7601 Lewinsville Road, Suite 460, McLean, VA 22102
Tel: (703) 992-9233; Fax: (703) 992-8675

Ivica Ducic, MD, PhD
Clinical Professor of Surgery
The George Washington University
Specializing in Peripheral Nerve Surgery,
Aesthetic & Reconstructive Plastic Surgery
www.DucicMD.com

Dear Patient:

Please read this entire cover letter since it contains important instructions.
This Questionnaire is created for patients considering consultation for peripheral nerve problems related to:

Chronic Migraine/Headache, Chronic Post-Traumatic or Post-operative Headache, Post-Concussion Sports Related Headache, Post-Whiplash/Car Accident Related Headache, Occipital Neuralgia, Trigeminal Neuralgia and/or Post-Herpetic/Shingles Headache

If you have any of these conditions despite medical care already prescribed to you, you may be an appropriate candidate for surgical treatment, addressing the cause of your symptoms. Although the final decision to proceed with surgical treatment is made at the time of the office visit, those that are identified as appropriate possible candidates for the treatment are invited for an appointment and surgery. This way, we are trying to help you save the time and money related to your initial office visit and/or trip to see Dr. Ducic (if out of town) just to initially hear whether you are a surgical candidate or what other tests you might need. In order to be able to answer your questions and thus determine if an appointment and possibly surgical treatment might be indicated, **please ANSWER ALL QUESTIONS we asked**. When submitting your request:

- **Complete** this fillable pdf file online, **save** it to your computer, **then upload** and **email it** to us

In addition to this questionnaire, you can send:

- Copy of your **written report of the diagnostic studies** you had *relevant to your current problem* (X-ray, US, CT, MRI or NCS = nerve test, nerve block). **Send REPORTS ONLY, DO NOT send hard copies or CD's**.

- Copy of **relevant operative reports**

These additional documents you can send as a separate pdf file by email when submitting your completed pdf-questionnaire; alternatively you can fax it to us. **Please do not send any other documents** at this time.

Payment needs to accompany your initial submission of aforementioned documents (questionnaire, relevant diagnostic studies report, operative reports). The **$155 payment** for processing your request (reviewing the records and providing summary report) needs to be made by secure PayPal / Credit Card link available on Dr. Ducic's website under **"Patient Forms".** Alternatively, if sending payment by mail, then a $155 check should be made payable to: "Plastic Surgery, Nerve & Headache Institute". Returned checks have a $30 processing fee. When submitting your documents by email and paying by PayPal or credit card, please do not forget to state in your email that the payment was posted for records review. The $155 *fee is non-refundable self-pay charge, and will not be billed to your insurance. Payment is due upon the submission of your records.* Should you be an appropriate candidate for an appointment and choose to initiate surgical care with Dr. Ducic, those professional services will then be processed through your insurance, or as a self pay charge for patients without insurance, beginning with your first office consultation. Upon receipt of your records, Dr. Ducic will get back to you with an answer if you would require an appointment or if additional tests might be needed prior to your office visit. Opinion provided to your questionnaire is for information only, where the final treatment recommendations are provided during your office visit. If we can be of further assistance, please do not hesitate to contact us: (703) 992-9233.

Sincerely,

Ivica Ducic, MD, PhD

New Patient Questionnaire for:

Chronic Migraine/Headache, Chronic Post-Traumatic or Post-operative Headache, Occipital Neuralgia, Trigeminal Neuralgia and/or Post-Herpetic/Shingles Headache

© Ivica Ducic, MD, PhD

Write your:

- Name: ______________________________________ """"""""Vqf c{)u'F cvg<"aaaaaaaaaaaaaaaa
- Gender: Male___ Female ___ Age: _______ Date of Birth: _________________
- Height: ___' ____" (or ___ cm) Weight: ____ (Lbs___ Kg___) BMI (office): ____
- Occupation: _________________________________
- Home address (incl. state & zip): ____
- Home phone number: ________________________
- ÁÁÁCell phone number: _________________________
- e-mail: ____________________________________
- Insurance: "___ _____ ____aaaaaaaaaaaaaaaa

1) What is the main concern you are requesting assistance for (check all that apply)?

- Occipital (back of the head) Neuralgia ____
- Frontal (front of the head) Neuralgia ____
- Temporal (side of the head) neuralgia ____
- Chronic Migraine / Headache: ____

2) Migraine / Headache / Neuralgia (Symptoms) present for **how long:""**_____ Years _____ Months

3) **Symptoms present:** Despite prescribed medical care ___, Constantly ___ Intermittently ___

4) Symptoms present for: **How many days per month:** _____ **How many hours per day:** _____

5) Symptoms **present at what part** of the head?

- back (occipital) ____
- front (frontal) ____
- side (temporal) ____

6) Symptoms **usually start** at **what part** of the head?

- back (occipital) ____
- front (frontal) ____
- side (temporal) ____

© Ivica Ducic, MD, PhD

7) Symptoms present at **what side** (**Laterality)**?

- Left only ___ Right only ___ Bilateral (Left & Right side) ___

8) **Pain level** (scale: 0 = none; 10 = highest): Average ____ Range ____ - ____

9) **Quality of life** affected by your condition: None___ Somewhat___ Moderate___ Significantly___

10) **History of**: Seizures ___ Blood Clots ___ HIV ___ Hepatitis B/C ___ Anaphylaxis ___ HTN ___

Heart Attack ___ Diabetes ___ Smoking (active) ___ Asthma ___ Sleep Apnea ___

Stroke ___ Concussion ___ MRSA/VRE ___ Cancer ___ Anxiety ___ Depression ___

11) History of **Trauma:** MVA (whiplash) ___ Assault ___ Hit / Fall ___ Sports Injury ___

- Did your symptoms start after the trauma: Yes ___ No ___

12) History of **Relevant Surgery or Procedures** (check all that apply)**:**

- Radio-Frequency Ablation ___ Nerve Stimulator ___ (Still present ___ Removed ___)
- Brain Surgery ___ Spine Surgery ___ Acoustic Neuroma Surgery ___
- ÁÁÁBrief title/type of surgery: ____
- Did your symptoms start after the surgery: Yes ___ No ___
- ÁÁÁOther head & neck surgery: ____
- Outcome of Surgery (helped?) Yes____ No____

13) Did you have **MRI or CT** of**: Brain (**Yes___ No___) **Spine (**Yes___ No___)

- Findings normal / non-significant: **(**Yes___ No___)
- If abnormal, enclose study written report only (do not send CDs)

14) List what **other medical problems** you currently have (unless previously listed/reported):

____

____

15) List your **allergies to food or medications:** ____

____

16) Did you have **Diagnostic Nerve BlocksA** ___ **BotoxA**___

- occipital (back of the head) nerves: Yes ___ No ___ Yes ___ No ___
- supraorbital/trochlear (front of the head) nerves: Yes ___ No ___ Yes ___ No ___
- zygomatico-temporal (side of the head) nerves: Yes ___ No ___ Yes ___ No ___
- **Was temporary positive effect observed** = relief of headache/pain in the area where diagnostic nerve block was given (even for few days, or weeks): Yes ___ No ___

17) Are you **under the care of headache specialized provider** for at least 3 months: Yes____ No____

18) List your **neurologist or pain management specialist** taking care of your problem:

- Doctor's name: ____
- Full mailing address: ____
- Phone number: ____

19) **Any other comment** regarding your chronic migraine, headache or neuralgia?

END OF QUESTIONNAIRE

Assessment / Plan (THIS SECTION IS FOR DR. DUCIC):

Continue medical supervision by neurologist / anesthesia pain or primary care specialist: ___

Additional evaluation/treatment needed by neurologist/anesthesia pain or other specialist: ___

Patient needs nerve block done: ___GON ___LON ___SON/STN/ITN ___ZTN ____ATN

Surgery: Neurolysis/Decompression: ___GON ___DON ___LON ___SON/STN/ITN

Surgery: Excision ___GON ___DON ___LON ___SON/STN/ITN ___ZTN ___ATN ___GAN

No Surgery, patient does not meet peripheral nerve surgery criteria: ___

Other: ____aaaaaaaa

© Ivica Ducic, MD, PhD