SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY

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# FOLLOW UP VISIT

Please checkmark and answer questions that pertain to your problem(s). You may select more than one answer per question. This information will help us give you an accurate appraisal of your problems, develop an appropriate plan of treatment, and will be included in your visit notes. If you have any questions please ask for assistance.

Today's Date:_____

Name:_____Date of Birth:_____Age:_____
Email Address:_____

- Has your address changed since your last visit? _____NO _____ YES – if so what is your new address: _____
- Has your phone number changed since your last visit? _____NO _____ YES – if so what is your new phone number:_____
- Do you have a new Primary Care Physician? _____NO _____ YES – Please provide information: _____

1. What is the nature of this follow-up appointment:
   _____ Routinely scheduled follow-up
   _____ Follow-up to review your diagnostic tests
   _____ Emergency follow-up
   _____ You called in wanting to be seen earlier than your scheduled appointment
   _____ Follow-up after recently being seen in an emergency room
   _____ Follow-up following Epidural Injection or Facet Block by Dr. Okafor
   Number of injections by Dr. Okafor or Dr. Marulanda. Circle one 1, 2, 3, 4, _____
   _____ Pre-operative Visit
   _____ Follow-up for surgery performed by Okafor or Dr. Marulanda less than 90 days ago
   _____ Follow-up for surgery performed by Okafor or Dr. Marulanda more than 90 days ago
   _____ Other: _____

2. What was your original complaint during your first visit to SICF?
   _____ Neck Pain
   _____ Neck Pain with Headaches
   _____ Upper Back pain
   _____ Right Arm Pain
   _____ Left Arm Pain
   _____ Lower Back Pain
   _____ Right Leg Pain
   _____ Left Leg Pain
   _____ Scoliosis
   _____ Numbness/Tingling In: _____
   _____ Weakness in: _____
   _____ Other: _____

   Do you have any?
   _____Weakness
   _____Numbness
   _____Tingling
   _____If so, Where?
   Describe_____
   _____
   _____

If one or more of the above chosen, which is the most problematic complaint? _____

3. Any "**New**" injury or accident since your last visit? _____NO _____ YES – If so please describe:
   _____
   _____

4. Are you experiencing any "**New**" or changed symptoms (different from what you had during your last visit)? _____NO ____YES – If YES, what are they?_____
   _____
   _____

5. List "**New**" Medication (if any) since your last visit?_____
   _____
   _____

6. List "**New**" Allergies (if any) since your last visit? _____
   _____
   _____

7. To the best of your knowledge, can you take anti-inflammatory medication? ____YES ____NO
   If "NO" please state the reason why you are not able to take this medication:_____
   _____

8. Current Smoking Status?
   _____ Non-smoker
   _____ Quit smoking since last visit
   _____ Still smoke
   _____ Use smokeless tobacco

9. Which term best describes your neck/back pain?
   _____ Sharp
   _____ Stabbing
   _____ Burning
   _____ Like Electricity
   _____ Dull
   _____ Ache
   _____ Pins and Needles

10. Which Term Best Describes your arm/leg pain?
    _____ Sharp
    _____ Stabbing
    _____ Burning
    _____ Like Electricity
    _____ Dull
    _____ Ache
    _____ Pins and needles

When did the problem start?_____

11. Since your last visit, your symptoms?
    _____ Have Improved (what percentage improvement_____%)
    _____ Have stayed the same
    _____ Have worsened
    _____ Come and goes (fluctuates)
    _____ Went from constant to intermittent

12. What time of the day is pain most intense? (check all that apply)
    _____ On first arising in the morning

_____ During the daytime or while at work
_____ At the end of the day before bedtime
_____ During the night

13. What aggravates the pain? (check all that apply)

_____Walking
_____Standing
_____Sitting
_____Lying down
_____Activity in General
_____Stooping/Bending
_____Nothing in particular
_____Other/Comments_____
_____
_____

14. What makes the pain better? (check all that apply)

_____Sitting
_____Lying down
_____Walking
_____Standing
_____Nothing in particular
_____Other/Comments_____
_____

15. Does the pain awaken you from sleep?

_____Never
_____Occasionally
_____Frequently

Does the pain keep you from sleeping?

_____Never
_____Occasionally
_____Frequently

16. Do you have any difficulty walking?

_____NO
_____YES, Can walk unlimited distances
_____YES, Can walk less than a mile
_____YES, Can walk only 1-2 Blocks
_____YES, Can walk less than 1 block
_____YES, Non-ambulatory (cannot walk)
_____Other_____

Do you use any of the following assistive device(s) for ambulation? (check all that apply)

_____NO _____ YES
_____Wheelchair _____Cane
_____Walker _____Crutches

If "YES" how long have you been using these assistive devices:_____
Do you use the assistive device _____Frequently _____Occasionally _____Rarely

17. Is the walking difficulty related to this condition?

_____YES _____NO , Explain _____

18. Are you presently or recently experiencing any of the following? (check all that applies)

_____ Fevers
_____ Chills
_____ Night sweats
_____ Headaches
_____ Chest Pain
_____ Fainting
_____ Difficulty with urination
_____ Burning with urination
_____ Swelling in legs
_____ Shortness of breath
_____ Nausea
_____ Vomiting
_____ Constipation

If you checked any of the symptoms in this question, does your Primary Care Physician know about these symptoms you check above in question #17? _____ YES _____NO

If you answer is "NO" make sure to notify your Primary Care Physician after this visit.

# REVIEW OF SYSTEMS

Have you ***recently*** experienced any of the following?

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional** | | | **Cardiovascular (Heart)** | | |
| Weight gain | YES | NO | Chest pain | YES | NO |
| Weight loss | YES | NO | Palpitations | YES | NO |
| Fevers | YES | NO | Swelling in lower extremities | YES | NO |
| Chills | YES | NO | | | |
| Night sweats | YES | NO | **Hematologic** | | |
| | | | Bleeding tendencies | YES | NO |
| **Psychiatric** | | | Bruising tendencies | YES | NO |
| Anxiety | YES | NO | Anemia | YES | NO |
| Depression | YES | NO | Emboli (blood clots) | YES | NO |
| Disorientation | YES | NO | Swollen glands | YES | NO |
| Loss of memory | YES | NO | | | |
| | | | **Gastrointestinal** | | |
| **Eyes** | | | Heartburn | YES | NO |
| Vision Loss | YES | NO | Blood in stool | YES | NO |
| Double Vision | YES | NO | Stool black in color | YES | NO |
| | | | Difficulty swallowing | YES | NO |
| **Skin** | | | Change in bowel habits | YES | NO |
| Changes in moles | YES | NO | Nausea | YES | NO |
| Breast Lumps | YES | NO | Vomiting | YES | NO |
| Rashes | YES | NO | | | |
| Itching | YES | NO | **Musculoskeletal** | | |
| | | | Weakness | YES | NO |
| **Ear / Nose / Throat** | | | Joint Pain | YES | NO |
| Nose Bleeds | YES | NO | Joint Stiffness | YES | NO |
| Difficulty Speaking (Hoarseness) | YES | NO | Muscle Stiffness | YES | NO |
| Hearing Loss | YES | NO | | | |
| | | | **Genitourinary** | | |
| **Neurological** | | | Frequent Urination | YES | NO |
| Dizziness | YES | NO | Difficulty with urination | YES | NO |
| Fainting | YES | NO | Blood in Urine | YES | NO |
| Frequent Headaches | YES | NO | | | |
| Disorientation | YES | NO | **Immunologic** | | |
| | | | Frequent Infections | YES | NO |
| **Respiratory** | | | | | |
| Coughing / Wheezing | YES | NO | **Dr. Signature:**_____ | | |
| Shortness of Breath | YES | NO | | | |

**PATIENTS, PLEASE PROCEED TO THE NEXT PAGE…**

OFFICE USE ONLY

(one of the 2 boxes below will be checked off by Physician during your visit)

- □ Informed patient to notify his/her primary care physician of any of the above positive review of systems. Patient verbally expressed understanding this instruction, and agrees to do so.
- □ Patient states that his/her Primary Care Physician is aware of all positive review of systems above.

19. Any **CHANGES** in Employment/Work Status since your last visit? _____ YES _____NO

*What is your current work status?:*

_____Regular employment – NO restrictions
_____Full time with restrictions
_____Part Time with restrictions
_____Part Time with restrictions
_____Part Time due to a spine problem
_____Part Time due to other medical reason, specify _____
_____Retired by choice
_____Retired due to a spine problem
_____Retired due to other medical reason, specify_____
_____Unemployed – Looking for work with NO restrictions
_____Unemployed – Looking for light duty work
_____Unemployed
_____Currently not working due to a spine problem
_____Currently not working due to other medical reason, specify_____
_____Student (what grade level, or type of training are you undergoing?_____

If NOT working, are you on Disability? _____YES _____NO

20. Do you have a **FAMILY HISTORY** of any of these diseases (check all that are appropriate).

| | | |
|---|---|---|
| _____None | _____Heart Disease | _____Scoliosis |
| _____Back /Neck problems | _____Hypertension | _____Stroke |
| _____Cancer | _____Osteoarthritis (wear & tear) | _____Other_____ |
| _____Diabetes | _____Rheumatoid Arthritis | |

21. Since your last visit have you had any of the following done:
    a. Diagnostic Studies/Test relating to your problem or injury (check all that apply).

| | | |
|---|---|---|
| _____X-Rays | _____EMG | _____Lab Work |
| _____CT Scans | _____Whole Body Bone Scan | _____None |
| _____MRI | _____Bone Mineral Density Test | |

    b. Surgery? _____NO _____YES
       If YES – what type_____

       Surgeon's Name_____
       Date of Surgery_____

    c. Have you had one or more of the following procedures since your last visit?
       - Epidural Injection _____NO _____YES
       - Facet Block Injection _____NO _____YES
       - Rhizotomy _____NO _____YES

       If "YES" did, you get:
       _____Temporary Relief _____No Relief _____ Lasting Relief of your Symptoms
       If Temporary Relief, How long did the relief last _____Minutes | Hours| Days | Weeks
    d. Are you currently attending a Physical Therapy Program? _____YES _____NO
    e. Are you participating in a Home Exercise Program? _____YES _____NO

22. Have you had any surgery by Dr. Okafor in the past? _____YES _____NO

If "YES", what is the Date of Surgery _____

and what Surgery did Okafor or Dr. Marulanda Perform _____

_____

| FOR OFFICE USE ONLY: | | | | | |
|---|---|---|---|---|---|
| RMDI: | /24 | VAS: | /10 | ODI: | NDI: |