EventID: 9146 First Name: _____ Last Name: _____ DOB: _____

Event:
Baseline Patient Information
Interval: Baseline
Study: SOLAS_DEG
Database: NuVasive
PhDxID: _____

SOLAS

Baseline Patient Information

To be completed by the PATIENT

Directions: *Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle. If you are unsure about how to answer a question, please give the best answer you can.* **Mark only one answer for each question unless instructed otherwise.**

Today's Date (MM/DD/YY) __ / __ / __

Shade circles like this: ● Not like this: ⊗ ✓

357 357 **For best results, please avoid contact with the outline of boxes.**

Last Name _____ First Name _____ MI

FOR PHYSICIAN OFFICE USE
Physician's Name:
Medical Record Number:

Street Address _____

City _____ State _____ Zip Code _____ - _____

Home Phone ( ) - Date of Birth (MM/DD/YYYY) / / Sex M/F

Cell Phone ( ) - Last 4 digits of Social Security Number XXX - XX - ____

Would you prefer to complete your surveys on line? ○ No ○ Yes If yes, provide your e-mail address: _____ (e.mail: example.john@abc.com)

01a. What is your ethnicity/racial background?
(Mark all that apply)

- ○ Hispanic or Latino Black
- ○ Hispanic or Latino White
- ○ American Indian/Alaska Native
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Black or African American
- ○ White
- ○ No response
- ○ Other

b. If 'Other', please specify.

_____

02. What is your current marital status?

- ○ Single, never married
- ○ Married or living with partner
- ○ Widowed, divorced, or separated
- ○ No response

03. Do you currently smoke or chew tobacco?

- ○ Yes
- ○ No

04. If 'Yes', how much do you smoke?

- ○ < 1 pack per day
- ○ 1 pack per day
- ○ 2 packs per day
- ○ >2 packs per day
- ○ N/A, currently use chewing tobacco

05. If 'No', specify below.

- ○ Never smoked
- ○ Quit 0 - 6 months ago
- ○ Quit 6 - 12 months ago
- ○ Quit > 1 year ago, < 2 years ago
- ○ Quit > 2 years ago

06. What is your current work status?

- ○ Currently working
- ○ Homemaker
- ○ Retired (due to ill health)
- ○ Retired (voluntarily)
- ○ Full-time student
- ○ Unpaid leave
- ○ Medical disability - short-term
- ○ Medical disability - long-term
- ○ Unemployed
- ○ No response

Please continue on next page

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EventID: 9146 First Name: _____ Last Name: _____ DOB: _____

PhDx ID: _____

07a. If 'Currently working', indicate work status.
- ◯ Full-time
- ◯ Part-time

b. If 'Currently working', indicate your work's physical demands.
- ◯ Sedentary - little or no lifting, seated most of the time
- ◯ Light/Moderate - light to moderate lifting, on feet part or most of time
- ◯ Heavy - heavy lifting, stairs, ladders, squatting, etc

c. If 'Currently working', has your spine condition impacted your work status and/or the amount of physical work you can perform?
- ◯ Yes
- ◯ No

08a. If 'Retired (due to ill health)', 'Unpaid leave', or 'Medical disability', is it related to your spine condition?
- ◯ Yes
- ◯ No

b. Indicate date last worked below.

___/___/___ (MM/DD/YY)

09a. Indicate the highest recreational level you engaged in just prior to your spine condition.
- ◯ Contact sports
- ◯ Non-contact sports
- ◯ Light recreational
- ◯ Sedentary
- ◯ N/A - Disabled
- ◯ No response

b. Is your recreational level affected by your spine condition?
- ◯ Yes
- ◯ No

10a. What is your current insurance coverage? *(Select single primary coverage)*
- ◯ Private insurance (HMO, PPO, etc.)
- ◯ Medicaid
- ◯ Medicare
- ◯ Workers Compensation
- ◯ No coverage
- ◯ Government insurance outside the U.S.
- ◯ Other

b. If 'Other', please specify.

_____

11a. Are you taking pain medication? *(Mark all that apply)*
- ◯ No
- ◯ Yes, over-the-counter pain medication
- ◯ Yes, prescribed pain medication

b. If 'Yes', how often do you take pain medication?
- ◯ One dose/week as needed
- ◯ 1 dose every 2 days
- ◯ 1 or 2 doses per day
- ◯ 3 or more doses per day

12a. Indicate if you have undergone any of the following therapies for your back/leg and/or neck/arm pain before today. *(Mark all that apply)*
- ◯ None
- ◯ Anti-depressant
- ◯ Acupuncture
- ◯ Bed rest
- ◯ Behavior therapy
- ◯ Bracing/immobilization
- ◯ Chiropractor
- ◯ Epidural steroid injections
- ◯ Medications
- ◯ EMG biofeedback
- ◯ Exercise therapy
- ◯ Physical therapy
- ◯ TENS
- ◯ Traction
- ◯ Other

b. If 'Other', please specify.

_____

13. Indicate if you are experiencing any of the following symptoms. *(Mark all that apply)*
- ◯ Back pain
- ◯ Neck pain
- ◯ Leg pain
- ◯ Arm pain
- ◯ Sensory deficits - numbness, tingling in limbs, etc.
- ◯ Motor deficits - weakness in limbs, etc.

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