Washington Nerve Institute

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QUESTIONNAIRE #1

FOR PATIENTS WITH:

Chronic Headache/Migraine, Chronic Post-Traumatic or Post-Operative Headache, Post-Concussion Sports Related Headache, Post-Whiplash/Car Accident Related Headache, Occipital Neuralgia, Trigeminal Neuralgia and/or Post-Herpetic/Shingles Headache

If you have any of these conditions despite prescribed medical care, you may be an appropriate candidate for surgical treatment, provided by Dr. Ducic. Although the final decision to proceed with surgical treatment is usually not made before your office visit, those that are identified as appropriate/possible candidates for surgical treatment are invited to schedule office appointment. This way, we are trying to help you save the time and money before your evaluation with Dr. Ducic, in the case we would define additional work-up or tests are needed. In order to answer your questions and thus determine if an appointment and possibly surgical treatment might be indicated, **please ANSWER ALL QUESTIONS we asked**. When submitting completed questionnaire, kindly follow these steps exactly as suggested:

1) **Download/save** this blank **fillable PDF** file **to your computer**
2) **Enter your data in corresponding fillable PDF** boxes, **and save it** to your computer
3) **Upload and email completed/saved form** as attachment **when replying to us.**

In addition to this questionnaire, you should send:

Copy of the **written report of the diagnostic studies** that are *relevant to your current problem* (X-ray, US, CT, MRI, NCS/EMG, or nerve block). Send written REPORTS ONLY, DO NOT send hard copies or CD's.

Copy of **relevant operative reports** (related to surgery in anatomical region where you have problems now)

You can send these documents as a separate PDF file by email (preferred) when submitting your completed PDF-questionnaire; alternatively, you can fax them. **Please do not send any other documents** at this time.

Upon review of your records, Dr. Ducic will get back to you with an answer if you should schedule an appointment or if additional tests are needed prior to your office visit. When corresponding, you acknowledge that our reply to the questionnaire with opinion is provided only as informational, while the official evaluation and treatment is not initiated until your office visit. If we can be of further assistance, please do not hesitate to contact us: (703) 992-9233.

Sincerely,

Ivica Ducic, MD, PhD

New Patient Questionnaire for:
Chronic Headache/Migraine, Chronic Post-Traumatic or Post-Operative Headache, Occipital Neuralgia, Trigeminal Neuralgia and/or Post-Herpetic/Shingles Headache

Write your:

- Name: _____ Today's Date: _____
- Gender: Male___ Female ___ Age: _____ Date of Birth: _____
- Height: ___' ____" (or ___ cm) Weight: ____ (Lbs___ Kg___) BMI (office): ____
- Occupation: _____
- Home address (incl. state & zip): _____
- Home phone number: _____
- Cell phone number: _____
- e-mail: _____
- Insurance: _____

1) What is the main concern you are requesting assistance for (check all that apply)?

- Occipital (back of the head) Neuralgia ____
- Frontal (front of the head) Neuralgia ____
- Temporal (side of the head) neuralgia ____
- Chronic Migraine / Headache: ____

2) Migraine / Headache / Neuralgia (Symptoms) present for **how long:** _____ Years _____ Months

3) **Symptoms present:** Despite prescribed medical care ___, Constantly ___ Intermittently ___

4) Symptoms present for: **How many days per month:** _____ **How many hours per day:** _____

5) Symptoms **present at what part** of the head?

- back (occipital) ____
- front (frontal) ____
- side (temporal) ____

6) Symptoms **usually start** at **what part** of the head?

- back (occipital) ____
- front (frontal) ____
- side (temporal) ____

7) Symptoms present at **what side (Laterality)**?

- Left only ___ Right only ___ Bilateral (Left & Right side) ___

8) **Pain level** (scale: 0 = none; 10 = highest): Average ____ Range ____ - ____

9) **Quality of life** affected by your condition: None___ Somewhat___ Moderate___ Significantly___

10) **History of**: Seizures ___ Blood Clots ___ HIV ___ Hepatitis B/C ___ Anaphylaxis ___ HTN ___
Heart Attack ___ Diabetes ___ Smoking (active) ___ Asthma ___ Sleep Apnea ___
Stroke ___ Concussion ___ MRSA/VRE ___ Cancer ___ Anxiety ___ Depression ___

11) History of **Trauma:** MVA (whiplash) ___ Assault ___ Hit / Fall ___ Sports Injury ___

- Did your symptoms start after the trauma: Yes ___ No ___

12) History of **Relevant Surgery or Procedures** (check all that apply)**:**

- Radio-Frequency Ablation ___ Nerve Stimulator ___ (Still present ___ Removed ___)
- Brain Surgery ___ Spine Surgery ___ Acoustic Neuroma Surgery ___
- Brief title/type of surgery: _____
- Did your symptoms start after the surgery: Yes ___ No ___
- Other head & neck surgery: _____
- Outcome of Surgery (helped?) Yes___ No___

13) Did you have **MRI or CT** of**: Brain (**Yes___ No___) **Spine (**Yes___ No___)

- Findings normal / non-significant: **(**Yes___ No___)
- If abnormal, enclose study written report only (do not send CDs)

14) List what **other medical problems** you currently have (unless previously listed/reported):

_____
_____

15) List your **allergies to food or medications:** _____
_____

16) Did you have **Diagnostic Nerve Blocks?** ___ **Botox?** ___

- occipital (back of the head) nerves: Yes ___ No ___ Yes ___ No ___
- supraorbital/trochlear (front of the head) nerves: Yes ___ No ___ Yes ___ No ___
- zygomatico-temporal (side of the head) nerves: Yes ___ No ___ Yes ___ No ___
- **Was temporary positive effect observed** = relief of headache/pain in the area where diagnostic nerve block was given (even for few days, or weeks): Yes ___ No ___

17) Are you **under the care of headache specialized provider** for at least 3 months: Yes____ No____

18) List your **neurologist or pain management specialist** taking care of your problem:

- Doctor's name: _____
- Full mailing address: _____
- Phone number: _____

19) **Any other comment** regarding your chronic migraine, headache or neuralgia?

END OF QUESTIONNAIRE

Assessment / Plan (THIS SECTION IS FOR DR. DUCIC):

Continue medical supervision by neurologist / anesthesia pain or primary care specialist: ___

Additional evaluation/treatment needed by neurologist/anesthesia pain or other specialist: ___

Patient needs nerve block done: ___GON ___LON ___SON/STN/ITN ___ZTN ___ATN

Surgery: Neurolysis/Decompression: ___GON ___DON ___LON ___SON/STN/ITN

Surgery: Excision ___GON ___DON ___LON ___SON/STN/ITN ___ZTN ___ATN ___GAN

No Surgery, patient does not meet peripheral nerve surgery criteria: ___

Other: _____