UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER
SPINE INSTITUTE

7505 Osler Drive – O'Dea Building
Suite 500
Towson, MD 21204
410-337-4882 | Fax: 410-337-6782
umstjoseph.org

Please complete all pages of the form in blue/black ink.

Name: _____ Age:_____ Date: _____

1. Reason for visit today
   - ☐ Routine post operative follow-up visit (date of surgery_____)
   - ☐ Review ordered test
   - ☐ Evaluate progress of therapy/injection
   - ☐ Discuss continuing problem
   - ☐ Other: _____
2. Please indicate on the line below how bad your pain is now.

   No Pain ----------Worst Possible Pain
   0 10

3. ☐ Current problem unchanged from last visit on _____ (date).
   ☐ Current problems changed from last visit on _____ (date).

   Describe changes: _____
   _____
   _____

4. What medication(s) and how much (either prescription or over the counter) are you currently taking for this pain?

   _____

   _____

   Pharmacy: _____ Number: _____

5. How many sessions of physical therapy have you had since your last visit? _____ ☐ N/A
6. How many injections have you had since your last visit? _____ ☐ N/A
7. Medical History (including illness, surgery, and medications) are:

   ☐ Unchanged ☐ Changed from last visit on _____ (date).

   Describe Changes _____

   _____
8. Are you currently working? ☐ Yes ☐ No
9. Check any allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Morphine ☐ Demerol
   ☐ Codeine ☐ Arthritis Drugs ☐ Anesthesia Problems ☐ Latex Allergy
   ☐ Other (list) _____
10. Do you smoke cigarettes now? ☐ Yes ☐ No

    If yes, how much: _____ packs per day for _____ years

If you smoked in the past, how long has it been since you stopped? _____

Patient Name:_____

This questionnaire asks for your views about your general health. This information will help keep track of how you are feeling and how well you are able to do your usual activities. For each of the following questions, please mark with an "X" in the one box that best describes your answer. Please do not skip any questions.

1. In general, would you say your health is:

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?

   ☐ Much better now than ☐ Somewhat better than 1 year ago
   ☐ About the same as 1 year ago ☐ Somewhat worse now than 1 year ago
   ☐ Much worse now than 1 year ago

3. The following items 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	Yes Not limited at all
a. Vigorous activities, such as running, lifting, heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than one mile	☐	☐	☐
h. Walking several blocks	☐	☐	☐
i. Walking one block	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

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

	Yes	No
a. Cut down the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kid of work or other activities	☐	☐
d. Had difficulty performing the work or other activities (e.g. it took extra effort)	☐	☐

5. During the past 4 weeks 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?)

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	☐	☐
b. Accomplished less than you would like	☐	☐
c. Were limited in the kind of work or other activities	☐	☐
d. Had difficulty preforming the work or other activities (for example, it took extra effort	☐	☐