Northwest Pain Care, Inc.

421 West Riverside Avenue, Spokane, Washington 99201 Phone: 509.863.9789 Fax: 855.630.0757 Web: WWW.Northwestpaincare.com

Spinal Cord Stimulation Implant Follow-up Visit Form

Complete this form for the pain location that we have been treating.

For example, **Back/leg <u>or</u> Neck/arm, not both.** * Do not complete form for multiple pain areas**.**

We will be unable to see you unless this form is <u>completely</u> filled out. We appreciate your thoroughness.

Name _____ Age _____ Today's Date _____

Referring doctor: _____ Primary doctor: _____

****FOR OFFICE USE ONLY:****

When was the stimulator implanted? _____

What type of stimulator was implanted?

☐Medtronic Restore Prime Advanced ☐Medtronic Restore Prime Advanced, Surescan

☐Medtronic Restore Prime ☐Medtronic Restore Ultra

☐Medtronic Restore Sensor ☐Medtronic Restore Sensor, Surescan

What type of stimulation is the patient utilizing? (mark all that apply)

☐High Frequency ☐High Pulse Width ☐Conventional

Is Adaptive Stimulation Activated? ☐ Yes ☐ No

Is Cycling Activated? ☐ Yes ☐ No

Where (what location) is your pain? _____

What does it feel like? Please check all that apply.

☐ **Aching**: ☐ Continuous ☐Intermittent ☐ **Dull**: ☐ Continuous ☐Intermittent

☐ **Sharp**: ☐ Continuous ☐Intermittent ☐ **Shooting**: ☐ Continuous ☐Intermittent

☐ **Burning**: ☐ Continuous ☐Intermittent

Does the pain radiate? ☐ Yes ☐ No

If yes, to where? ☐ Left ☐Right

Please describe:

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Rate your pain on a scale of 0 to 10. 0 is no pain and 10 is the worst pain imaginable.

Current pain: ___/10 **Average pain**: ___/10 **Least pain**: ___/10 **Worst pain**: ___/10

Pain prior to spinal cord stimulation implant: ___/10

What percentage of relief have you had since your stimulator was implanted?_____% Relief

Rate your activity level on a scale of 0 to 10. 0 is no activity and 10 is full activity.

Average activity: ___/10 **Least activity**: ___/10 **Most activity**: ____/10

How often do you adjust your spinal cord stimulator?

☐ Never ☐ Rarely ☐ Frequently ☐ Constantly

Do you get uncomfortable stimulation with position change? ☐ Yes ☐ No

Do you feel paresthesia (buzzing)? ☐ Yes ☐ No

If yes, is it in the correct location? ☐ Yes ☐ No

If no, please explain?

If your stimulator is rechargeable, how often do you recharge?

Every _____ ☐ hour(s) ☐ day(s) ☐ week(s) ☐ month(s)

How long do you recharge the stimulator? _____ hours

Have you had any <u>NEW</u> loss of control of bowel function? ☐ Yes ☐ No

If yes, explain?

Have you had any <u>RECENT</u> <u>NEW</u> loss of control of bladder function? ☐ Yes ☐ No

If yes, explain?

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Have you had any <u>RECENT</u> (within 3 months) non-purposeful weight loss? □ Yes □ No

If yes, explain?

Have you had any <u>RECENT</u> numbness (inability to feel) in your arms/legs ? □ Yes □ No

If yes, where? {Arm(s) or leg(s)}

Have you had any tingling (sensation that your arms/legs are falling asleep)? □ Yes □ No

If yes, explain? {Arm(s) or leg(s)}

Have you had any <u>NEW</u> weakness? □ Yes □ No

If yes, where? {Arm(s) or leg(s)}

How far can you walk without stopping due to pain?

_____ □ miles □ blocks

How long can you stand up straight without moving at all?

Less than _____ minutes

Do you bend over and hold on to a cart while shopping?

□ Yes □ No

Out of 100% of your total pain, on average, in terms of how much it bothers you, what percent of that 100% is in the **back/neck** or your **legs/arms**? Arm pain is from the shoulder down and leg pain is from the buttock down. This has to add up to 100%.

% Back/neck _____ % Leg/arm _____

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Imaging:

Have you had any new imaging since we last saw you**?** □ Yes □ No

Please List:

_____

_____

Do you have any NEW MEDICAL PROBLEMS? □ Yes □ No

Please list any new medical problems

Have you had any SURGERIES since your last visit? □ Yes □ No

Please list any new surgeries.

Do you have any NEW ALLERGIES? □ Yes □ No

Please list any new allergies.

Medications: Please list all medications. **Make sure to list all blood thinners**.

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Review of Systems: Please check ALL that currently apply to you.

Constitutional:

☐ Chills ☐ Fatigue ☐ Recent Fever ☐ Generalized Weakness
☐ Recent Weight Gain ☐ Recent Weight Loss

Eyes:

☐ Blurry vision ☐ Cataracts ☐ Eye discharge ☐ Double vision ☐ Excessive tearing
☐ Eye pain ☐ Eyeglass use ☐ Glaucoma ☐ Eye infections ☐ Pain w/ light
☐ Recent eye injury ☐ Eye redness ☐ Vision loss

ENT:

☐ Nasal discharge ☐ Frequent colds ☐ Hay fever ☐ Nasal obstruction ☐ Recent nose bleeds
☐ Chronic sinusitis ☐Recent gum bleeding ☐ Change in dentition ☐ Recent hoarseness ☐ Dentures
☐ Ear discharge ☐ Dizziness ☐ Hearing aid use ☐Ear infections ☐ Ear pain
☐ Ringing in the ears ☐ Hearing loss ☐ Frequent sore throats ☐ Neck tenderness ☐ Enlarged tonsils
☐ Neck mass

Respiratory:

☐ Asthma ☐ Recent cough ☐ Recent wheezing ☐Bronchitis ☐ Coughing up blood
☐ Pleurisy (Pain with Breathing) ☐ Shortness of Breath ☐ Sputum production ☐ History of TB
☐ Recent pneumonia ☐ Recent night sweats ☐ Recent chest wall pain

Cardiovascular:

☐ Recent chest pain ☐ Congestive heart failure ☐ Palpitations ☐ Varicose veins
☐ Cool extremities ☐ Discolored extremities ☐ Heart murmur ☐ High blood pressure
☐ History of heart attack ☐ Leg pain while walking ☐ History of rheumatic fever
☐ Shortness of breath with exertion ☐ Leg swelling ☐ Leg ulcers ☐ Mitral valve prolapse
☐ Unable to breathe while flat ☐Difficulty breathing

Gastrointestinal:

☐ Recent abdominal pain ☐ Recent constipation ☐ Recent Diarrhea ☐ Recent heartburn
☐ Jaundice ☐ Liver disease ☐ Rectal bleeding ☐ Black, tarry stools
☐ Recent change in stool color ☐ Decreased appetite ☐ Excessive Thirst ☐ Gallbladder disease
☐ Hemorrhoids ☐ Recent nausea ☐ Recent vomiting ☐ Difficulty swallowing
☐ Bloody stools ☐ Hepatitis C ☐ Hepatitis B ☐ Hepatitis A
☐Vomiting up blood ☐ Increased appetite

Musculoskeletal:

☐ Arthritis ☐ Joint pain ☐ Gout ☐ Back problems ☐ Joint stiffness
☐ Muscle cramps ☐ Muscle stiffness ☐ Muscle weakness ☐ Neck problems ☐ Mid-back problems

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Psychiatric:

☐ Recent anxiety ☐ Recent depression ☐ Recent behavioral change ☐ Recent disorientation
☐ Disturbing thoughts ☐ Excessive stress ☐ Hallucinations ☐ Memory loss
☐ Mood changes ☐Suicidal thoughts ☐ Panic attacks ☐ Bipolar disease
☐ Paranoia ☐ Schizophrenia ☐ Personality disorder ☐Previous psychiatric care
☐ Suicide attempts ☐ Inability to sleep ☐ Obsessive/Compulsive ☐ Nervousness

Skin:

☐ Eczema ☐ Itching ☐ Dryness ☐ Easy Bruisability ☐ Hair texture change
☐ Hives ☐ Lumps ☐ Increased mole size ☐ Nail changes ☐ Recent rashes
☐ Skin color change ☐ New skin moles

Neurological:

☐ Burning sensation ☐ Dizziness ☐ History of head injury ☐ Recent headaches
☐ Recent memory loss ☐ Recent numbness ☐ History of paralysis ☐ Strokes
☐ Recent tingling ☐ Recent tremors ☐ Unsteady gait ☐ Seizures
☐ Discoordination ☐ Recent passing out ☐Speech difficulty

Endocrine:

☐ Recent weight gain ☐ Recent weight loss ☐ Intolerance to cold ☐ Fatigue ☐ Goiter
☐ Intolerance to heat ☐ Increased thirst ☐ Recent sweats ☐ Thyroid trouble ☐ Excessive urination

Hematological/Lymph:

☐ Bleeding tendency ☐ Anemia ☐ Blood clots ☐ Radiation exposure
☐ Transfusion reaction ☐ Tender lymph nodes ☐ Swollen lymph nodes
☐ Current Blood thinner use ☐ History of blood transfusions ☐ Easy bruising

Allergy/Immunologic:

☐ Hives ☐ Itchy eyes ☐ Itchy nose ☐ Recurrent infections
☐ Runny nose ☐ Sneezing ☐ Watery eyes ☐ Wheezing ☐ Food allergies
☐ Insect allergies ☐ Dye allergy ☐ Pollen/Seasonal allergy ☐ Environmental allergy

Urinary:

☐ Blood in urine ☐ Difficulty starting stream ☐ Recent flank pain ☐ Incontinence
☐ Urine odor ☐ Difficulty urinating ☐ Kidney failure ☐ Dialysis
☐ Sexual difficulty ☐ Frequent UTI's ☐ Urinary burning ☐ Unusual urine color
☐ Elevated creatinine ☐ Endometriosis ☐ Painful menstrual cycle ☐ Prostate problems
☐ Frequent urination ☐ Kidney stones ☐ Painful urination ☐ Urinary retention
☐ Kidney transplant ☐ Awakening to urinate ☐ Nighttime Urination ☐ Urgent Urination

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Smoking:

Have you stopped smoking since the last visit? □ Yes □ No

When did you quit smoking? Month _____ Day _____ Year _____

Have you started smoking since the last visit? □ Yes □ No

When did you start smoking? Month _____ Day _____ Year _____

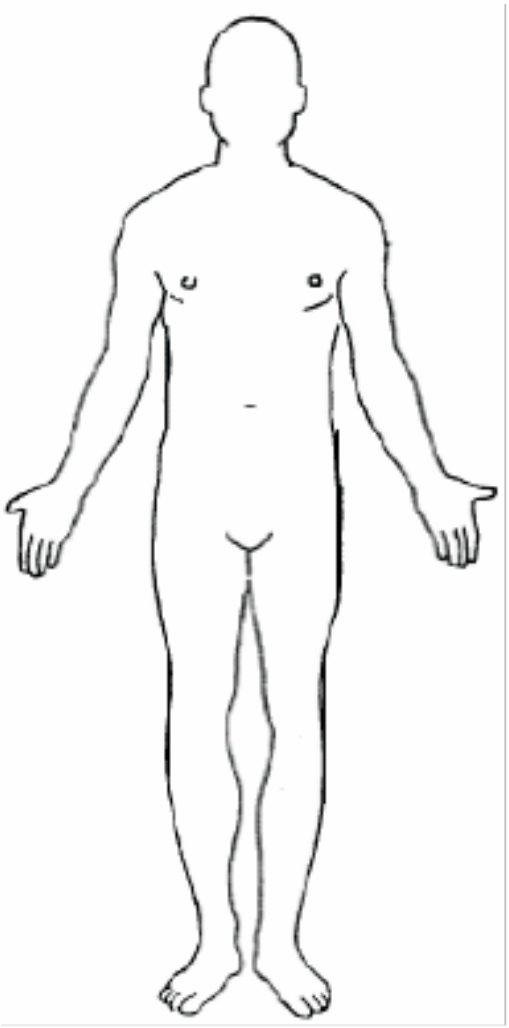
Do you smoke every day? □ Yes □ No

Do you smoke some days? □ Yes □ No

How much do you smoke? Packs _____ per day.

Please draw on the diagram where your pain is:

Right **Front** Left



Left **Back** Right