Washington Nerve Institute

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QUESTIONNAIRE #2

FOR PATIENTS WITH:

Nerve Injuries Presenting as Chronic Pain, Numbness, Burning or Muscle Weakness Following Any Surgery or Trauma, Oral/Dental Procedures, Compression Neuropathy (Carpal/Cubital/Tarsal Tunnel, Meralgia Paresthetica, Wrist/Foot Drop), Nerve Tumors, or Shingles-Related Post-Herpetic Neuralgia

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:
Nerve Injuries, Chronic Pain Following Surgery or Trauma,
Peripheral Neuropathy, Post-Herpetic (Shingles) Neuralgia and Nerve Tumors

É Ivica Ducic, MD, PhD

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)?

- peripheral neuropathy (any extremity numbness, pins/needles, pain or muscle weakness) ___
- chronic pain following any surgery or trauma ___
- nerve injury following any surgery or trauma ___
- peripheral nerve tumor ___
- post herpetic neuralgia ___
- Other: _____

2) Symptoms include: **Pain**___, **Numbness**___, **Burning sensation**___, **Muscle weakness**___

3) **Anatomical localization:**
Left___ Right___ Upper Extremity___ Lower Extremity___ Trunk___ Groin___ Other_____

4) For **how long** is the problem present? ____ Years ____ Months; Since _____

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

6) Symptoms **present:** constantly___ intermittently ___ increase with activities ___ affect sleep ___

- If intermittently, how many days per month: _____

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

8) History of **associated trauma:** No___ Yes___ (MVA ___ Assault ___ Hit by object ___ Fall ___)

- The part of the body involved: _____
- Work related trauma/injury**:** No ___ Yes ___
- Symptoms started after the trauma: No ___ Yes ___ Approx. date: _____
  - How soon? Immediately___ Days___ Weeks___ Months___

9) History of **surgery relevant to the current condition:** No ___ Yes ___

- If yes, please provide a copy of the operative report related to the surgery you had in the anatomical area where you have problems now (FYI: if you are presenting with leg pain, no need to send a report of your shoulder surgery).
- The part of the body involved:_____ Approx. date of surgery: _____
- Type/title of surgery:_____
- Symptoms started after surgery: Yes___ No___
  - How soon? Immediately ___ Days___ Weeks ___ Months___
- History of Brain surgery: No ___ Yes ___ What: _____
- History of Spine surgery: No ___ Yes ___ (Cervical ___ Lumbar ___)

10) Do you have **Neck pain** or pain radiating from the neck to the arm(s): No ___ Yes ___

11) Do you have **Lower back pain** or pain radiating from the back to the leg(s): No ___ Yes ___

12) **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___

13) **MRI or CT** of the involved anatomical area done? No___ Yes___ (Normal/no significant findings ___)
(If findings abnormal, do not send CD's; submit written MRI/CT report only)

14) **Nerve Conduction Studies** (NCS/EMG) done? No___ Yes___ (Normal/no significant findings ___)
(If findings abnormal, submit written NCS/EMG report)

15) **Diagnostic nerve blocks** done? No ___ Yes ___

- What nerves: _____; Temporary effect observed: Yes ___ No ___

14) Any **other current medical problem** (ulness already reported): _____

16) List **medications** you usually take: _____

- Any drug allergies? No ___ Yes ___ (what):_____

17) Currently, you are **under the care of:** PCP ___ Neurologist___ Pain Specialist ___ Surgeon___

18) **Treatments done this far for the current problem**:

- Medical Yes ___ No ___ Effective : Yes ___ No ___ N/A ___
- Surgical Yes ___ No ___ Effective : Yes ___ No ___
  - What surgery:_____
- Pain Management Yes ___ No ___ Effective : Yes ___ No ___ N/A ___
- Radio Frequency Ablation Yes ___ No ___ Effective : Yes ___ No ___
- Nerve Stimulator Yes ___ No ___ Effective : Yes ___ No ___

19) **List** your neurologist, pain specialist, PCP or surgeon (**your main doctor**) currently taking care of you:

- Name: _____
- Full mailing address: _____
- Phone number: _____

20) **Any other comment** regarding your peripheral neuropathy / chronic pain / nerve injury / other:

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: _____ NCS/EMG:_____

Surgery - Neurolysis of: _____

Surgery - Excision of: _____

Surgery - Reconstruction of: _____

No Surgery (patient does not meet peripheral nerve surgery criteria): ____

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Other: _____