THE METROPOLITAN NEUROSURGERY GROUP LLC

FOLLOW UP QUESTIONNAIRE

DATE: _____/_____/_____

FIRST NAME_____ **LAST NAME**_____ D.O.B._____ POST OP. (within 3 months of surgery) YES NO LAST VISIT DATE: _____ MOST RECENT SURGERY DATE: _____ Type of surgery:_____ _____	Primary Care Physician:_____ PCP Tel: _____Fax:_____ Address:_____ _____ _____ Please list all physicians we should send today's visit note to: _____ _____ _____ _____

IS THERE A CHANGE OF ADDRESS? □ NO □ YES (UPDATE BELOW)
_____

IS A NEW PHONE NUMBER OR EMAIL? □ NO □ YES (UPDATE BELOW)
_____

Preferred Pharmacy Name and Address:	Pharmacy phone no:

Height:	**Weight:**	**BP** (leave for staff):	**HR** (leave for staff):
_____' _____"	_____**lbs.**	_____ /_____	_____ / min

List the 3 top concerns that you would like to discuss today:

1_____
_____
_____

2_____
_____
_____

3_____
_____
_____

New Imaging, tests or reports brought for review today:

1_____**2**_____
3_____**4**_____

Indicate severity using number scale | 1 = None | 2 = Mild | 3 = Moderate | 4 = Severe | 5 = Incapacitating

NEUROLOGICAL						**MUSCULOSKELETAL**					
Hyperaccusis/sensitivity to noise	1	2	3	4	5	Neck pain on bumpy roads	1	2	3	4	5
Ringing in the ears	1	2	3	4	5	Muscle pain at rest	1	2	3	4	5
Loss of hearing	1	2	3	4	5	Cramps/stiff muscles	1	2	3	4	5
Balance disorder	1	2	3	4	5	Pain in legs while walking	1	2	3	4	5
Vertigo (room spinning around)	1	2	3	4	5	Back pain when lying down	1	2	3	4	5
Dizziness/lightheadedness	1	2	3	4	5	Scoliosis	1	2	3	4	5
Shaking episodes (dystonias)	1	2	3	4	5	Back pain walking up incline	1	2	3	4	5
Seizures	1	2	3	4	5	Lower back pain	1	2	3	4	5
Tremors	1	2	3	4	5	Sacral pain	1	2	3	4	5
Headache	1	2	3	4	5	Sleep with knees bent	1	2	3	4	5
Neck pain	1	2	3	4	5	**CARDIOVASCULAR/AUTONOMIC NERVOUS SYSTEM**					
Loss of consciousness/syncope	1	2	3	4	5	Feeling heart beats/palpitations	1	2	3	4	5
Pre-syncope	1	2	3	4	5	Chest tightness/pain at rest	1	2	3	4	5
Concentration difficulties	1	2	3	4	5	Chest pain on exertion	1	2	3	4	5
Memory loss	1	2	3	4	5	Shortness of breath at night	1	2	3	4	5
Blurred vision	1	2	3	4	5	Shortness of breath at rest	1	2	3	4	5
Double vision	1	2	3	4	5	Shortness of breath on exertion	1	2	3	4	5
Teichopsia (vision flashes)	1	2	3	4	5	Fingers change color with temperature	1	2	3	4	5
Photosensitivity (light sensitivity)	1	2	3	4	5	Excessive sweating	1	2	3	4	5
Hyperolfaction (sensitivity to smell)	1	2	3	4	5	Heat intolerance	1	2	3	4	5
Facial numbness	1	2	3	4	5	Elevated temperature of >101.5 °	1	2	3	4	5
Paresthesia/tingling/sensory loss	1	2	3	4	5	Sleep disturbances	1	2	3	4	5
Leg weakness	1	2	3	4	5	Abnormally dilated pupils	1	2	3	4	5
Arm weakness	1	2	3	4	5	**GASTROINTESTINAL**					
Nausea/vomiting	1	2	3	4	5	Abdominal pain	1	2	3	4	5
Poor coordination	1	2	3	4	5	Bloating	1	2	3	4	5
Speech difficulty	1	2	3	4	5	Constipation	1	2	3	4	5
Hoarseness	1	2	3	4	5	Heart burn/ GERD	1	2	3	4	5
Choking	1	2	3	4	5	Diarrhea	1	2	3	4	5
Difficulty swallowing	1	2	3	4	5	Black stool/blood in stool	1	2	3	4	5
CONSTITUTIONAL						Loss of bowel control	1	2	3	4	5
Fatigue	1	2	3	4	5	**GENITOURINARY**					
Rashes	1	2	3	4	5	Burning with urination (dysuria)	1	2	3	4	5
Easily bruised	1	2	3	4	5	Increased frequency / urination	1	2	3	4	5
Joint pain	1	2	3	4	5	Loss of bladder control	1	2	3	4	5
Poor wound healing	1	2	3	4	5	Nocturia (urination at night)	1	2	3	4	5
Frequent infections	1	2	3	4	5	Difficulty initiating stream	1	2	3	4	5
Anemia	1	2	3	4	5	Unable to empty bladder	1	2	3	4	5
Excessive bleeding	1	2	3	4	5	Enuresis (bedwetting)	1	2	3	4	5
Swollen lymph nodes	1	2	3	4	5	**PSYCHIATRIC**					
Thyroid disorder	1	2	3	4	5	Depression	1	2	3	4	5
						Anxiety/panic	1	2	3	4	5

SYMPTOMS

What symptoms are improved since your last visit or surgery?:

_____
_____
_____
_____

What symptoms have not changed since your last visit or surgery?:

_____
_____
_____
_____

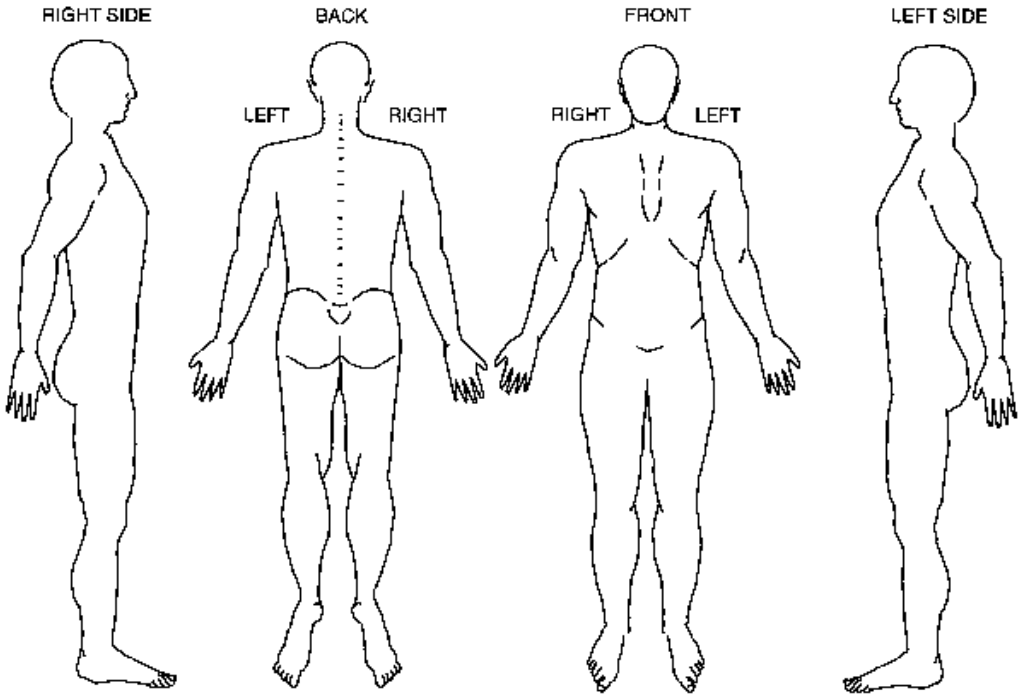
What symptoms worsened since your last visit or surgery?:

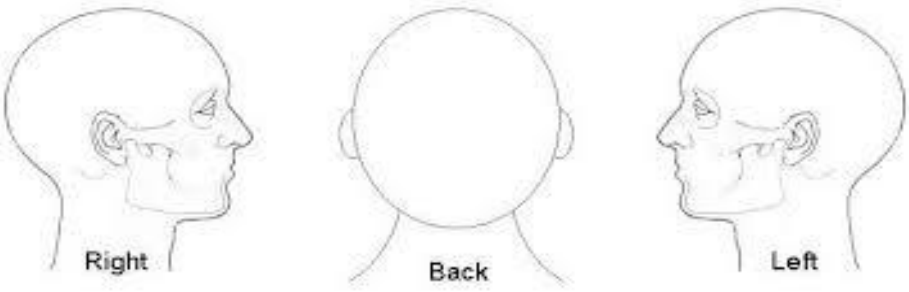
_____
_____
_____
_____

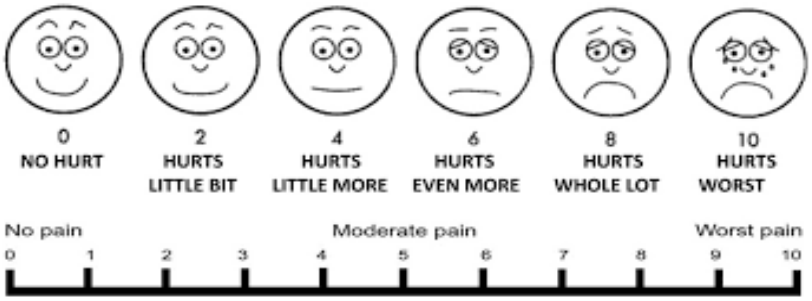
What is your overall pain level (0-10): _____

PAIN ASSESSMENT:

Using the diagrams below, please indicate pain location, type, frequency and intensity.







PAIN TYPE: **FREQUENCY**

+ aching **↓↓ pins and needles** **© continuous**
♯ numb **● dull/throb** **≠ on and off**
▼sharp **≈ nerve pain**

PLEASE LIST ANY CONSERVATIVE TREATMENTS THAT YOU HAVE TRIED SINCE LAST VISIT (if no change since last visit write "SAME"):

PHYSICAL THERAPY:

_____
_____

OCCUPATIONAL THERAPY:

_____
_____

OTHER TYPES OF THERAPY (aqua, massage, dry needling, acupuncture, etc):

_____
_____

NERVE BLOCKS AND EPIDURAL INJECTIONS:

_____
_____

OTHER PROCEDURES/TREATMENTS (BACLOFEN PUMP, TENS UNIT, etc.):

_____
_____

BRACES:

_____

OTHER PROCEDURES, TREATMENTS OR MEDS (e.g. medications you have tried in the past for related symptoms, such as neurogenic bladder, chronic constipation/gastroparesis, nausea, POTS, etc).

_____

_____

ANY MEDICATION CHANGES FROM LAST VISIT (DISCONTINUED AND NEW)

Nr.	Medication	Dose	Frequency	Prescribing Physician	Since (year)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					

ALLERGIES

Nr.	Allergen	Reaction	Mild	Moderate	Severe
1					
2					
3					
4					
5					
6					
7					

STANDING TIME (Please circle one)

0 - On most occasions, I can stand as long as necessary without experiencing orthostatic symptoms
1- On most occasions, I can stand *more than 15 minutes* before experiencing orthostatic symptoms
2- On most occasions, I can stand *5-14 minutes before* experiencing orthostatic symptoms
3- On most occasions, I can stand *1-4 minutes before* experiencing orthostatic symptoms
4- On most occasions, I can stand *less than 1 minute before* experiencing orthostatic symptoms

ORTHOSTATIC (Please circle one)

1. **Frequency of orthostatic symptoms**
   - 0- I *never or rarely* experience orthostatic symptoms when I stand up
   - 1- I *sometimes* experience orthostatic symptoms when I stand up
   - 2- I *often* experience orthostatic symptoms when I stand up
   - 3- I *usually* experience orthostatic symptoms when I stand up
   - 4- I *always* experience orthostatic symptoms when I stand up
2. **Severity of orthostatic symptoms**
   - 0- I *do not* experience orthostatic symptoms when I stand up
   - 1- I experience *mild* orthostatic symptoms when I stand up
   - 2- I experience *moderate* orthostatic symptoms when I stand up and *sometimes* have to sit back down for relief
   - 3- I experience *severe* orthostatic symptoms when I stand up and *frequently* have to sit back down for relief
   - 4- I experience *severe* orthostatic symptoms when I stand up and *regularly faint* if I do not sit back down
3. **Conditions under which orthostatic symptoms occur**
   - 0- I *never or rarely* experience orthostatic symptoms under any circumstances
   - 1- I *sometimes* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 2- I *often* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 3- I *usually* experience orthostatic symptoms under certain conditions, such as prolonged standing, a meal, exertion (e.g. walking), or when exposed to heat (e.g. hot day, hot bath, hot shower)
   - 4- I *always* experience orthostatic symptoms when I stand up; the specific conditions do not matter
4. **Activities of daily living**
   - 0- My orthostatic symptoms *do not interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 1- My orthostatic symptoms *mildly interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 2- My orthostatic symptoms *moderately interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 3- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)
   - 4- My orthostatic symptoms *severely interfere* with activities of daily living (e.g. work, chores, dressing bathing)/ *I am bed or wheelchair bound because of my symptoms*

WOOD MENTAL FATIGUE INVENTORY

In the last month, have you been bothered by each of the following? (Please check the most appropriate box)

	Not at All	**A Little**	**Some-what**	**Quite A Lot**	**Very Much**
Spells of confusion	( )	( )	( )	( )	( )
Thoughts getting mixed up	( )	( )	( )	( )	( )
Poor Concentration	( )	( )	( )	( )	( )
Difficulty making decisions	( )	( )	( )	( )	( )
Poor memory for recent events	( )	( )	( )	( )	( )
Can't take things in when speaking to people	( )	( )	( )	( )	( )
Thoughts are slow	( )	( )	( )	( )	( )
(CONTINUED)					
Muzzy or foggy head	( )	( )	( )	( )	( )
Can't find the right words	( )	( )	( )	( )	( )
Scoring for each item:	**0**	**1**	**2**	**3**	**4**

KARNOSKY SCALE (Please circle one)

100% - Normal; no complaints and no evidence of disease
90%- Able to carry on normal activities; minor signs or symptoms of disease
80%- Normal activities but with effort; some signs of symptoms or disease
70%- Cares for self, but is unable to carry on normal activities or to do active work
60%- Requires occasional assistance, but is able to care for most needs
50%- Requires considerable assistance and frequent medical care
40%- Disabled; requires special care and assistance
30%- Severely disable; hospitalization is indicated but death is not imminent
20%- Hospitalization necessary, very sick, active supportive treatment necessary
10%- Moribund; fatal processes progressing rapidly

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? (Circle One Number on Each Line)

	Yes, Limited a Lot (1)	Yes, Limited a Little (2)	No, Not limited at All (3)
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Walking more than a mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing or dressing yourself	1	2	3

OTHER PERTINENT INFORMATION YOU WOULD LIKE TO ADD:

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Tel 301-654-9390, Facsimile 301-654-93