



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

David Janerich, D.O.  
Efrain Perez-Bravo, M.D.  
Anita Vijapura, M.D.  
Michael Andrews, D.O.  
Kyle Hummerston, D.O.  
James Snyder, 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.

Pain Spine Center

Today's Date:

Please complete the following questions in order to assist us in your care.

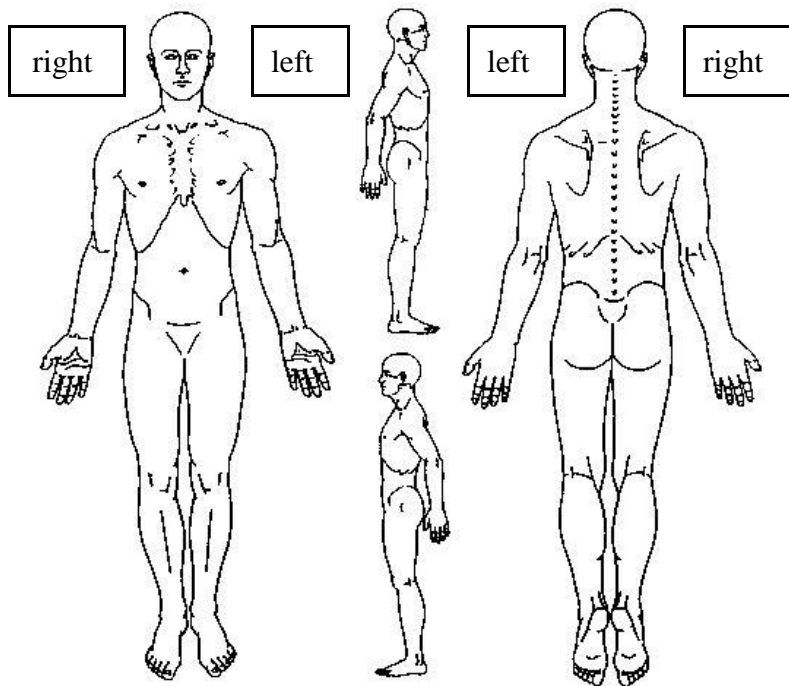
Name:

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 of 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.

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







**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: \_\_\_\_\_

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