**DATA SHEET**

**First name:** Klicken Sie hier, um Text einzugeben.

**Last name:** Klicken Sie hier, um Text einzugeben.

**Address**: Klicken Sie hier, um Text einzugeben.

Head of department

**Dr. med. Biren Desai**

*Specialist for orthopadics & trauma surgery*

*Special orthopedic surgery*

*Specialist for surgery*

*Manual therapy/ chirotherapy*

**International Office**

International Patient Management

E-Mail: dfk-international@sana.de

Köln, 28.05.2021

**Phone**: Klicken Sie hier, um Text einzugeben.

**Birthdate**: Klicken Sie hier, um ein Datum einzugeben.

**E-Mail:** Klicken Sie hier, um Text einzugeben.

**Height (cm):**  Klicken Sie hier, um Text einzugeben.

**Weight (kg):** Klicken Sie hier, um Text einzugeben.

**Occupation**: Klicken Sie hier, um Text einzugeben.

**Which month is best for your surgery?**  Wählen Sie ein Element aus.

**How did you know about of us?**

[ ]  Web-site [ ]  Friend [ ]  Doctor [ ]  Referral [ ]  Other

Pain history:

**Length of time:** Klicken Sie hier, um Text einzugeben.

**Describe numbness, weakness, neurological deficits, leg pain (if any, left/right/both):**

Klicken Sie hier, um Text einzugeben.

**What makes pain worse?**

Klicken Sie hier, um Text einzugeben.

**How long is your walking distance on straight ground (in meters)?**

Klicken Sie hier, um Text einzugeben.

**Previous spine surgeries:**

Klicken Sie hier, um Text einzugeben.

**Other surgeries:**

Klicken Sie hier, um Text einzugeben.

**Pain medication:**

Klicken Sie hier, um Text einzugeben.

**Medications (other):**

Klicken Sie hier, um Text einzugeben.

**Allergies (medications, metals, etc.):**

Klicken Sie hier, um Text einzugeben.

*Kindly advise if you are taking Fentanyl or morphine patches. We supply standard German pain management but not these specifically. These and other medications that are non-pain related should be brought with the patient.*

Back pain history:

*(Accidents, events requiring visit to doctor, conservative treatment for spine problem etc.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Event** | **Date** | **Data/ Films/MRI/ CT** | **Description/ Results** |
| Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. |
| Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. |
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| Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. | Klicken Sie hier, um Text einzugeben. |

Personal medical history (answer yes/no. Detail if necessary):

|  |  |  |  |
| --- | --- | --- | --- |
| **Cardiovascular diseases** | **Yes** | **No** | **Detail (if yes)** |
| Blood pressure/ hypertension |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Stroke |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Heart trouble |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Irregular heartbeat |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Blood clots/ embolism |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Respiratory system** | **Yes** | **No** | **Detail (if yes)** |
| Nose throat problem |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Breathing problem |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Chest pain  |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Asthma |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Pneumonia |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Tuberculosis  |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Hormonal/ metabolic diseases** | **Yes** | **No** | **Detail (if yes)** |
| Diabetes |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Thyroid problem |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Diseases of the nerve system** | **Yes** | **No** | **Detail (if yes)** |
| Migraine headache |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Nervous breakdown  |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Eye problems |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Epilepsy |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Depression |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Gastrointestinal tract/ organs** | **Yes** | **No** | **Detail (if yes)** |
| Stomach problem |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Pyrosis |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Colitis |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Hepatitis/ Jaundice |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Kidney problems  |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Infectious diseases** | **Yes** | **No** | **Detail (if yes)** |
| HIV positiv |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Hepatitis |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Blood diseases/ Anemia/ Transfusion** | **Yes** | **No** | **Detail (if yes)** |
| Bleeding problem | [ ]  |[ ]  Klicken Sie hier, um Text einzugeben. |
| Transfusion |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Anemia |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Joint/ bone diseases** | **Yes** | **No** | **Detail (if yes)** |
| Lupus |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Arihritis |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| Back problems (other) | [ ]  |[ ]  Klicken Sie hier, um Text einzugeben. |
| Osteoporosis |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |
| **Cancer** | **Yes** | **No** | **Detail (if yes)** |
|  |[ ] [ ]  Klicken Sie hier, um Text einzugeben. |

Habit details*(Please note all information is strictly confidential)*

|  |  |
| --- | --- |
|  | **Consumption (daily, weekly, etc.)** |
| Alcohol | Klicken Sie hier, um Text einzugeben. |
| Cigarettes | Klicken Sie hier, um Text einzugeben. |
| Drugs (Cannabis, etc.) | Klicken Sie hier, um Text einzugeben. |

Case history – work involvement and leisure time activities:

The physical strain in job and leisure time plays a major role for orthopedic diagnosis and therapy. This questionnaire will therefore help us to help you.

1. **What ist your profession you work in?**

Klicken Sie hier, um Text einzugeben.

1. **Have you had to stop working or change jobs because of your condition?** Yes [ ]  No [ ]

**If yes, when?**

Klicken Sie hier, um Text einzugeben.

**What job are you working in at present?**

Klicken Sie hier, um Text einzugeben.

1. **You are working under these conditions?** Fulltime [ ]  Klicken Sie hier, um Text einzugeben. hours/per day

Part-time [ ]  Klicken Sie hier, um Text einzugeben. hours/per day

A few hours per day [ ]  Klicken Sie hier, um Text einzugeben. hours/per day

1. **Is your job physically straining for you?**  Yes [ ]  No [ ]

**Is it associated with monotonous body postures?** Yes [ ]  No [ ]

**Does your status make it difficult to work?** Yes [ ]  No [ ]

1. **Do your complaints allow you to do sports?** Yes [ ]  No [ ]

**If yes, what kind of sports are you doing?**

Klicken Sie hier, um Text einzugeben.

**Did you do any sports before?** Yes [ ]  No [ ]

**If yes, what kind of sports?** Klicken Sie hier, um Text einzugeben.

1. **Will you have someone to support you at home after surgery?** Yes [ ]  No [ ]

**Who would help you?**

Klicken Sie hier, um Text einzugeben.

Body Scheme: Please mark pain and/or numbness



**Choose here the anterior-side:**  **Choose here the posterior-side:**

Wählen Sie ein Element aus. Wählen Sie ein Element aus.

Wählen Sie ein Element aus. Wählen Sie ein Element aus.

Wählen Sie ein Element aus. Wählen Sie ein Element aus.

Wählen Sie ein Element aus. Wählen Sie ein Element aus.

Wählen Sie ein Element aus. Wählen Sie ein Element aus.

Visual Analogue Scale/ Patient Satisfaction:

The visual analog scale is a horizontal straight line with the left end of the line representing no pain and the right end of the line representing the worst possible pain. Please make a mark on each line that represents the intensity of the pain in your back, in your left leg and in your right leg. The first line is an example of how to make the mark on the line.

***Example:***

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [x]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

*No pain*  *worst possible*

*pain*

**Back pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

***In case of lumbar complaints:***

**Left leg pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

**Right leg pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

***In case of cervical complaints:***

**Left arm pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

**Right arm pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

**Left hand pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

**Right hand pain:**

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

 0 1 2 3 4 5 6 7 8 9 10

Oswestry Disability Index

This questionnaire is designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box which most closely describes your problem.

|  |  |
| --- | --- |
| **Section 1 - Pain Intensity**[ ]  (0) I have no pain at the moment[ ]  (1) The pain is very mild at the moment[ ]  (2) The pain is moderate at the moment[ ]  (3) The pain is fairly severe at the moment[ ]  (4) The pain is very severe at the moment[ ]  (5) The pain is the worst imaginable at the Moment**Section 2 – Personal Care (washing, dressing, etc.)**[ ]  (0) I can look after myself normally without causing extra pain [ ]  (1) I can look after myself normally but it is very painful[ ]  (2) It is painful to look after myself and I am slow and careful[ ]  (3) I need some help but manage most of my personal care [ ]  (4) I need help every day in most aspects of self care[ ]  (5) I do not get dressed, wash with difficulty and stay in bed**Section 3 – Lifting** [ ]  (0) I can lift heavy weights without extra pain [ ]  (1) I can lift heavy weights but it gives extra pain[ ]  (2) Pain prevents me from lifting heavy weights off the floor  but I can manage they are conveniently positioned, for example on a table [ ]  (3) Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.[ ]  (4) I can lift only very light weights [ ]  (5) I cannot lift or carry anything at all **Section 4 – Walking** [ ]  (0) Pain does not prevent me from walking any distance [ ]  (1) Pain prevents me walking more than 1 kilometer[ ]  (2) Pain prevents me walking more than ½ kilometer[ ]  (3) Pain prevents me walking more than 100 meter[ ]  (4) I can only walk using a stick or crutches[ ]  (5) I am in bed most of the time and have to crawl to the toilet**Section 5 – Sitting**[ ]  (0) I can sit in any chair as long as I like[ ]  (1) I can sit in my favorite chair as long as I like[ ]  (2) Pain prevent me from sitting more than 1 hour [ ]  (3) Pain prevent me from sitting more than ½ hour [ ]  (4) Pain prevent me from sitting more than 10 minutes[ ]  (5) Pain prevent me from sitting at all | **Section 6 - Standing** [ ]  (0) I can stand as I want without extra pain[ ]  (1) I can stand as long as I want but it gives me extra pain [ ]  (2) Pain prevents me from standing for more than 1 hour[ ]  (3) Pain prevents me from standing for more than ½ hour [ ]  (4) Pain prevents me from standing for more than 10 minutes[ ]  (5) Pain prevents me from standing at all**Section 7 – Sleeping** [ ]  (0) My sleep is never disturbed my pain [ ]  (1) My sleep is occasionally disturbed my pain[ ]  (2) Because of pain I have less than 6 hours sleep[ ]  (3) Because of pain I have less than 4 hours sleep[ ]  (4) Because of pain I have less than 2 hours sleep[ ]  (5) Pain prevents me from sleeping at all**Section 8 – Sex Life (if applicable)** [ ]  (0) My sex life is normal and causes no extra pain[ ]  (1) My sex life is normal and causes some extra pain[ ]  (2) My sex life is nearly normal but is very painful [ ]  (3) My sex life is severely restricted by pain [ ]  (4) My sex life is nearly absent because of pain [ ]  (5) Pain prevents any sex life at all**Section 9 – Social Life**[ ]  (0) My social life is normal and causes no extra pain [ ]  (1) My social life is normal but increases the degree of pain [ ]  (2) Pain has no significant effect on my social life apart from limiting my more energetic interests such as sports, dancing etc. [ ]  (3) Pain has restricted my social life and I do not go out as often[ ]  (4) Pain has restricted my social life to my home[ ]  (5) I have no social life because of pain**Section 10 – Traveling** [ ]  (0) I can travel anywhere without extra pain[ ]  (1) I can travel anywhere but it gives extra pain [ ]  (2) Pain is bad but I manage journeys over 2 hours [ ]  (3) Pain is bad but I manage journeys less than 1 hour[ ]  (4) Pain is bad but I manage journeys less than 30 minutes[ ]  (5) Pain prevents me from traveling except to receive treatment |

SF – 36

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:**

Excellent Very good Good Fair Poor

 [ ]  [ ]  [ ]  [ ]  [ ]

1. **Compared to one year ago, how would you rate your health in general now?**

Much better now Somewhat better now About the same Somewhat worse now Much worse now

 [ ]  [ ]  [ ]  [ ]  [ ]

1. **The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**

Yes, limited a lot Yes, limited a little No, not limited at all

Vigorous activities, such as running, [ ]  [ ]  [ ]

lifting heavy objects,

participating in strenuous sports

Moderate activities, such as moving [ ]  [ ]  [ ]

a table, pushing a vacuum cleaner,

bowling, or playing golf

Lifting or carrying groceries [ ]  [ ]  [ ]

Climbing several flights of stairs [ ]  [ ]  [ ]

Climbing one flight of stairs [ ]  [ ]  [ ]

Bending, kneeling, or stooping [ ]  [ ]  [ ]

1. **During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?**

Yes No

1. Cut down on the amount of time you spend on work or other activities [ ]  [ ]
2. Accomplished less than you would like [ ]  [ ]
3. Were limited in the kind of work or other activities [ ]  [ ]

Had difficulty performing the work or other activities [ ]  [ ]

(for example, it took extra effort)

1. **During in the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?**

Yes No

1. Cut down on the amount of time you spend on work or other activities [ ]  [ ]
2. Accomplished less than you would like [ ]  [ ]
3. Didn´t do work or other activities as carefully as usual [ ]  [ ]
4. **During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?**

Not at all slightly moderately quite a bit extremely

 [ ]  [ ]  [ ]  [ ]  [ ]

1. **How much bodily pain have you had during the past 4 weeks?**

None Very mild Mild Moderate Severe Very severe

 [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. **During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?**

Not at all A little bit Moderately Quite a bit Extremely

 [ ]  [ ]  [ ]  [ ]  [ ]

1. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.**

How much of the time during the past 4 weeks….

 All of most of a good bit some of a little of none

 the time the time of the time the time the time of the time

1. Did you feel full of pep? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
2. Have you been a very nervous person? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
3. Have you felt so down in the dumps

that nothing could cheer you up? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]

1. Have you felt calm and peaceful? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
2. Did you have a lot of energy? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
3. Have you felt downhearted and blue? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
4. Did you feel worn out? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
5. Have you been a happy person? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
6. Did you feel tired? [ ]  [ ]  [ ]  [ ]  [ ]  [ ]
7. **During past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

All of the time most of the time some of the time a little of time none

 [ ]  [ ]  [ ]  [ ]  [ ]

1. **How TRUE or FALSE is each of the following statements for you?**

I seem to get sick a little easier than other people [ ]  [ ]  [ ]  [ ]  [ ]

I am as healthy as anybody I know [ ]  [ ]  [ ]  [ ]  [ ]

I expect my health to get worse [ ]  [ ]  [ ]  [ ]  [ ]

My health is excellent [ ]  [ ]  [ ]  [ ]  [ ]

Optional note: BACK PAIN SCALE (VAS) DOES NOT ALLOW FOR INSERTION