NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

Visit Date (mm/dd/yy): ____/____/____ Name (Last, First): _____

Date of birth (mm/dd/yy): ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Who referred you to this office?

☐ Referring Doctor: _____ Address: _____ Phone: _____

☐ Primary Physician: _____ Address: _____ Phone: _____

☐ Self Referral

A. Symptoms & Pain Assessment

1. Chief Complaint: _____
2. How long have you had these symptoms?: _____Days _____Weeks _____Months _____Years
3. Describe the quality of your pain (Please check ✓ in the box):
   ☐ Burning ☐ Sharp ☐ Shooting ☐ Tingling ☐ Numbness
   ☐ Pinprick ☐ Stabbing ☐ Deep-pressure ☐ Tightness ☐ Spasms
   ☐ Other (Please describe) _____
4. How often do you experience the pain?
   ☐ Constant ☐ Intermittent - ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____
5. How did your pain start? ☐ Gradually ☐ Suddenly
   What day did your pain start? _____
6. Since the pain began, is it ☐ Worse ☐ Better ☐ Unchanged?
7. Does the pain radiate to.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both

   Do you have weakness in.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both

   Do you have numbness in.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
8. Any changes in bowel or bladder function?
   ☐ No ☐ Yes - ☐ Bowel incontinence ☐ Bladder incontinence ☐ Constipation ☐ Hesitancy ☐ Other: _____

MD Initial: _____ **Date:** _____ **Time:** _____

NEW PATIENT HISTORY

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9. Was there any injury/event that caused your pain?

☐ No ☐ Yes - Date of Injury (mm/dd/yy): ____/____/____

Please describe how you were injured: _____

_____

a. Legal actions pending? ☐ No ☐ Yes
b. Work related?
☐ No
☐ Yes - Employer at time of injury: _____
Job Title: _____
Worker's Compensation? ☐ No ☐ Yes - Name of your attorney: _____

10. Any prior back or neck injury/pain before the event above?
☐ No ☐ Yes - What type? (Please describe) _____

♦ Quadruple Visual Analogue Scale

How severe is your pain today?
(Please circle the number to indicate how bad you feel your pain is today.)

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

11. Pain Rating

Please rate your **Average** level of pain on the following scale (circle one)

0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain)

Please rate your **Worst** level of pain on the following scale (circle one)

0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain)

Please rate your **Best** level of pain on the following scale (circle one)

0 (No pain) 1 2 3 4 5 6 7 8 9 10 (Worst pain)

MD Initial: _____ **Date:** _____ **Time:** _____

NEW PATIENT HISTORY

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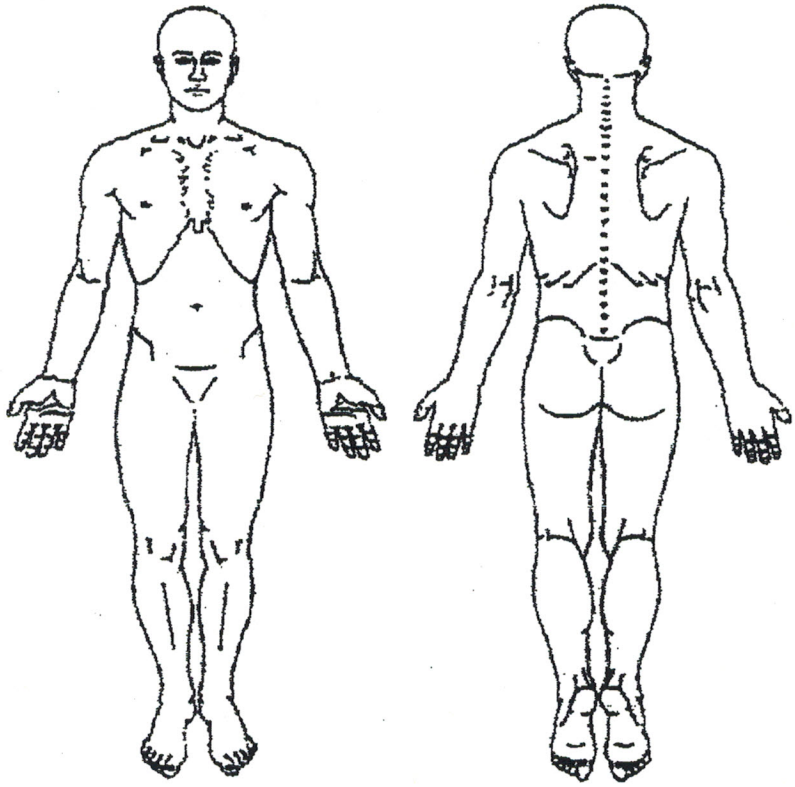
◆ Pain diagram

Using the symbols given below, mark the areas on your body where you feel the described sensation include all affected areas.

Numbness = = = **Pins&Needles ooo** **Burning xxx** **Stabbing ///** **Aching (((**



12. Do you have pain at night?
☐ No ☐ Yes - Does your pain wake you up from sleep? ☐ No ☐ Yes

13. What makes your pain better?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down ☐ Walking
☐ Epidural injections ☐ Nerve Blocks ☐ Physical therapy ☐ Acupuncture ☐ Massage
☐ Chiropractic ☐ Medications ☐ Other _____

14. What makes your pain worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down ☐ Walking ☐ Neck movement ☐ Coughing/Sneezing
☐ Other _____

MD Initial: _____ **Date:** _____ **Time:** _____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

B. Previous Treatment & Evaluation

1. What diagnostic test have you had for this problem?
   ☐ X-ray ☐ MRI ☐ CT ☐ EMG ☐ Bone Scan ☐ Myelogram ☐ Discogram ☐ Blood/Laboratory

2. Please check ✓ any of the following if you have tried for your pain or discomfort:
   ☐ Surgery ☐ TENS ☐ Epidural injections ☐ Nerve Blocks ☐ Physical therapy ☐ Acupuncture
   ☐ Massage ☐ Anti-inflammation medications ☐ Chiropractic ☐ Other _____

   a. Which treatment have you tried for your pain or discomfort is the **best** treatment?
   _____

C. Medical/Surgical History

1. Please list other medical problems (Please check ✓ in the box):
   ☐ High blood pressure ☐ Arthritis ☐ Diabetes ☐ Heart disease - type: _____
   ☐ Stroke ☐ Osteoporosis ☐ High Cholesterol ☐ Cancer - type: _____
   ☐ Thyroid ☐ Asthma ☐ Stomach Ulcer ☐ Kidney stones
   ☐ Blood clots in leg ☐ Blood clots in lungs ☐ Depression ☐ Arthritis
   ☐ AIDS/HIV ☐ Other _____

2. Have you ever had **spine surgery** in the past?
   ☐ No
   ☐ Yes - Type of spine surgery: _____ Date: _____
   _____ Date: _____
   _____ Date: _____

3. Please list other non-spinal surgeries: _____ Date: _____
   _____ Date: _____
   _____ Date: _____
   _____ Date: _____

D. Family Medical History (Please check ✓ in the box):

☐ Arthritis ☐ Bone Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer

Mother	Age: _____	☐ Healthy	☐ Deceased due to: _____
Father	Age: _____	☐ Healthy	☐ Deceased due to: _____
Brother/Sister	Age: _____	☐ Healthy	☐ Deceased due to: _____
	Age: _____	☐ Healthy	☐ Deceased due to: _____

E. Social History (Please check ✓ in the box):

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number of children: _____

MD Initial: _____ **Date:** _____ **Time:** _____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

E. Social History (con't) (Please check ✓ in the box):

Do you drink alcohol? ☐ No ☐ Yes If Yes, how much? _____

Do you smoke? ☐ No ☐ Yes If Yes, how much? _____

Do you use recreational substances? ☐ No ☐ Yes If Yes, Type and Frequency: _____

Are you currently working?

☐ No

☐ Yes - Employer: _____ Job Title: _____

How long have you worked there? _____ Days _____ Weeks _____ Months _____ Years

Length of time on job: _____hours/day _____days/week

Movements required for your job (Please check ✓ in the box):

☐ twisting ☐ pushing ☐ pulling ☐ sitting ☐ standing ☐ stopping ☐ crawling

☐ bending ☐ crouching ☐ grasping ☐ balancing ☐ squatting ☐ kneeling ☐ climbing stairs

☐ climbing ladders ☐ lifting ___pounds ☐ reaching above shoulders ☐ repeated wrist/hand movements

Sitting time: _____hours/day Standing time: _____hours/day Machines used: _____

Are you able to perform your usual duties? ☐ No ☐ Yes

F. Review of Systems

(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Skin
- ☐ Skin rash
- ☐ Easy bruising/bleeding
- ☐ Abnormal hair loss

Neurological
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Paralysis

Eyes
- ☐ Visual loss
- ☐ Double vision
- ☐ Glaucoma
- ☐ Glasses/Contacts

Bone/Joint/Muscles
- ☐ Muscle wasting
- ☐ Muscle cramping
- ☐ Joint pain

Ears/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐ Vertigo/dizziness
- ☐ Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐ Asthma/Bronchitis
- ☐ Cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema / COPD

Gastrointestinal
- ☐ Appetite changes
- ☐ Jaundice
- ☐ Irritable bowels
- ☐ Nausea/Vomiting

Endocrine
- ☐ Goiter
- ☐ Heat/Cold intolerance
- ☐ Increased thirst
- ☐ Increased size of hands or feet

Cardiovascular
- ☐ Palpitations
- ☐ Chest pains
- ☐ Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐ Fever/chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Blood System
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Bruising

MD Initial: _____ **Date:** _____ **Time:** _____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

MEDICATION

1. **Do you have any Allergies to Medications, Food or Latex?**
   - ☐ No Known Allergies
   - ☐ Yes - Allergies:_____ Reaction:_____
     Allergies:_____ Reaction:_____
     Allergies:_____ Reaction:_____
     Allergies:_____ Reaction:_____
     Allergies:_____ Reaction:_____
     Allergies:_____ Reaction:_____

2. **Current Medications:**
   - ☐ None
   - ☐ Yes, listed below:

Medications	Dose	Route	Frequency	Time & Date Last Taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				

MD Initial:_____ **Date:**_____ **Time:**_____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

SF-12 v. 2 HEALTH SURVEY

This Survey asks you for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

MD Initial:_____ **Date:**_____ **Time:**_____

5. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

6. These questions are about how you feel and how things have been with during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

MD Initial:_____ **Date:**_____ **Time:**_____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

OSWESTRY QUESTIONNAIRE

How long have you had back pain? _____ Years _____ Months _____ Weeks _____ Days
How long have you had leg pain? _____ Years _____ Months _____ Weeks _____ Days

This Questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the **ONE** box which 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 which most clearly describes your problem.*

SECTION 1 - Pain Intensity
- ☐ I can tolerate the pain I have without using pain killers.
- ☐ The pain is bad but I manage without pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain.

SECTION 2 - Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without causing pain.
- ☐ I can look after myself normally but causes more pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty, and I stay in bed.

SECTION 3 - Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light weights if they are conveniently placed.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than 1/2 mile.
- ☐ Pain prevents me from walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair(s) as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than 1/2 hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 - Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than six hours sleep.
- ☐ Even when I take tablets I have less than four hours sleep.
- ☐ Even when I take tablets I have less than two hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - Sex Life
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severly restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

SECTION 9 - Social Life
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - Travelling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 min.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

MD Initial:_____ **Date:**_____ **Time:**_____

NEW PATIENT HISTORY

Daniel S. Yanni, MD

Minimally Invasive, Thoracoscopic, and Complex Spine Surgery

NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

This Questionnaire has been designed to give your health care provider information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the **ONE** box which 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 which most clearly describes your problem.*

SECTION 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - Personal Care (Washing, Dressing, etc.)

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

SECTION 3 - Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light weights if they are conveniently placed.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 - Reading

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I can't read as much as I want because of moderate neck pain.
- ☐ I can hardly read at all because of severe neck pain.
- ☐ I cannot read at all.

SECTION 5 - Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all of the time.

SECTION 6 - Concentration

- ☐ I can concentrate fully when I want with no difficulty.
- ☐ I can concentrate fully when I want with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating when I want.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want.
- ☐ I cannot concentrate at all.

SECTION 7 - Work

- ☐ I can do as much work as I want.
- ☐ I can do my usual work but no more.
- ☐ I can do most of my usual work but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 - Driving

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 - Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain.
- ☐ I am able to engage in all my recreation activities with some neck pain.
- ☐ I am able to engage in most but not all of my usual recreation activities because of neck pain.
- ☐ I am able to engage in all few of my usual recreation activities because of neck pain.
- ☐ I hardly do any recreation activities because of neck pain.
- ☐ I can't do recreation activities at all.

MD Signature:_____ **Date:**_____ **Time:**_____

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.