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.

Also, please remember to bring the following studies along to your appointment as well as the reports. **If your studies were performed at our office, a Wellspan Facility (i.e. Apple Hill, York or Gettysburg Hospitals), Hanover Hospital or Memorial Hospital we have access to these images. Therefore there is no need for you to acquire them.**

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 **4 attending physicians** and **several associates.** Please be aware that at your visit, you may be seen by one of the associates 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) 747-8303.

We look forward to participating in your care.

We're a TEAM

Thank you for choosing the ***OSS 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 Pain Management Team*** consists of four 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.
Brian Steinmetz, D.O.

Associate Physicians

Jesse Bernstein, M.D.
Gregory Burkard Jr., D.O.
Shawn Murphy, D.O.
Swaroop Gonchikar, M.D.
Farzad Karkvandeian, D.O.
Justice Otchere, 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 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 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

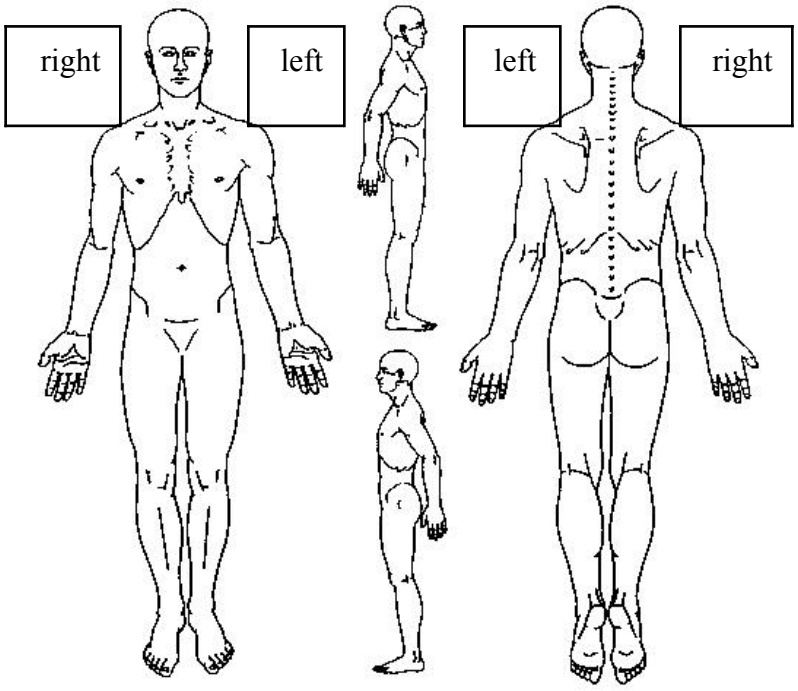
the attention of the staff.

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

8Have 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 MOST 10

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

2

----1--- ---- 4-- 5- 6- 7- 8- 9-

LEAST 0 --- ---- [3] **-- --- --- --- --- -- 10 MOST**

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

12. Have you missed any work because 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: [redacted] **DOB:**_____ **Age:** [redacted] **Date:**_____ **Appt.**_____

Height: _____ **Weight:** _____ **Gender:** M F O □ **Right hand dominant**

□ **Left hand dominant**

Marital status: Single Married Partnered Widowed Separated Divorced **Occupation**:_____

Family Dr: _____ **Requesting Dr:** _____

Other treating physicians: _____

What will we be seeing you for? _____

YOUR PAST MEDICAL HISTORY (6 months or longer ago)

No significant past medical history □

Do you have now, or have you ever had any of the following?

	No	Yes			No	Yes	
Abdominal aortic aneurysm	□	□	_____	Heartburn	□	□	_____
Alzheimer's disease	□	□	_____	Reflux	□	□	_____
Anemia	□	□	_____	GERD	□	□	_____
Anxiety	□	□	_____	Hepatitis	□	□	_____
Arthritis	□	□	_____	Liver Disease	□	□	_____
Asthma	□	□	_____	High Blood Pressure	□	□	_____
Back Disorder	□	□	_____	High Cholesterol	□	□	_____
Bleeding Disorder	□	□	_____	HIV/AIDS	□	□	_____

Blood Clots/DVT	□	□	_____	Irregular Heart Rate	□	□	_____
Cancer (Location)	□	□	_____	Kidney Disease	□	□	_____
Carotid artery disease	□	□	_____	Lung Disease	□	□	_____
Crohn's	□	□	_____	Supplemental Oxygen	□	□	_____
Irritable Bowel	□	□	_____	Malignant Hyperthermia	□	□	_____
COPD	□	□	_____	Migraines	□	□	_____
Congestive heart failure (CHF)	□	□	_____	MRSA	□	□	_____
Coronary artery disease	□	□	_____	Neuropathy	□	□	_____
Diabetes - Type I	□	□	_____	Osteoporosis	□	□	_____
Diabetes - Type II	□	□	_____	Pacemaker	□	□	_____
Depression	□	□	_____	Defibrillator	□	□	_____
Emphysema	□	□	_____	Prostate Problems	□	□	_____
Rheumatoid Disease	□	□	_____	Psychiatric Disease	□	□	_____
Epilepsy / Seizures	□	□	_____	Pulmonary embolus	□	□	_____
Gallbladder Disease	□	□	_____	Serious Infection	□	□	_____
Glaucoma	□	□	_____	Sleep Apnea	□	□	_____
Gout	□	□	_____	Stroke	□	□	_____
Heart Attack/MI	□	□	_____	Thyroid Disease	□	□	_____
Heart Murmur	□	□	_____	Ulcers	□	□	_____
Venereal Disease / STD	□	□	_____	Vascular Disease/Stents	□	□	_____

Other	□	□	___

IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING, PLEASE CIRCLE:

SHELLFISH IODINE X-RAY DYE EGGS POULTRY FEATHERS LATEX METAL NICKEL

If allergic, what was your reaction? _____

DRUG ALLERGIES or ADVERSE REACTIONS: □ **None**

ALLERGY	**REACTION**	**ALLERGY**	**REACTION**

LIST ALL MEDICATIONS AND SUPPLEMENTS. Please Include Dosage: □ No Medications

Do you take any blood thinners? □ NO □ YES

PRESCRIPTION MEDICATIONS:

MEDICATION	**DOSE**	**DIRECTIONS/SIG**	**REASON/ INDICATION**

OVER THE COUNTER MEDICATIONS: _____

HERBALS, VITAMINS OR SUPPLEMENTS: _____

_____

HOSPITALIZATIONS: □No □Yes—please explain **Year** **Hospital**

SURGERY (TYPE): □No □Yes—please explain

SOCIAL HISTORY – Please mark every area

YOUR PERSONAL HABITS: Do you…	**YES**	**No**	**If YES, Please explain:**
Smoke? / Use any tobacco products?	□	□	how much? _____
If ever, when did you stop?			_____
Use alcohol?	□	□	how much? _____
Were you ever a heavy drinker?	□	□	_____
Use illegal drugs?	□	□	

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

No significant past family history □ **Unknown family history** □

Disease	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Other Relative
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 -						

REVIEW OF SYSTEMS

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

General

Fever □No □Yes

Sweats □No □Yes

Respiratory

Cough □No □Yes

Shortness of Breath □No □Yes

Wheezing □No □Yes

Genitourinary

Urinary frequency □No □Yes

Burning □No □Yes

Blood in urine □No □Yes

Difficulty urinating □No □Yes

Skin

Itching □No □Yes

Rash □No □Yes

Slow healing wounds □No □Yes

Neurologic

Numbness

Tingling

Headaches

Weakness

Allergy

Hives

Seasonal symptoms

Sneezing

Nasal congestion

Musculoskeletal

Joint swelling □No □Yes

Joint pain □No □Yes

Muscle pain □No □Yes

Eyes

Blurred vision □No □Yes

Changing vision □No □Yes

Double vision □No □Yes

Wear glasses □No □Yes

Wear contacts	□No □Yes	Blood in stool	□No □Yes		
Mental Health		**Endocrine**		**Ear/Nose/Throat**	
Insomnia	□No □Yes	Excessive urination	□No □Yes	Ear pain	□No □Yes
Anxiety	□No □Yes	Excessive thirst	□No □Yes	Hearing loss	□No □Yes
Depression	□No □Yes	Fatigue	□No □Yes	Nose bleeds	□No □Yes
Suicidal thoughts	□No □Yes	Heat or cold intolerance	□No □Yes	Sore throat	□No □Yes
Memory loss	□No □Yes				

□Yes
□Yes
□Yes
□Yes

The above information is true and correct to the best of my belief.

_____ _____

Patient Signature (Parent or Guardian for Minor) / Date Physician Signature / Date

CLINICAL ASSISTANT/REVIEWER INITIALS: _____

OSTEOPOROSIS - What is your risk?

Name: _____ Age: ____ Weight: ____

DOB: _____ Today's Date: _____ Male ___ Female ___ Other ___

Osteoporosis is a disease in which bones become fragile and are more likely to break.

There are some reasons (called risk factors) that increase your likelihood of developing osteoporosis.

Risk Factors – check each question Yes or No.

Yes	No	
☐	☐	Have you broken any bones as an adult?
☐	☐	Do either of your biologic parents have a history of a hip or spine fracture?
☐	☐	Do you smoke?
☐	☐	Have you ever been on oral steroid therapy for more than 3 months?
☐	☐	Do you have rheumatoid arthritis?

Please circle any of the following disorders that you have:
Type 1 Diabetes, **Osteogenesis Imperfecta** (Weak Bones), **Hyperthyroidism**, **Hypogonadism**, **early menopause (< 45 years), chronic malnutrition**, **malabsorption syndrome (**difficulty digesting or absorbing nutrients from food) or **chronic liver disease**

☐	☐	Do you have a small, thin frame? (Less than 105 lbs)
☐	☐	Have you ever had a bone density test? If yes, was it normal or abnormal? If yes, when was it done? _____

STAFF USE ONLY- Check all that apply

- ☐ A woman age 65 or older, even without any risk factors
- ☐ A man age 70 or older, even without any risk factors
- ☐ A postmenopausal woman under age 65 with one or more risks factors for osteoporosis
- ☐ A man age 50-70 with one or more risk factors for osteoporosis
- ☐ A woman or man after age 50 who has broken a bone
- ☐ Adults with a condition or taking a medication associated with low bone mass or bone loss (prednisone >= 5mg for more than 3 mos., rheumatoid arthritis)
- ☐ A woman going through menopause with certain risk factors
- ☐ A postmenopausal woman who has stopped taking estrogen therapy (ET) or hormone therapy (HT)

Reviewed by: _____ DXA scan ordered? Yes No

1855 Powder Mill Office Directions

Directions OSS HEALTH
1855 Powder Mill Road
York, PA 17402
(717) 848-4800

(From the North/ Harrisburg)

Take I-83 south to EXIT 14 (Leader Heights Road). Go left at the exit, past Gladfelter Insurance and the Leaders Heights Animal Hospital. Turn left onto Powder Mill Road. Our new office is a short distance down Powder Mill Road on the right.

(From the South/ Baltimore)

Take I-83 north to EXIT 14 (Leader Heights Road). Go right at the exit, past Gladfelter Insurance and the Leaders Heights Animal Hospital. Turn left onto Powder Mill Road. Our new office is a short distance down Powder Mill Road on the right.

(From the West/Gettysburg)

Take US-30 East toward Lancaster, Merge onto I-83 South toward Baltimore, Take South Queen Street Exit 16A (this is the 2nd Queen Street Exit), Turn Right on St Charles Way (St Charles Way becomes DewDrop Road), Turn Left onto Powder Mill Road. Our office is a short distance down Powder Mill Road on the left.

(From the East/Lancaster)

Take US-30 West, Turn Left onto North Hills Road, Turn Right on East Market Street, Merge onto I-83 South, Take South Queen Street Exit 16A (this is the 2nd Queen Street Exit), Turn Right on St Charles Way (St Charles Way becomes DewDrop Road), Turn Left onto Powder Mill Road. Our office is a short distance down Powder Mill Road on the left.