MSSIC Data Registry
Cervical 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

Neck & Arm Pain Scale

Please describe your neck and arm pain when off your pain medication. Please rate your neck pain and arm 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 neck pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your arm 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?	☐	☐	☐	☐	☐

Modified Japanese Orthopedic Association Myelopathy Scale (modified Chiles version)

Each of the 6 questions below has a choice of answers. Please indicate which answer best describes your own health state today.

1. Feeding and use of your hands and arms.

   Describe your ability to feed yourself.

   ☐ Unable to feed myself
   ☐ Unable to use both hands for knife and fork, but I am able to eat using a fork or spoon with one hand
   ☐ Able to use a knife and fork with much difficulty
   ☐ Able to use a knife and fork with slight difficulty
   ☐ Able to feed myself with no difficulty using both hands

2. Walking and use of your legs. Describe your ability to walk.

   ☐ Unable to walk
   ☐ Can walk on flat surface with a cane or walker
   ☐ Can walk up or down stairs with support of a handrail
   ☐ Some trouble walking smoothly and problems with balance
   ☐ No problem walking

3. Loss of feeling or numbness in hands and arms.

   Describe your ability to feel sensation in your hands or arms.

   ☐ Severe loss of feeling in my hand or arm, loss of pain, touch or sensation
   ☐ Mild loss of feeling in my hand or arm
   ☐ No loss of feeling in my hands and arms

4. Loss of feeling or numbness in legs.

   Describe your ability to feel sensation in your legs.

   ☐ Severe loss of feeling in my legs
   ☐ Mild loss of feeling in my legs
   ☐ No loss of feeling in my legs

5. Loss of feeling or numbness in the trunk of my body.

   Describe your ability to feel sensation in your body.

   ☐ Severe loss of feeling in my body
   ☐ Mild loss of feeling in my body
   ☐ No loss of feeling in my body

6. Problems with urinating.
   ☐ Cannot urinate, void, or pee
   ☐ Severe difficulty because of feeling of residual urine or retaining urine even after voiding or because of straining to go or just dribbling when urinating
   ☐ Mild difficulty because of problem with initiating or getting started or problem with urinating either too frequently or hardly ever
   ☐ No problems with urinating or peeing

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) ***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