

# Buffalo Spine Surgery

Center for Excellence in Spine Care

Andrew Cappuccino, MD  
FAAOS, FACS  
Diplomate American Board  
Of Orthopedic Surgery  
Charter Diplomate American Board  
Of Spine Surgery  
BES - Biomedical Engineering  
Fellowship Trained Spine Surgery

Sarah Martineck, RPAC  
Eric Dean, RPAC

Name \_\_\_\_\_ Date \_\_\_\_\_

1. When (what date) did your present pain start? \_\_\_\_\_

What caused the pain to start \_\_\_\_\_

Have you ever had similar problems? \_\_\_\_\_

if yes please explain \_\_\_\_\_ . Are

you still working? Yes \_\_\_\_\_ No \_\_\_\_\_ Last day worked. \_\_\_\_\_

2. How did the pain start? Circle all that apply.

Suddenly	Injured at work	Lifting	Injured in auto accident
Fall	Hit from behind	Pulling	Injured during sports
Twisting	Bending	Gradually	No apparent cause

3. What activities make the pain worse? Circle all that apply

Exercise(during)	Exercise (after)	Sitting
Standing	Walking	Bending Forward
Bending backwards	Coughing	Sneezing

4. What relieves the pain? Circle all that apply.

Lying down	Sitting	Standing	Walking
Aspirin, Anti-inflammatories	Pain Pills	Injections for Pain	
Muscle Relaxant Pills	Manipulation	Exercise in PT	
Other _____			

5. How long have you had this pain? \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days

How long have you had similar pain? \_\_\_\_\_ Years \_\_\_\_\_ Months \_\_\_\_\_ Days

6. Have you had any of the following tests?

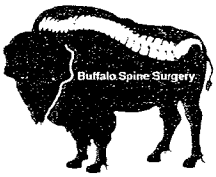
Diagnostic X-rays	Date and Facility _____
CAT scans	Date and Facility _____
Myelogram (x-ray with dye)	Date and Facility _____
EMG	Date and Facility _____
Discogram	Date and Facility _____
MRI	Date and Facility _____
Arthrogram	Date and Facility _____
Sonogram	Date and Facility _____
Injections	Date and Facility _____

7. Have you ever been hospitalized for this problem? No Yes

Number of Times \_\_\_\_\_

46 Davison Court Lockport, New York 14094  
716-438-2973

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8. Have you ever had surgery for this problem? No Yes

Number of times \_\_\_\_\_

Please List: Dates \_\_\_\_\_

Hospitals \_\_\_\_\_

Surgeons \_\_\_\_\_

9. Have you ever been hospitalized for other medical or psychiatric problems?

No Yes Number of Times \_\_\_\_\_

Describe \_\_\_\_\_

10. Please list medication that you are currently taking

\_\_\_\_\_

11. Do you take antacids? No Yes (please provide medication name)

\_\_\_\_\_

12. Do you have any of the following conditions (circle all that apply)

Stomach Problems      Diabetes      Arthritis      Heart

Bowel/Bladder Problems      Hepatitis      High Blood Pressure      Cancer

Sexual Difficulties      Gout      Epilepsy      AIDS

Weight Loss      Psychiatric Treatment or Disorders

Lung Problems

Other \_\_\_\_\_

Details \_\_\_\_\_

13. Do you have allergies? No Yes (please List)

\_\_\_\_\_

14. Do You Smoke? No Yes How Many Packs Per Day \_\_\_\_\_

How Many Years \_\_\_\_\_

Do You Drink Alcohol? No Yes How Much Per Week \_\_\_\_\_

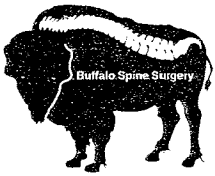
Do You Use Recreational Drugs? No Yes Which Ones \_\_\_\_\_

15. What other types of health care providers have you seen for this condition?

\_\_\_\_\_

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Susan Tobias, ANP-C

16. Do you have any additional information that would be helpful to understanding your problem?  
\_\_\_\_\_  
\_\_\_\_\_

17. What was the last grade of school that you completed \_\_\_\_\_

18. Please circle all that apply:

I Am On Worker's Compensation

I Am Receiving Disability Income

I Have Legal Proceedings Pending

I Have Malpractice Proceedings Pending, Ongoing or Settled

19. Do you plan to be at your regular job in 6 months? No Yes

20. Please send reports to \_\_\_\_\_

21. I have read and understand the above questions and have answered them truthfully and correct.

PLEASE PRINT NAME \_\_\_\_\_

PLEASE SIGN NAME \_\_\_\_\_

DATE \_\_\_\_\_