


RYGGKIRURGISKA KLINIKEN I STRÄNGNÄS
Personal information

First name	Surname	Personal ID number
Street address	Postcode	Place
Home telephone	Work telephone	Mobile telephone
County authority	E-mail address	

Illness-related questions

Do you have a doctor in your home district who is treating you?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Doctor's name	Doctor's address		
Are you listed with a local health centre?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
Name of local health centre	Address of local health centre		

Have you previously been a patient of our clinic?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
		Which year?	
If yes, were you an	<input type="checkbox"/> Out-patient	or were you	<input type="checkbox"/> Admitted

Have you previously had a back operation?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
For what?	When?	At which hospital?	

Have you had any radiological examinations of your back?		<input type="checkbox"/> No	<input type="checkbox"/> Yes
If Yes, what type of radiological examination?		<input type="checkbox"/> X-ray	<input type="checkbox"/> Magnetic resonance MRT
		<input type="checkbox"/> Computed tomography CT	
At which hospital?		On what date?	

Note! Kindly attach the results of all radiology examinations to simplify our processing

When did your back problems start?	Date
Was the start of pain connected with any special incident?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If Yes, what incident?	
.....	

Where is the pain?	<input type="checkbox"/> Lower back	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Have no pain in the back	<input type="checkbox"/> Other
If Other, where is the pain?				

Do you have pain in the centre of the spinal column or to the side? Centre To the right To the left

What kind of pain do you have in your back? Burning Dull Sharp
 Smarting Stabbing Other

State other type of pain

If you have sharp pains in the back, are these centrally in the spinal column? No Yes Have no sharp pains

Does the pain radiate out to either leg? Left leg Right leg Have no pain in either leg

Does the pain radiate out to any toes? No Yes If Yes, which toes?

What type of leg pain? Burning Dull Sharp
 Smarting Stabbing Other

State other type of pain

If you have pains in the legs, which leg is worse? Right Left

Do you have any numbness in the legs? No Yes If Yes, since when?

Do you have any muscle weakness in the legs? No Yes

Where is the pain worst? Back Leg Other

If Other, state where

Which of these situations make the pain worse? Walking Standing Sitting
 Lying down Other

State other situation

Which of these situations make the pain better? Walking Standing Sitting
 Lying down Other

State other situation

Do you need any walking aids? No Yes

If Yes, what do you need?

Do you have any problems with urinating or emptying your bowels? No Yes

If Yes, in what way?

What medicines do you take? Name	Strength	Dose
.....		
.....		
.....		
.....		
.....		

Are you allergic to any medicines? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If Yes, state what medicine and type of reaction		
Do you have any other illnesses? For example, high blood pressure, vascular spasms, COPD or diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If Yes, what illness?		
Have you been operated on for any other illnesses? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If Yes, for what illness have you had an operation?	When was the operation?	At which hospital was the operation?
Do you have a pacemaker/ear prosthesis/metal implant or other surgically implanted item? <input type="checkbox"/> No <input type="checkbox"/> Yes		
If Yes, what was implanted?		

Your height	Your weight
cm	kg

Do you have a free card for medical visits? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, when is it valid until?	Free card number
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The form should be posted to:
 Ryggkirurgiska Kliniken
 Löt
 645 94 STRÄNGNÄS

You will receive a written confirmation that we have received your form within a week.