

Physical Medicine and Rehabilitation
Occupational/Musculoskeletal Medicine
EMG and Nerve Conduction Studies
Independent Medical Exams (IMEs)
Therapeutic Spinal Injections
General Physiatry (PM&R)
Sports Medicine



Patrick Foye, M.D.
UMDNJ: New Jersey Medical School
90 Bergen Street, D.O.C. Suite 3100
Newark, N.J. 07103-2499
Tel: 973-972-2802
Fax: 973-972-2825
www.TailboneDoctor.com

**QUESTIONS for Patients to *Complete In Advance* and *Bring* to Dr. Foye
(Questionnaire for Patients with COCCYX PAIN)**

This helps us to take care of you.

Form Revised: 3-10-10

Patient Name: _____

Date form completed: _____, 2010

Chief complaint: Is coccyx (tailbone) pain a primary area of concern? **Yes or No.** [if No, please explain].

Onset Date:

Referred by: (e.g., found me via internet?)

Patient's home city/state, and driving distance to this office:

Patient's preferred e-mail address (where Dr. Foye can email the patient):

HISTORY: Age: _____ years old.

Gender (circle one): Male or Female.

Occupation (specify): _____

Please write a general narrative paragraph summarizing how the symptoms started and treatment so far:

Tailbone-related questions

Duration/onset date of tailbone pain:

TRAUMA: Any identifiable traumatic incident:

- Any recent coccyx trauma:
- Any remote (long ago) coccyx trauma:

EXACERBATING FACTORS (e.g. prolonged sitting, sitting on hard versus soft surfaces, pain when standing up after sitting):

What makes the pain worse??

Is your pain worse while **sitting**? Circle your answer: Yes or No or Unsure

Is pain with sitting worse when you lean partway backwards: Yes or No or Unsure

When you first get up from sitting, does your tailbone pain get worse for a few moments?

Circle your answer: Yes (pain gets worse) or No or Unsure

What **sitting surface** is worse for you? Circle your answer: **Hard** surface or **Soft** surfaces or **Other**:

Any other things that make the coccyx pain worse? (Explain:)

CUSHIONS tried (e.g., donut cushions, wedge cushions):

Have you tried "**donut**" cushions (i.e., with the whole in the middle)? Yes or No

Was it helpful? Yes or No

Have you tried "**wedge**" cushions (with a triangular "wedge" shape cut out of the back)? Yes or No

Was it helpful? Yes or No

If you tried **both** types, which cushion helped more? Circle one: wedge or donut or same or neither

SITTING TOLERANCE:

How long can you sit for the pain makes you change positions?: _____ minutes

SEVERITY of coccyx pain: (0-10 scale): At best: _____ /10. At worst: _____ /10. Average: _____ /10.

SPECIALISTS who you have already seen: Indicate if you have seen any of the following for this pain:

Primary care physician? Name(s):

"Pain management" doctor? Name(s):

Chiropractor? Name(s):

Surgeon? Name(s):

PM&R (Physical Medicine and Rehabilitation)? Name(s):

Physical therapy:

Other:

Interventional Pain Management INJECTIONS and response to these (e.g. whether helpful or not):

(e.g., caudal or other epidurals, local anesthetic blocks, steroid injections, etc. and asking whether these were blind versus fluoroscopically-guided): **If done, try to bring the procedure note (paper report) for Dr. Foye to review.**

TYPE OF INJECTION	Done? (Yes or No)	Date(s) (if done)	Did the injection help?
Coccyx injection with STEROID, blind (with OUT fluoroscopic guidance):			
Coccyx injection with STEROID, WITH fluoroscopic guidance):			
Ganglion Impar injection (sympathetic nerve block):			
EPIDURAL steroid injection:			
FACET joint injection:			
SACROILIAC joint injection:			
PIRIFORMIS muscle injection:			
Other lower back or pelvic injections (Pudendal nerve, etc) (specify)			

IMAGING STUDIES (Please obtain and bring the official, written radiology reports for any tests):

Dr. Foye will want to see the **actual images** (on computer CD or actual films) **AND** see the **radiology reports**. Call your radiology facility to get a copy of the actual images and the official/typed radiology report (**important**).

	Done? (Yes or No)	Date (if done)	If done, can you bring the radiologist's paper report?	If done, can you bring the actual images (either films or on computer CD)?
<u>Lumbosacral X-rays:</u>				
<u>Lumbar (or lumbosacral) MRI:</u>				
<u>Lumbar (lumbosacral) CT scan:</u>				
<u>Pelvic (or Coccyx) MRI:</u>				
<u>Pelvic (or Coccyx) CT scan:</u>				
<u>Coccyx X-rays:</u>				
<u>Coccyx X-rays, seated (dynamic):</u>				
<u>Bone scan:</u>				

GI (Gastroenterology: which means abdomen/intestines/etc) symptoms

Circle any of the following symptoms that you have, and then explain if positive:

- pain with bowel movements (including coccyx pain with bowel movements):
- constipation
- diarrhea
- bright red blood per rectum
- melena [black, tarry stool]
- fecal incontinence
- rectal or anal pain or itching
- other (explain):

GI (gastroenterology) workup (e.g., GI consult, colonoscopy, digital/finger rectal exam, etc.):

Have you seen any **GI specialist** (gastroenterologist)? **Circle your answer:** Yes or No or Unsure
 When is the last time that a physician performed a **rectal exam** (placing a finger inside your anus)? ____
 Did you ever have a **colonoscopy** (a scope of the large intestine) or sigmoidoscopy (lower colon)? ____
 If so, when was it? _____
 If so, has this test been performed **AFTER** the time that the tailbone pain started? Yes or No
 If so, please obtain a copy of the report, to provide to Dr. Foye for review.

Have you ever been told you have a "Pilonidal Cyst"? (Circle one: Yes or No)

If so, when was that?
 How was it treated? Surgery?
 Were you ever specifically told that you do NOT have a pilonidal cyst? (Circle one: Yes or No)

Skin (Dermatologic) symptoms:

Any **itching** over the skin near the coccyx or buttocks? Circle one: Yes / No
 Any **rash** over the skin near the coccyx or buttocks? Circle one: Yes / No
 Any **pressure sores** (e.g. bed sores)? Circle one: Yes / No
 Have you needed **creams/lotions**, to treat skin problems near the coccyx, anus, or buttocks? Yes / No

Urinary symptoms:

Any urinary **incontinence** (loss of bladder control for urinating)? Circle one: Yes / No
 Any **burning or pain** when urinating? Circle one: Yes / No

Urinary diagnostic workup (urology consult, urinalysis, etc., since onset of coccyx symptoms):

Have any of these urologic consults/tests been done????

If so, were they done since the onset of coccyx symptoms??

This box is for FEMALE patients only (MALE patients should cross out this whole box)

Female patients: intra-pelvic history:

Have you ever been diagnosed with uterine fibroids?

Have you ever been diagnosed with ovarian cyst?

Have ever been diagnosed with any other obstetric/gynecologic condition?

Female patients: obstetric history:

How many children have you had?

Were these children delivered through the vagina or were they through a cesarean section?

Were there any tailbone problems with any of these deliveries?

Female patients: OB/Gyn evaluation?

Have you seen your obstetrician/gynecologist since the time that you are tailbone symptoms started?

If so, did the OB/GYN think that any OB/GYN condition was causing the tailbone pain?

Note that we recommend OB/GYN evaluation for female patients with tailbone pain.

Female menopausal status (Please circle one: *Pre-Menopausal*, *Peri-Menopausal*, or *Post-Menopausal*)

Pain during (or after) sexual intercourse:

Does sexual intercourse make your tailbone pain feel worse? Circle one: Yes No Not Applicable

Pudendal nerve: Have you ever been told you have Pudendal nerve problems? Yes No

Do you have pain, tingling, or numbness in the external genital region? Yes No

Lower limb neurologic symptoms (e.g. any leg pain, or any leg numbness or weakness):

Do you have any pain that travels down into the leg? Yes or No. If so, how far down the leg?

Do you have any numbness or weakness in either leg?

Ischial bursitis: (e.g., lower/ ischial buttock pain due to leaning to either side to avoid sitting with pressure in the midline/coccyx):

Do you get pain at the bottom of either cheek of the buttocks (e.g. pain at the "sit bones")? Yes or No.

Body weight: (e.g., has there been any significant increase or decrease in body weight preceding the onset of the symptoms?)

Current height: _____ feet _____ inches

Current weight: _____ pounds

Was there any significant increase in weight before the coccyx symptoms started? _____

Was there any significant decrease in weight before the coccyx symptoms started? _____

Any other significant changes in weight? Circle one: No or Yes (explain):

Cancer history (e.g., especially prostate, ovarian, cervical, testicular, colon or any other cancers):

Have you ever been diagnosed with any cancer? Yes or No
If so, explain (what body region, when, and how was it treated):

Cancer history or risk factors: (e.g., any blood per rectum or abnormal vaginal bleeding? Any unexplained weight loss, fevers, or chills? Any of these should be promptly evaluated for your primary care physician and/or other specialists.)

Do you have any of these risk factors???? (**Circle** any above that are positive, or write in details):

Medications tried so far (to treat your coccyx pain) and your response to these (did it help?):

Circle any of the following that you have ALREADY tried using forward your coccyx-region pain:

Nonsteroidals: ibuprofen/Motrin/Advil, naproxen/Naprosyn, etc

Meds for nerve pain: Neurontin/gabapentin, Lyrica, Cymbalta, etc

Opioid painkillers: Percocet/Roxicet, oxycodone, OxyContin, Tylenol with Codeine (T#3),

Other pain meds: Tylenol. Tramadol (Ultram/Ultracet).

Topical meds: Lidoderm (lidocaine). Flector (diclofenac). Voltaren gel (diclofenac).

Other meds that you have tried:

CURRENT MEDICATIONS: (For *pain* medications, list the actual doses, but do NOT list doses for other meds)

Allergies: (Are you allergic to any medications?) No or Yes (List the allergies:)

Are you allergic to iodine, shellfish or medical contrast? No or Yes (List the allergies:)

Past Medical History (previously diagnosed conditions):

List any medical conditions that you have had (such as high blood pressure, diabetes, etc.):

Surgical History: List any/all surgeries you have had and the approximate year of each surgery:

Have you undergone coccyx surgery (coccygectomy): No or Yes (List the date:)
and do your best to bring the surgical report.

Family History: List any diseases that run in your family: (e.g. diabetes, pelvic cancers, colon cancer):

Social History:

Do you smoke?: No or Yes

Do you drink alcohol?: No or Yes (if so: how many drinks in a typical week?):

What is your job title?

Does your tailbone pain cause you difficulty with performing your job? No or Yes (explain):

Patient agrees to follow-up with any involved or relevant Primary Care Physician, Gastroenterologist (GI), Urologist, OB/GYN, Surgeon, etc., for any relevant care related to those or other medical specialties.

Patient signature: _____ Date: _____