Washington Nerve Institute

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:

Nerve Injuries, Chronic Pain Following Any Surgery, Trauma, Oral/Dental Procedures, Peripheral Neuropathy (Upper & Lower Extremities, Meralgia Paresthetica), Post-Herpetic Neuralgia Following Shingles, and Nerve Tumors

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:

Nerve Injuries, Chronic Pain Following Surgery or Trauma,
Peripheral Neuropathy, Post-Herpetic (Shingles) Neuralgia and Nerve Tumors

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Write your:

- Name: ____ Vqf c{)u'F cvg< aaaaaaaaaaaaaaa
- Gender: Male___ Female ___ Age: ______ Date of Birth: ________________
- Height: ___' ____" (or ___ cm) Weight: ____ (Lbs___ Kg___) BMI (office): ____
- Occupation: ______________________________
- Home address (incl. state & zip): ____a
- Home phone number: ______________________
- Cell phone number: ________________________
- e-mail: ____
- Insurance: ___ _____ _____________________________aaaaaaaaaaaaaaaaaaaaaaaaa

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

- peripheral neuropathy (any extremity numbness, pins/needles, pain or muscle weakness) ___
- chronic pain following any surgery or trauma ___
- nerve injury following any surgery or trauma ___
- peripheral nerve tumor ___
- post herpetic neuralgia ___
- Other: ____

2) Symptoms include: **Pain____**, **Numbness____**, **Burning sensation____**, **Muscle weakness____**

3) **Anatomical localization:**
Left___ Right___ Upper Extremity___ Lower Extremity___ Trunk___ Groin___ Other________

4) For **how long** is the problem present? ____ Years ____ Months; Since ________________________

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

6) Symptoms **present:** constantly____ intermittently ____ increase with activities ____ affect sleep ____

- If intermittently, how many days per month: ____

7) **Quality of life** affected by condition: None ___ Somewhat ___ Moderate ___ Significantly ___

8) History of **associated trauma:** No___ Yes___ (MVA ____ Assault ____ Hit by object **aaaa** Fall ___)

- The part of the body involved: ____
- Work related trauma/injury**:** No ___ Yes ___
- Symptoms started after the trauma: No ___ Yes ___ Approx. date: __________________
  - How soon? Immediately____ Days____ Weeks____ Months____

9) History of **surgery relevant to the current condition:** No ___ Yes ___

- If yes, please provide a copy of the operative report related to the surgery you had in the anatomical area where you have problems now (FYI: if you are presenting with leg pain, no need to send a report of your shoulder surgery).
- The part of the body involved:___________________________ Approx. date of surgery: _________
- Type/title of surgery:____
- Symptoms started after surgery: Yes____ No____
  - How soon? Immediately ____ Days____ Weeks ____ Months____
- History of Brain surgery: No ___ Yes ___ What: _______________________________________
- History of Spine surgery: No ___ Yes ___ (Cervical ___ Lumbar ___)

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10) Do you have **Neck pain** or pain radiating from the neck to the arm(s): No ___ Yes ___

11) Do you have **Lower back pain** or pain radiating from the back to the leg(s): No ___ Yes ___

12) **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 ___

13) **MRI or CT** of the involved anatomical area done? No___ Yes___ (Normal/no significant findings ___)
(If findings abnormal, do not send CD's; submit written MRI/CT report only)

14) **Nerve Conduction Studies** (NCS/EMG) done? No___ Yes___ (Normal/no significant findings ___)
(If findings abnormal, submit written NCS/EMG report)

15) **Diagnostic nerve blocks** done? No ___ Yes ___

- What nerves: ___________________________________; Temporary effect observed: Yes ___ No ___

14) Any **other ewttgpv'medical problem** (ulness already reported): ____________________________________

16) List **medications** you usually take: ____

- Any drug allergies? No ___ Yes ___ (what):____

17) Currently, you are **under the care of:** PCP ____ Neurologist____ Pain Specialist ____ Surgeon____

18) **Treatments done this far for the current problem**:

- Medical   Yes ___ No ___   Effective : Yes ___ No ___ N/A ___
- Surgical   Yes ___ No ___   Effective : Yes ___ No ___
    - What surgery:____
- Pain Management   Yes ___ No ___   Effective : Yes ___ No ___ N/A ___
- Radio Frequency Ablation Yes ___ No ___   Effective : Yes ___ No ___
- Nerve Stimulator   Yes ___ No ___   Effective : Yes ___ No ___

19) **List** your neurologist, pain specialist, PCP or surgeon (**your main doctor**) currently taking care of you:

- Name: ____
- Full mailing address: ____
- Phone number: ____

20) **Any other comment** regarding your peripheral neuropathy / chronic pain / nerve injury / other:

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: _________________________ NCS/EMG:__________________________

Surgery - Neurolysis of: ____

Surgery - Excision of: ____

Surgery - Reconstruction of: ____

No Surgery (patient does not meet peripheral nerve surgery criteria): ____

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Other: ____aaaaaaaaaaaaaaaaaaaaaaa