



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 Headache/Migraine, 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 likely 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:

**1) Complete this fillable PDF file online, then first save it to your computer, before uploading/emailing it to us**

In addition to this questionnaire, you should send:

- 2) Copy of your written report of the diagnostic studies** you had *relevant to your current problem* (X-ray, US, CT, MRI, NCS/EMG, or nerve block). Send written **REPORTS ONLY**, **DO NOT** send hard copies or CD's.
- 3) Copy of relevant operative reports** (if you had surgery in anatomical region where you have problems now)

You can send these documents as a separate PDF file by email (preferred) when submitting your completed PDF-questionnaire; alternatively you can fax them. **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: "Washington Nerve Institute". Returned checks have a \$35 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. Patients proceeding with the surgery will be credited \$155, otherwise this record review 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. When corresponding, you acknowledge that our reply to the questionnaire with opinion is provided for your information only, while the official evaluation and treatment is not initiated until the time of your first 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 Headache/Migraine, Chronic Post-Traumatic or Post-Operative Headache,**  
**Occipital Neuralgia, Trigeminal Neuralgia and/or Post-Herpetic/Shingles Headache**

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**Write your:**

- Name: \_\_\_\_\_
- Gender: Male \_\_\_ Female \_\_\_      Age: \_\_\_\_\_      Date of Birth: \_\_\_\_\_
- Height: \_\_\_' \_\_\_" (or \_\_\_ cm)      Weight: \_\_\_\_\_ (Lbs \_\_\_ Kg \_\_\_)      BMI (office): \_\_\_\_\_
- Occupation: \_\_\_\_\_
- Home address (incl. state & zip): \_\_\_\_\_
- Home phone number: \_\_\_\_\_
- ~~MC~~ Cell phone number: \_\_\_\_\_
- e-mail: \_\_\_\_\_
- Insurance: " \_\_\_\_\_ aaaaaaaaaaaaaaaaaa

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) \_\_\_\_\_

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 \_\_\_
- ~~W~~Brief title/type of surgery: \_\_\_\_\_
- Did your symptoms start after the surgery: Yes \_\_\_ No \_\_\_
- ~~W~~Other 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 Blocks**A \_\_\_ **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

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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