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ESTABLISHED 1947

INTERVENTIONAL PAIN MANAGEMENT

KEVIN T. TOLIVER, M.D.

**NECK AND BACK PAIN HISTORY FORM
Larry D. Dodge, M.D.**

Name: _____ Age: _____

Occupation: _____ Date: _____

1) What date (roughly at least) did your present pain start? _____

2) Mechanism of pain onset:

- | | | | |
|--------------|-----|----------------------|-----|
| a) suddenly | () | g) pull | () |
| b) gradually | () | h) injured at work | () |
| c) lifting | () | i) auto accident | () |
| d) twisting | () | j) hit in back | () |
| e) fall | () | k) sports | () |
| f) bending | () | l) no apparent cause | () |

3) What activities make the pain worse?

- | | | | |
|--------------------|-----|---------------------|-----|
| a) during exercise | () | f) bending forward | () |
| b) after exercise | () | g) bending backward | () |
| c) sitting | () | h) coughing | () |
| d) standing | () | i) sneezing | () |
| e) walking | () | | |

4) What reduces your pain?

- | | | | |
|---------------------|-----|---------------------|-----|
| a) lying down | () | g) pain pills | () |
| b) sitting | () | h) muscle relaxants | () |
| c) standing | () | i) aspirin | () |
| d) walking | () | j) other _____ | () |
| e) manipulation | () | k) nothing | () |
| f) physical therapy | () | | |

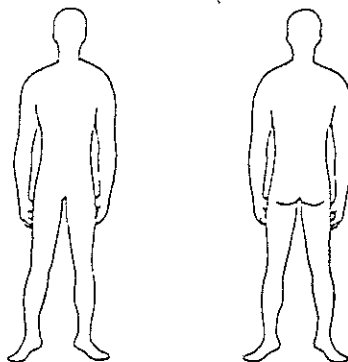
5) How long have you had any neck/back pain?

_____ years _____ months _____ weeks

How long have you had any arm/leg pain?

_____ years _____ months _____ weeks

6) Please mark on the diagram where your pain is located.



7) Does your pain interfere with sleep or awaken you at night?

_____ yes _____ no

8) Have you had any x-rays? Yes ___ No ___
Date _____

a) Have you had a CAT scan? Yes ___ No ___
Date _____

b) Have you had a myelogram? Yes ___ No ___
Date _____

c) Have you had an EMG? Yes ___ No ___
Date _____

d) Have you had a discogram? Yes ___ No ___
Date _____

e) Have you had an MRI scan? Yes ___ No ___
Date _____

9) Are you now unable to work because of back or neck pain?

Yes _____ No _____

How long have you been off work?

_____ years _____ months _____ weeks

10) Have you been in the hospital for your back or neck problem?

Yes ___ No ___ Number of times ___ Dates _____

11) Have you had any neck or back surgery? Yes ___ No ___

Number of times _____ Dates _____

12) Have you been in the hospital with other medical problems?

Yes ___ No ___ Number of times ___ Describe _____

13) Please list current medications (if none, please state) _____

14) General medical problems:

- | | | | |
|--------------------------------------|-----|----------------|-----|
| a) stomach problems, ulcers, etc. | () | g) cancer | () |
| b) diabetes | () | h) heart | () |
| c) arthritis | () | i) epilepsy | () |
| d) gout | () | j) other_____ | () |
| e) sexual difficulties | () | k) weight loss | () |
| f) bowel or bladder | () | | |

15) Medication Allergies: Yes ___ No ___

Please list _____

16) Do you smoke? Yes ___ No ___ How much? _____

17) Do you drink alcoholic beverages? Yes ___ No ___

How much? _____

18) What other types of doctors have you seen for this condition? _____

19) Do you have any additional information that would be helpful to understand your problem? _____

To be sure paperwork is filled out correctly, please check if appropriate:

- | | |
|-----------------------------|-----|
| On workers' compensation | () |
| Receiving disability income | () |
| Legal proceedings pending | () |

Thank you.