Kyphoplasty Patient Information

Patient:_____ Today's Date: ____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Is anyone with you today? Yes No Name: _____

Referring MD: _____

Primary Doctor, if different: _____

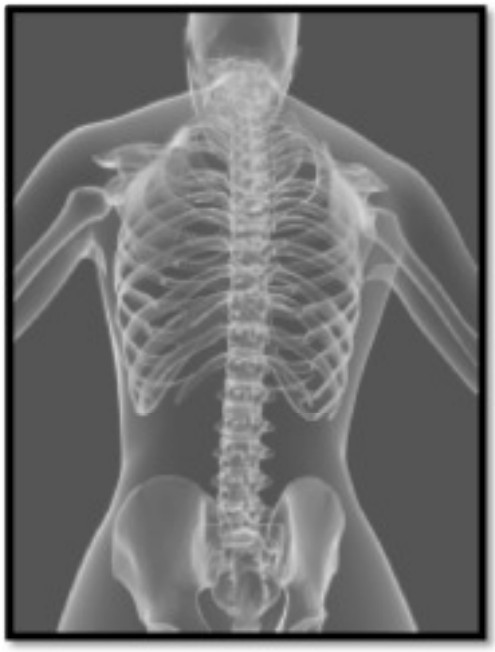
When did your back pain start? _____ Describe where it hurts: _____

On the diagram, draw a circle around the area of your back that hurts most.

Do you know how your fracture happened? Yes No

If yes, describe briefly: _____

_____



Does your pain go down your leg(s)? Yes No

On a scale of 0 – 10, with 0 being NO PAIN and 10 being SEVERE:

What number would your rate your **pain when it first occurred**?

0 1 2 3 4 5 6 7 8 9 10

What number would you rate your pain now?

0 1 2 3 4 5 6 7 8 9 10

Have you had an MRI of your back? Yes N o

If yes, where: _____

_____

Date of MRI: ___/___/_____ Do you know of any reason you cannot have one, such as an aneurysm clip or pacemaker? Yes No If yes, please explain: _____

Have you ever had a bone density study (DEXA scan) to see if you have osteoporosis? ☐ Yes ☐ No

If yes, where did you have it? _____ Date of DEXA: ___/___/_____

Results: _____

_____

Do you live: ☐ Alone ☐ With spouse/ family member ☐ Assisted living facility ☐ Other

Can you do your normal activities of daily living: (shopping, cleaning, cooking, dressing, etc.) ☐ Yes ☐ No

☐ Yes, with limitation (explain) _____

Check all that apply to your health:

☐ Osteoporosis ☐ Diabetes ☐ High Blood Pressure

☐ Lung/ Breathing Problems ☐ Tendancy to fall ☐ Thyroid Problems

☐ Heart Problems ☐ Coronary stents (within past year)

☐ Cigarette smoker ☐ Steroids (Prednisone) ☐ Prior Back Pain

☐ Prior Back Surgery ☐ Cancer , describe: _____

Please complete the back of this form

List all current medications you are taking, including herbals:

_____ _____

_____ _____

_____ _____

_____ _____

Are you on blood thinners, such as Coumadin (warafin), Plavix, Lovnox, Heparin, or Aspirin? If yes, list which ones and daily dose: _____

List all medication allergies: ☐ NONE ☐ I am allergic to: _____

_____

_____

_____

Are you allergic to x-ray dye (used for CT scans, angiograms, heart catherizations, kidney studies, etc. This is not the same dye as used in MRI scans.) ☐ NO ☐ YES If yes, describe your reaction, and when it occurred: _____

Patient Signature : _____

(PHYSICIAN USE ONLY)

Does patient wish to be scheduled? ☐ YES ☐ NO

Schedule for: ☐ Dr. Payne ☐ Dr. Knelson ☐ Dr. Mathan ☐ Dr. Harris

DATE: _____/_____/_____

Level(s): _____ _____ _____

BIOPSY? ☐ Yes ☐ No Hx: _____

Patient TBA? ☐ Yes ☐ No

Scheduled by: _____