MSSIC Data Registry
Lumbar 1 and 2 Year PostOperative Patient Questionnaire

Patient Name: _____ **MRN:** _____ **Registry ID:** _____

Date of Questionnaire: _____

We ask that you please complete this form as fully and accurately as possible. Some questions may be difficult, but we ask that you answer them to the best of your ability. Please be sure to follow the directions in each section. Clearly print responses and mark boxes where needed.

Thank you for your time filling out this questionnaire, your answers will help us to provide the best possible spine care.

Follow-Up Questionnaire Time Interval – How long has it been since your last surgery?

- ☐ 1 Year
- ☐ 2 Years

Which answer best represents your level of satisfaction with your surgical outcome?

- ☐ Surgery met my expectations
- ☐ I did not improve as much as I had hoped but I would undergo the same operation for the same results
- ☐ Surgery helped but I would not undergo the same operation for the same results
- ☐ I am the same or worse as compared to before the surgery

Back & Leg Pain Scale

Please describe your back and leg pain when off your pain medication. Please rate your back pain and leg pain on a scale of 0 to 10, where zero (0) would mean "no pain" and a ten (10) would mean "worst pain imaginable."

For example, describe your pain when you are off your medication, after your pain medication has worn off, when you are due to take your next pill, that is please describe how your pain would feel if you were not on pain medication.

Please rate your back pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your leg pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Overall Quality of Life (EQ-5D) © EuroQol Research Foundation
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By marking one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

Self-Care

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety/Depression

- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

PROMIS short form - Physical Function

Please respond to each question or statement by marking one box per row.	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	☐	☐	☐	☐	☐
Are you able to go up and down stairs at a normal pace?	☐	☐	☐	☐	☐
Are you able to go for a walk of at least 15 minutes?	☐	☐	☐	☐	☐
Are you able to run errands and shop?	☐	☐	☐	☐	☐

Mood/Emotion

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day
2. Feeling down, depressed, or hopeless
   - ☐ Not at all
   - ☐ Several days
   - ☐ More than half the days
   - ☐ Nearly every day

Surgical Outcomes

Have you been able to return to work after your operation?

- ☐ Yes - Full-time
- ☐ Yes - Part-time
- ☐ No
- ☐ No - Retired
- ☐ No - Volunteering
- ☐ No – On Disability
- ☐ Not applicable

*If "**Yes" Either "Full-time" or "Part-time**"*
Date you returned to work: _____

*If **"Yes – Part-time", "No", or "No – Retired"***
Are you part-time, not working or retired because of your back or neck problem?
☐ Yes ☐ No

Readmission

Were you readmitted to the hospital (surgery center) within 90 days of discharge, ***or since you last filled out a questionnaire***?

☐ Yes ☐ No

If "Yes": Which hospital? _____

If "Yes": Reason for readmit

- ☐ Deep venous thrombus (DVT)
- ☐ Pulmonary embolism (PE)
- ☐ Myocardial infarction (MI)
- ☐ Stroke (CVA)
- ☐ Surgical site infection or wound dehiscence (SSI)
- ☐ Urinary tract infection (UTI)
- ☐ Surgical site hematoma
- ☐ Unsure
- ☐ Other Specify Other: _____

Did you require revision surgery?

☐ Yes ☐ No *If "Yes":* Date of revision surgery: _____

INSTRUCTIONS: *For the questions in this section, "narcotic/opioid-based pain medications" include the following: Vicodin, Lortab, Norco, hydrocodone, codeine, Tylenol #3 or #4, fentanyl, Duragesic, MS Contin, Percocet, Tylox, OxyContin, oxycodone, methadone, tramadol, Ultram, Dilaudid.*

1. Are you currently taking narcotic/opioid-based pain medication? (This may mean having restarted after stopping the use of the original prescription.)

   ☐ Yes
   ☐ No

   If "Yes" – currently taking narcotic/opioid-based pain medication:

   a. Who is prescribing this narcotic/opioid-based pain medication (check all that apply)?

      ☐ Primary care physician
      ☐ Surgeon who performed your back surgery
      ☐ Physical Medicine & Rehabilitation Department
      ☐ Other _____
      ☐ Pain Medicine Clinic
      ☐ Other Medical Professional
      ☐ Not obtained through prescription

   b. Are you taking this pain medication to control the pain related to your back or neck (surgical) problem?

      ☐ Yes
      ☐ No

   c. Are you taking opioid pain medication ***daily***?

      ☐ Yes
      ☐ No

What is your preference for future contact for this study?

☐ E-mails with access to web-based questionnaires - E-mail address: _____
☐ Telephone calls with questionnaires by interview process - Phone number: _____
☐ Mailings with paper questionnaires to be returned