Treatment to resolve reaction

Please list ALL substances that were non-food or drink items consumed in the last 30 days.

- **Prescription Medications:** including inhalers, radiology contrasts, blood, IV solutions, eye drops, as needed mediations

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

- **Over the Counter Medications:** i.e. Cold/Flu, pain, headache, vitamins, diet related, sleep aids, stomach, diarrhea, constipation, sinus

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

- **Sports/Dietary Supplements & Herbals:** i.e. pills, powders, gels, teas, drinks, creams

Name of Medication	How/When you take the medication	Why you take this drug	Amount taken: mgs; ½ tab etc.	Time/Date last dose

Print Name: _____ **Date of Birth:** _____

Date of Appt: _____

Please use reverse side for additional listings

The Oswestry Disability Index for Back Pain

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. Please answer every section, and mark in each section the **one box** that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that **most closely** describes your present day situation.

Section 1. Pain Intensity:

- ☐ A. My pain is mild to moderate. I do not need pain killers.
- ☐ B. The pain is bad, but I manage without taking pain killers.
- ☐ C. Pain killers give complete relief from pain.
- ☐ D. Pain killers give moderate relief from pain.
- ☐ E. Pain killers give very little relief from pain.
- ☐ F. Pain killers have no effect on the pain.

Section 2. Personal Care:

- ☐ A. I can look after myself normally without causing extra pain.
- ☐ B. I can look after myself normally but it causes extra pain.
- ☐ C. It is painful to look after myself and I am slow and careful.
- ☐ D. I need some help but manage most of my personal care.
- ☐ E. I need help every day in most aspects of self-care.
- ☐ F. I do not get dressed, I wash with difficulty and stay in bed.

Section 3. Lifting:

- ☐ A. I can lift heavy weights without causing extra pain.
- ☐ B. I can lift heavy weights but it gives me extra pain.
- ☐ C. Pain prevents me from lifting heavy weights off the *floor,* but I can manage if they are conveniently positioned, for example on a table.
- ☐ D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ E. I can lift very light weights.
- ☐ F. I cannot lift or carry anything at all.

Section 4. Walking:

- ☐ A. I can walk as far as I wish.
- ☐ B. Pain prevents me from walking more than 1 mile.
- ☐ C. Pain prevents me from walking more than 1/2 mile.
- ☐ D. Pain prevents me from walking more than 1/4 mile.
- ☐ E. I can walk only if I use a cane or crutches.
- ☐ F. I am in bed or in a chair for most of every day.

Section 5. Sitting:

- ☐ A. I can sit in any chair for as long as I like.
- ☐ B. I can sit in my favorite chair only, but for as long as I like.
- ☐ C. Pain prevents me from sitting for more than 1 hour.
- ☐ D. Pain prevents me from sitting for more than 1/2 hour.
- ☐ E. Pain prevents me from sitting for more than 10 minutes.
- ☐ F. Pain prevents me from sitting at all.

Section 6. Standing:

- ☐ A. I can stand as long as I want without extra pain.
- ☐ B. I can stand as long as I want, but it gives me extra pain.
- ☐ C. Pain prevents me from standing for more than 1 hour.
- ☐ D. Pain prevents me from standing for more than 1/2 hour.
- ☐ E. Pain prevents me from standing for more than 10 minutes.
- ☐ F. Pain prevents me from standing at all.

Section 7. Sleeping:

- ☐ A. Pain does not prevent me from sleeping well.
- ☐ B. I sleep well but only when taking medicine.
- ☐ C. Even when I take medication, I sleep less than 6 hours.
- ☐ D. Even when I take medication, I sleep less than 4 hours.
- ☐ E. Even when I take medication, I sleep less than 2 hours.
- ☐ F. Pain prevents me from sleeping at all.

Section 8. Social Life:

- ☐ A. My social life is normal and causes me no extra pain.
- ☐ B. My social life is normal, but increases the degree of pain.
- ☐ C. Pain affects my social life by limiting only my more energetic interests, such as dancing, sports, etc.
- ☐ D. Pain has restricted my social life and I do not go out as often.
- ☐ E. Pain has restricted my social life to my home.
- ☐ F. I have no social life because of pain.

Section 9. Sexual Activity:

- ☐ A. My sexual activity is normal and causes no extra pain.
- ☐ B. My sexual activity is normal, but causes some extra pain.
- ☐ C. My sexual activity is nearly normal, but it very painful.
- ☐ D. My sexual activity is severely restricted by pain.
- ☐ E. My sexual activity is nearly absent because of pain.
- ☐ F. Pain prevents any sexual activity at all.

Section 10. Traveling:

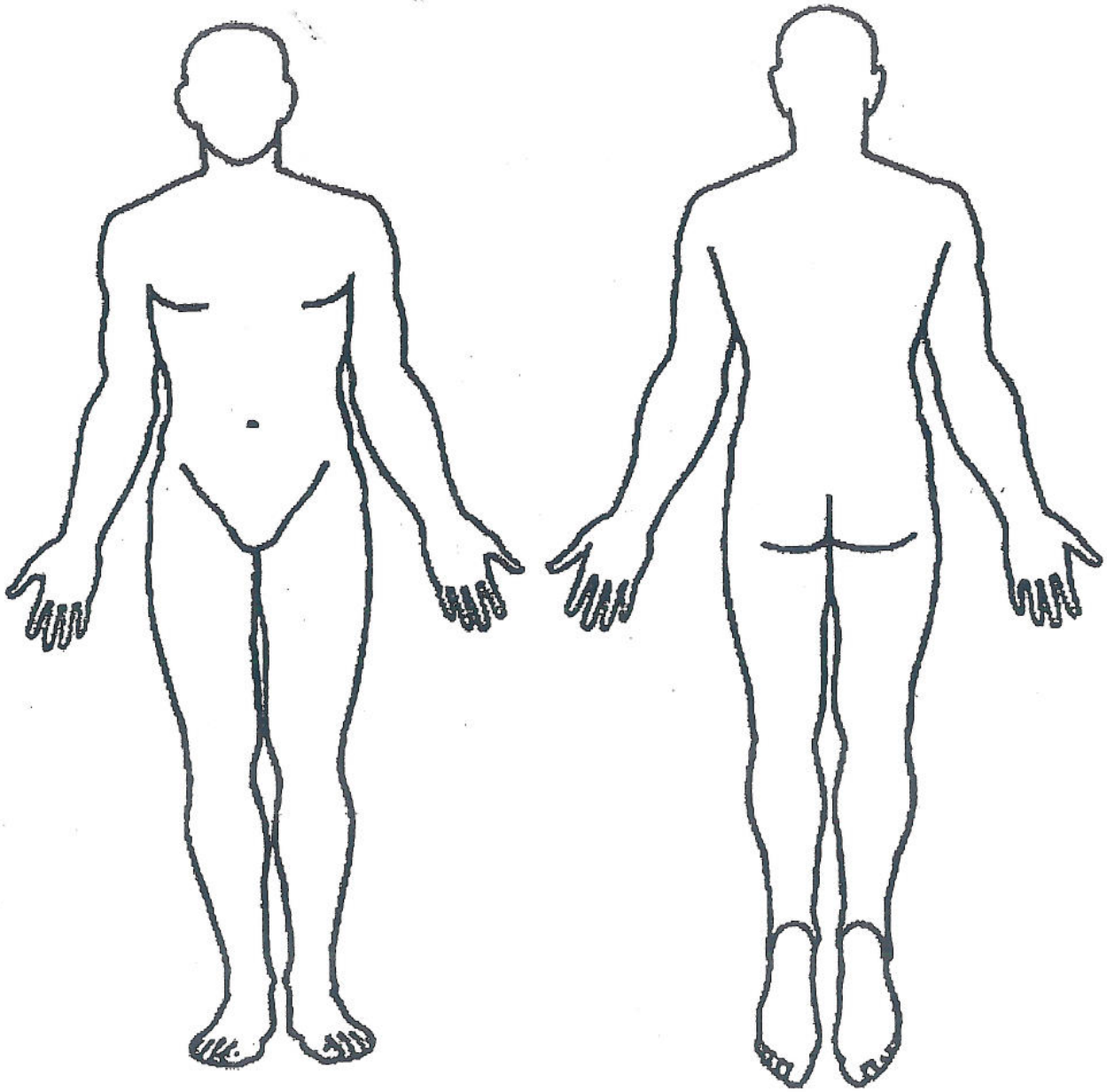
- ☐ A. I can travel anywhere without extra pain.
- ☐ B. I can travel anywhere, but it gives me extra pain.
- ☐ C. Pain is bad, but I manage journeys over 2 hours.
- ☐ D. Pain restricts me to journeys of less than 1 hour.
- ☐ E. Pain restricts me to necessary journeys under 1/2 hour.
- ☐ F. Pain prevents traveling except to the doctor/hospital.

Patient Name: _____

Date:_____ Score:_____/_____

Mark the area of your body where you feel described sensations and/or injury. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness:	- - - - - - - - - - - - - - -
Pins and needles:	**********
Burning:	xxxxxxxxxxxxxxxxxx
Stabbing:	/ / / / / / / / / / / / / / / /
Pain:	++++++++++++++++



MEDICAL RECORD SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE	**Medicine Clinic: ADULT OUTPATIENT SCREENING**	OTSG APPROVED (Date)
YES NO	Are you allergic to latex?	☐ Refer to PCM
YES NO	Is this appointment related to a deployment of you or your spouse?	☐ SEE NOTE
YES NO	Do you have difficulty with any particular self care activity to include dressing, eating, or hygiene? YES NO Have you experienced decrease strength, range of motion, endurance or sensation in your upper extremity to include shoulder, elbow, wrist, or hand? YES NO Have you experienced a decline in the way in which you walk, balance yourself, or otherwise move? YES NO Do you experience pain, decrease strength, range of motion or endurance, that limits your daily activities in your neck, shoulders, back, hips, knees, legs or feet?	**(Check all that apply)** ☐ SEE SF 600 ☐ Refer to OT ☐ Refer to PT ☐ See Previous Note(s) ☐ Chronic Condition, already assessed.
YES NO	Do you have physical pain that needs the attention of the provider you are seeing today? **If you answered "Yes," complete questions 1-4.** **1.** Describe the location of the pain: **2.** How long have you experienced this pain? **3.** Describe the pain: (Circle) Sharp Dull Burning Stabbing Shooting Other: **4.** Circle the number below to indicate the level of pain you feel. **0_1_2_ Mild pain** **3_4_ Nagging pain** **5_6_ Miserable** **7_8_ Intense** **9_10 Worst pain**	**(Check all that apply)** ☐ SEE NOTE ☐ See Previous Notes) ☐ Refer to PCM ☐ Chronic Condition, already assessed.
YES NO	Do you have difficulty chewing, swallowing, feeding yourself, or preparing meals? YES NO Do you feel your diet is inadequate, and need to see a dietian? YES NO Have you had a recent unintentional excessive change in weight and / or change in eating behavior?	☐ SEE SF 600 ☐ Refer to Nutrition Care
YES NO	Do you have any concern about physical or emotional abuse?	☐ Refer to Family Advocacy
YES NO	Have you ever had a severe allergic reaction to any medication? YES NO Are you taking any medications for a chronic condition? Tell your provider if you are taking any drugs / herbals /performance enhancers or over–the-counter products	☐ SEE NOTE ☐ Refer to PCM ☐ See Previous Notes)
YES NO	Do you have an Advanced Directive, Living Will or durable Health Care Power of Attorney? If yes, where is the document located?	☐ Refer to Legal Assist.
YES NO	Have you felt down, depressed or hopeless in the past 2 months? YES NO Are you bothered by having little interest or pleasure in normal activities? YES NO Do you have thoughts of harming yourself or others?	☐ Refer to PCM ☐ SEE NOTE ☐ See Previous Notes)
YES NO	Do you use any amount or form of tobacco? YES NO Are you a former user of tobacco products? YES NO Do you want information to help you quit?	☐ Refer to HAWC ☐ SEE NOTE

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: first, middle; grade; date; hospital or medical facility) *Name – last,*

Patient's Name:

Sponsor's Social:

Records Kept At: Date of Birth:

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

YES **NO** Do you have any religious / cultural / spiritual practices that may impact your care or education? **YES** **NO** Do you have any barriers preventing good communication? ☐ Hearing ☐ Speech ☐ Vision ☐ Other: Main language spoken: ☐ English ☐ Other: Reading preference: ☐ English ☐ Other: Highest education level: ☐ High School ☐ College ☐ Other **YES** **NO** Do you have any physical limitations that may influence your learning? **YES** **NO** Do you or your family need information on any of the subjects below?	☐ SEE NOTE ☐ Refer to HAWC Provider's Signature / Date **(Signature required to close above indicated actions.)**

☐ Current Illness ☐ Medications ☐ Nutrition ☐ Community Resources ☐ Tobacco Cessation
☐ Equipment ☐ Home Care ☐ Prevention ☐ Controlling Pain ☐ Other:

Are you interested in learning about your health care and the issues listed above? ☐ Yes ☐ No

Subject	Method	Level of Understanding	Other(s) Involvement	Staff Signature
	D=Discussion H=Handout V=video (circle one)	D=Demonstration V=Verbalize		

I understand the above instruction, and have no questions regarding content.
(Please sign after instruction has taken place.)
PATIENTS SIGNATURE: **DATE:**

DURING THE PATIENT'S NEXT APPOINTMENT, REVIEW INFORMATION AND NOTE SCREENING BELOW.

I HAVE READ AND REVIEWED THE INFORMATION ON THE FRONT OF THIS DOCUMENT AND ALL INFORMATION **(CIRCLE ANSWER)** IS / IS NOT CURRENT/ACCURATE. Patient Signature:

Provider Signature / Date : If information is not current/accurate note updates below.

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