

Have You Ever Had Spine Surgery? Yes [] No [] If Yes Fill Out the Questions Below:

How Many Surgeries? Where? When?

Where You Better After Spine Surgery? Yes [] No []

Rate Your Present Level of Activity

Normal []

Slightly Restricted []

Moderately Restricted []

Severely Restricted []

Does Walking Make Your Pain Worse? Yes [] No []

Is Your Pain Worse at Night? Yes [] No []

Do You Have Any Weakness in Your Legs? Yes [] No []

What Percent of the Time Are You in Pain? []

If There is Pain, How Many Hours a Day Must You Be Lying Down? []

If There is Pain How Severe Does it Get Each Day (On a Scale of 1-10) []

What Medications Do You Take for Pain Relief? (Include aspirin, non-steroidal and steroidal
inflammatories such as ibuprofen, and narcotics with frequency and dosage)

What Other Medications Do Take On a Daily Basis?

Do You Have Any Drug Allergies?

List Your Height [] Weight [] Have You Lost Height? Yes [] No []

List Any Noteworthy Medical Problems (i.e. diabetes, hear disease, cancer, lung problems)

List All Previous Noteworthy Non-Spine Surgical Procedures and Results:

Are You Now A Cigarette Smoker? Yes [] No []

If Yes How Much a Day? [] For How Many Years? []

If Yes Are You Aware That Cigarette Smokers Have a 3-4x Higher Incidence of Disc
Degeneration in Their Spines Compared to Non-Smokers? Yes [] No []

Do You Do Aerobic Exercise On a Regular or Daily Basis? Yes [] No []

Thank You For Filling Out This Questionnaire.