Dear Patient:

In anticipation of your upcoming evaluation, we would appreciate if you could complete the enclosed **"New Patient Questionnaire"** prior to your visit. Please fill it out the best you can.

If you have had any of the following studies completed at any facility other than OSS Health, please bring the report and imaging to your appointment. Images will need to be on a disk.

Bringing this information to your appointment allows our physicians to review it in order to provide the best treatment plan for you.

X-ray films
MRI scans
CT scans
Electrodiagnostic evaluations (EMG/NCV)
Serologic studies (blood tests) (within the last two months)

Even if another doctor from our group has already viewed the radiographic images, we need to personally look at your films and not just the written reports. Having the above information will allow us to do a more thorough evaluation and will help us avoid unnecessary delays during your visit.

Within our group of pain doctors, there are **6 attending physicians** and **several Interventional Spine and Sports Medicine fellows.** Please be aware that at your visit, you may be seen by one of the fellows as well as the attending physician. Attached is a letter composed by the physicians regarding their approach to your treatment.

If you have questions, please don't hesitate to call our office (717) 848-4800.

We look forward to participating in your care.

We're a TEAM

Thank you for choosing the ***OSS Health Pain Management Team*** to assist you on the road to feeling better. We take the team approach to your treatment by providing experienced and expertly trained physicians in Pain Management. Because we specialize in the care of patients with painful conditions, it is important to evaluate and treat you in a timely manner.

The ***OSS Health Pain Management Team*** consists of six senior Attending Physicians and six Associate Physicians who work closely to provide you with comprehensive care.

Attending Physicians

Michael B. Furman, M.D.
James J. Gilhool, D.O.
Paul S. Lin, M.D.
Shannon Schultz, M.D.
Brian Steinmetz, D.O.
Brady Wahlberg, D.O.

Fellow Physicians

Brandon Cohen, D.O.
Anita Garg, D.O.
Larry Guinto, M.D.
Elizabeth Lin, M.D.
Perry Zelinger, M.D.
Bruce Zhang, M.D.

One of our Attending Physicians will be directly involved in your care. We will do our very best to honor requests for a specific physician, but please be aware that a specific request may limit appointment availability and timeliness.

OUR PROMISE TO YOU:

By working with you and your requesting physician, we will create a program that best addresses your unique needs. We will do everything within our realm of specialty to explain the options for treatment to you and your family, to rapidly address your medical needs, and to alleviate your pain.

Our highly skilled nursing and technical personnel have helped to create the caring and compassionate atmosphere that is the signature of the ***OSS Health Pain Management Team***. The confidence you have in ***OSS Health*** is well placed, and we will make every effort to exceed your expectations.

We appreciate that your time is valuable and that delays in a physician's office can be a trying experience. We attempt to schedule our patients to provide adequate time to complete the necessary paper work and to have sufficient time with our physicians and staff to address your needs and concerns. From time to time, because of the nature of our practice, emergencies do present themselves. This may cause delays in our schedule and cause longer wait times for our patients. Please accept our apology if this happens to you.

The entire ***OSS Health Pain Management Team*** wants to thank you again for choosing us to care for you and your family. If you have any special needs or comments, please bring them to the attention of the staff.

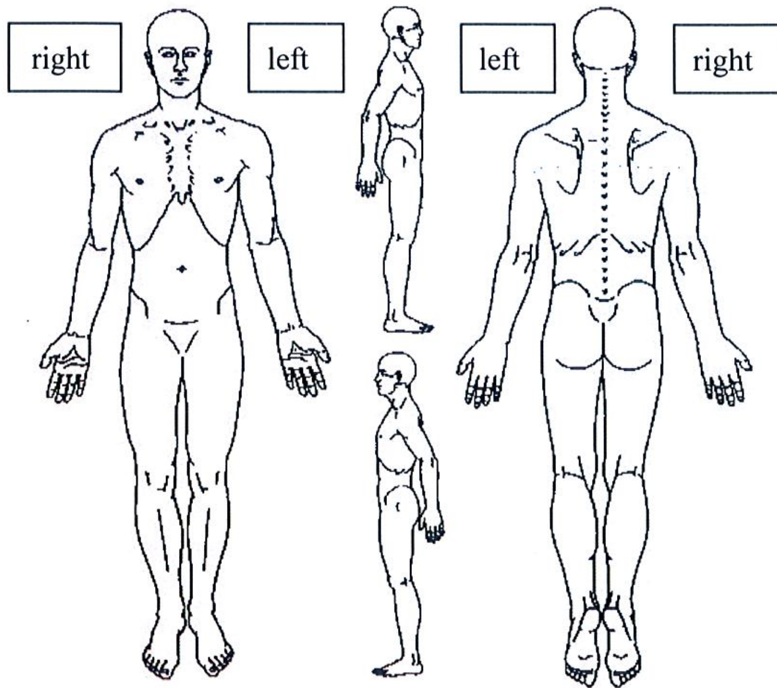
OSS Health

Pain Spine Center

Today's Date:
Please complete the following questions in order to assist us in your care.
Name: Age:
Date of Birth: Occupation:

1. Please mark the figure with the location of your symptoms.

Pain = X
Numbness = /
Tingling = #



Have you had surgery on your Back or Neck?
Date:
Facility:
Outcome: successful in relieving symptoms?

2. What makes your pain worse (please circle)?

BENDING FORWARD BENDING BACKWARD REACHING LYING ON BACK

LYING ON STOMACH SITTING ANY ACTIVITY WEIGHTBEARING STANDING

WALKING CHANGING POSITIONS ROTATION COUGHING SNEEZING

3. Is your pain worse in the: AM PM
4. Does the pain awaken you? YES NO
5. Have you lost control or your bowel or bladder function? YES NO
6. What makes the pain better (please circle)?

BENDING FORWARD BENDING BACKWARD REACHING LYING ON BACK

LYING ON STOMACH SITTING ANY ACTIVITY WEIGHTBEARING STANDING

WALKING CHANGING POSITIONS ROTATION COUGHING SNEEZING

7. What types of medications are you taking for the pain?
MUSCLE RELAXER ANTI-INFLAMMATORY STEROID PAIN MEDICATION

8. Have you tried any of the following treatments? If YES, how long did you get relief of your pain?

PHYSICAL THERAPY-
SPINAL PROCEDURES-
CHIROPRACTIC CARE-
ACUPUNCTURE-
HOT OR COLD PACKS-

9. Do you have any of the following symptoms?
FEVER CHILLS NIGHT SWEATS UNEXPLAINED WEIGHT LOSS

10. Mark the following scale to reflect your pain when it is at its **lowest:**
LEAST 0 ----1--- 2 ----3 ----4 ----5 ----6 ----7 ----8 ----9---10 MOST

Mark the following scale to show your pain when it is at its **worst:**

LEAST 0 ----1------ 2 ----3----4---- 5---- 6---- 7---- 8---- 9--- 10 MOST

11. Are you currently? ___ Working Full time ___ Working Part time___ Unemployed
___ Retired ___ Disabled, Temporarily ___ Disabled, Permanently ___ Other

12. Have you missed any work as a result of this injury? YES NO

13. Do you have any work restrictions? YES NO If yes, please explain:

14 If you are currently NOT working, how long have you been off work due to your back/neck pain?
____

15. What is your occupation? ______________________________

16. Please indicate which studies have been completed, when and where?
X-RAYS
MRI
CT SCAN
NERVE TEST (EMG)
DISCOGRAM
MYELOGRAM

Thank you for taking the time to provide the necessary information regarding your symptoms and previous medical care.

The staff and providers of the OSS Spine Center are dedicated to providing the most technically advanced care while preserving excellent customer service. It is our goal to exceed your expectations. By working with our patients and their families as a team we can continue to improve the services we render and provide you with the highest quality care.

PATIENT HEALTH HISTORY QUESTIONNAIRE

The following information is very important to your plan of care.
Please take time to fully and completely fill out this important information.
We are counting on you. Please complete every section. Do not leave any blanks.

Name: ______________________ **DOB:** __________ **Age:**____ **Date:** __________ **Appt.**__________

Gender: M F O **Marital status:** Single Married Partnered Widowed Separated Divorced

Family Dr. ______________________________ **Requesting Dr.** ______________________________

Other treating physicians: ____

What will we be seeing you for? ____

Spoken language: ________________________

Preferred Language for Medical Information: ____

YOUR PAST MEDICAL HISTORY

Do you have now, or have you ever had any of the following? Mark all that apply.

□ Abdominal Aortic Aneurysm	□ Gallbladder disease	□ Osteoporosis
□ Alzheimer's disease	□ Glaucoma	□ Pacemaker
□ Anemia	□ Gout	□ w/Defibrillator
□ Anxiety	□ Heart Attack/MI	□ Prostate problems
□ Arthritis	□ stent(s)	□ Psychiatric disease
□ Asthma	□ Heart Murmur	□ Pulmonary Embolus
□ Back disorder	□ Heartburn: □ occasional	□ Rheumatoid Arthritis
□ Bleeding disorder	□ GERD	□ Serious Infection
□ Blood Clots/DVT	□ Hepatitis: □ A	□ Sleep Apnea □CPAP
□ Cancer (location)	□ B	□ Stroke
□ Carotid Artery disease	□ C	□ TIA
□ Crohn's disease	□ High Blood Pressure	□ Thyroid disease
□ Irritable Bowel Syndrome	□ High Cholesterol	□ Ulcers
□ Celiac disease	□ HIV/AIDS	□ Vascular disease/Stents
□ COPD	□ Irregular Heart Rate	□ heart

□ Congestive Heart Failure (CHF)	□ Kidney disease	□ other
□ Coronary Artery disease	□ Lactose Intolerance	□ Venereal disease/STD
□ Diabetes: □ Type I	□ Lung disease	
□ Type II	□ Supplemental oxygen	□ Other:
□ Pre-diabetic	□ Malignant Hyperthermia	
□ Depression	□ Migraines	
□ Emphysema	□ MRSA/MSSA	
□ Epilepsy/Seizure disorder	□ Neuropathy	

Have you ever had SURGERY? □Yes—please explain □ No **Year** **Hospital**

____ _____ __________

____ _____ __________

____ _____ __________

Have you ever been HOSPITALIZED? □Yes—please explain □ No

____ _____ __________

____ _____ __________

____ _____ __________

<u>Assistive Devices:</u> □ cane □ walker □ crutches □ wheelchair □ other________________

MEDICATIONS: (Please Include Dosage) □ No Active Medications

Do you take any blood thinners? □Yes □ No

PRESCRIPTION Medications	DOSE	DIRECTIONS	PURPOSE

Over the counter medications: (like Aspirin, Ibuprofen, Naproxen, etc)

Vitamin, Mineral, and Herbal Supplements:

Are you ALLERGIC to any of the following? ☐ No (if yes, please explain your reaction)

☐ **SHELLFISH** ________ ☐ **EGGS** ________ ☐ **LATEX** ________
☐ **IODINE** ________ ☐ **POULTRY** ________ ☐ **METAL** ________
☐ **X-RAY DYE** ________ ☐ **FEATHERS** ________ ☐ **NICKEL** ________
☐ **Bee Stings** ________ ☐ **Seasonal/Environmental** ________

DRUG ALLERGIES or ADVERSE REACTIONS: ☐ **No Known drug allergies**

ALLERGY	REACTION	ALLERGY	REACTION

FAMILY HISTORY – Has anyone in your family had any of the following problems?

No known family history ☐ Unaware of family history details ☐

Disease	Mother	Father	Brothers	Sisters	Daughters	Sons
High blood pressure/ Hypertension						
Heart Attack/ Heart surgery						
Diabetes						
Stroke						
Cancer (type)						
Osteoporosis						
Thyroid problems						
Problems with anesthesia						
Malignant hyperthermia						
Blood clots/Blood Diseases						
Other -						

SOCIAL HISTORY – Please mark every area

Occupation:________________________ ☐ Right Hand Dominant ☐ Left Hand Dominant

Personal Habits:………………….	No	Yes – please explain (type/amount/ frequency/quit date)	
Use Tobacco products currently	☐	☐	________________
Used Tobacco products in the past	☐	☐	________________
Use Alcohol products currently	☐	☐	________________
Used Alcohol products in the past	☐	☐	________________
Use illegal drugs currently	☐	☐	________________
Used illegal drugs in the past	☐	☐	________________

REVIEW OF SYSTEMS

Have you been troubled with any of the following symptoms within the last 4 – 6 weeks?

General
- □No □Yes Fever
- □No □Yes Sweats

Skin
- □No □Yes Itching
- □No □Yes Rash
- □No □Yes Slow healing wounds

Hematologic
- □No □Yes Easy bruising
- □No □Yes Easy bleeding
- □No □Yes Hard to stop bleeding

Eyes
- □No □Yes Blurred Vision
- □No □Yes Changing Vision
- □No □Yes Double Vision
- □No □Yes Wear glasses
- □No □Yes Wear contacts

Neurologic
- □No □Yes Numbness
- □No □Yes Tingling
- □No □Yes Headaches
- □No □Yes Weakness

Allergy
- □No □Yes Hives
- □No □Yes Seasonal symptoms
- □No □Yes Sneezing
- □No □Yes Nasal congestion

Cardiovascular
- □No □Yes Chest pain
- □No □Yes Chest pressure
- □No □Yes Ankle swelling
- □No □Yes Irregular heartbeat

Mental Health
- □No □Yes Insomnia
- □No □Yes Anxiety
- □No □Yes Depression
- □No □Yes Memory loss
- □No □Yes Suicidal thoughts

Nutrition
- □No □Yes Special diet
- □No □Yes Weight loss
- □No □Yes Weight gain
- □No □Yes Change in appetite

Respiratory
- □No □Yes Cough
- □No □Yes Shortness of Breath
- □No □Yes Wheezing

Endocrine
- □No □Yes Excessive urination
- □No □Yes Excessive thirst
- □No □Yes Fatigue
- □No □Yes Heat or cold intolerance

Is there someone in your life who is physically or emotionally harming you? □No □Yes

Patient Signature: ______________________________ Date: ________________

OSS HEALTH

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