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? ☐ No ☐ Yes

Doctor´s name	Doctor´s address

Are you listed with a local health centre? ☐ No ☐ Yes

Name of local health centre	Address of local health centre

Have you previosly been a patient of our clinic? ☐ No ☐ Yes

Which year?

If yes, were you an ☐ Out-patient or were you ☐ Admitted

Have you previosly had a neck operation? ☐ No ☐ Yes

For what?	When?	At which hospital?

Have you had any radiological examinations of your neck? ☐ No ☐ Yes

If Yes, what type of radiological examination? ☐ X-ray ☐ Magnetic resonance MRT ☐ 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 neck problems start? Date

Was the start of pain connected with any special incident? ☐ No ☐ Yes

If Yes, what incident?

Where is the pain? ☐ Cervical spine ☐ Thoracic spine ☐ Have no pain in the neck ☐ 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 neck? ☐ Burning ☐ Dull ☐ Sharp ☐ Smarting ☐ Stabbing ☐ Other

State other type of pain

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

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

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

What type of arm pain? ☐ Burning ☐ Dull ☐ Sharp ☐ Smarting ☐ Stabbing ☐ Other

State other type of pain

If you have pains in the arms, which arm is worse? ☐ Right ☐ Left

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

Do you have any muscle weakness in the arms? No ☐ Yes

Where is the pain worst? ☐ Neck ☐ Arm ☐ Other

If Other, state where

VWhich 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

What medicines do you take? Name	Strength	Dose

Are you allergic to any medicines?	☐ No	☐ 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?	☐ No	☐ Yes
If Yes, what illness?		
Have you been operated on for any other illnesses?	☐ No	☐ 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?	☐ No	☐ Yes
If Yes, what was implanted?		

Your height	Your weight
cm	kg

			If Yes, when is it valid until?	Free card number
Do you have a free card for medical visits?	☐ No	☐ Yes		

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.